Presidenza del Consiglio dei Ministri

COMITATO NAZIONALE
PER LA BIOETICA

INTENSIVE CARE UNIT "OPEN" TO FAMILY VISITS

19th of july 2013

INDEX

Presentation

The Opinion deals with a particular aspect of healthcare organisation, that of *visiting policies* (accompaniment and family visits) in the ICU: an application of the principle of respect of the person in healthcare treatments (Article 32, para.2) that is not always adequately considered. This principle involves taking charge of the patient, not only as an isolated individual and as a mere body to be treated, but as a person with meaningful relationships; which, the patient should not forcibly be deprived of, so as not to add the weight of loneliness (sense of segregation and separation) to the already serious condition of illness. In addition, the presence of loved ones, can be seen as an application of the principle of protection of autonomy, both because it satisfies a fundamental requirement of the patient according to his own instructions and because the patient receives support from his loved ones accompanying him during the stay in the ICU. *Last but not least*, given that, by so doing there is also an improvement in the same quality of the medical care, the model of the open ICU is to be recommended even for reasons of improved efficiency of the safeguarding of health. The ethical dimension of the problem is in accord with that of medical efficiency.

Numerous data, in fact, suggest that promoting access to the ICU for family members and visitors, not only does not prove dangerous for patients, but rather it is beneficial both for them and their families. In particular the "opening" of the ICU does not cause an increase in infections in patients, while statistically there is a significant decrease in both cardiovascular complications as well as *anxiety scores*; in addition, patients have hormonal indices of stress that are significantly lower. A further positive effect is represented by the clear reduction of anxiety in family members. For example, mothers of hospitalised children in an “open” ICU have stress indices that are lower than those with children in an ICU with "limited access".

The Opinion makes clear, however, that an "open" ICU in no way means an ICU without rules, and it is therefore necessary to draw up guidelines which allow for organising the opening so as to safeguard the other values at stake (such as, security, order in the hospital, hygiene, privacy, confidentiality, intimacy). Therefore the Opinion also highlights the problem of the rules of behaviour which the visitors themselves must comply with; behaving respectfully towards people and places, in order to maintain orderly and advantageous access to hospitals and intensive care in particular.

The Opinion concludes by recommending promotion of the right of patients admitted to ICUs to have their families or loved ones close to them in accordance with their instructions. In order to achieve this general objective, ICUs must adapt their organisation and visiting policies to the model of the "open" ICU.

The Opinion has been drawn up by Prof. Andrea Nicolussi. In the drafting of the Opinion, Prof. Nicolussi primarily made use of the consultation and extensive written contributions of Dr. Alberto Giannini, who has worked for years, regarding both the theoretical elaboration as well as practical experience, in the development of the organisational model of the open ICU. Prof. Rodolfo Proietti, a member of the expert Committee in this field, carried out general scientific and technical supervision. Other written contributions were received from Prof. Antonio Da Re and the late Prof. Adriano Bompiani,

just a few days before his death. The Opinion also takes into account the suggestions of Profs. Salvatore Amato, Francesco D'Agostino, Lorenzo d'Avack, Riccardo Di Segni, Silvio Garattini, Marianna Gensabella, Laura Guidoni, Laura Palazzani and Monica Toraldo di Francia.

In the plenary session of the 19th July 2013, the Opinion was approved unanimously by those present, Profs. Salvatore Amato, Luisella Battaglia, Stefano Canestrari, Francesco D'Agostino, Lorenzo d'Avack, Antonio Da Re, Riccardo Di Segni, Carlo Flamigni, Romano Forleo, Silvio Garattini, Marianna Gensabella, Laura Guidoni, Demetrio Neri, Andrea Nicolussi, Laura Palazzani, Rodolfo Proietti, Giancarlo Umani Ronchi, Monica Toraldo di Francia, Grazia Zuffa. Profs. Cinzia Caporale and Assuntina Morresi not present at the time of voting subsequently approved the Opinion.

The President
Prof. Francesco Paolo Casavola

1. Introduction

The National Bioethics Committee in this Opinion pays attention to a particular aspect of healthcare organisation - that of the presence of family members and visitors in the intensive care unit - which not only has implications on the quality of care, but also involves elements of particular importance even as regards specific bioethical reflection.

The issue pertains to the more general question of the humanisation of care, of which accompaniment and visits to hospitalised people constitute a fundamental part. It can be seen as a time of development of the tendency to promote a greater respect for the individual in treatment and healthcare facilities, also consistent with a conception conducive to a broader protection of health, inclusive of the material and social conditions most suitable for the well-being of the person. This new orientation, above all starting from the second half of the twentieth Century, led to introduce significant changes in the healthcare organisation. Even in Italy, notwithstanding frequent delays, the regional inequalities and organisational difficulties often reported in our Country, some progress has been made, particularly since Law No. 833 of 23rd December 1978. By means of this a general framework for the development of Italian healthcare has begun to be delineated, establishing in an organic manner the different sectors and introducing the collaboration of the various requests of civil society that have emerged in the meantime: take for example the "movement for the protection of the rights of the sick "and the movement for the so-called humanisation of hospitals" to the training and legal recognition of voluntary assistance in its various forms, these contributions were institutionally recognised and received intrahospital representation, contributing to modernising hospital management.

In this context, enhanced by a renewed culture of the protection of health, sensitive also to the recommendations from the psychology and sociology of health, the then new requirements were able to become relevant and were initially met, even thanks to cultural stimulus and the collaboration of universities. One need only recall psychological assistance by suitably trained workers, the preparatory courses for pregnancy and childbirth which also included the presence (if requested by the parturient) of the father in the delivery room, "*rooming in*" in order to facilitate initial "maternal- neonatal attachment", the possibility for mothers to stay next to sick children even during the night in pediatric wards - when recommended, longer visiting times by family members to patients and, more recently, the discipline of palliative care. These are examples of a progressive modification of the approach that was in the past dominant in hospitals - characterised by a "directorial and paternalistic" attitude and by an objectivising conception of the hospitalised person, reductively considered merely as a body, the object of treatment - towards a greater openness to human needs and better co-operation with families which even in Italy is gradually being achieved, despite persisting difficulties not only of an economic nature.

Indisputably, much is still to be done to make health facilities and the training of personnel better equipped to promote full respect of the human person as patient, making possible, as appropriate, the presence of loved ones, and so avoid imposing, on those who are already in a serious condition of

discomfort, an artificial separation from their relational life. In this broader framework, this Opinion of the NBC focuses on the particularly sensitive sector of hospital stays in intensive care and resuscitation units.

Precisely from this specific point of view, it may be appropriate to recall that more than ten years have gone by since Hilmar Burchardi, then president of the *European Society of Intensive Care Medicine* (ESICM), wrote in an editorial in the official journal of ESICM that "*it is time to recognise that the intensive care unit should be a place where humanity is given the highest priority. It's time to open those intensive care units that are still closed* "[1]. The time interval that has elapsed since then has certainly led to the changes in direction desired by Burchardi, but the "'openness" of Intensive Care (ICU) even if it is no longer a "dream" is certainly still far from being completely a "reality".

The international literature in the field provides a mixed picture regarding *visiting policies* (i.e. the rules that govern the presence of family members and visitors) in the ICU. The most recent data indicate that the percentage of ICUs that do not place restrictions on visiting over 24 hours is 70% in Sweden [2], 32% in the U.S. [3], 23% in the UK [5], 14% in Holland [6], 7% in France [7] and 3.3% in Belgium [8].

According to the data of two recent studies [9, 10], Italian ICUs maintain on the whole one of the most restrictive *visiting policies*. However, over the last five years in Italy there has been a small but not negligible change: the median of daily visiting hours has essentially doubled (from 1 to 2 hours) and there was a real increase (from 0.4-2%) in the percentage of ICUs that allow visiting over the entire 24 hours. However, in ICUs for adults, there are restrictions on both the number of visitors (92% of ICUs) and on the type of visitors (17% of the wards admit only close family members, 69% do not allow children to visit). In addition, a part of the ICUs do not change their rules regarding access for visitors neither if the patient is a child (9%) nor if the patient is dying (21%). Almost all of the ICUs impose the use of protective clothing (lab coat, shoe covers, mask, gloves). A particularly significant aspect is the fact that a quarter of ICUs for adults do not have a waiting room for family members.

As regards Italian pediatric ICUs [11], currently visiting hours are on average five per day. 12% of wards do not impose restrictions in the 24 hours on the presence of parents, while 59% do not allow the constant presence of a parent, not even during daylight hours. Lastly, one-third of pediatric ICUs, do not have a waiting room for family members.

In Italy even neonatal ICUs have, on the whole, rather restrictive visiting policies: only 30% of them, for example, allow entry to parents 24 hours a day (compared to 100% of Swedish, Danish and UK ICUs, or 71 % of those in France) [12].

2. Promoting visiting policies in the ICU

2.1. The reasons for a choice

For many doctors and nurses the expression "open" ICU is still a sort of oxymoron or, in practice, an unrealistic condition: noun and adjective would be opposed in an inescapable contradiction. This point of view is largely consistent with the origins of intensive care medicine. In fact, since their introduction less than fifty years ago and for many years afterwards, ICUs have been - in Italy as

elsewhere - "closed" wards where access to family members and visitors were regarded unfavorably and, therefore, very limited. This separation of the patient from the people dear to him was motivated mainly by fears regarding the risk of infection, interference with patient care, increased stress for patients and their families, and breach of the confidentiality of information [1, 13].

So, for many years the admission of a patient in the ICU has followed what has been described as the "principle of the revolving door" [9]: when the patient entered, the family was sent out. The logic that one can see in these consolidated behaviours can be traced to a technocratic-rationalist conception that tends to rigidly separate the places of different technical and work activities from those of family relations, while absolutising the good reasons relating to organisation, safety or hygiene. In this perspective, in fact, we tend to believe that, in terms of a strategic objective of primary importance such as the protection of the life and health of the patient, we can proceed to a sort of "kidnapping" of the patient. The reduction or abolition of contacts with the patient's own world of meaningful relationships and affections would, in other terms, be the price to pay for having a significantly higher benefit, which is, precisely, the protection of life and health. Hence the lack of concern to make compatible with such an objective the maintaining of relationships, as far as possible, and therefore combine rather than separate, biological life and relational life.

However, on the basis of scientific evidence not only do certain reasons given for limiting visiting have no basis [1, 13], indeed there are strong arguments in favour of increased access to the ICU by the patient's family members. Current knowledge has shown that separation from loved ones is a significant cause of suffering for the patient admitted to the ICU [14, 15] and that, for the family, to be able to visit without excessive restrictions, represents one of the most important needs [16 - 18]. In this regard, it is interesting to note that doctors and nurses greatly underestimate both the need of the patient to have their loved ones close to them [15] as well as the need of the family [19] to receive information and to be able to be near to the loved one (these needs, together with reassurance, support and comfort are those mostly manifest by the families of the patients of ICUs) [17-19].

Considering more specifically the pediatric field, separation from parents has long been recognised as a major source of stress for hospitalised children [20]. From the point of view of parents, as well as the uncertainty related to the child's illness and its outcome, a significant cause of stress is the loss of their parental role. [20]. Being with the child, along with frequent and accurate information about his condition, represents the greatest need of parents and often their priority is not being constantly present at the child's bedside, but rather the possibility of visiting the child when they can or wish to [21]. *Mutatis mutandis*, the separation from loved ones is a serious limitation also for the elderly who often need the comfort and support of family members even to make decisions relating to health care treatments.

The separation from loved ones for the patient often becomes an additional and unjustified "price to pay" that is not related to the illness or to the serious event giving rise to admission to the ICU. Alongside the suffering of the patient there is, however, also that of members of the family, which often goes unrecognised or is not considered: symptoms of anxiety and depression, for example, have been detected respectively in 73% and 35% of family members [22]. In addition, symptoms of post-traumatic stress compatible with a moderate

to severe risk of post-traumatic stress disorder (PTSD) have been reported in 33% of family members [23]. It is important to point out that the suffering of the family is neither a tardive event (i.e. associated only with prolonged hospitalisation) nor a transient one. Conversely, it begins early and may be persistent. Data in literature indicate that already 3-5 days after admission of the patient to the ICU a high percentage of family members have symptoms of traumatic stress (57%), anxiety (80%) and depression (70%) [24]. In addition 6-12 months after discharge, it is estimated that 27% of the parents of children admitted to a pediatric ICU is at high risk of PTSD (compared to 7% of the parents of children admitted to a ward). [25]. These and other studies have helped to define a precise framework, called *post-intensive care syndrome family* (PICS-F), constituted by a series of psychological complications occurring in the family members of a patient admitted to the ICU [26, 27].

Numerous data suggest that promoting access to the ICU for family members and visitors [16, 28] not only does not constitute a danger for patients, but rather it is in fact beneficial both for them and for their families. In particular, the "opening" of the ICU does not cause an increase in infections in patients [29-32], while there is a statistically significant decrease in both cardiovascular complications and the *anxiety score* [29] Furthermore, patients present significantly lower hormonal stress indices [29]. A further positive effect is represented by the sharp reduction in anxiety in family members [33, 34]. For example, mothers of children admitted in the "open" ICU have stress indices lower than the mothers of children in ICUs with "limited access" [35].

Lastly, the respect of secrecy (or confidentiality) of information, is not infringed by the presence of family members and visitors, but this may occur through incorrect methods of communication. In fact, it is both appropriate and essential when consulting family members and, in particular, when communicating clinical data, the submission of assessments of possible prognostic and therapeutic choices, to dedicate the necessary time, as well as to apply the appropriate procedures and if possible, set aside a suitable place. The question of correct procedure also concerns the related topic of respect for the intimacy of patients, which however is an issue that regards all patients admitted to healthcare facilities in general.

2.2. Visits by children

Also children visiting family members patients in the ICU, represent, under certain conditions, a positive event[36]. In this regard, a Swedish national multicentric study found that all the ICUs involved had a favorable *policy* regarding visits by children to adult patients, even though 34% of the wards actually had some restrictions [2].

It should also be taken into account that there are no real reasons to systematically discourage the visits of brothers and sisters to children hospitalised in the ICU: the presence of a brother or sister can have a positive and reassuring effect on the patient. Apart from certain specific exceptions (such as when the visitor has an ongoing contagious disease), if the child is properly prepared and supported by the family (and other "strong" educational contexts", such as school) to be able to pay a visit to a brother or sick sister helps to dispel fantasies of loss or death, and gives reassurance regarding the constant attention of the parents [37].

2.3. The presence of family members during procedures

This issue has been particularly investigated in the pediatric field and has been recently reviewed [38], almost all parents want to be able to choose whether to stay with the child during invasive procedures and resuscitation, and those who made this choice would do the same thing again in future. Parents can soothe or emotionally support the child and help the team. In addition, reduction of anxiety and aid in the process of mourning are two of the main benefits for parents who have had the opportunity to be present during procedures or resuscitation.

Although the presence of family members during resuscitation procedures has been the subject of recommendations [39, 40] and have shown, on the whole, to be beneficial for family members (in terms of reduced incidence recorded in time of symptoms related to PTSD, anxiety, and depression) [41], nevertheless it is not unanimously considered as positive and continues to cause some concern among doctors and nurses [42, 43].

In Italian pediatric ICUs a clear trend has been detected towards limiting the presence of parents during procedures (including those of ordinary *nursing*) and resuscitation manoeuvres [11], while no data are available on ICUs for adults. In 38% of pediatric ICUs parents are not allowed to attend the normal nursing procedures such as endotracheal suctioning. In the case of invasive procedures such as the placement of a central venous catheter and in the case of cardio-pulmonary resuscitation, the presence of parents is allowed respectively in only 3% and 9% of ICUs.

3. The “open” Intensive Care Unit

3.1. Ethical aspects

Though in general there is essentially no solid scientific basis for impeding or unnecessarily restricting the access of family members and visitors to the ICU [1, 13, 16, 28], there are good reasons both ethically and clinically, for making it possible and encouraging it. Only serious risks to public health – such as, particularly serious epidemic phases - may exceptionally justify impeding visits [44].

A first element to be considered from the point of view of ethics is constituted by the principle of respect for the individual as patient in the medical treatments, foreseen in art. 32 para.2. The individual must be respected in his entirety and therefore in relation with others, without imposing unjustifiably the condition of separation at the very moment in which he is subjected to medical treatment. The places of care, and medical treatments should therefore be arranged so as to separate the individual the least possible from his life-worlds, favouring the moments of continuity with the family and the social experiences of the persons involved. In this way, the autonomy of the patient is also respected, being supported and strengthened by the presence and accompaniment of loved ones, while unnecessarily enforced solitude exacerbates the already difficult condition of illness and constriction in the ICU. The decisional autonomy of the patient is also respected at least when the patient is able to express his own will regarding the presence of the persons close to him, with whom to maintain meaningful relationships. In fact, the patient - when circumstances permit - should have the opportunity to state which persons are particularly significant to him and therefore those who he

wishes to have next to him during the difficult time of illness. This, moreover, is one of the main needs expressed by patients admitted to the ICU [45]. Over the last decades the medical field has also developed a more mature sensibility towards the person as a whole, perceiving not only the physical-objective dimension, but also the subjective one, bringing awareness to the need to respect this dimension also and especially in the sick person by virtue of his condition of frailty and dependence. Therefore, during the period of illness not only should implementation of the rights of the sick person as an individual be supported and made effective, but - even if altered and reduced - the patient's significant emotional relationships should not be mortified let alone abolished.

Moreover, from the practical point of view, a substantial percentage of the admissions to the ICU is not caused by acute or sudden events, but is instead scheduled (major surgery, transplants) or it is a predictable stage in the evolution of chronic diseases (cancer, heart, respiratory, neurological diseases etc.). There are therefore numerous possibilities to consult with patients regarding their wishes, so that they can decide in advance those whose presence is important to them. The treating physician should therefore feel the responsibility to consult patients in good time on this issue. Even later, during hospitalisation in the ICU, patients should always be able to exercise the right to determine and request that the presence of significant individuals within their familiar and emotional world be permitted.

Of course, those unable to express their will and children must also be respected in their need to maintain relations with family members. Respect for the human person transcends the ability to express one's wishes and will.

A further consideration concerns the ethical principles of *beneficence* and *non-maleficence.* On the basis of current scientific knowledge and extensive practice, the presence of loved ones next to the patient does not in any way constitute a "threat" to the patient, on the contrary, it is a positive action capable of producing beneficial effects in a situation which is particularly arduous, both for the patient and family members. In ethical terms, it is therefore not justifiable - except in exceptional cases - to renounce carrying positive action in this regard, able to offer benefits to the patient. The protection of health, in other words, does not necessarily require the sacrificing of relational life, not even in ICUs.

Although doctors and nurses have no formal specific obligation towards family members, but only towards the patient, many studies and recommendations today acknowledge the opportunity for the team of doctors and nurses in the ICU to take care not only of the patient, but, in a broad sense, also of his family. [46] First of all, consideration shown to family members is, in most cases, deemed as consideration towards the patient himself who has not severed family ties, eliminating, so to speak, life's experiences. And such attention, considering him as a person with his own experiences and significant relationships has as a result an improvement in care itself. In addition, wherever this can be achieved while respecting the autonomy of the patient, the consideration of his family relations has beneficial effects also as concerns the family members themselves. This approach has led to the elaboration of the initial model of the "patient-centered" ICU and, therefore, of the "family-centered" ICU (*patient centered Intensive Care Unit* and *family centered Intensive Care Unit*) [26, 46, 47].

Philosophical reflection has pointed out that the ability to recognise *the face of the other* generates in the interlocutor responsibility *towards* him and

relationship *to* him [48]. It is possible to "translate" these terms - *responsibility and relationship* - even in the complex world of intensive care medicine, generating new action and language. It is in this perspective that the choice of "open" ICUs also makes sense on an intrinsically ethical level, and it becomes necessary precisely because it not only responds more fully to the needs of the other, but also because it expresses more adequately consideration and respect for the life and well-being of the other.

3.2. Field experience

With the understanding that fostering an extension of visiting hours has beneficial effects both for the patient and family members, the need to "open" ICUs has been highlighted and recommended on several occasions and in an authoritative way [1, 13, 16, 49, 50]. However, from the framework outlined above we can say that in many Countries, and in Italy in particular, there still is not full consciousness that the presence of loved ones is beneficial to the patient and that in the context of intensive care the family actually constitutes a resource more that a hindrance [51, 52].

The experience of wards that have already liberalised their visiting policies provides some interesting information. A French study, for example, has highlighted three aspects [34]. First, the average time for visiting is about two hours a day and the majority of family visits are concentrated mostly in the afternoon and in the evening (therefore not causing any "invasion" of the ICU). This probably happens because relatives even during this particular period of difficultly and suffering, are still forced to deal with all the commitments imposed by normal working and family life - and at times are forced to perform a balancing act. Secondly, doctors and nurses have recognised that liberalisation of visiting has not compromised patient care (even though a certain uneasiness on the nurses' part stemming from fear of interference with care has been noted). Finally, the majority of family members report that being "open" over 24 hours has eased their anxiety. A recent Italian study also found that the majority of doctors and nurses of ICUs positively evaluate this "openness" in the ward and, on the whole, they have retained this opinion a year after the *policy* change [53].

3.3. Not only a question of time

The promotion of *visiting policies*, however, represents only one aspect of a more complex issue and it is useful to propose a change of perspective. Creating "open" ICUs is not just a question of visiting times: we need to consider them as "open" also on the physical and relational level. Pertaining to the *physical level* are all the barriers that, for different reasons, are proposed or imposed on the visitor, such as the absence of physical contact with the patient and the use of protective clothing (whose effectiveness in terms of infection control is called into question [1]). Pertaining to the *relational level* instead, are all the expressions, of varying intensity, of fragmented, compressed or ineffective communication [54] between the three elements that make up the vertices of the particular "relational triangle" that is established in the ICU: the patient, the treatment team and the family. If we consider these aspects, an "open" ICU may be defined as *the unit of intensive care where one of the objectives of the team is a rational reduction or abolition of all restrictions that are not justifiably necessary on the temporal, physical and relational level* [55, 56].

Seeing with their own eyes the work carried out in the ICU helps to reassure family members, reinforcing in them the belief that their loved ones are cared for in a thoughtful and constant manner. In addition, "open" access contributes to better communication with doctors and nurses [28], and considerably increases trust and appreciation towards the team. An expression of this may be the data recorded by an American study which showed that liberalisation of *visiting policies* in the ICU has improved the perception of patients and their families regarding the quality of care, and has also led to a reduction in litigation [57].

3.4. A new language

The work in the ICU and the efforts to create ICUs focused on the patient and his family [16, 58] can be enriched with new words and actions, through this "openness". For example, the words *reception and hospitality* are very rich and suggestive expressions to indicate the modality of relation with the other, even in a hospital setting. They can certainly be "inflected" in the specific reality of the ICU and transformed into concrete gestures and coherent behaviours.

An "open" ICU therefore offers the possibility to create new actions and language full of humanity. A first example concerns the body: touching the body of the patient, caressing, feeding it a little, and so on, are gestures of enormous value both in relational and therapeutic terms. An effort must be made to create the necessary conditions to make this possible (with all due care), but it must be clear that the patient's body is not necessarily "expropriated" and inaccessible to his loved ones.

This society does not want to "see death", it censures and conceals it. But no branch of medicine more than that of intensive care makes clear how medicine is in fact governed by limitations [59]. The doctors and nurses of the ICU experience first-hand the extent of these limits and deal with *death* almost on a daily basis. In light of the above considerations on the significance of the "open ICU", even death can be approached differently, with language and gestures different from the usual ones. In fact, we are generally accustomed to the act of *delivering the body* after death, but instead we can create the conditions for *the person to be accompanied* during the time of death. Provided that circumstances permit, and death is not an acute and unexpected event, it is important to allow family members to stay with their loved one even in the final stages of his life, staying close to him, caressing him (or if it is a child holding him in their arms), talking to him with the gestures and vocabulary of their special intimacy. These are difficult and complex stages that, however, are enormously important. Moreover, all these farewell gestures are the first step in a proper grief process.

3.5. Facing the difficulties. An “open” ICU does not mean an ICU without rules

The "open" ICU is therefore able to offer more complete and appropriate answers to some of the needs of patients and their families. However, it would be wrong to minimise the difficulties or inconvenience related to an innovative choice of this kind. These are mostly related to habits and aspects of a "cultural" nature, involving the medical and nursing team as much as the family members of the patients themselves.

An "open" ICU does not mean in any case an ICU "without rules" [55], and a regulation is useful and necessary organizing the opening hours in order to

safeguard also the other values at stake. Family members and visitors should therefore be requested not only to give close attention to all the patients in the ward, but also to comply with certain rules of hygiene (e.g. washing hands before and after the visit), security (e.g. avoid touching equipment or infusion lines) and management (e.g. going out during emergency operations). One must also take into account the concerns put forward by some doctors concerning the risk that relatives may take outside the most dangerous and selected germs by antibiotics. Even from this point of view the most appropriate measures should be adopted. Furthermore, one should also take into account the patients' right to respect for their privateness and their privacy by visitors who are strangers to them. It is a problem that actually relates to hospitals in general, but which carefully considered even in reference to the specificity represented by the ICU should provide rules, routes and other forms of protection to safeguard patients even in regard of their condition of frailty. This is one aspect, however, which is connected to the need, certainly not confined to the ICU, to introduce and make fully operative a charter of duties of the visitor, distinguishing between stable visitors and occasional visitors, in order to avoid confusion, impediments, and lack of respect for patients and the people who work in the healthcare facility in general. It is also important to ensure the team of doctors and nurses their own time and spaces, allowing them freedom of communication, with full respect for confidentiality and some essential pause that is not fragmented by interruptions.

Finally, one should not negate or underestimate the difficulties that the team of the ICU (particularly the nurses) might encounter with the opening of the unit, difficulties connected basically to a different way of relating to family members and to the effort of learning to work when observed by family members. Doctors and nurses must therefore be adequately prepared and supported in the various stages of realisation of the "open" ICU model.

4. Conclusions and recommendations

The NBC believes, therefore, that the organisational model defined above as the "open" ICU:

a) fully expresses the principle of respect for persons in health care treatments orienting health care organisation according to the primacy of the dignity and rights of the person, even in a time of particular fragility and dependency as represented by serious illness requiring intensive care;

b) is a useful and effective choice to respond to some important needs of the patient and his family.

On the basis of these considerations, the NBC puts forward the following recommendations:

1) the organisation of ICUs should be geared to promoting the right of patients admitted to the ICU to have present beside them the family members or loved ones who they consider as significant figures;

2) family members - and especially the parents of hospitalised children and close relatives of the elderly - and in general persons specified by the

patient must be able to have the opportunity to stay close to the patient in the ICU;

3) patients who are able to express their will must therefore be consulted as to the persons they want to remain beside them, while in the case of patients currently incapable of expressing their wishes, their previous "advance directives for treatment"[1] must be taken into account, and of course even the choice of the patient not to receive any visits must be respected;

4) ICUs must gradually adapt, i.e. in relation to the compatibility with existing facilities and currently existing equipment, and taking into account the other values at stake (e.g. Privacy and intimacy), their organisation and their *visiting policies* to the "open" ICU model;

5) the doctors and nurses of ICUs should receive adequate and updated training regarding the precautions to safeguard hygiene, safety and orderly conduct of visits, communication, conflict management, the ability to recognise and address the needs of family members as well as their anxiety and stress;

6) National and regional plans for the construction of health facilities must include spaces that are adequately equipped to foster the presence of the families of patients and of visitors;

7) the Health Administration, in its various aspects, must undertake to promote and support implementation of the "open" ICU model.

Bibliography

1. Burchardi H (2002) Let's open the door! Intensive Care Med 28:1371-2.
2. Knutsson SE, Otterberg CL, Bergbom IL (2004) Visits of children to patients being cared for in adult ICUs: policies, guidelines and recommendations. Intensive Crit Care Nurs 20:264-74.
3. Lee MD, Friedenberg AS, Mukpo DH, et al (2007) Visiting hours policies in New England intensive care units: strategies for improvement. Crit Care Med 35:497-501.
4. Lautrette A, Darmon M, Megarbane B, et al (2007) A communication strategy and brochure for relatives of patients dying in the ICU. N Engl J Med 356:469-78.
5. Hunter JD, Goddard C, Rothwell M, et al (2010) A survey of intensive care unit visiting policies in the United Kingdom. Anaesthesia 65:1101-5.
6. Spreen AE, Schuurmans MJ (2011) Visiting policies in the adult intensive care units: a complete survey of Dutch ICUs. Intensive Crit Care Nurs 27:27-30.
7. Soury-Lavergne A, Hauchard I, Dray S, et al (2012) Survey of caregiver opinions on the practicalities of family-centred care in intensive care units. J Clin Nurs 21:1060-7.
8. Vandijck DM, Labeau SO, Geerinckx CE et al (2010) An evaluation of family-centered care services and organization of visiting policies in Belgian intensive care units: a multicenter survey. Heart Lung 39:137-146.
9. Giannini A, Miccinesi G, Leoncino S (2008) Visiting policies in Italian intensive care units: a nationwide survey. Intensive Care Med 34:1256-62.
10. Giannini A, Marchesi T, Miccinesi G (2011) "Andante moderato": signs of change in visiting policies for Italian ICUs. Intensive Care Med 37:1890.
11. Giannini A, Miccinesi G (2011) Parental presence and visiting policies in

[1] As regards advance directives for treatment, see the NBC Opinion, *Advanced treatment statements* dated 18th December 2003.

Italian pediatric ICUs: a national survey. Pediatric Critical Care Medicine 12:e46–e50.
12. Greisen G, Mirante N, Haumont D, et al (2009) Parents, siblings and grandparents in the Neonatal Intensive Care Unit. A survey of policies in eight European countries. Acta Paediatr 98:1744-50.
13. Berwick DM, Kotagal M (2004) Restricted visiting hours in ICUs: time to change. JAMA 292:736-7.
14. Nelson JE, Meier DE, Oei EJ, et al (2001) Self-reported symptom experience of critically ill cancer patients receiving intensive care. Crit Care Med 29:277-82.
15. Biancofiore G, Bindi ML, Romanelli AM, et al (2005) Stress-inducing factors in ICUs: what liver transplant recipients experience and what caregivers perceive. Liver Transpl 11:967-72.
16. Davidson JE, Powers K, Hedayat KM, et al (2007) Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004-2005. Crit Care Med 35:605-22.
17. Molter NC (1979) Needs of relatives of critically ill patients: a descriptive study. Heart Lung 8:332-9.
18. Leske JS (1986) Needs of relatives of critically ill patients: a follow-up. Heart Lung 15:189-93.
19. Bijttebier P, Vanoost S, Delva D, et al (2001) Needs of relatives of critical care patients: perceptions of relatives, physicians and nurses. Intensive Care Med 27:160-5.
20. Melnyk BM (2000) Intervention studies involving parents of hospitalized young children: an analysis of the past and future recommendations. J Pediatr Nurs 15:4-13.
21. Whitis G (1994) Visiting hospitalized patients. J Adv Nurs 19:85-8.
22. Pochard F, Darmon M, Fassier T, et al (2005) Symptoms of anxiety and depression in family members of intensive care unit patients before discharge or death. A prospective multicenter study. J Crit Care 20:90-6.
23. Azoulay E, Pochard F, Kentish-Barnes N, et al (2005) Risk of post-traumatic stress symptoms in family members of intensive care unit patients. Am J Respir Crit Care Med 171:987-94.
24. McAdam JL, Dracup KA, White DB et al (2010) Symptom experiences of family members of intensive care unit patients at high risk for dying. Crit Care Med 38:1078-85.
25. Rees G, Gledhill J, Garralda ME, et al (2004) Psychiatric outcome following paediatric intensive care unit (PICU) admission: a cohort study. Intensive Care Med 30:1607-14.
26. Davidson JE, Jones C, Bienvenu OJ (2012) Family response to critical illness: postintensive care syndrome-family. Crit Care Med 40:618-24.
27. Needham DM, Davidson J, Cohen H, et al (2012) Improving long-term outcomes after discharge from intensive care unit: report from a stakeholders' conference Crit Care Med 40:502-9.
28. Slota M, Shearn D, Potersnak K, et al (2003) Perspectives on family-centered, flexible visitation in the intensive care unit setting. Crit Care Med 31(5 Suppl):S362-6.
29. Fumagalli S, Boncinelli L, Lo Nostro A, et al (2006) Reduced cardiocirculatory complications with unrestrictive visiting policy in an intensive care unit: results from a pilot, randomized trial. Circulation 113:946-52.

30. Malacarne P, Pini S, De Feo N (2008) Relationship between pathogenic and colonizing microorganisms detected in intensive care unit patients and in their family members and visitors. Infect Control Hosp Epidemiol 29:679-8.
31. Malacarne P, Corini M, Petri D (2011) Health care-associated infections and visiting policy in an intensive care unit. Am J Infect Control 39:898-900.
32. Adams S, Herrera A III, Miller L et al (2011) Visitation in the intensive care unit: impact on infection prevention and control. Crit Care Nurs Q 34:3-10.
33. Simon SK, Phillips K, Badalamenti S, et al (1997) Current practices regarding visitation policies in critical care units. Am J Crit Care 6:210-217.
34. Garrouste-Orgeas M, Philippart F, Timsit JF, et al (2008) Perceptions of a 24-hour visiting policy in the intensive care unit. Crit Care Med 36:30-5.
35. Proctor DL (1987) Relationship between visitation policy in a pediatric intensive care unit and parental anxiety Child Health Care 16:13-17.
36. Hanley JB, Piazza J (2012) A visit to the intensive cares unit: a family-centered culture change to facilitate pediatric visitation in an adult intensive care unit. Crit Care Nurs Q 35:113-22.
37. Page NE, Boeing NM (1994) Visitation in the pediatric intensive care unit: controversy and compromise. AACN Clin Issues Crit Care Nurs 5:289-295.
38. Dingeman RS, Mitchell EA, Meyer EC, et al (2007) Parent presence during complex invasive procedures and cardiopulmonary resuscitation: a systematic review of the literature. Pediatrics 120:842-54.
39. Fulbrook P, Latour J, Albarran J, et al (2008) The presence of family members during cardiopulmonary resuscitation. Paediatr Nurs 20:34-6.
40. Morrison LJ, Kierzek G, Diekema DS, et al (2010) Part 3: ethics: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Circulation. 122(18 Suppl 3):S665-75.
41. Jabre P, Belpomme V, Azoulay E, et al (2013) Family presence during cardiopulmonary resuscitation. N Engl J Med 368:1008-18.
42. O'Brien MM, Creamer KM, Hill EE, et al (2002) Tolerance of family presence during pediatric cardiopulmonary resuscitation: a snapshot of military and civilian pediatricians, nurses, and residents. Pediatr Emerg Care 18:409-13.
43. Waseem M, Ryan M (2003) Parental presence during invasive procedures in children: what is the physician's perspective? South Med J 96:884-7.
44. Rogers S (2004) Why can't I visit? The ethics of visitation restrictions - lessons learned from SARS. Crit Care 8:300-2.
45. Olsen KD, Dysvik E, Hansen BS (2009) The meaning of family members' presence during intensive care stay: a qualitative study. Intensive Crit Care Nurs 25:190-8.
46. Ciufo D, Hader R, Holly C (2011) A comprehensive systematic review of visitation models in adult critical care units within the context of patient- and family-centred care. Int J Evid Based Healthc 9:362-87.
47. Davidson JE (2012) Time for a formal assessment, treatment, and referral structure for families of intensive care unit patients. Crit Care Med 40:1675-6.
48. Lévinas E (1985) Ethics and infinity. Duquesne University Press, Pittsburgh.
49. American Association of Critical Care Nurses (2011) Family presence: visitation in the adult ICU. http://www.aacn.org/WD/practice/docs/practicealerts/family-visitation-adult-icu-practicealert.pdf. Accessed 23 February 2013.
50. Gibson V, Plowright C, Collins T, et al (2012) Position statement on visiting

in adult critical care units in the UK. Nurs Crit Care 17:213-8.
51. McAdam JL, Arai S, Puntillo KA (2008) Unrecognized contributions of families in the intensive care unit. Intensive Care Med 34:1097-101.
52. Garrouste-Orgeas M, Willems V, Timsit JF, et al (2010) Opinions of families, staff, and patients about family participation in care in intensive care units. J Crit Care. 25:634-40.
53. Giannini A, Miccinesi G, Prandi E, et al (2012) 'Opening' ICU: views of ICU doctors and nurses before and after liberalization of visiting policies. Critical Care 16(Suppl 1):P492.
54. Azoulay E, Chevret S, Leleu G, et al (2000) Half the families of intensive care unit patients experience inadequate communication with physicians. Crit Care Med 28:3044-9.
55. Giannini A (2007) Open intensive care units: the case in favour. Minerva Anestesiol 73:299-305.
56. Giannini A (2010) The "open" ICU: not just a question of time. Minerva Anestesiol 76:89-90.
57. Roland P, Russell J, Richards KC, et al (2001) Visitation in critical care: processes and outcomes of a performance improvement initiative. J Nurs Care Qual 15:18-26.
58. Carlet J, Garrouste-Orgeas M, Dumay MF et al (2010) Managing intensive care units: Make LOVE, not war! J Crit Care 25:359.e9-359.e12.
59. Wildes KW (1995) The moral paradox of critical care medicine. In Wildes KW (ed) Critical choices and critical care. Catholic perspectives on allocating resources in intensive care medicine. Kluwer Academic Publisher, Dordrecht Boston London, pp. 1-4.