Paved With Good Intentions: Hospital Visitation Restrictions in the Age of Coronavirus Disease 2019*

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Abstract: Hospital visitation restrictions have been widely implemented during the coronavirus disease 2019 pandemic as a means of decreasing the transmission of coronavirus. While decreasing transmission is an important goal, it is not the only goal that quality healthcare must aim to achieve. Severely restricted visitation policies undermine our ability to provide humane, family-centered care, particularly during critical illness and at the end of life. The enforcement of these policies consequently increases the risk of moral distress and injury for providers. Using our experience in a PICU, we survey the shortcomings of current visitation restrictions. We argue that hospital visitation restrictions can be implemented in ways that are nonmaleficent, but this requires unwavering acknowledgment of the value of social and familial support during illness and death. We advocate that visitation restriction policies be implemented by independent, medically knowledgeable decision-making bodies, with the informed participation of patients and their families. (*Pediatr Crit Care Med* 2020; 21:e924–e926)

Key Words: COVID-19; critical care; death and dying; hospital visitation; patient support

Supporting families through a child's critical illness is fundamental to the practice of pediatric critical care medicine. This is rarely easy. People can be unpredictable, sometimes volatile in grief. Nevertheless, healthcare providers value familial and social support during critical illness, and it is rare to deny access to the bedside of a dying patient.

Rather, it was rare prior to coronavirus disease 2019 (COVID-19). Now, children admitted to the PICU in our institution are permitted a single designated visitor. This is similar to newly restricted policies in other institutions (1–10). If two caregivers are present when the child is admitted, we force them to choose: who will sit vigil alone at the bedside and who will walk away, leaving their critically ill child and grieving partner behind?

The response to the COVID-19 pandemic has included drastic hospital visitation restrictions, a well-intentioned extension of social distancing meant to minimize hospital traffic. It may be prudent and ethical to limit visitation in the interests of public health during times of pandemic (11). However, the severe limitation—and in some cases outright elimination—of visitation implemented during COVID-19 prevents us from providing humane, family-centered care, particularly during critical illness and at the end of life. Implementation of these policies was abrupt and lacked sufficient input from key constituencies, including frontline providers, patients, and families.

The United States appears to have crested the initial surge in COVID-19 cases, but as states roll back social distancing measures in the absence of widespread testing, herd immunity, or a vaccine, we will see additional outbreaks. It is therefore imperative to assess our initial responses, including drastic visitation restrictions, before they become codified and culturally ingrained. We make the case for the rejection of these policies based on our experiences in a PICU setting, though we believe our arguments deserve consideration across adult and pediatric services.

Current restricted visitation policies prioritize, above all else, containment of the coronavirus. Containment is an unambiguous public good that will prevent suffering and death. But quality healthcare must also aim to deliver other goods, including support for the ill, the dying, and the bereaved. Suffering is compounded when one suffers alone.

Nationwide, orders to shelter in place grant exceptions for essential activities and interactions. *Being in the presence of a loved one while ill and especially at the end of life is an essential human interaction,* long supported in medical and legal frameworks (12–14). There is no substitute. Setting up an iPad to prevent patients from dying alone is not a solution (15). We should instead reject the argument that the public good requires patients to die alone. The value of social support during illness and death should be restored to the moral calculus driving hospital policy.

Many institutions do allow exceptions to these policies, particularly at the end of life. In our institution an exception may be granted if death is expected within 24 hours. This is well-intentioned, but insufficient. Even if a patient has a very low likelihood of death, caregiver anxiety and grief over being "in the PICU" should not be minimized or dismissed (16, 17).

***See also p. 913.**

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Further, it is difficult to identify whether and when death is "expected." Patients are rarely admitted to the PICU without a potentially life-threatening problem, and their pathophysiology is variable; some patients deteriorate progressively, but others die suddenly. Regardless of mechanism, our predictions of mortality are unreliable (18, 19). The 24-hour criterion is also arbitrary. If, to the best of our ability, we predict that a child will die in the PICU, then it should not matter whether their dying process takes minutes, hours, or days. Under such circumstances, no unit of time is less precious than any other.

Finally, it is difficult to comprehend the magnitude of trauma we will inflict—upon patients, families, and ourselves—if we are wrong in our end-of-life predictions. Even with unencumbered bedside access and ideal social support, bereaved caregivers are at higher risk of physical and mental health problems (20). Imagine sending a parent or loved one away from the bedside over their anguished objections—because we have gambled the patient will make it through the night—and the child dies. There is no metric for such suffering.

In addition to their flawed justification and construction, the implementation of hospital visitation restrictions may be a moral hazard for frontline providers (11). Despite having had little say in the construction of these policies, their enforcement—that is, the responsibility to ask loved ones to leave and call security if they do not comply—often falls to the bedside clinicians, a setup that abuses our proximity and dedication to patients. Being forced to be agents for policies on which we have had little input compounds our risk of moral distress and injury, especially when these actions so plainly add to our patients' pain.

Although current widespread policies are flawed, we believe effective and humane visitation restrictions are possible. Ethicists have advocated that during a pandemic, decisions such as resource allocation should be assigned to independent committees charged with creating guidelines (21). If we must consider visitation a limited resource, then it is appropriate for independent decision-making bodies to allocate it. However, such committees should not consist exclusively of hospital administration; input from providers with diverse training is required, including in critical care, palliative care, ethics, and social work. Further, construction of these policies should consider input from patients and their families, since care provision and allocation under extraordinary circumstances should incorporate both medical expertise and community values (22). Guidelines should be in place for how the committee's policies will be enacted and enforced, and must include a mechanism of deployment that is independent of—or at least not primarily dependent upon—bedside providers (11).

As was the case prior to COVID-19, specific visitation policies will vary by institution based on physical capacity, equipment availability, severity of circumstances, and cultural expectations. However, given the inherent physiologic and emotional value of a support person for an ill and especially a dying patient (12–14), visitation should not be eliminated under any circumstances. We further advocate against restricting visitation to fewer than two persons for any critically ill child, given the distress an ICU admission can cause for a caregiver (16, 17, 23, 24). In addition to providing each other with essential emotional support, the presence of two caregivers improves their opportunities for self-care, which is especially important during prolonged admissions. Allowing two caregivers at the bedside also partially mitigates the potential harm of an incorrect mortality prediction, since neither parent is denied time with their critically ill child. However, given the diversity of family structures, the support person role should not be defined by a particular relationship to the patient: grandparents, stepparents, etc. should be equally eligible for designation.

Relaxation of visitation restrictions for high-risk and/or actively dying patients is also prudent. We recommend the committees responsible for visitation policies also establish physiologic and/or therapeutic parameters for patients who merit exceptions, for example, those with severe intracranial hypertension or who require extracorporeal support. With clear parameters in place, the exception may then be invoked by bedside clinicians. Knowing our ability to predict mortality is poor, we recommend clinicians err on the side of allowing expanded visitation if, in their opinion, there is a high likelihood of a child's death. We further recommend a critical or palliative care–trained member of the committee be available on call for discussion if there is concern about an individual child's eligibility for an exception.

We who practice medicine know what it is to fear. We fear our decisions will harm our patients. We fear our patients will die. We fear we will get sick. Though COVID-19 has intensified these fears, they are not new. But COVID-19 has brought new fears. We now fear standing between a terrified mother and her dying son. We fear denying a father the chance to see his daughter be born. We fear that if we get sick, we ourselves may die alone. These new fears are avoidable. Hospital systems have chosen these fears for us. As providers charged with providing the best care possible for critically ill children and their families, we should demand to choose differently.

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