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EDITORIAL

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Re-visiting visiting hours

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For a long time, intensive care unit (ICU) clinicians (physicians, nurses, and other clinical disciplines in the ICU) behaved as though critical care units were designed for them, rather than for patients and their loved ones. Across the globe, in every ICU regardless of discipline or location, determining appropriate visiting hours is a challenge [1–3]. The study in this issue of *Intensive Care Medicine* by Giannini and colleagues [4] suggests that there is a willingness on the part of clinicians to provide enhanced benefits to patients and their loved ones by making more time available for family visits.

Although visiting hours have long been recognized as a quality indicator in critical care [5–8] and an unmet need for families of critically ill patients [8–10], many questions are posed by ICU clinicians: How does this affect the staff? Will it interfere with staff workflow? Will it lead to adverse effects on patients or staff? Without question, liberal or unrestricted visiting hours can be more burdensome for clinicians who work in the ICU, particularly nurses, because of the potential disruption of daily workflow that might result from consistent family presence at the bedside [11, 12]. Although it may be hard for us to admit, it is easier to navigate the bedside of critically ill patients without family "in the way."

The real question is why "open visiting hours" causes such concern among critical care personnel. What are the obstacles to providing families with frequent access to their loved ones in the ICU? Multiple published reports have demonstrated no adverse effects, such as infections or unstable vital signs, on quality of care in the ICU, and yet ICU clinicians continue to cite concerns about safety as justification for limited, restricted visiting hours [13–17]. How can we account for the reported resistance to opening visiting hours in critical care?

Giannini and colleagues' study identified the level of burnout among physicians and nurses in eight Italian ICUs before and at 6 and 12 months after liberalizing visiting hours. This study demonstrated two important findings. First, there was a 10 % increase in the reported level of burnout at both time periods after visiting hours were liberalized. This increase was seen predominantly among the nurses. Second, despite the increase in the reported levels of burnout, the opinion of the physicians and nurses toward liberalizing visiting hours remained favorable and essentially unchanged before and after the policy change. This latter finding is an important one and represents a significant shift in attitude on the part of ICU clinicians. Both physicians and nurses acknowledged the importance of liberalized visiting hours to patients and their families. This suggests that there is a willingness on the part of clinicians—even at the risk of their own discomfort—to provide enhanced benefits to patients and their loved ones by making more time available for family visits.

The implications of this study are important, but might be controversial. Some ICU clinicians might interpret this study to mean that we should approach opening visiting hours with great caution and should further limit opportunities for families to be with their loved ones during critical illness. However, the nurses' attitude toward liberalizing visiting hours remained positive even after the visiting hours were opened. This is good news for patients and their loved ones. As described by the authors, the change in visiting hours was associated with beneficial effects on ICU staff, especially in terms of relationships with family members, despite the increased report of

burnout. This implies that opening visiting hours can provide benefit for patients, families, and clinicians in the ICU—more contact between patients and their loved ones, enhanced communication between families and clinicians in the ICU, and greater family satisfaction without compromise to the ICU staff (Table 1). However, the potential for increased burnout should be addressed.

These results also suggest that ICU clinicians appreciate the importance of creating a patient- and family-centric environment. By demonstrating the persistent positive view of clinicians before and after liberalizing visiting hours, the study provides evidence that ICU clinicians recognize that the need for family presence during times of critical illness takes precedence over clinicians' being inconvenienced by having people "interfere" with their workflow at the bedside—even if this leads to increased burden on their workflow.

An important issue that was not covered in the trial is the potential of family burnout. A prolonged presence at the bedside may expose family members to another type of anxiety caused by frequent interruption due to healthcare professionals who may not always prioritize communication with families, especially when unexpected deterioration of the patient occurs and rapid life-saving measures have to be taken. In our opinion, opening of visiting policies should be accompanied by implementation of a consistent family support policy (social work, palliative care, and other counseling services) to improve communication with families, especially but not exclusively, when the medical team is busy with life-saving procedures.

It is also important to point out that "open visiting hours" does not mean "visiting without rules". Family member behavior can be "restricted" if it is disruptive to the care of the patient or other patients in the ICU and family members can be expected to follow the same rules concerning infection control as ICU clinicians.

While policies that burn out clinicians are counterproductive and unlikely to result in high quality care, providing support to ICU clinicians by recognizing the added challenge that open visiting hours may bring will also be essential. As we open ICUs to longer—or unrestricted—visiting hours to honor the needs of patients, the increased burden on clinicians must also be acknowledged and supported. Administration—and families as well—must be educated to understand the demand that this change brings. Simple acknowledgment may be all many ICU clinicians require in support of this change, but for others, a different level of support may be required such as help in asking families to leave when certain bedside care occurs or during other similar moments when clinicians need family members to step outside the room, however briefly. These kinds of support for nurses and other clinicians from families, administrators, and fellow ICU clinicians can enable the change in visiting hours to be beneficial for all inhabitants of the ICU. The responsibility to request families to step away from the bedside in order to facilitate nursing tasks should not fall only to nurses. Intensivists can provide valuable support by taking on and supporting this task. Recognition by hospital administration of the value to loved ones of critically ill patients of liberalizing visiting hours can also go a long way to supporting ICU clinicians in this effort. Truly, this may usher in a new era in which patient-centered, family-centered, and clinician-centered care can all be one and the same.

All of us who work in the ICU recognize the natural urge to "do everything" for loved ones in times of need. Of course, this is heightened when death may be imminent. As clinicians who are loyal to the interests of our patients, we owe it to them to provide them the kind of environment in which critical care and death have occurred for many years—surrounded by the people they care about the most, rather than by strangers.

Table 1 Top 10 reasons to implement open visiting hours

1.	Improve communication between patients, families, and ICU staff
2.	Facilitate closer contact between patients and families
3.	Create a patient- and family-centered environment
4.	Improve patient and family satisfaction
5.	Improve understanding by family about nature of their loved one's illness enhancing shared decision-making about patient care
6.	Facilitating family presence for CPR and procedures, which can improve family outcomes
7.	Allowing for families with difficult work schedules to visit
8.	More rapid communication to family of changes in diagnosis or therapeutic plans or changes in condition or prognosis
9.	Recognize that family members are more important to patients than clinicians
10.	Facilitate a culture of respectful language by clinicians in the ICU

Conflicts of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

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