Why restrictive visiting hours in ICU must end

Paternalistic arguments are restricting family visits to patients in intensive care, writes Samuel M Brown

Tom, my friend’s father, unexpectedly had a cardiac arrest at age 68. Flash pulmonary oedema spiralled out of control in the ambulance as it rushed him to the hospital. Although chest compressions and intravenous adrenaline (epinephrine) restored his circulation, Tom then lay for three days in the agonising uncertainty of coma after cardiac arrest.

Despite some hope from therapeutic hypothermia, we physicians in the intensive care unit (ICU) are mostly powerless to treat neurological injury after cardiac arrest. So we wait our three days, hoping that closed eyes will open again. We join families in a desperate, powerless yearning that these patients will once more speak and think and love.

I couldn’t find words for my anger when my friend called to explain that hospital policy barred Tom’s wife and children from his bedside as he lay, comatose, in hospital. No more than two visitors for 20 minutes at two hour intervals for a maximum of five times a day, the dehumanising policy stipulated. My friend explained how desperately they wanted to be at Tom’s side and how mystified they were by the restrictions. As life drained from Tom the clinicians forced his family to abandon him for most of each day.

After the three day vigil Tom’s family let him finish his mortal course in a natural death. But the brutality of their exclusion from what had, in retrospect, been Tom’s dying bed poisoned their bereavement, possibly for years to come.

It’s been a decade since a call to open ICUs to families was published in JAMA, and we shouldn’t have to say it again. But recent surveys and the experience of thousands of families like Tom’s have shown that we still do. Anecdotally, some hospitals have established places for the family’s presence once death is certain, but, as in Tom’s case, death generally comes uncertainly. By the time death is truly imminent the damage from excluding families may have already been done.

Clinician centred organisational practices have been shown to contribute to post-intensive care syndrome among family members, including substantial anxiety and post-traumatic stress disorder.

Debilitating “bed rest” and the false protection of paternalism

In the past, clinicians universally restricted ICU visits because they believed that patients should not be stimulated during illness—the same philosophy that led to debilitating “bed rest.” (A related paternalistic argument held that it was better for families to be separated from ailing patients, despite their objections, to avoid over-stimulating the family members.) No substantial science ever stood behind this obsolete conception. On the contrary, studies have shown improved physiological, psychological, and satisfaction outcomes from patient centred visitation.

Two years ago—in light of cases like Tom’s, complaints from patients and families, and interest in patient centred care—our ICU decided to limit visits only if the patient or family requested them or for specific procedures. My clinical experience has improved substantially as our ICU has welcomed family partners, and I feel sad now when they are not present. I love having them as full partners in care; their presence keeps the patient, and me, human.

As policy makers, clinicians, and reformers move to create patient centred care and to engage patients and families, it’s hard to imagine a better target for intervention than physical barriers to participation. We cannot coherently advocate engagement while employing clinician centred visits. Restrictive visiting hours reflect a brutish paternalism that has no place in contemporary medicine. My clinical experience has improved substantially as our ICU has welcomed family partners, and I feel sad now when they are not present. I love having them as full partners in care; their presence keeps the patient, and me, human.

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Open, patient directed visits

Other than inertia and the remnants of paternalism, those who oppose it cite nurses’ satisfaction and patient safety as barriers to patient directed visits. But those reservations have lost any credibility that they once might have had. The only real risks from patient directed visits are nurse burnout and the possibility of errors from interruption or distraction. But careful planning and changes to clinicians’ expectations can prevent both. What had seemed impossible becomes probable and then routine. Such has been the experience in our ICU with open, patient directed visits.

Trade-offs exist in visits, as they do everywhere. Different patients want distinct levels of visits, not all possible visitors are welcome at the sickbed, and visitors may create noise that disturbs other patients. Improved ICU architecture, management of noise levels, and collaboratively developed visit plans can tackle these trade-offs directly, in a patient centred framework. Whatever the solutions are, decisions belong primarily in the hands of patients and families: any restrictions must arise from them.

Restrictive, clinician centred ICU visiting policies are cruel and unnecessary. There are no more excuses for managing what may be a patient’s last days under a regime fit for a prison. Samuel M Brown is director, Center for Humanizing Critical Care, Intermountain Medical Center, 5121 South Cottonwood Street, Murray, UT 84107, USA, and assistant professor, pulmonary and critical care medicine, University of Utah School of Medicine, samuel.brown@imail.org

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Feature: BMJ roundtable debate: How can we get better at providing patient centred care? (BMJ 2015;350:h412)
Editorial: Time to deliver patient centred care (BMJ 2015;350:h530)
Editorial: A more encouraging future for hospitals? (BMJ 2014;349:g6780)
Meet the Robodocs

“I am struck by how much the military invest in resilience training,” said Terence Stephenson, the GMC’s new chair, at a recent hearing of the Commons Health Committee. He went on to say, “They do not wait until they are out in Helmand province; they start at recruitment and training.” He added, “That is probably something that we could think about exploring . . . building in resilience training when people are medical students and young trainees rather than waiting . . . until you’ve been reported or had a complaint.”

At last: joined-up health policy. Let’s forget the hostile, overcrowded hospital terrain; the tanks of revalidation and the friends and family test on the lawn; and the inaccurate aim of the Care Quality Commission’s bullets. With special resilience training you too can learn to stop complaining and start coping. You can see more patients with more complex problems, superfast and stress free. Why worry so much about the associations between reduced staffing and patient mortality? or indeed that in England hospital beds fell in number by 59% from 1979 to 2012 despite our ageing, multimorbid population?

It can hardly be a coincidence that NHS England chief executive Simon Stevens chose the same week to announce that primary care doctors will be available instantly for online video chat with their younger patients because “the idea of booking appointments and physically turning up to their GP surgeries for routine things is an alien concept.” Instead, they can “call up a doctor or a nurse on [their] iPhone and have the face to face interaction there”—odd, considering how capable the young people around here are of interacting with their GPs in real time and real life.

It’s clear where policies like this will eventually lead: Robodocs. These automatons will have resilience of steel and will unquestionably follow the instructions of higher powers. Clinical examinations and smear tests will be done by robots delivered by drone, and empathy will be delivered, in response to a patient’s distressed tones, by a head nodding device.

Empathy will be delivered, in response to a patient’s distressed tones, by a head nodding device

IF I RULED THE NHS Mary Church

We need drones, robots, and autonomous ambulances

The problem with the NHS today is too many patients, not enough staff, and a severe outbreak of “inspectionitis.” While there’s no doubt the running of the service should be handed back to doctors—who, let’s face it, have all the necessary qualifications, brains, and arrogance—what’s needed is a huge injection of drones, robots, and autonomous ambulances.

Take the current crisis in hospital emergency departments. We urgently need a solution. Double decker beds and trolleys should be brought in, halving the bed problem at a stroke, with top deck patients attended to by long armed robots and drones for the rest. These devices will be operated by the depleted medical staff from the comfort of a posture chair in a high tech computer room. Not only will this allow more accurate, quicker diagnosis, it will also prevent the spread of infection in either direction. Driverless ambulances, further reducing staff costs, will cut queues outside casualty departments.

Intelligent triage, “iTriage,” though not the preference of some politicians, is supported by doctors. The current technology used in out of hours services—a human with a certificate gained after a two week course on how to triage potential risk, including the risk of avoiding risk—will be replaced by medically qualified clinicians. GPs will be cloned to meet the 24/7 demand, making it much easier for patients to seek a second opinion.

The TV medic Doc Martin has got it absolutely right: patients need to do what the doctors tell them, forget patient choice, and pull themselves together. They must stop wasting time by asking questions, internet medical downloads will be banned at consultations, and opinions, unless given by the doctor, won’t be needed. To cut time waiting for a GP appointment patients should access their records online. Confidentiality won’t be a problem, as anyone with a computer will be able to access personal data. No need to waste a GP appointment if further clarification is needed: Twitter and Facebook are available.

Since Sherlock Holmes’s faithful friend John Watson was struck off the general medical register, it has been clear things have to change. The GMC will be put back in the hands of doctors, with “Innocent until proven guilty” its motto. Doctors will be tested on their trolley-side manner and will be able to refer malicious complaints to the GMC (General Patient Council). Butch inspection teams failed to recognise that doctors are indeed lovely people. Replacing the teams with iRobots that can think for themselves will be much more fun and even more effective when the proposed weaponisation comes into play.

A system in crisis needs new intelligent thinking. The use of technology controlled by medics will solve many of the NHS’s problems.

Mary Church is a general practitioner, Glasgow

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Margaret McCartney is a general practitioner, Glasgow

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The BMJ readers can buy Margaret’s new book, Living with Dying, for £7.99 (RRP £11.99) from www.pinterandmartin.com with code BMJ799

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