Ethics for Lunch: September 15, 2020 12:00 – 1:00 pm via Zoom Webinar

Hospital Visitation during the COVID-19 Pandemic: Weighing the Benefits and Harms of Restricting Visitors

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The September Ethics for Lunch addressed the issue of visitation during the COVID-19 pandemic. In March 2020, the Johns Hopkins Health System instituted a policy to restrict visitors in the hospital and the outpatient clinics to reduce the spread of the COVID-19 virus. The policies and procedures were put in place for the safety of patients, families, and staff, but it became clear over the course of the pandemic that patients and their families also suffered as a result of restricting visitors. Patients and family members have been traumatized, and clinicians feel the moral residue from this trauma. Exceptions to the policy have been made to acknowledge individual needs of patients and families, but questions remain as to how decisions to allow visitation are made and for whom. As the cases of COVID-19 have declined in Maryland, Johns Hopkins Medicine is currently re-evaluating its policy, trying to find the right balance of safety and harm.

Key points:

1. During the pandemic, clinicians have reported the difficulties associated with family members not being able to be involved in decision-making for hospitalized patients as they usually are. Family members cannot directly observe the course of the patient's illness to inform good decision-making. This is especially true for patients facing the end of life.

2. With the pandemic, clinicians have been asked to enlarge their ethical framework from focus on the individual patient to a public health perspective, attending to the safety of all the people in a healthcare system. This may lead some clinicians to feel they are abandoning their primary ethical obligation and this can leave a moral residue.

3. Clinicians going above and beyond their usual duties assume an emotional surrogacy for patients whose families are not able to visit. This is especially true for nurses who have a sustained presence at the bedside.

4. In making difficult policy decisions, it is important to acknowledge the pain and suffering that has come with the pandemic but also in management of infectious disease historically. Infection prevention practices like isolation precautions and personal protective equipment entail time and expense. A patient in isolation may have less contact with providers.

5. Another infection prevention measure that challenges ethical frameworks is mandatory vaccination. Requiring some vaccinations like the influenza vaccine for employees is done for

the benefit of reducing the chances of infection but comes with some infringement on autonomy.

6. Another infection prevention policy that involved ethical considerations was management of Ebola virus disease and the creation of a biocontainment unit. Highly contagious diseases with high mortality rates raise many questions about risks to health care providers and whether their clinical care should be required or voluntary.

7. In the pandemic, once the transmission rate became high enough in the community and in the organization, visitor restrictions were put in place. Most employees who have gotten COVID-19 have acquired it from community transmission. The rare cases of spread in the hospital from employee to employee have because of not adhering to social distancing practices (e.g. taking mask off in break rooms in order to eat). Infection prevention measures can be highly effective provided they are followed.

8. Changes in visitor restriction policies are made after considering public health metrics about the extent of the virus in the community, the percent positivity in testing, and the number of case per 100,000 population in a geographic region around a hospital. Then there can be additional considerations for situations when exceptions should be made on a case-by-case basis (e.g., pediatrics, obstetrics, end of life, and need for care partner).

9. The Patient Experience perspective is to view visitors as Care Partners. They are not casual visitors but instead are integral members of the care team. Family members are an extra set of eyes and ears for the patient--they assist with patient education and help with discharge planning. They can help prevent harm to the patient.

10. A standing committee has been created to assess the current state of the pandemic and the permissibility of care partners at the bedside in consultation with members of the Patient and Family Advisory Committees (PFACs). The COVID ActNow website provides a snapshot of the pandemic in a city, county, or state and can be used to help formulate policy.

11. A framework for changing visitation policies considers the risk of transition in the community (high, medium, low tiers), the location of the patient in the hospital, the length of stay, and the clinical situation. For instance, a patient with an extended hospital stay would benefit from the presence of a Care Partner so the Care Partner can see the progress of the hospital journey and help with medical decision-making and discharge planning.

12. Visitors who are allowed to visit a patient must follow guidelines that they are given at the time an exception is made. These include wearing a mask, maintaining social distancing, staying in the patient's room except to get food. If guidelines are not followed, visitors will be asked to leave. Visitors are not tested for COVID-19 but instead are asked to complete a screening questionnaire.

13. Hopkins has 17 PFACs and they have been working with senior leaders of the health system, the ethics committee, and representative of the Resilience in Stressful Events (RISE) teams to monitor the process for making exceptions to the visitor restriction policy. Requests for exceptions have typically been made by care teams on behalf of patients. The request is reviewed by a senior administrative leader, who then has to make the difficult decision of whether to approve or deny the request. Requests are assessed on a daily basis.

14. From March through mid-August at The Johns Hopkins Hospital, 24,000 unique patients were served, with over 64,000 unique admissions. There were 1,976 exceptions for visitors made during that time, with no racial differences in the approvals or denials. Over 80% of the requests were granted exceptions. Over 50% of the admissions were for African American patients; only 30% of the requests for exceptions were for African American patients. 36% of admissions were for White patients; over 50% of the requests were for White patients.

15. The health care team may need to be more proactive in suggesting to patients or families that an exception should be requested. They may also need to convey that it is safe to come to the hospital provided social distancing practices are followed.

16. When visitors are permitted, their approval is noted in the electronic record and reviewed by security when they present at hospital entrances. There are no time limits to visitation, although it is anticipated family will not stay for 24 hours. The period of time they can arrive for visitation goes until 7 p.m., although exceptions can be made after hours. The hospital does not want queuing of visitors at entrances and would prefer visits are staggered throughout the day.

17. When visitors are not permitted, clinical care teams are encouraged to keep the lines of communication open with them. Patients are encouraged to use their electronic devices to stay in touch with their family. Staff may be able to assist with setting up virtual communication, although resources are limited and this adds another level of stress for staff who are already doing so much. It would be nice if there were volunteers to serve as communication ambassadors, but there is also a need to limit the number of people in the hospital where possible.

18. Patients are being asked to wear masks to help prevent spread to staff members. They will also need to consider whether to wear a mask when Care Partners visit depending on whether they are in the patient's "bubble."

Readings:

1. Johns Hopkins Medicine Visitor, Family, Care Partner Restrictions Related to COVID-19
2. Colimore SLC, et al. Johns Hopkins Medicine responds to COVID-19: Adjusting patient- family- and staff-centered care. Patient Experience Journal 2020;7(2):118-124.
3. Andrist E, Clarke RG, Harding M. Paved With Good Intentions: Hospital Visitation Restrictions in the Age of Coronavirus Disease 2019. Pediatr Crit Care Med. 2020 Oct;21(10):e924-e926.

4. Virani AK, et al. Benefits and Risks of Visitor Restrictions for Hospitalized Children During the COVID Pandemic. Pediatrics. 2020 Aug;146(2):e2020000786.
5. Valley TS, et al. Changes to Visitation Policies and Communication Practices in Michigan ICUs during the COVID-19 Pandemic. Am J Respir Crit Care Med. 2020 Sep 15;202(6):883-885.
6. Hart JL, Turnbull AE, Oppenheim IM, Courtright KR. Family-Centered Care During the COVID-19 Era. J Pain Symptom Manage. 2020 Aug;60(2):e93-e97.
7. Frampton S, Agrawal S, Guastello S. Guidelines for Family Presence Policies During the COVID-19 Pandemic. JAMA Health Forum. Published online July 6, 2020.
8. Covid ActNow. America's COVID Warning System.