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MINERVA ANESTESIOL 2007;73:299-306

REVIEW ARTICLE

Open intensive care units: the case in favour

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ABSTRACT

Intensive care units traditionally have a closed structure in Italy. They generally have highly restrictive visiting policies, limiting the admission and attendance of family members. This article deals with the issue of open intensive care unit (ICU), *i.e.* a unit oriented towards the implementation of non-restrictive visiting policies and committed to removing all barriers that have no justifiable necessity, on the level of time, on the physical level and on the level of relationships. The most common objections to opening intensive care units are examined, and the clinical and ethical reasons behind this alternative are considered. As things stand, there is no solid scientific basis for limiting visitors' access to ICUs and keeping ICUs "closed". On the contrary, opening ICUs offers a strategy which is to patients' advantage. Opening ICUs should come about not so much in answer to pressure generated by a growing social awareness, or in simple recognition of a right, but because this policy addresses more comprehensively the issue of respect for the patient, as well as providing more appropriate responses to many needs of both patients and families. It is a decision which requires doctors and nurses to rethink their relationships with patients and their families, which calls for original solutions for each individual situation, and which should be subject to periodic checks.

Key words: Intensive care units - Family - Parents - Ethics.

Who is visiting whom?
Health care institutions and professionals
are the visitors in the patients' lives,
not the other way around.

D.M. Berwick and M. Kotagal
(JAMA, 2004)[1]

A recent editorial by H. Burchardi in *Intensive Care Medicine* concluded with two important claims: "It is time to acknowledge that the ICU must be a place where humanity has high priority. It is time to open those ICUs which are still closed".[2] The implications of these challenging conclusions call for a reassessment not only of the route Italy has taken in this area, but above all of the rationale underpinning the everyday reality of work in Italian intensive care units (ICUs).

Although ICUs have a relatively short history, dating back less than 40 years, they have made dramatic progress during their lifetime, with advances both in the clinical understanding of events, and in the development of diagnostic and therapeutic tools. Throughout this evolution, however, one element has remained constant, at least in Italy, and that is the "closed" structure of the ICU. I use the term "closed intensive care unit" to refer to an ICU with restricted access, either limiting or excluding the presence of family members; in some cases even visiting is restricted, with any contact being confined to brief "windows" of time, generally no longer than 1 h per day. There are no specific data dealing with this subject in Italy; however, a recent French study found that 97% of ICUs under consideration have limited periods of access (only once a day in 33% of cas-

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es, twice in 62%).[3] In contrast, a nationwide Swedish survey revealed that 70% of ICUs have no restrictions at all on visiting hours, whether during the day or at night.[4] These trends are probably a reflection of different cultural contexts and the different attitudes they foster.[4]

The closed nature I refer to, however, is not in my opinion, limited to the time dimension, but is also evident on the physical level, and especially in the area of relationships. On the physical level I include all the barriers which, for various reasons, are suggested to or imposed upon the visitor (no physical contact with the patient, wearing of gown, mask, gloves etc.). The area of relationships involves every expression of the communication — fragmentary, compressed or even withheld — among the members comprising the particular "triangle of relationships" that is set up in the ICU: the patient, the family and the medical team.

The logic behind this entrenched behaviour is that the strategic objective of prime importance, *i.e.* the life and health of the patient, justifies resorting to a kind of "sequestration" of that patient. The reduction or abolition of contacts with the patient's affective world is considered a reasonable price to pay in order to obtain the far greater goals of life and health.

The practice in many other countries, both in North America and in Europe, has for some years already had a very different orientation, and can thus give us pause for thought. In Italy, too, there are from time to time attempts to transform the traditional model of the "closed" ICU, but this is taking place almost exclusively in certain paediatric ICUs.

The Bioethical Commission of the Società Italiana di Anestesia, Analgesia, Rianimazione e Terapia Intensiva (SIAARTI) has undertaken a commitment to investigate these questions in great depth, in order to make a report to SIAARTI containing specific proposals.

The objective, therefore, of this contribution is to address the issue of "open" ICUs and visiting policies for patients' family members.

Open intensive care: the objections

In describing the "closed" ICU, I earlier considered 3 specific dimensions (time, the physical aspect, and relationships). By analogy, but almost in antithesis to this, I believe we may define an "open" ICU as consisting of a unit in which one of the medical team's objectives is a rational reduction or elimination of any limitations imposed on these three dimensions for which there are no strict reason.

In the medical-nursing teams in ICUs there are deeply-held convictions opposed to the opening of the units and to the presence of the patient's family and loved ones.[5] The reasons behind these convictions may be summarized as follows:[1, 2, 6, 7]

a) increased risk of infection for the patient;

b) interference with the patient's treatment, increase of the team's workload and constraints on the efficiency of the ICU;

c) increase in patients' stress levels;

d) increase in stress levels for patients' family members;

e) violation of patients' privacy.

However, a critical assessment of these points may provide the necessary reassurance.

Risk of infection

There is no evidence of increased incidence of infections in open ICUs:[6] this is a myth which must be dispelled. The aetiology of serious infections of the critically ill patient is of a completely different order from that represented by "pollination" from visitors, and even direct physical contact with the patient is not "intrinsically" dangerous. For patients, the most significant external risk factor for infection is that from the nurses and doctors themselves.[2] Moreover, the use of safeguards such as gowns, shoe covers, gloves and masks has no particular usefulness in preventing infections in the ICU, though putting on a gown may perhaps be of psychological value in that it emphasizes the special nature of the ward the visitor is entering.[2]

Finally, it is worth pointing out, that attempts to create a genuinely closed and "aseptic" ICU have not only proven to be totally ineffective in reducing infections, but they are also extremely expensive.

Interference with treatment

The presence of parents or other family members in itself does not reduce the level of patient

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care,[8] though it may sometimes slow down the work of the team.[9] Although on the one hand the presence of family members may be an additional stress factor for the team[10] (and as such it should be acknowledged and treated accordingly), on the other hand it may offer valuable support to the patient during the particularly difficult period of admission to intensive care, as well as facilitating communication between patients and caregivers.[8]

Stress for the patient

The presence of family or, more generally, of the patient's loved ones is a positive factor for the patient,[11, 12] giving comfort, and reducing anxiety and stress.[13, 14] Furthermore, the presence of family has not been shown to cause any alteration in parameters such as heart rate, blood pressure and intracranial pressure,[15, 16] as may happen in the presence of nurses.[8, 17] Moreover, contrary to what is often thought, family members do not cause any particular disruption to the patient's rest; indeed, the staff do so to a much greater extent.[18] For instance, even in a paediatric ICU with restricted access, a young patient undergoes manipulation or is involved in some kind of manoeuvring 25 times in an 8-hour shift.[19] Rather, the presence of a parent or family member provides reassurance to patients, and thus also makes it easier for them to rest.[10] We may also make an analogous case for adult patients.

The overall objective, however, is not the wholesale opening of ICUs to any and every visitor, but that of permitting patients themselves – wherever possible – to decide whose visits are important to them.[1]

Stress for the family

Admission of a family member to intensive care is, without doubt, a particularly traumatizing event, but "open" access to the patient reduces stress[10, 20] and has provem to have a beneficial effect on 88% of families, and to have reduced anxiety in 65% of families.[21] Moreover, it has been found that mothers of children admitted to ICUs with "open access" have lower stress levels compared to those of children admitted to ICUs with "restricted access".[22]

Being able to see the work carried out in the ICU with their own eyes thus helps to give the family reassurance, strengthening their conviction that their loved one is being properly looked after around the clock. In addition, "open" access makes for better communication[9] with the nurses and doctors as well as increasing the family's trust in and appreciation of the team. It may inevitably be that, in certain circumstances, family members exhibit an "over-vigilant" or even hostile attitude,[9] which may be in response to a closed stance adopted by the ICU team (in the form of restricting information, excluding family from the decision-making process on key issues etc.). It is in the interests of the patient that these relationships be carefully restored to mutual trust and respect.

Privacy

Respect for the confidentiality of information is not compromised by the presence of visitors, but rather by the inappropriate handling of communication. It is essential to dedicate adequate time to communicating clinical data and presenting prognostic assessments and possible treatment options, but it is equally important that such information be communicated in an appropriate manner and, if possible, in an appropriate place. A hasty "one-way" style of communication, from the foot of the patient's bed, bears no comparison to sitting down together (a powerful traditional gesture of welcome), allowing sufficient time for genuine dialogue, listening and reassuring, preferably away from the bedside or in a place specifically set aside for that purpose.

A common complaint is that in ICUs there is often inefficient communication,[11, 23-28] and bad communication leads the family – and for that matter the patient, to have false expectations, as well as increasing their fear, feeding their lack of trust or their hostility, and intensifying their stress.[11] A recent French study found that family members of patients admitted to an ICU may have a misunderstanding of the diagnosis in 20% of cases, of the prognosis in 43% of cases, of the treatment in 40% of cases, or of some combination of these elements in 53% of cases.[24] It is, therefore, reasonable to assume that the traditional policies governing the presence of the family in ICUs do not make for effective communication with the medical team.

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Finally, let me comment on the particular situation in paediatric ICUs. The presence of the parents is not only reassuring for the child, but makes the work of the nurses easier and, to some extent, helps to preserve the unique and vital relationship between child and parents.[9] The presence of the parents cannot, therefore, be considered a special privilege to be conferred, but rather a necessary component for the wellbeing of both the patient and the family.[29, 30] Today's often-quoted terms "patient-centred care" and "family-centred care" refer precisely to the inclusion of the family in the patient's treatment.[11, 31] The presence of parents is a significant contribution towards this objective. Moreover, the opening of ICUs an offer a more effective response to the five principal needs of the family of a patient in intensive care:[9, 16] to receive reassurance; to remain close to the patient; to be informed; to be supported; and to be made comfortable. It has been pointed out that for the parents there is an overriding need not so much to be constantly present at the child's side in the ICU as to have the freedom to be close to their child when they are able or if they wish to, together with the possibility of obtaining clear information about what is going on.[6]

The visit by children to family members taken into intensive care is also, under certain conditions, a positive and welcome occurrence. On this subject, a nationwide multi-centre study in Sweden found that all the ICUs covered by the study had a positive policy regarding visits by children to adult patients, though 34% of the wards had some *de facto* restrictions in place.[4] Arguably, there are no real reasons for systematically discouraging visits by siblings to children admitted to intensive care: the presence of a sister or brother has a positive and reassuring effect on the patient. Apart from certain specific exceptions (*e.g.* when the visitor has a contagious infection etc.), if the child is suitably prepared and supported by the family context (and by other "powerful" contexts, such as school), the visit to an ill sibling helps to dispel the children's fears and fantasies of loss or death, and reassures them of their parents' continuing attention.[10] In closing, I would also note that there have also been pilot schemes allowing pets into paediatric ICUs as a form of reassurance and "treatment".[16]

A meaningful choice: the ethical aspects

Let me make a patently obvious premise: the basic choice between "closed" and "open" ICUs cannot in any way be allowed to interfere with the work of the medical team in the strictest sense, as the best possible care must always be provided to the patient, according to the most appropriate standards.

Why, therefore, even consider making ICU an open structure? The most frequent reply usually focuses on the question of rights (of the patient, of the family, etc.), but I believe that it is equally important to consider the intrinsically ethical aspect of the choice, which allows us to explore the deepest meaning and value of our decisions and actions.

Over the last 30 years, a more mature social sensitivity has without doubt fostered the awareness that the ill not only fully maintain all their rights but even to some extent acquire more rights by virtue of their particular conditions of fragility and dependence. Moreover, during a period of illness not only are the patients' rights not suspended, but nor are their relationships with family and friends – though they may be modified and reduced. It is from this perspective that we must consider, for example, the texts of the various Italian regional laws regarding the protection of a child patient in the hospital.[32-35]

The behaviour of the doctor and his or her relationship with the patient operates on at least 3 levels: legal, deontological and ethical. Briefly, we may say that the legal level expresses what, at a particular time and in a particular society, is recognised as lawful or otherwise. The deontological level governs the relationships among those belonging to the "medical community" and dictates the norms of the relationship between a doctor and patient. This aspect is also strongly conditioned by historical and social contexts: different eras have had different deontological codes. The ethical level, however, is essentially concerned with the intrinsic value of an action, its "goodness" and acceptability. In any specific circumstance these three different levels then have to be integrated and, so to speak, given a "hierarchy".

The viewpoint I would like to explore here is one which states that it is not sufficient for an action merely to represent the fulfilment of a duty

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or a norm, however right and proper that may be. There is also an ethical requirement to be considered.

It therefore seems to me that in the specific professional environment of medicine it is not enough that an action constitutes the fulfilment of a *duty* or a precept: the action – forgive the unorthodox terminology – must aim for *beauty*, *i.e.* the full realization of the sense and significance of our encounter with another person. Clearly the relationship with the other, especially in the doctor-patient relationship, involves a series of well codified duties (laws, deontological code etc.) which are nowadays reinforced by a certain sensitivity or social pressure (Patients' rights Tribunal etc.). All of this represents a necessary but not sufficient condition. The category of "beauty" which I made an ethical rather than an aesthetic category refers to the fullest and most rewarding dimension of the encounter with the other, the valuing of that person's life and respect for it. The "face of the other" – to use the expression dear to the philosopher Emmanuel Lévinas [36] – and above all the face of someone rendered vulnerable, calls on medical staff to show responsibility, which must prompt an effective response to that person.

I personally believe that the fullness of one's relationship with the other – which I have referred to with the evocative terms face and responsibility – should be recognised even in the narrow and confined environment of the ICU, and must therefore also be expressed through the language of welcome and hospitality. It is in this perspective that the choice of the open ICU makes sense, also on an intrinsically ethical level and thus it becomes necessary, precisely because it more fully addresses not only the needs of the other, but also the valuing of, and respect for, that person's life.

Opening the door: the day-to-day experience

"Open" ICUs may therefore provide fuller and more appropriate responses to some of the needs of patients and their families. However, it would be wrong to play down the difficulties or inconveniences involved in such an innovative choice. These are for the most part associated with habits and "cultural" aspects, which constrain both the medical team and the patient's family. We should also bear in mind that personality traits or habits such as obtrusiveness, aggressiveness or mistrust almost always tend to be exacerbated by new, stressful situations such as the serious illness of a member of the family. This whole matter is often dealt with in a rigid fashion, with reference more to the regulations (a true *totem* of hospital life) than to the meaning of the events and a search for balanced and rational solutions.

The decision to "open" ICUs entails the need to set up ongoing education aimed at families who come into contact with the world of the ICU, as well as for staff who make up the constantly changing medical teams. It is neither a simple nor an incidental undertaking, and is strictly linked with the aims of delivering improved patient care, considering the patient's family context and, last but not least, developing social maturity in health matters.

An "open" ICU does not, however, mean an ICU "without rules", and it is both practical and necessary draw up some guidelines. Visitors should be required not only to show the greatest consideration for all the patients in the unit, but also to follow some basic rules concerning hygiene (*e.g.* to wash their hands before and after the visit); security (*e.g.* not to touch equipment or vascular access lines); and operations (*e.g.* to move out of the way during emergency manoeuvres). Each individual ICU may draw up its own rules and modify them over time on the basis of a critical assessment of their own operations. It is also important to give the medical team time and space of their own, allowing free communication and full respect of confidentiality, but also some indispensable breaks not constantly punctured by interruptions.[9] I must, however, stress what I stated earlier: the term "open" ICU cannot simply refer to the aspect of time, limiting itself to merely extending the visiting hours of the family, but it must also move into the physical dimension and that of relationships. It is not therefore just a question of "leaving the door ajar" at ICUs and nothing more, but we have to come up with original solutions, based on the justified and rational premise of building new relationships with patients and their families.

It is rare for an intensive care doctor to recognise the need to acquire communication skills as a specific professional competence. In my opinion, it is

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therefore indispensable to identify suitable paths for training both doctors and nurses in order to improve the quality and effectiveness of communication with patients and their families.[37]

To my mind, the terms welcome and hospitality are rich and evocative ways of referring to the way we relate to the others, even in the context of a hospital. But how can they be “inflected” in the specific reality of the ICU, how can they be translated into behaviour or attitudes? Each context is unique and each individual must feel involved in identifying solutions suitable to the particular context. Without attempting to be exhaustive, therefore, let me list a few simple ideas:

— visiting policies: there are really very few justifications for restricting visiting, and the habits of the team are not generally a sufficiently good reason. Occasionally, however, it may be necessary to insist that visitors show consideration in the presence of other patients and to reduce access, if the number of visitors becomes excessively high and starts becoming disruptive. There are many diagnostic or therapeutic operations that do not necessarily require family members to leave: once staff have overcome a certain embarrassment, after a while they become used to carrying out various operations in the presence of visitors (from bronchial aspiration to ultrafiltration) and realize that the visitors are not in themselves a hindrance. The general aim, however, is not to open the ICU indiscriminately to all comers, but to allow the patient – where this is possible – to decide which visitors are important to him/her.[1]

— Information: the presence of family members over a longer period of time necessarily means having to learn to communicate with them more frequently and more clearly. It becomes important to describe what is happening – even with only a few words – and to give reasons for decisions that are taken, so that family are included in the process and properly informed.

— Nights: parents do not disturb the sleep patterns of the child in ICU. The request to leave the unit at night may rather be justified on the not inconsiderable grounds of allowing the parents to have a suitable period of rest and of giving the family at least a brief period of time in which to meet and spend time together. These are also choices to be shared and planned with the family, on the basis of the various needs of patient, family and medical team.

— Being able to sit down: it is a commonplace gesture, but providing a chair or armchair to put by the bed makes a big difference in the course of a tiring day. The same can be said for having a bathroom available or the possibility of getting basic refreshments such as water and coffee.

— A room for family members: where it is physically feasible, a room adjoining the ICU should be set aside specifically for the families of patients; it should be made welcoming and be furnished to make the stay more comfortable during the day (*e.g.* by providing a few armchairs and lockers for personal effects).

— Telephone communication with family members: current laws and a number of security regulations forbid the giving of information over the phone. If we exclude specific information on diagnosis and prognosis, I believe that some reasonable exceptions may be made: on more than an occasion a night time phone call from a mother and father, previously arranged with them, has become truly “liberating”, providing the reassurance needed to allow them to rest for a few hours. In France, 94% of ICUs can be reached by phone by families to receive information.[3]

I would like to conclude with two considerations which I believe to be particularly significant. I make them with reference to the context of paediatric ICUs, but they most certainly also apply to the world of adults and — *mutatis mutandis* — may easily be applied to the reality of general ICUs. The first is about the body: touching the child’s body, holding the child (even if still intubated and on a ventilator, or on non-invasive ventilation), feeding the child a little, and so on, are gestures of enormous value both on the level of the relationship and on the therapeutic level. An effort is required to create the conditions to make this possible, with all the due security safeguards, but it must be made evident that the body of the child-patient is not something “expropriated” and inaccessible to the parents.

The final consideration concerns death. We live in a society which does not like to “see people die”, which censors death and hides it away.[38] I do not intend to go into the reasons behind this, but it is a powerful observation, with repercussions on the

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way in which death in an ICU is experienced and – to use a brutal, but effective word – "managed". In the light of the considerations explored above as to what open intensive care means and the reasoning behind it, death too, may be approached in a different way, with a different "language" and gestures from the customary ones. We are generally accustomed to the gesture of delivering a body after death, but I believe we can instead create the conditions whereby the person is accompanied at the time of death. I believe the semantic and symbolic difference is obvious, but experience also shows that there is a profound practical difference between the two. Providing that circumstances permit it, and if death is not an acute and unexpected event, it is important to allow parents to be with their child even in the terminal phase of life, staying close by, touching, caressing, and holding the child, speaking to him or her with their own intimate gestures and words. These are heartrending, unutterable moments — literally "unspeakable" — but absolutely central to the parent-child relationship. Moreover, all these gestures of leave-taking represent the first step on the way to working through the grieving.

An "Open" ICU thus offers us the possibility of providing care and attention even when the therapeutic limit has been reached [39] and death is approaching.[2] In these circumstances it is essential to create an appropriate setting for the patient to be accompanied during the terminal phase of life, both in terms of relationships and on a clinical level, with all the tools of palliative medicine and avoiding any form of "therapeutic abandonment".

Conclusions

The facts show no solid scientific basis for restricting access for visitors to ICUs and keeping ICUs "closed".[2, 9] As was recently written in a comment in JAMA, "restricting visiting in ICUs is neither caring, compassionate, nor necessary".[1] On the contrary, opening ICUs does not create problems for patients, and the family can play an active role in the treatment.[1]

However, it is not easy to "open" ICUs. It undoubtedly involves calling into question rhythms and rules belonging to a well-established and reassuring tradition. But, above all, we need a certain degree of cultural change and to think seriously about the sense and quality of relationships with patients and their families.[2] It is a choice which commits us to coming up with original solutions for each individual situation, which will require regular monitoring, and will need to be renewed and remotivated over time, especially in view of the high turnover in intensive care teams.

"Opening" ICUs is not a new craze or the latest politically correct fashion in the health sector. I have attempted to instead show how it is not only a useful and effective strategy for the patient, but above all, an expression of the respect and greater attention due to one who is living through the difficult period of illness. I consider that the time is right in Italy to bring about this change and to enhance our "therapeutic covenant" with new actions.

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Member of the SIAARTI Bioethical Commission.

Acknowledgements.—I am indebted to M. Langer (Policlinico San Matteo, Pavia) for an intense and rewarding exchange of ideas over the years on this subject.

Received on March 15, 2005 - Accepted for publication on October 18, 2006.

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