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COVID-19 Visitor Restrictions Ethics Review:

Assessing Exceptional Circumstances, Particularly End-of- Life Scenarios

General Comments and Ethical Considerations

- Good ethics is based on established facts, and so the ethical justification for limiting visitation in exceptional situations such as end-of-life and other scenarios must be **anchored to the most current, credible scientific evidence**, including the clinical expertise of those most competent to interpret the evidence;

- Covenant has adopted *AHS Insite* updates regarding visitor restrictions (**latest statement March 25, 2020**) as the source of truth, notwithstanding the need to contextualize and interpret the guidelines based on clinical assessment, in real-time, at the point of care.

- We also work within an **unique cultural context,** in which decision-making is informed by Covenant's values, ethical traditions, and recognition of day-to-day site operational realities;

- However, even with the most credible information, clearly stated guidelines, and historic cultural norms to draw on, it's reasonable to expect **prudential judgements** will be required;

- Given the evolving nature of COVID-19, it's also likely that visitor restriction guidelines will become **increasingly more restrictive** as the risk of vector spread of community cases grows;

- We see evidence of this in hospitals elsewhere that are completely overrun by COVID-19 patients, **requiring cessation of all visitors**, including being with patients at the end-of-life;

- The principle of **benefit and burden** shifts along this continuum, balancing the good visitation brings in serving the well-being of the patient/resident, or comfort to the dying person, with the burden of risk of harm in spreading infection within the facility, or afterwards in the community;

- Narrowing the benefit-burden calculation and its application requires defining what constitutes an **essential visitor**, and the prudent steps to **verify, screen, and escort** essential visitors to patient/resident rooms. The guidelines also limit the **number** of essential visitors to one, and automatically excluding symptomatic visitors, including children, youth and pets.

- Shifting priority from the needs of individuals to that of the welfare of the population as a whole is ethically justified from a **utilitarian** perspective. This is reflective of the overall goals found in most pandemic ethics frameworks that seek to **minimize illness, death, and societal disruption**;

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- However, it's also ethically important that in fulfilling these goals we take the **least restrictive measures** possible (e.g., voluntary self-isolation vs. mandatory quarantine), as well, to ensure the restrictions placed on individuals are **proportionate, measured, and fair** given what that individual must give up. This is another way in which we need to balance benefits and burdens;

- Those who bear the greater burden in being restricted access to their loved ones should be at least be provided a **transparent rationale** for the decision, as well as **alternative means** to facilitate meaningful contact;

- In that regard, facilitating **family presence** is a key consideration during a pandemic, not necessarily or always *physical visitation*, as meaningful connection can still be achieved virtually by means of telephone, video calling, FaceTime, etc.;

- **Fairness** also requires means for family to question and appeal decisions, as well, provided the assurance that restrictions are not arbitrary nor personal. Its critically important that we treat like situations in like manner, and strive for **consistent approaches** to exceptional situations, based on objective, transparent criteria;

- We also need to widen our understanding of health to ensure we are not narrowly focusing on trajectory of disease alone, but rather, a **holistic approach** that recognizes the benefit of emotional and spiritual support, both for the person in care and their families, as well as for staff who may not be able to provide these supports during a crisis;

- We also need to widen our time frames in which benefit/burden will be measured. Families who may be unfairly and disproportionately deprived of timely presence during their loved one's imminent dying could result in a lifetime of complicated grief due to lack of closure, guilt, comfort measures, etc. The overarching goals of minimizing social disruption must include these **collateral harms**;

- Similarly, the risk of moral residue among staff who fear granting visitor access to our facility, resulting in community spread "and shutting down the hospital", or; conversely, denying access to family members and subsequently vilified for lacking compassion must also be recognized. The **principle of reciprocity** requires that we support our staff who will make these and other prudential decisions, knowing it will be impossible to guarantee the correct judgment call in all situations, no matter how much may be available at the time.

- Some visitors may underreport their symptoms that later results in harm, that an individual staff member could be unfairly blamed. Covenant's **Just Culture** policy needs to support and back up our staff who face this burden of responsibility;

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- Increasing **public messaging** from high level officials (e.g., from the MOH) regarding visitor restrictions will help ease this burden from clinicians, as well as to prepare the public of what to expect should they be denied access. The new video on *Insite* is a good start, but more explicit public statements about assessing exemptions at the end-of-life are required;

- Finally, Covenant's code of conduct, *Our Commitment to Ethical Integrity*, upholds the **principle of subsidiarity**, in striving for decision-making at the most appropriate levels. We need to balance the roles and responsibilities of our clinical disciplines who may hold divergent opinions, or perceived levels of authority to grant or deny visitation.

- This requires clarifying the current role of hospice and other site leaders as the ultimate decision-makers, with recommendations by IPC and other disciplines, recognizing this could change as the pandemic evolves;

- The ethics dictum that "good people may draw different conclusions," will certainly be evident in emotionally charged events like a pandemic, and Covenant's Just Culture also applies in helping bridge potential misunderstanding and judgement over differences of professional opinion. **Mitigating the loss of trust or damaged relationships** is another form of social disruption to avoid;

- In a public health emergency, utilitarian ethics principles tend to trump individual rights, including the authority of individual families, site operational leaders, or other clinical disciplines, but these should always be proportionate for what we are trying to achieve overall.

- Catholic social teaching upholds the **principles of solidarity and the common good,** and its in aligning our efforts, collective wisdom, and our trust in one another that will best help us respond to the pandemic, and the recovery afterwards.

Application of Principles to Specific Scenarios

Despite permitting only one essential visitor, and absolutely precluding symptomatic individuals and children to visit, the Visitor Restrictions during Pandemic (dated March 20, 2020, and last reviewed March 28th), *nevertheless* allow exceptions to these restrictions on a case-by-case basis, subject to the following:

- The requests are reviewed and approved by the unit manager or nursing staff;
- Visitors with symptoms and children are provided PPE and escorted to and from the room

A similar statement issued March 28, 2020 specifically addressed Hospice Visitor Guidelines. Given that no two situations are alike, potential variation in how one unit or hospice manager justifies exceptions is likely, and thus it's important that IPC, Ethics, Patient Relations, OSH, Spiritual Care,

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and other disciplines are consulted for their input to ensure as consistent practice across Covenant as possible.

We have already seen evidence of diminished public trust and concerns raised by families in being denied access to visits, which in turn will increase pressure on staff granting or declining requests, and feeling morally conflicted in doing so.

Conflict can also arise if exceptions to the rule are too broadly interpreted. For example, requests to visit patients undergoing cancer treatment, or those in the early stages of their palliative journey, or even frail but relatively stable seniors would generally not compel granting an exception as would the request involving an actively dying person.

Along with the new **Visitor Restrictions at End-of-Life,** it's more than likely further updates will be necessary, as already seen in some settings overrun by COVID-19 patients, when all visitors are restricted – without exceptions – even at the end-of-life.

IPC input and guidance is critical for the assuring the best decisions, and to support unit managers in making those judgment calls. Their expertise is essential in helping creating a care plan, including the necessary safety preparations before the visit, and each step throughout the process – upon the essential visitor's arrival to the facility, during their visit, and afterwards.

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Covenant Health, March 30, 2020