

The Ethical Complexity of Restricting Visitors during the COVID-19 Pandemic

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Accepted 21 June 2023
Published Online First
21 July 2023

BACKGROUND

Across the globe, there were significant variations in government responses to the COVID-19 pandemic, with some countries putting in place public health measures which were criticised as too draconian, while elsewhere there were calls for a further tightening of restrictions to protect vulnerable members of society. As the pandemic unfolded, healthcare leaders responded rapidly to the urgent need to contain the spread of infection and to ration and reallocate resources. One of the most controversial and emotive issues arising from the critical phases of the pandemic was the imposition of restrictions on visitors to hospitals and nursing homes. Regarded at the time as a measure which was necessary to mitigate the spread of the disease, policies limiting visiting rights have been subject to heavy criticism since the waning of the pandemic.¹⁻³ The idea of people dying alone in hospital or living in residential care settings for months with no access to family members or loved ones is particularly troubling and it is difficult in retrospect to avoid hindsight bias. What generates controversy is not the question of whether restrictive measures were necessary, but the specifically ethical question of whether their implementation was proportionate, fair and adequately justified. In this issue of the journal, Collier *et al*⁴ conclude their qualitative study of the experiences of clinicians and families in relation to visitor restrictions in end-of-life and palliative care settings by drawing attention to the importance of ‘ethical legitimacy in public health measures’.⁴ Their paper corroborates the findings of other commentators but stops short of providing a full analysis

of the harms and benefits associated with the implementation of visitor restrictions during the pandemic.

Identifying ethically defensible options

Given that there are no universally recognised standards for determining what is morally right, the question of what is ‘better’ or ‘best’ in a given context may give rise to legitimate disagreement.⁵ In the face of such disagreement, an appeal may be made to ethical frameworks and well-established ethical principles, such as fairness, autonomy, equity and solidarity, to identify ethically acceptable courses of action, scrutinise the values at risk, and guide analysis of harms and benefits.⁶ In conjunction with principles drawn from philosophy and bioethics, the public defensibility of the decision-making process also rests on procedural values such as proportionality, transparency, consistency and accountability.⁷ While frameworks and established ethical principles play a crucial role in justifying decisions, the procedural values that underpin the *process* by which decisions are made are equally important (table 1).

Maximising benefit and minimising harm

Over the course of the past 20 years, visitors have come to be seen as an integral part of healthcare delivery.⁸ As Collier *et al*⁴ observe, visitors in healthcare organisations are not ‘passive bystanders’ but often assume the roles of companion, translator, navigator and planner. Positive benefits of integrating visitors into the provision of healthcare include assistance with feeding and self-care and, most importantly, emotional support.⁹ Negative consequences of visitation restrictions during the pandemic included increased patient loneliness, agitation, depression, decreased nutrition



► <http://dx.doi.org/10.1136/bmjqs-2022-015471>



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To cite: Campbell L, Morley G. *BMJ Qual Saf* 2023;**32**:689–692.

Table 1 Ethical principles and procedural values with example applications in the case of visitation restrictions

| Principle | Description | Example application |
|-------------------------------------|--|---|
| Respect for autonomy | The ability to determine one's own course of action in accordance with one's values without external interference. | <ul style="list-style-type: none"> ▶ Permitting residents or patients to receive visitors if they choose to do so. ▶ Allowing residents or patients freedom of movement within an institution. |
| Maximising well-being (beneficence) | Promoting the overall benefit—clinically, emotionally and psychologically—of individual patients. In the public health context, well-being is defined collectively rather than individually. | <ul style="list-style-type: none"> ▶ Acting to ensure the well-being of vulnerable patients and residents by protecting them against the spread of disease. ▶ Ensuring that patients or residents who are seriously ill or dying have the social and emotional support they need. |
| Avoiding harm | Taking action to minimise harm, or taking preventative steps to minimise foreseeable harms. | ▶ Ensuring that psychological, social or emotional harm to patients or residents posed by restrictions on visitors is kept to a minimum. |
| Solidarity | A collective commitment to a particular cause, even if there is some cost to oneself. | ▶ Identifying a commitment to protecting vulnerable members of society and then restricting visitation to protect those individuals, even at personal cost. |
| Fairness | Treating individuals, or similarly situated individuals, the same by providing equal access or opportunity. | ▶ Restricting or facilitating visitation for all patients or residents, irrespective of individual or unique circumstances. |
| Equity | Ensuring that individuals, or similarly situated individuals, are provided with equal access or opportunity based on need or to overcome disadvantage. | ▶ Restricting or facilitating visitation for similarly situated individuals but allowing for flexibility based on individual need, such as allowing visitation for a resident with developmental disability to assist with self-care and meals. |
| Procedural values | | |
| Proportionality | Ensuring that measures put in place to minimise risk and maximise benefit are an appropriate response to the nature, likelihood and severity of the anticipated risk and based on best available evidence. | ▶ Restricting or facilitating visitation based upon the nature, likelihood and severity of the risk of transmission in a given population and setting. |
| Transparency | A commitment to openness around the decision-making process. | ▶ Clearly communicating how decisions are made and how values, burdens and benefits are weighed or impacted. |
| Consistency | Applying a rule or guideline in the same way across multiple instances. | ▶ Facilitating or restricting visitation for individual patients or residents in similar circumstances over time. |
| Accountability | A willingness to take responsibility for decisions that are made. | ▶ Leaders being open to scrutiny of decisions made regarding the facilitation or restriction of visitation. |

and daily activity, increased reports of pain and other symptoms, increased stress and anxiety reported by family members, and staff moral distress.^{10–14} Context, however, is important. The harm caused by restricting visitors had to be balanced against the benefit of protecting patients, residents and healthcare workers from the disease. At the beginning of the pandemic, COVID-19 was seen to pose a threat to the functioning of healthcare systems; knowledge of the mechanisms by which the virus spread, including the role of asymptomatic carriers, was sparse and there were concerns that supply of personal protective equipment (PPE), even hospital beds and ventilators, would not be able to meet demand^{8 10 11} (images of nurses in New York City wearing bin bags in place of PPE and the issuing of new guidance to reuse previously single-use N95/FFP3 masks highlighted the scarcity of PPE at the time). In the face of enormous clinical uncertainty, there was a strong utilitarian rationale for limiting visitors to hospitals and nursing homes as cases of infection multiplied across the globe. Not only were healthcare workers required to assume additional risk working in extenuating circumstances,⁸ many of them taking on the emotional labour of staying with patients who were dying and facilitating virtual goodbyes with loved ones,¹⁵ but they were also instrumentally valuable

as a resource to provide care for future patients who would contract COVID-19. The imperative to protect patients, healthcare workers and members of the community against the virus and the need to maintain functioning healthcare systems provided the ethical justification for prioritising the safety of the broader community above the needs of individuals by restricting visitors to hospitals and nursing homes.⁹

It is clear, as Collier *et al*⁴ point out, that the restrictions on visitors resulted in substantial harm to patients, their loved ones and to staff.^{11–13} Any intervention that has the potential for harm requires ethical scrutiny, deliberation and justification, with efforts made in advance to mitigate foreseeable harms.^{8 9} Decisions about balancing harms and benefits which are difficult to quantify should not be made on an ad hoc basis. Collier *et al*⁴ draw attention to the need for policies governing visiting rights which are attuned to the tension between the quality and safety of care provision and the need to protect patients and residents from harm in pandemic situations. These findings raise important questions about the process by which visitation policies and other pandemic-related policies were developed, and the consistency with which they were implemented. In their analysis, Jones-Bonofiglio *et al* call for ‘explicit and transparent processes’ to provide those affected by decisions an opportunity to

understand the rationale for those decisions, even if they are not in agreement with them.⁸

Importance of procedural values

In response to the outbreak of the pandemic, national frameworks were published in many jurisdictions to guide ethically defensible public health decision-making at local levels. Such frameworks rest on and promote values which are publicly accepted as valid, such as reasonableness, fairness, inclusivity, equity, proportionality, accountability and flexibility.^{7 9 12 16} The challenge for local decision-makers was to devise and implement visiting policies informed by these more general ethical frameworks and to understand the potential for conflict among the ethical principles on which they were based. Central to the implementation at local level of higher-level guidance is transparency about how different harms and benefits are understood and weighted in specific contexts. Absolute consensus about what constitutes a harm in a given context does not exist. Minimising harm, for example, may be interpreted either in terms of protecting vulnerable patients or residents against infection, or in terms of ensuring that they have the support of close family and friends in times of serious illness. It is therefore vital that a principled rationale for how decisions are made is publicly available.

It is generally accepted that in times of crisis, policies designed to promote public health and safety prioritise collective well-being—such as protection from the spread of disease—above individual rights such as autonomy. Nonetheless, policies developed within hospitals or at the level of health districts or Trusts must balance consistency and flexibility in their implementation; they must be fair but capable of accommodating the needs of individual residents in specific circumstances, and their implementation must not create or exacerbate inequity.¹² One example is the ‘practical’ framework put forward by Jones-Bonofiglio *et al.*⁸ The authors suggest that during times of surge capacity, loved ones could be asked to supply their own PPE but this has the potential to put families with less resources, who may be unable to source their own PPE, at a disadvantage, thereby violating the principle of equity. The same framework includes the provision of a healthcare worker ‘support companion’, which in times of conventional care would ensure support for visitors. However, in times of surge capacity where nurse-to-patient ratios are so stretched that the quality and safety of care are diminished, the justifiability of this suggestion may be questioned. In proposing a more flexible approach to visitation restrictions, Jones-Bonofiglio and colleagues⁸ raise further questions which highlight the challenges of developing and applying ethical frameworks fairly, equitably and consistently. Decision-making in relation to compassionate exceptions generates challenges stemming from conflicts between avoiding harm and maximising

benefit, promoting autonomy and ensuring fairness—and should be based on an explicit, transparent and defensible process, rather than being the responsibility of individual clinicians working under crisis or contingency conditions^{15 17} (Morley *et al.*¹⁵ found that intensive care unit nurses felt responsible for the implementation and enforcement of visitation restrictions and for decision-making regarding compassionate exceptions, such as end-of-life visitation; see also Brewer *et al.*¹⁷).

Finally, review is an integral component of sustainable policy development and visitation policies which are perceived by patients, family members or healthcare workers as disproportionate or unfair require scrutiny. While the constraints on working conditions imposed by the pandemic meant that opportunities for policy review and consultation were sparse, this does not remove the obligation to revisit the most restrictive elements of policies which limited visitation with a view to achieving a more proportionate balance between harm and benefit in line with emerging evidence.

Collaborative decision-making: the role of clinical ethics support services

Collier *et al.*⁴ draw attention to the importance of proportionality and transparency in the implementation of visiting policies that have the potential to cause harm to those who will be affected by them. They argue that patients, families, clinicians, ethicists and community leaders should be involved in the development of visitation policies at the local level which are transparent, consistent, publicly available and evidence based and which ‘balance compassionate care and human rights with public health principles’.⁴ At the height of the pandemic, Fritz *et al.* called for formalised and properly resourced clinical ethics support structures to assist healthcare professionals in interpreting and applying national guidance.¹⁸ Clinical ethics support services are increasingly recognised as a mechanism for enhancing the clarity, consistency and defensibility of healthcare decision-making and may have had an additional role to play in lessening ‘the substantial burden of making urgent and complex [decisions]’ during the pandemic.¹⁸ While clinicians are adept at balancing harms and benefits in a medical context, ethicists are trained to determine the defensibility of interventions by balancing harms and benefits at a more general level in accordance with decision-making frameworks which take account of the empirical data, principles and values at play.

Explicit scrutiny of values, fair process and transparent criteria for decision-making are as important in public health ethics as they are in clinical ethics, given the potential for conflict in the pandemic context between individual autonomy and more community-oriented principles such as solidarity, reciprocity or harm minimisation. One of the lessons

learnt from the pandemic may be that it is time, not only to invest in clinical ethics support services in the acute care setting,¹⁹ but also to recognise a broader role for clinical ethics expertise in public health decision-making.

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Contributors Both authors contributed to writing the editorial.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Ethics approval Not applicable.

Provenance and peer review Commissioned; internally peer reviewed.

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REFERENCES

- Monteverde S. Who is essential in care? Reflections from the pandemic's backstage. *Nurs Ethics* 2022;29:1096–106.
- Kemp CL. Morethanavisitor: families as "essential" care partners during COVID-19. *Gerontologist* 2021;61:145–51.
- Nash WA, Harris LM, Heller KE, *et al.* We are saving their bodies and destroying their souls": family Caregivers' experiences of formal care setting visitation restrictions during the COVID-19 pandemic. *J Aging Soc Policy* 2021;33:398–413.
- Collier A, Balmer D, Gilder E, *et al.* Patient safety and hospital visiting at the end of life during COVID-19 restrictions in Aotearoa New Zealand: a qualitative study. *BMJ Qual Saf* 2023;32:704–11.
- Molewijk B, Reiter-Theil S. The particular relevance of clinical ethics support in psychiatry: concepts, research, and experiences. *Clinical Ethics* 2016;11:43–4.
- Campbell L, McCarthy J. A decision-making tool for building ethics capacity among Irish health professionals. *Clinical Ethics* 2017;12:189–96.
- Department of Health. Procedural values for decision-making in a pandemic. In: *gov.ie - Procedural Values for Decision-Making in a Pandemic (www.gov.ie)*. 2020.
- Jones-Bonofiglio K, Nortjé N, Webster L, *et al.* A practical approach to hospital visitation during a pandemic: responding with compassion to unjustified restrictions. *Am J Crit Care* 2021;30:302–11.
- Chew. An ethical framework for hospital visitor restrictions in the COVID-19 pandemic. 2020. Available: visitor-restrictions-v1-FINAL.pdf (unimelb.edu.au) [Accessed 06 Jan 2023].
- Hugelius K, Harada N, Marutani M. Consequences of visiting restrictions during the COVID-19 pandemic: an integrative review. *Int J Nurs Stud* 2021;121:104000.
- Sizoo EM, Monnier AA, Bloemen M, *et al.* Dilemmas with restrictive visiting policies in Dutch nursing homes during the COVID-19 pandemic: a qualitative analysis of an open-ended questionnaire with elderly care physicians. *J Am Med Dir Assoc* 2020;21:1774–81.
- Russell B, William L, Chapman M. An ethical framework for visitation of Inpatients receiving palliative care in the COVID-19 context. *J Bioeth Inq* 2022;19:191–202.
- Hartigan I, Kelleher A, McCarthy J, *et al.* Visitor restrictions during the COVID-19 pandemic: an ethical case study. *Nurs Ethics* 2021;28:1111–23.
- Silverman HJ, Kheirbek RE, Moscou-Jackson G, *et al.* Moral distress in nurses caring for patients with COVID-19. *Nurs Ethics* 2021;28:1137–64.
- Morley G, Copley DJ, Field R, *et al.* RESPONDER: a qualitative study of ethical issues faced by critical care nurses during the COVID-19 pandemic. *J Nurs Manag* 2022;30:2403–15.
- UK Department of Health and Social Care. Responding to COVID-19: the ethical framework for adult social care. 2020.
- Brewer KC, Horning MA, Walker MS, *et al.* Analyzing the effects of family presence and visitation restrictions during the COVID-19 pandemic among nurse leaders and non-nurse leaders. *J Nurs Adm* 2023;53:132–7.
- Fritz Z, Huxtable R, Ives J, *et al.* Ethical road map through the COVID-19 pandemic. *BMJ* 2020;369:m2033.
- Machin LL, Wilkinson M. Making the (business) case for clinical ethics support in the UK. *HEC Forum* 2021;33:371–91.