

Visitors in the Intensive Care Unit in the COVID Era

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Healthcare institutions and professionals are the visitors in patients' lives, not the other way around.

Variations of the above sentiment have been noted by multiple healthcare workers. Donald Berwick lucidly noted *we are guests in our patients' lives* in his comment "What 'Patient-centered' Should Mean: Confessions of an Extremist."¹ Our editorial is written in that same spirit, being extremist about advocating open visiting policies in our intensive care units (ICUs). This is a major goal of patient-centered care. The power relation between a patient and family with that of the physician, healthcare worker, and hospital administrator is an unequal one. It is exceedingly difficult for patients and families to challenge the healthcare system they find themselves in. We the physician and healthcare community need to constantly remind ourselves that we are the visitors in the lives of our patients and their families.

The last one decade or two have seen ICUs becoming more and more open to liberal visiting hours. It now seems anachronistic and even cruel to limit visiting hours to a minimum. It is also increasingly clear that limiting visiting hours under the guise of infection control has no scientific validity.²⁻⁵ Similarly, requesting visitors to remove their shoes, etc., should be yet another remnant of a past era. Over the last two decades, our ICU (Hinduja Hospital, Mumbai) has become increasingly open in terms of visitor's hours. A fully open policy allows one or two members of the immediate family to be at the bedside at all times except those that compromise the patient's privacy. This open policy is a privilege, not a right for the relatives, as the primary focus should always be on the patient, and the secondary focus on the relatives and the ICU personnel. Personally, I (FNK) am comfortable for one or two relatives to be in the room during rounds, and on occasion, during a procedure. If the relatives are already with the patient, I inform them that they do not need to leave the bedside during my rounds.

There are plenty of reasons to believe, and evidence to show, that liberal visitors are beneficial for patients and their families and loved ones. These include decreased incidence of delirium^{2,6,7} and anxiety,^{4,7} shorter ICU stay² in the patient population, and reduced stress and anxiety among families.^{5,7} Most of these are observational or pilot studies. A relatively large randomized clinical trial (RCT) by Rosa et al. studied the effect of visiting hours on delirium in ICU and found no significant difference between flexible visiting hours and restricted visiting hours. They also noted that there was no difference in infection rates and in staff burnout between the two groups. They noted a significant reduction in anxiety and depression among families.⁵ It is difficult to interpret these studies, as many benefits of liberal visiting hours may only be reflected in soft-end points like a greater patient and relative satisfaction. We believe that the benefits of patients having access to their loved ones are self-evident. The main role of RCTs is to document adverse consequences of a liberal visiting policy. In the

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absence of these, hospitals should opt for liberal visiting policies for ICU patients.

There are obvious hurdles to liberal or open visiting hours,^{8,9} including overcrowding. A common but unstated one is that the relatives will note the inefficiencies in the delivery of care and the errors that have occurred. They may note the episodes where equipment has malfunctioned, or the tussles between different members of the treating teams. These are legitimate concerns on part of the ICU team and the hospital. They should serve as an incentive to minimize these problems, not to brush them under the carpet by restricting visitors. There are occasional disruptive relatives, and the focus then unfortunately switches from patient care to deal with that particular individual. This can be resolved by reminding the individual that the open visiting policy is a privilege, not a right, and security can be called to remove them from the ICU.

The coronavirus disease (COVID) pandemic placed extreme burdens on healthcare systems and ICU personnel. Government lockdowns, isolation and quarantine policies, and the need for vast quantities of personal protective equipment (PPE) put the question of ICU visitors on the back burner. This question applied not only to COVID ICUs, but also to non-COVID ICUs and to non-ICU patients in the COVID and non-COVID parts of the hospital. The easiest way to deal with this was to stop all visitors. This was certainly very distressing to the patients and their families.¹⁰ Luckily, in this pandemic, the free availability of mobile devices allowed a fair degree of communication between patients and families.¹¹ However, some patients were too unwell to use these devices, and some elderly patients were unfamiliar with their use.

Patients' sense of isolation was amplified because all ICU personnel looked identical in their PPE, often without any labels regarding the name and the position of the ICU personnel. A particularly distressing event for patients was a nearby patient's death. They may have witnessed the event or noted the empty bed. Subsequent discussions with their family members highlighted that patients were extremely disturbed by observing these events. The

families requested their loved ones be shielded from witnessing other such events.

The extreme “no visitors” policy at the beginning of the pandemic was later loosened to allow immediate family to the ICU at the end of life (EoL). As medical and ICU staff adapted to the COVID restrictions, the issue of visitors needed to be addressed. The goal should presumably be that the visitor’s policy in COVID and non-COVID ICUs be identical, with visitors taking the same levels of precautions and wearing the same level of PPE as the ICU personnel. We are far from this situation, and the level of restrictions probably varies between various hospitals and COVID centers.

In this issue of IJCCM, Chanchalani and colleagues addressed this question. They conducted a survey in 292 COVID and non-COVID ICUs. On the one hand, the survey covered a very large geographical area, 18 countries from South Asia and the Middle East representing a sizable percentage of the global population. On the other hand, there was only one response per ICU and it is possible that this individual impression did not capture the reality of that ICU. A survey that only goes by the impression of the participants, rather than the actual data can be inaccurate and misleading. Despite the limitations, the study gives us many useful insights. Not surprisingly, there was a significant decrease in the visiting hours. Equally unsurprisingly, there was much more communication between families and medical personnel through mobile devices compared to direct face-to-face communication. This remote communication with family members was related to getting consent for procedures, giving information about the medical status of the patient, and framing limitations of care and EoL decisions. The qualitative comments of the individual participants of the survey (at the end of the Results section) vividly demonstrate how unsatisfactory the situation was. Chanchalani and colleagues note that this survey cannot judge the impact of these changes on the physical and mental well-being of patients and their families and they recognized the need for further research targeting clinical outcomes.

What messages can we take from this survey? From my (FNK) personal perspective, it was disappointing to note that nearly 80% of ICUs had restricted visiting hours in the pre-pandemic era. Our Asian region has been slow in adapting to a more liberal and open policy for visitors compared to other geographical regions.^{12,13} The pandemic further restricted visiting hours, as well as changed the nature of communication from physical to virtual.

The pandemic and this survey should give practitioners and policy makers an opportunity to review their visitor’s policy. This review should not be narrowly focused on policies for the pandemic, rather they should focus on liberalizing the visitor’s policies for all ICU patients, now and in the future. As we evolve our new policies, we should remember the words of Donald Berwick who lucidly stated.

“I eschew compromise words like “partnership.” For better or worse, I have come to believe that we—patients, families, clinicians, and the healthcare system as a whole—would all be far better off if we professionals recalibrated our work such that we behaved with patients and families not as hosts in the care system, but as guests in their lives.”

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