Assessing Visitor Policy Exemption Requests During the COVID-19 Pandemic

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During the coronavirus disease 2019 (COVID-19) pandemic, many hospitals have added COVID-19–specific visitor restrictions to their routine visitor restrictions. These additional visitor restrictions are designed to reduce viral transmission, protect patients and staff, and conserve personal protective equipment. They typically exempt patients with disabilities and those who are dying. Consistent application of these policies may, however, be inequitable. We present the case of a single mother seeking an individual exemption to both a routine and a COVID-19 specific visitor restriction. One commentator focuses on the importance of clear and transparent processes for considering requests for exceptions. The other argues that disproportionate burdens may be mitigated in other ways and the policy maintained.

The coronavirus disease 2019 (COVID-19) pandemic raises unprecedented challenges for health care systems and society at large. Although vaccine roll out is now ongoing, prevention through public health measures focused on reduction of transmission, such as masking, hand-washing, and physical distancing, remains paramount. Many health care facilities have substantially augmented existing visitation restrictions. These stricter restrictions are justified to limit unnecessary contact, protect patients and staff, and reduce personal protective equipment consumption. Such policies typically have exceptions for childbirth, patients with disabilities, and end of life, as discussed in a Pediatrics Ethics Rounds in 2020. Uniform application of these policies may, however, create disproportionate burdens for vulnerable individuals, such as single parents and those living in poverty. We present a case in which consistent application of both a routine and a COVID-19 visitor restriction is inequitable and ask when individual or unique exceptions should be made.

THE CASE

A 5-year-old girl is tracheostomy dependent with medical history significant for prematurity of 30 weeks’ gestational age, severe bronchopulmonary dysplasia, grade III intraventricular hemorrhage, spastic cerebral palsy, epilepsy, gastrostomy tube dependence, and developmental delay. She was formerly ventilator dependent continuously but has weaned to only nocturnal ventilatory support.

The patient’s mother brought her emergently to the emergency department after accidental decannulation. The mother was unable to replace the tracheostomy tube at home but maintained the stoma’s patency with a small catheter. The otolaryngology team performed serial dilations and
The patient’s mother appreciates this support, but worries about leaving her younger child with unknown persons. She worries this creates a new source of COVID-19 exposure for her family, including the patient on discharge from the hospital. She requests an exemption to the visitation restrictions and the social worker is unsure what to do; she worries that the hospital visitation restrictions place an undue burden on the family, but an exception would be unfair to other families and might be unsafe for the patient’s sibling.

ELIZABETH LANPHIER, PHD,
COMMENTS

This case raises questions about appropriate targets of justice in a clinical context, how to balance considerations of clinical risk and considerations of fairness, and how social and economic inequities impact clinical care. It also reflects how the COVID-19 pandemic continues to reveal health and social inequities experienced by individuals and families.

Unlike principles of autonomy, beneficence, or nonmaleficence, which focus narrowly on the patient, justice requires a wider lens. If justice is each person receiving their due, then each person is due something in relation to and from others and institutions. When concerns of injustice arise, it is because certain benefits or burdens are not fairly distributed among individuals or groups.

Traditional accounts of justice associate universalizability and equality with fairness. But critics of universalist programs for justice note how adopting formal equality, according to which persons are presumed equal and equal persons are due identical treatment, fails to account for differences produced through luck, chance, and circumstance that advantage some while disadvantaging others. Universalist approaches can flatten difference in ways that overlook rather than address structural oppression and bias, including implicit bias.

Henry T. Puls contends that “as it pertains to justice, any policy restricting visitors for pediatric patients should be applied equally.” Applying a visitor policy equally without exception applies formal equality: each patient and family is treated exactly the same. Yet this case shows how each patient and family is unique. Chance, luck, or circumstance create disproportionate burdens on some relative to others that can render equal treatment inequitable treatment.

For example, historical racial oppression and ongoing explicit and implicit racial and ethnic bias can create inequitable conditions that formal equality cannot address. The allocation of COVID-19 vaccines by age, according to which older age groups were prioritized first, is an example of a formally equal process. Yet by allocating vaccines “equally” by age in the US, according to Sarah Reber, “you’re going to vaccinate white people who have lower risks before you vaccinate Black people with higher risks,” although Black individuals were dying at higher rates from COVID-19 than white individuals during the pandemic. Procedural equality would seek a more refined process for adjusting for structural difference, such as vaccinating by social vulnerability index or other metrics, which Reber notes could yield a program to “vaccinate Blacks who are about 10 years younger than whites” in the same vaccination waves.

According to Margaret Urban Walker, justice requires adequate attention rather than equal attention...
in moral matters. Adequate attention assesses unique circumstances with the understanding that they may require formally unequal response to be equitable. Walker's view recognizes different needs, starting points, and hardships and that justice requires attention to differences.

Following Walker, adequate attention supports a kind of procedural equality rather than formal equality for visitor policy exemption requests. Each family has equal access to a clear and transparent process for equitable consideration of their request. Depending on the institution and its existing systems, this could entail a standing team comprising clinician, social work, ethics, and family relations representatives, or a set process for convening a team to include representation of specific roles (ie a physician, nurse, and social worker from the primary team, ethics, and family relations).

Crystal Brown and Georgina Campelia advocate for "equity consultants and committees" composed of "ethics consultants, clinicians, researchers, or other advocates with expertise in issues around health equity" to support clinical care and decision-making within hospitals, including in the context of COVID-19 visitor restriction policies. Brown and Campelia consider equity committee review of visitor policy exemption requests for "patients with low English proficiency who typically rely on family to help with translation or advocacy," for example. Such situations may not standardly meet narrow clinical risk/benefit thresholds to grant an exemption, but when assessed through an equity lens could warrant exemption.

Equity consultants or committee members would also be aware of and help mitigate implicit bias that can arise even when one believes to be implementing a policy or decision fairly. Additionally, they could participate in policy development or review to ensure that policies routinely triggering equity concerns are revised in ways that meet clinical and equity objectives.

In this case, it would be important for the consultants or committee to talk with the patient's mother to better understand the effects of the policy on her and her family. This conversation might reveal that both currently proposed options undermine justice considerations and are unfavorable from a clinical risk/benefit standpoint. The clinical and psychological needs of this particular patient may only be adequately supported through parental presence, reducing risks of the patient harming herself and increasing the likelihood of a successful procedure. Respite care could significantly increase the sibling's exposure to COVID-19 and, by extension, exposure of the patient and mother, as well as be psychologically harmful to the mother and sibling. Delaying the procedure to allow for family to travel and quarantine from out of state may pose disproportionate risks to the patient and may not be logistically or economically feasible. Such additional information might justify granting an exemption to both visitor policies.

A formalized process for exemption request evaluation takes a more substantive view of justice, recognizing social and economic features impacting health care. Turning adequate attention to this family's situation helps identify a bias within the visitor policies obscured by their supposed universality: the policies disadvantage families that do not have coparents, extended family, or paid caregivers involved in their lives, on whom they can rely for child care.

Would a formal review of the exemption request suggest revising the visitor policy entirely, such that solo parents are permitted to bring additional children to the hospital during the COVID-19 pandemic, or room in overnight? Such a conclusion misses the importance of both the risk-related reasons for the visitor restrictions and the equity considerations that might warrant at times overriding them.

Not all families have the same resources, or constraints. It is easy to imagine multiracial households facing significant limitations on child care resources or work schedule constraints that limit their ability to be at bedside even if they believe their presence is essential to their child's care. In contrast, some solo parents of multiple children might have access to supportive networks of paid or family caregivers and access to paid leave from work.

Having established policies in place is essential for reasons of safety and efficiency. At the same time, extending adequate attention to particular situations enables balancing equity considerations within health considerations. During the COVID-19 pandemic, relevant health considerations also include attention to local COVID-19 transmission rates and travel restrictions impacting access to family members from outside the region, at the time of this patient's care.

Hospitals have mechanism to consider visitor exemptions. My suggestion is that more robust and transparent processes, such as visitor restriction review committees, equity committees, or individual equity consultants, as Brown and Campelia suggest, do a
better job of promoting justice in health care than putatively equal treatment and ad hoc exemptions, which could be susceptible to bias or inattentive to structural inequality. However this process is structured, having clear and communicable processes mitigates perceptions of unfairness, while attending to structural differences and promoting greater equity.

Some might worry granting one or both exceptions would be unfair to other families and, potentially, to hospital staff. Other families have additional child care duties yet adhere to visitor policies without accommodation. Staff could be in the difficult position of navigating the presence of a minor sibling in the patient’s room during care, especially overnight, or responding to frustrated families who see a minor sibling present on the unit.

When other families express concern that the visitor policy is unfairly implemented because they see the patient’s 2-year-old sibling on the unit, or when staff express concern about how to explain these differences, the response is grounded in a commitment to equitable family centered care. Instead of divulging individual families’ circumstances by way of explanation, staff can explain how a commitment to equitable family centered care translates into a review process that extends adequate attention to each family’s needs, including, if they would like, their own.

LUKE MOSLEY, MD, MTS, COMMENTS

Aimed at preventing transmission of SARS-CoV-2 and limiting the impact of COVID-19 at both an institutional and societal level, visitor restriction policies raise a number of ethical concerns when concretely applied. This family’s request for exemption intersects with a preexisting policy preventing minors from rooming-in overnight and a pandemic-specific policy strictly limiting visitation to 2 adult caregivers.

Hospital visitor restrictions reflect (potentially competing) interests of safety, duty, and justice. Hospitals have a duty to both (1) care for patients and protect the safety of patients, families, visitors, and staff. Parents and guardians have (2) a comparable duty to care for their children. Hospital policies must be applied fairly to uphold (3) a principle of justice, including equal application that does not discriminate on the basis of age, sex, gender, religion, race, ethnicity, or socioeconomic status. Ideal hospital policy balances these 3 interests, allowing all parties to uphold their particular duties as best as possible.

In this case, both routine and pandemic visitor restriction policies impact these 3 interests. The routine policy aims to protect both patients and visitors in multiple ways. First, these policies limit infectious risks in the hospital (even in the absence of pandemic risks) by restricting minor presence overnight. Similar restrictions have been associated with significantly decreased health care–acquired respiratory viral infections among patients. Second, the policy mitigates possible safety concerns, including the myriad risks of a sibling in a hospital environment overnight. In this scenario, siblings may be inadequately supervised around medications, hospital equipment, and medical supplies while parents are sleeping and/or attending to the needs of the patient along with hospital staff, ultimately placing patient, family, and staff at risk for harm. The policy upholds the hospital’s duty to protect patient safety and, by extension, family, visitor, and staff safety through risk mitigation.

Compliance with the policy is one way for parents to uphold their duty of care by helping reduce their child’s risk of respiratory infection during hospitalization as well as limit the sibling’s potential exposure to harm. However, this restriction does place significant burdens on families. Families may not have physical or material means to arrange child care for siblings. Parents are then faced with the difficult choice to leave the patient alone during much if not all of the hospitalization. Although hospital staff is well equipped to provide for the physical safety and wellbeing of the patient, a potential for psychological harm to the child or medical error without a caregiver present is real, particularly in the context of a child with complex illness. Here, a parent’s duty to care for their children (both patient and sibling) is compromised.

This case demonstrates that equal application of policy does not necessarily ensure equitable application. A policy that effects more vulnerable populations disproportionally is in fact inequitable. Although this policy places inconvenience on those who can afford private child care or rely on family members to help watch siblings, the restriction can, as in this case, place substantial burden on other parents and subsequently prevent them from upholding their duty of care. In this setting, the rule is unjust.

Cases like this one are not particularly rare. Our institution recognizes this inequity, and works toward just solutions. As with this case, some families are offered emergency respite services for siblings. Although placing children with unfamiliar caregivers is not ideal, it has proven to be a safe and successful option. In other cases, particularly with infant siblings, exceptions to the policy have been
granted and siblings have been allowed to remain with the patient and parent overnight. Exceptions are granted on a case-by-case basis, whereby the risk versus benefit of allowing a sibling to stay is evaluated by the social work department, sometimes in conjunction with ethics consultation.

Within this framework of justice and equity, the parent’s request in this case is reasonable and necessitates close consideration. Outside of the current pandemic, I would argue that the mother’s request should be granted. The procedure itself is uncomplicated and the hospitalization is not expected to be protracted. Denying the exception request poses potential risk of psychological distress for both mother and children. If left with hospital staff, the patient could become agitated and place herself at risk for harm. Conversely, if the mother remains with the patient and places the sibling in respite care, the sibling could experience distress being in the care of unknown providers. In either scenario, the mother is also at risk for psychological distress while worrying about the child not in her direct care. Without financial or social resources to choose otherwise, this mother has 2 poor options, both of which impede her ability to care for her children as she sees fit. Arguably the application of the routine visitor restriction in this case is inequitable, and as such, exception is justifiable.

However, this case does not occur within “normal” times and must be scrutinized within the context of the COVID-19 pandemic and the secondary policy restricting all patient visitation to 2 adult caregivers. This case hinges on whether the COVID-19 pandemic substantially alters the balance of a hospital’s duty, a parent’s duty, and justice.

SARS-CoV-2 has extensive community spread. Communities continue to see dramatic increases in case positivity, emergency department visits, hospital admissions, and death. Without widespread vaccination, strict visitation restriction remains a critical public health measure. These realities alter the ethical dialectic. The risk of viral spread and illness to both patients and the community is dramatically heightened. As a direct corollary, hospitals are ethically justified, and arguably, required, to rigorously implement policies to protect the health and safety not only of patients, families, and staff but also at the scale of population health. A hospital’s duty shifts during a pandemic beyond the needs of immediate individuals. Visitation restriction, known to reduce viral transmission in routine medical care, can and should be bolstered, including not only more stringent visitation restrictions but also raising the threshold for justifiable exemption. The mother’s exemption request in this case must be reexamined with this altered balance of burdens, risks, and benefits.

With both routine and pandemic restriction, the mother remains faced with the choice to be physically present with either the patient or the sibling overnight. The pandemic restriction extends this choice to daytime hours as well. The primary burdens remain unchanged: potential psychological distress on family and hindrance of the mother’s ability to ideally care for both children. Weighed in light of the current state of the COVID-19 pandemic, however, these burdens no longer reach the threshold required for exemption. The risk of COVID-19 transmission at the community level and within the hospital setting is simply too high. Societal costs of not reducing spread are dire: higher death tolls, continued economic debilitation, and yet unquantified morbidity. Furthermore, the COVID-19 pandemic has disproportionately affected minority populations across multiple domains. Inadequate prioritization of public health measures then simultaneously runs the risk of propagating preexisting health inequities for already vulnerable populations.

Within this case, then, the potential benefit of strict adherence to visitation restriction increases, as does risk of nonadherence. The burden of the policy’s application to this individual family is similar to nonpandemic times. The alternative options offered to the mother, either leaving the patient in the care of hospital staff or placing the sibling in temporary respite care, are safe, reasonable solutions, although certainly not ideal. The patient’s mother will undoubtedly be dissatisfied with what feels like an imposition on her ability to care for her children as wished. She may, indeed, refuse all the options presented as untenable pathways to dutifully care for her children and defer the patient’s procedure. Such a decision, however, would reasonably be critiqued as not in the patient’s best interest given the medical risks of inaction. Because difficult social situations are unfortunately not rare for our patients, offering exemption becomes problematic. Even a small set of exemptions to policy within the context of a global pandemic can effectively negate the benefits of the rule, essentially eliminating the value of social distancing. Justice here takes a different tone. A hospital’s expanded sphere of duty during pandemic necessitates a broadened view of justice. During a pandemic, population level considerations take precedent over (but do not erase) individual considerations. The application of
the rule continues to have elements of inequity and uneven burdens. However, individual, family, community, and truly global health and societal justice are at stake. The balance of benefit and risk is shifted, and fair application is concordantly reframed.

OUTCOME
The hospital upheld both visitor policies without exception. It believed that making safe child care available for the patient’s sibling at no cost to the patient’s mother adequately addressed the disproportionate effect of the policies on this patient and her family.

The patient’s mother decided to delay the procedure. She rescheduled for 5 weeks after the patient’s initial emergency department admission for a family member to travel from out of state and quarantine before caring for the patient’s sibling during the patient’s hospital stay. Although the procedure was delayed beyond the recommended time frame, the patient did not experience any adverse outcomes because of this postponement. Her mother was able to remain with her throughout her hospitalization.

ARMAND H. MATHENY ANTOMMARIA, MD, PhD, COMMENTS
Although increasing vaccination rates may permit some relaxation of increased visitor restrictions, they are unlikely to return to “normal” for the foreseeable future. Not making an exception to them might be fair but result in significant harm to the patient. The hospital has been attentive to the disparate impact of its visitor restrictions on this patient and her family. It attempted to address the family’s unique circumstances and the disproportionate burden on them by arranging safe and reliable child care for the patient’s sibling. The potential risks and discomforts to the sibling are commensurate to those experienced by other children, for example, left in the care of a co-worker’s adolescent child or a fellow member of a religious community. If the patient’s mother, however, is unwilling to accept this option and postpones the patient’s care indefinitely, the patient may be placed at significant risk of harm. If there is an imminent risk of death or serious disability, postponing treatment might constitute medical neglect. Coercing treatment might, however, result in other significant, secondary harms. Even if it does not constitute medical neglect, the patient might be at substantially increased risk of serious complications including a hypoxic ischemic injury. Depending on the magnitude and frequency of these risks, granting an exception to the visitor restrictions to permit the sibling to stay overnight might be unfair to other patients and families but justified on the basis of protecting the patient’s best interests.

ABBREVIATIONS
COVID-19: coronavirus disease 2019
SARS-CoV-2: severe acute respiratory syndrome coronavirus 2

REFERENCES

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Pediatrics 2021;148;
DOI: 10.1542/peds.2021-051254 originally published online May 14, 2021;

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DOI: 10.1542/peds.2021-051254 originally published online May 14, 2021;

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