CONCEPTUAL PAPER

Visitors not Welcome: Hospital Visitation Restrictions and Institutional Betrayal

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Abstract

Healthcare organizations' continued restrictions on hospital visitation during the COVID-19 pandemic can be considered a violation of the rights of hospitalized patients to receive family visitors. Despite expert opinion related to the safety of visitation and low risk of visitor transmission with appropriate monitoring and precautions, hospital visitation restrictions have continued beyond the initial crisis phase of the pandemic, with little transparency or inclusion of key stakeholders in the decision-making process. Particularly on critical care units, blocking access to family visitors can contribute to additional harm and trauma for care-dependent hospitalized patients and their families. Utilizing an institutional betrayal framework, the aim of this commentary on hospital ICU visitation policy is to provide a discussion of how hospitals who serve a care-dependent population have placed critically ill patients, families, and healthcare workers at risk for complex trauma. Hospital social workers should incorporate an integrated social work approach to advocacy efforts which address not only individual hospitalized patient service needs, but also the uneven power differential that can contribute to inequity in visitation, medical mistrust, and long-term community trauma. On the interprofessional ICU team, social workers can function as trauma informed systems experts, coordinating and facilitating supports to help patients and families cope with hospitalization, while also advocating within their institution and with elected officials for policy change to protect patient and family–centered visitation rights.

Keywords Hospital visitation · COVID-19 · Policy practice · Critical care social work · Institutional betrayal

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Introduction

Prior to the first documented cases of COVID-19, a widespread recognition of the value of hospital visitation, and the essential contribution of family care partners to recovery, comfort, and healing contributed to the growth of patient and family–centered models of open visitation (Nassar et al., 2018; Rosa et al., 2019; Shulkin et al., 2014). In patient and family–centered models of care, family visitors, or care partners are defined by patient choice and are not limited to biological family (Frampton et al., 2017). Care partners have been recognized as vital members of patient care teams due to their knowledge of health history, their abilities to assist with medical decision-making, and their essential role as care providers for safe discharge planning. In the years between the H1N1 pandemic and the first cases of COVID-19 in the USA, a culture shift from traditional provider-centric visitation policy to patient and family–centered care models for visitation was propelled by research evidence and a need to improve patient satisfaction scores linked to reimbursement by the Patient Protection and Affordable Care Act (Frampton et al., 2017; Gasparini et al., 2015; Milner et al., 2021). Evidence supporting open visitation has shown that patients with unrestricted access to family visitors have decreased frequency of delirium (Nassar et al., 2018; Rosa et al., 2017), fewer cardiovascular complications (Fumagalli et al., 2006), reduction in depression and anxiety (Nassar et al., 2018), shorter stays in the ICU (Rosa et al., 2017), and increased overall patient and family satisfaction with care (Shulkin et al., 2014).

An environmental scan of hospital visitor policies taken just prior to the pandemic, revealed that 51% of hospitals were describing their ICU visitation policy as open, welcoming family and visitor presence at all times, and adjusting provider practice to accommodate unrestricted bedside presence of care partners (Milner et al., 2020). At the start of the pandemic in the winter of 2020, US healthcare systems faced an unprecedented crisis and needed to urgently reduce the number of people on hospital grounds due to uncertainty surrounding the novel coronavirus disease (COVID-19), a shortage of available PPE, and the speed of transmission. Drastic shifts in hospital visitor policies suspended all open visitation, which had become the recommended evidence-based approach on critical care units (Azoulay et al., 2021; Dokken et al., 2021; Nassar et al., 2018; Society of Critical Care Medicine, 2020).

The End of Open Visitation

Shortly after the first wave of cases began to surge and the demand for hospital ICU beds increased, the US Declaration of National Emergency was enacted for the purpose of mitigation of the COVID-19 pandemic (Valley et al., 2020; Zeh et al., 2020). The emergency declaration contained no federal policy change or mandate related to hospital visitation; however, widespread visitation restriction occurred due to the momentum of this declaration, a lack of knowledge related to disease transmission, concern for the safety and the strain placed on healthcare workers, and a limited supply of reliable testing and personal protective equipment (Jaswaney et al., 2021; Valley et al., 2020). Critical care units, with the highest acuity and most care-dependent patients, experienced a

rapid culture shift and an end to visitation. Estimates of between 93 and 98% of hospitals enforced policies of no visitation at all on ICUs during the first several months of the pandemic (Azoulay et al., 2021; Valley et al., 2020).

Restricted Visitation as Infection Control

In hospitals, strategies for infection control precautions traditionally fall into one of two categories: standard and enhanced transmission precautions (Centers for Disease Control & Prevention, 2016). Enhanced transmission precautions are infection control strategies beyond standard precautions. These recommendations vary by pathogen type and method of transmission (i.e., direct or indirect human contact, respiratory droplets, or airborne) (Leung, 2021). Pre-pandemic, infection control to address respiratory illness transmission focused primarily on the creation of safe spaces in hospitals for both identified patients and healthcare workers (Centers for Disease Control & Prevention, 2016). PPE shortage and uncertainties related to the virus that causes COVID-19 (SARS-CoV-2) caused hospital systems to approach transmission precautions with an overall hospital population parameters approach (number of people who can safely occupy space in the hospital) (Escandón et al., 2021; Gandhi, 2022; Leung, 2021). Crisis response early in the pandemic reduced the number of non-essential people permitted on the grounds of the hospital for work, non-emergent medical procedures, and visiting (Escandón et al., 2021; Valley et al., 2020).

Most experts believe that this first crisis response of visitor restrictions was an appropriate response to protect healthcare workers and mitigate the spread of a novel coronavirus in which science had not yet been able to determine the best practice for infection control (Munshi et al., 2021; Passarelli et al., 2021). Several studies have now shown that actual incidence of visitor-to-patient transmission was minimal in the first wave of infections before restrictions were enforced (Rhee et al., 2020; Wee et al., 2021; Zhou et al., 2020). Despite this new evidence and current availability of PPE and vaccines, there are still US hospitals that continue to enforce no visitation policies for some patients, even at times, for patients at end of life (Azoulay et al., 2021; Marmo & Milner, 2022; Siddiqi, 2020).

On September 15, 2020, the Centers for Disease Control (CDC) released recommendations for returning visitors to healthcare facilities through safe facilitation of visitation. Individuals wanting to visit loved ones should use designated entrances, have no acute respiratory illness symptoms, and adhere to national personal protective equipment standards (Center for Disease Control and Prevention, 2020). Nearly 2 years into the pandemic, most experts agree that full restriction of visitation is not necessary and should never happen again. Despite these expert recommendations, most healthcare institutions continue to require their employees to restrict visitors on critical care units (Jones-Bonofiglio et al., 2021; Leiter & Gelfand, 2021).

Federal Policy Related to Hospital Visitation

The right of a hospitalized patient to receive visitors while in a hospital was addressed in Conditions of Participation (CoP's) and by Presidential Memorandum pre-pandemic.

Prior to 2010, hospitals could limit visitation to patient's immediate family, which contributed to inequity in visitation rights for same-sex couples and for those who wanted their own choice in visitors (Cappellini et al., 2014). In 2010, a Presidential Memorandum changed that practice and ensured that any hospital that received federal funding must respect the rights for patients to designate their own visitors, and those visitors must have same rights as immediate family members. Within this rulemaking, there is consideration of "the need for hospitals to restrict visitation in medically appropriate circumstances" (Memorandum, 2010).

Conditions of Participation (CoP's) are published in the Code of Federal Regulations and are requirements that hospital systems must comply with in order to participate and receive funding from the largest payors for healthcare in the USA — Medicare and Medicaid. According to *Patients' Rights Condition of Participation, 42 CFR § 482.13* (2011).

> A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights, and the reasons for the clinical restriction or limitation.

Written prior to the pandemic, both regulations do allow for hospitals to restrict visitation for medical reasons; however, the hospital needs to provide written policies and procedures to justify if these are *clinically necessary or reasonable restrictions* (*Patients' Rights Condition of Participation, 42 CFR § 482.13*, 2011).

Although the CDC is the national public health agency, CDC tends to serve an advisory role, so the recommendations for a return to visitation are not able to be considered official public policy, but rather offers guidance which can be made into enforceable policy through Joint Commission Accreditation, Medicare Conditions of Participation, or legislative action. As of the writing of this article, neither Joint Commission nor the Centers for Medicare and Medicaid Services have released specific clinical guidance related to safe visitation during the pandemic, but have recognized the current deficiencies, poor quality care outcomes, and decreased patient and family satisfaction caused by restricted visitation during the pandemic (Escandón et al., 2021; Gandhi, 2022).

Medical Mistrust and Inequity

While mistrust of healthcare institutions has increased among all populations (Brenan, 2021), there continues to be large disparities in trust level by race/ethnicity. During COVID, this has contributed to a higher likelihood of patients who are not White experiencing inequitable care and healthcare outcomes, especially when family is prevented from visiting, advocating, and providing needed support to hospitalized patients (Gandhi, 2022; Hugelius et al., 2021). Patients with limited English proficiency often find themselves at a disproportionate disadvantage with strict visitation restrictions. Blocking access to family visitors reduces communication and understanding of illness (Espinoza & Derrington, 2021; Kucirek et al., 2021). Families with language barriers have also face additional barriers to

visitation, including often having English-only visitation policies available to the public via hospital website, written communication, and media (Jaswaney et al., 2021; Valley et al., 2020).

Patients from Black, Hispanic, Indigenous, and other minoritized groups experience greater medical mistrust and higher likelihood to perceive hospitalization as a traumatic event (Hagiwara et al., 2013; Hoffman et al., 2016). The removal of family visitors has placed a disproportionate risk of harm on women and patients of color with more opportunities for unfair treatment and a higher likelihood for both inherent and overt bias to go unnoticed. Laster Pirtle and Wright (2021) suggests that an intersectional analysis of the COVID-19 pandemic sheds light on how healthcare provider bias based on gender and race impacts the quality of care in hospitals disproportionately. When examining systemic racism and distrust of healthcare organizations through a trauma lens, Klest et al. (2020) noted that people who are not White have experienced worse treatment, higher mortality, and higher levels of feelings of betrayal by healthcare institutions, contributing to a higher likelihood of a complex trauma response.
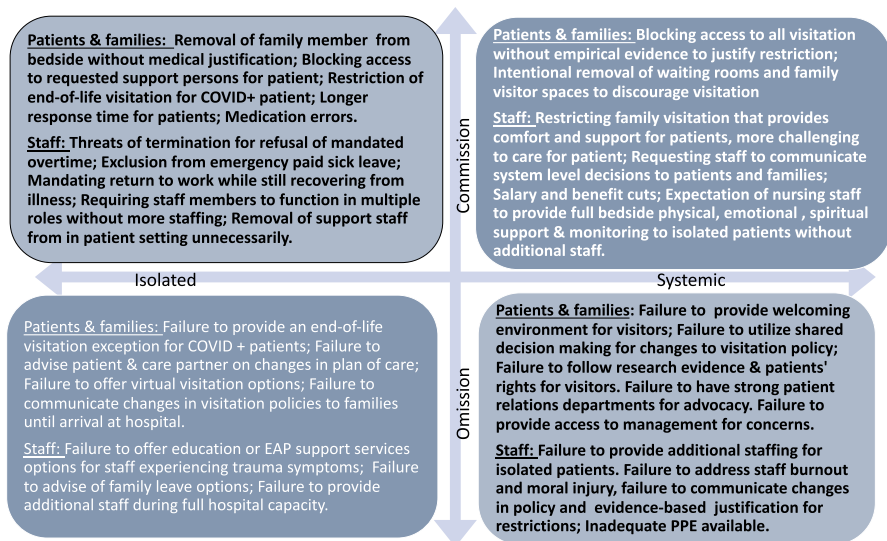
Institutional Betrayal

Institutional betrayal views institutions that serve dependent populations as trustworthy, but fallible and capable of inflicting additional harm (Thompson, 2021). This concept is based on Betrayal Trauma Theory, which posits that harm within a trusted relationship can create complex trauma through a breaking of trust (or revictimization) of those already in a vulnerable or dependent state (Smith & Freyd, 2014). This betrayal is especially harmful due the violation of trust from an entity that is designated to a role of providing protection and safety (Birrell & Freyd, 2006; Smith & Freyd, 2014). Originally conceptualized to apply to trauma in terms of an individual relational context, institutional betrayal develops this theory further to include how violations can be committed by institutions (such as law enforcement organizations, victims' advocacy services, schools, and hospitals) (Smith & Freyd, 2014). Even among those that may not trust institutions, such as minority groups that experience medical mistrust, the unavoidable dependence on the institution of healthcare creates a relationship in which betrayal can be experienced (Smith & Freyd, 2014). Institutional norms and attitudes contribute to policies and structures that then impact the behaviors of individuals within the institution, such as healthcare providers (Hoefer, 2022).

Initial decisions to restrict visitors reflected the good intentions of the healthcare system to act in the best interest of their patients and staff, and to relieve pressure on the healthcare system in a time of crisis. However, as the pandemic progressed beyond the initial crisis, continued institutional policies, blocking visitor access without transparent and evidence-based decision-making, have been harmful to patients and care partners who are dependent upon that institution for their health. When the options for safe visitation are available, restricting visitors does not minimize harm to patients and places vulnerable populations with less locus of control over their care and at a higher risk for harm (Hartigan et al., 2021).

Large healthcare systems' inadequacies have been described as *institutional betrayal* against the community of those who depend on these institutions (Klest et al., 2020). Examples of institutional betrayal include creating an environment in which unsafe healthcare experiences seem normal or more likely to occur, lack of responsiveness to concerns, and denying of experiences (Smith, 2017). Institutional betrayal has been shown to impact patient trust (Shoemaker & Smith, 2019; Smith, 2017), and is associated with PTSD-related symptomatology (Klest et al., 2019; Smith & Freyd, 2014).

Institutional betrayals can be acts of commission or omission, or multiple occurrences. Acts of commission have occurred through direct action, such as blocking access to visitors beyond the initial crisis phase of the pandemic, while acts of omission occur through inaction (i.e., negligence), such as lack of transparency or participation in shared decision-making with key stakeholders regarding visitation policies. The experience is interpreted as a betrayal when it does not align with patients', families', or healthcare workers' expectations of safety and support. See Fig. 1 for examples of how hospital policies and actions related to restricted visitation can contribute to the development of additional trauma for patients, families, and healthcare workers. In the betrayal trauma framework, the trusted entity's actions result in medical mistrust, disengagement from healthcare, and the development of traumatic response related to healthcare experiences.

While there is much evidence to support the dedication that front line healthcare workers have demonstrated during the pandemic, there have also been reports of how some healthcare providers prefer the absence of family, so that full attention can be given to the work of patient care, and less interruptions by family (LoGiudice & Bartos, 2021; Marmo & Milner, 2022). While widespread recognition of the value,

Patients & families: Removal of family member from bedside without medical justification; Blocking access to requested support persons for patient; Restriction of end-of-life visitation for COVID+ patient; Longer response time for patients; Medication errors.

Staff: Threats of termination for refusal of mandated overtime; Exclusion from emergency paid sick leave; Mandating return to work while still recovering from illness; Requiring staff members to function in multiple roles without more staffing; Removal of support staff from in patient setting unnecessarily.

Patients & families: Blocking access to all visitation without empirical evidence to justify restriction; Intentional removal of waiting rooms and family visitor spaces to discourage visitation

Staff: Restricting family visitation that provides comfort and support for patients, more challenging to care for patient; Requesting staff to communicate system level decisions to patients and families; Salary and benefit cuts; Expectation of nursing staff to provide full bedside physical, emotional, spiritual support & monitoring to isolated patients without additional staff.

Commission

Isolated — Systemic

Patients & families: Failure to provide an end-of-life visitation exception for COVID + patients; Failure to advise patient & care partner on changes in plan of care; Failure to offer virtual visitation options; Failure to communicate changes in visitation policies to families until arrival at hospital.

Staff: Failure to offer education or EAP support services options for staff experiencing trauma symptoms; Failure to advise of family leave options; Failure to provide additional staff during full hospital capacity.

Patients & families: Failure to provide welcoming environment for visitors; Failure to utilize shared decision making for changes to visitation policy; Failure to follow research evidence & patients' rights for visitors. Failure to have strong patient relations departments for advocacy. Failure to provide access to management for concerns.

Staff: Failure to provide additional staffing for isolated patients. Failure to address staff burnout and moral injury, failure to communicate changes in policy and evidence-based justification for restrictions; Inadequate PPE available.

Omission

Fig. 1 Dimensions and examples of Institutional Betrayal experienced by key stakeholders due to restricted visitation during COVID-19

sacrifice, and heroism of frontline healthcare workers is certainly justified, hospital institutions have not responded to the increased workload created in caring for COVID patients through better monitoring of safe visitation. During this crisis, healthcare systems have also engaged in cost-saving measures such as salary cuts, benefit reduction, denial of time off, and inadequate PPE, which immediately impacted their already depleted and overworked employees (Yong, 2021). This is institutional betrayal of healthcare workers. Current employment statistics reflect a growing shortage of healthcare workers. Since the start of the pandemic, over half a million healthcare workers, approximately 1 in 5 of all healthcare workers, have left their jobs (Yong, 2021) and nearly 66% of all acute and critical care nurses have considered leaving the profession of nursing altogether (Munro & Hope, 2022). Larger healthcare systems need to respond to this healthcare emergency with increased staffing and authentic offers of support to assist with communication, coordination, monitoring, and education to families about safe visitation.

Trauma Framework

Institutional betrayal and betrayal trauma theory are aligned with the definition of trauma by The Substance Abuse and Mental Health Service Administration [SAMHSA]. This conceptualization of trauma, described as the "3 Es", utilizes a framework of events, experience, and effects (Lathan et al., 2021). Events are objective experiences, experiences are subjective interpretations of the event, and effects are the impact of the trauma exposure (Lathan et al., 2021). As shown in Fig. 2, applying this trauma framework to hospitalization during COVID-19 draws attention to the disproportionate power that large hospital healthcare systems have on how a potentially traumatic *event* such as COVID-19 hospitalization is *experienced* by patients, families, and healthcare staff. Increased involvement and presence of family in ICU hospitalizations have been shown in the research to act as a protective factor against the development of feelings of fear, anxiety, and PTSD symptoms (Nassar et al., 2018; Rosa et al., 2017; Zeh et al., 2020). Therefore, decisions to restrict or facilitate family visitation can contribute substantially to how an individual *experiences* trauma, along with the potential for developing long-lasting complex adverse *effects* of that trauma.

Evidence of patient distress due to the absence of family members has been well documented during the pandemic (Bartoli et al., 2021; Hugelius et al., 2021; Matheny Antommaria et al., 2021; Montauk & Kuhl, 2020), along with heightened family distrust of medical staff (LoGiudice & Bartos, 2021), traumatic response to separation (Montauk & Kuhl, 2020), and complex bereavement response for those separated during the dying process (Diolaiuti et al., 2021). Front line healthcare workers have reported symptoms of Post-Traumatic Stress Disorder (PTSD) (Azoulay et al., 2020; Wozniak et al., 2021), burnout, and intention to leave their jobs due to their roles enforcing no visitation policies (Malliarou et al., 2021).

Prior to the pandemic, visitation policies have been primarily a nursing-led decision-making process (Khaleghparast et al., 2016). However, currently, front-line healthcare workers have reported a lack of input into the decision-making process that occurs
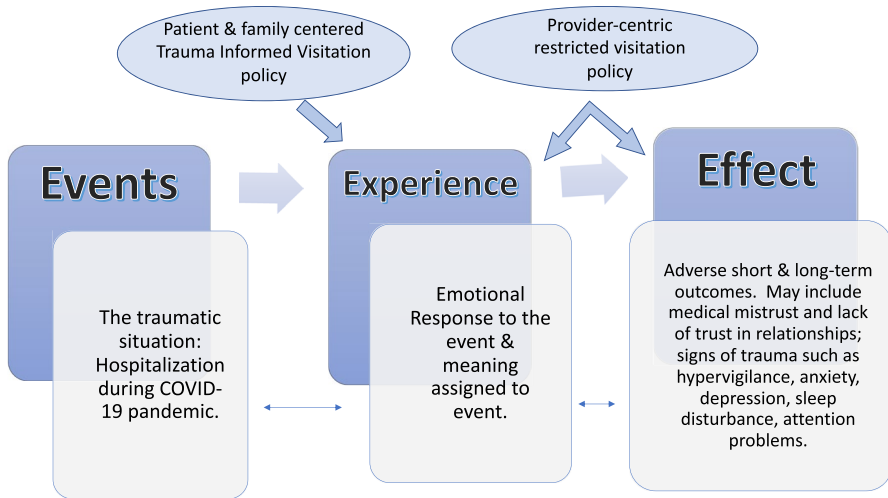
Fig. 2 Three E's Trauma Framework & Hospitalization during COVID-19

outside the realm of their control, practice, or influence (Marmo & Milner, 2022). It has become largely the responsibility of larger hospital systems to conduct evidence-informed safety and risk assessments when establishing visitation policy (Raphael et al., 2021). Larger hospital systems' lack of research evidence as a primary driver of visitation policy has resulted in diverse and inconsistent visitor policies from hospital to hospital (Marmo & Milner, 2022; Munshi et al., 2021; Valley et al., 2020; Weiner et al., 2021). Key stakeholders, including patients, families, and healthcare workers, continue to not have any input or control over visitation, making the development of complex trauma response more likely due to an ongoing sense of fear, helplessness, or power-lessness over an extended period of time.

Implications for Social Work Policy Practice

Much of the research that supports family visitation in healthcare facilities has appeared in the nursing and medical literature, with very little research or opinion related to hospital or healthcare visitation in social work journals. One exception is a 2005 research study comparing the impact of pet visitation to "people" visitation in long-term care facilities (Lutwack-Bloom et al., 2005). Hospital social workers work in environments that traditionally place primacy on the physical needs of patients using a medical model, with the disciplines of medicine and nursing as primary drivers of the care a patient receives. During the COVID-19 pandemic, decisions regarding hospital visitation have been even more removed from daily social work practice, and are occurring on larger system levels, with little to no input from any key stakeholders, including patients, families, nursing, medicine, social work, or any other ancillary service. Given that communication and support with family has been described as a key responsibility of hospital social workers, and communication with family related to medical status has

become an additional responsibility that social workers have had to adopt during the busiest times of the pandemic, policies that restrict or fully ban any hospital visitation should be a priority area for social work policy practice. More equitable visitation policy that facilitates family presence can benefit from social work intervention on multiple levels of practice.

On the micro level of practice, individual healthcare social workers can advocate for families to be able to visit more often with patients in need of support and to provide reminders to other disciplines of the need to involve family when patients are experiencing changes in plans of care. Social workers should continue to model patient and family–centered care practice when participating in interprofessional team meetings and question visitation decisions that do not align with best evidence–based practice. Social workers can also advocate for support programs to help families by creating and facilitating virtual support groups to help build connection to the hospital and offer avenues for communication of concerns.

On the mezzo level of practice, social workers have been leaders in transforming individual human service organizations with Trauma Informed Care in community-based practice. Social worker's advocacy in hospitals can include prioritizing and educating leadership on what it means to be trauma-informed, and to utilize social workers' expertise in trauma to adopt hospital education and training programs in culturally competent and trauma-informed approaches to patient care, which include improving access to family visitors for patients in need.

On the macro level of practice, social work leadership in healthcare systems offer opportunities for collaboration on policy implementation and use of evidence-based practice, two areas of expertise that social workers can be prepared to utilize to help facilitate improved and inclusive visitation policy in alignment with social work values and patient and family–centered care. Hospital social workers can use community-organizing skills to recruit volunteers to help with communication, education, and monitoring of visitors, and ensure compliance with safe visitation requirements. Hospital social workers can also collaborate with other social workers to form advocacy coalitions for contacting their state and federal legislators and influencing the political process to advocate for legislation to guarantee access to visitors. On the state level, Florida (No Patient Left Alone, 2022) and North Carolina (No Patient Left Alone Act, 2021) have all recently enacted legislation to guarantee hospitalized patients access to visitors. These acts require hospitals to facilitate in-person visitation beyond comfort care exceptions to include patients who are grieving a loss, struggling with lack of family support, requiring assistance with eating or drinking, making one or more major medical decisions, or experiencing emotional distress.

Conclusion

An important concept in Betrayal Theory is institutional courage, in which Adams-Clark and Freyd has described as the "antidote" for institutional betrayal (2021). Institutional courage refers to accountability, transparency, and support for those individuals who have been harmed by institutions and involves a commitment "to protect and care for those who

depend on the institution" (Redden, 2021, para. 3). Social workers in healthcare need to participate in correcting the human rights violation caused by restricted visitation and advocate for critically ill patients who do not have the power to lend their voices to the dialog around hospital visitation rights. Utilizing an institutional betrayal framework can help inform research and policy practice and serve as a call to action for the social work profession to correct harms currently being inflicted on care-dependent critically ill hospitalized patients. Utilizing an institutional betrayal framework will help to shape an approach to social work practice that includes trauma-informed policy practice, leadership, and advocacy for securing visitation rights for all hospitalized patients.

Declarations

Conflict of interest The authors declare no competing interests.

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