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Laboring alone? Brief thoughts on ethics and practical answers during the coronavirus disease 2019 pandemic

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The iconic image of the mid-20th century childbirth is a woman's partner—always a man, always her husband—pacing in a waiting room until a nurse in white bursts through the door to announce that his wife (always again) had given birth to a boy or a girl. This is followed by much backslapping and cigar smoking with the other expectant fathers until, hours later, the new father peers through a nursery glass to pick out his child from the assembled rows of newborns.

Such has not been the norm for decades, and obstetricians and midwives would have thought that the days of sequestering partners outside labor and delivery units were long past. Yet, these are extraordinary times, and during the current coronavirus disease 2019 (COVID-19) pandemic, hospitals have been eliminating patient visitors in an effort to promote social distancing and protect the health of their workforce and patients. We understand that asymptomatic individuals can be carriers of severe acute respiratory syndrome coronavirus 2 and transmit COVID-19, and this recognition makes banning visitors from accompanying patients to their cardiologist's office and banishing a partner from the bedside of a patient recovering from a myocardial infarction in the cardiac care unit seem prudent.

However, in most institutions, labor and delivery units have been rare exceptions to the "no-visitor" rules because visitors in the labor and delivery units are believed to have, in the words of the New York Department of Health, an "essential" role in the process of care, and not having a partner present for the birth of a child seems unimaginable, unkind, and, for some, even traumatic. Yet as the pandemic grows, challenging and sometimes humbling the capacity of units to accommodate, some have begun to rethink this exception. Several hospitals and systems in New York City, hit hard by an overwhelming number of patients with COVID-19, enacted a ban on labor and delivery visitors, hoping to reduce unnecessary staff exposures that were challenging their ability to maintain a needed complement of providers and support staff. The ensuing reaction and concern—a mix of grief, incomprehension, and outrage—were both local and national. Many worried that such a policy would push women, including many with risks not conducive to such, to plan home deliveries or uproot themselves during a time of quarantine and seek care and delivery at hospitals elsewhere that still permitted an accompanying support person. Responding to the publicity and controversy, the New York City Department of Public Health published guidance declaring a support person in labor to be, as noted above, "essential," and the governor of New York issued an executive order requiring hospitals to allow (healthy) visitors.

As a matter of medicine, policy, and ethics, what is right here? In this commentary, we will briefly outline the considerations important to answer those questions. Unlike many choices in medicine, this policy decision affects not just the patient but also other individuals including the patient's family and the healthcare team. Accordingly, the issue may be best considered from the perspective of the community rather than just the individual. We recognize that to some, the arguments laid out and conclusions we reach may seem long settled or obvious, yet we still regularly hear questions from others—providers, staff, hospital leaders and administrators, patients, and the public—wondering why we do not allow more visitors or, conversely, why we allow any at all? Those continued questions argue to us for the merit in laying out the facts, principles, and underlying rationale clearly for all.

Goals, risks, and benefits of different participants in the process of labor and delivery

This piece will consider visitor policy from an ethical perspective. It is important to understand, as this conversation progresses, that ethics are not strictly an abstract or ethereal art. These are informed by facts. So, for example, if an obstetrician is wrestling with the ethical question of whether to accede to a patient's request for a cesarean delivery of a fetus at 22 and a half weeks of gestation, the ethical conundrum would be quite different and perhaps vanish entirely if a sonogram revealed that the fetus was in fact only 19 weeks. In this article, the facts that are contributory are the risks and benefits of visitor policies, and as we will discuss, those can vary widely based on technology and policy. Emotion is another factor that flavors ethical positions. In Phillipa Foot and Judith Jarvis Thomson's classic thought experiment about an out-of-control trolley racing toward

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several innocent children, participants are asked whether they would push a man onto the tracks to stop the train and save the children. When this thought experiment is offered to a subject lying in a flow magnetic resonance imaging, the decision to "kill" the man varies depending on whether the emotional (save the man) or intellectual (kill the man) part of the study subject's brain lights up. Hence, fears of contagion will undoubtedly play a role in how the issues discussed here are viewed. As we have previously written, "The strength of the physician-patient bond is dependent, at least in part, on patients' belief in their physicians' altruism, i.e., their willingness to do what is in the best interests of patients (i.e., to fulfill their fiduciary obligation) and, historically, to occasionally do so at some risk."[1] Although those words—written in the context of the Ebola epidemic—focused on patients, not partners, it is not extreme to recognize that the best interests of patients include having their partners present. Partner issues cannot supersede substantive risks of contagion, but they should not be dismissed out of hand.

The patient and her partner

In times free of COVID-19, having 1 or more visitor is important for all patients. We have been taught the words of Hippocrates since medical school, "cure sometimes, treat often, care always." Facilitating ongoing contact with loved ones is a critical component of caring. This is even more important in the context of childbirth. Having individuals present to attend and support a woman during her labor and delivery is not just expected but is, in fact, generally encouraged. These support people serve many important roles:

- They provide not only emotional support and encouragement but also distraction and just plain company to speed the passing of what, in some case, can be many hours. Such support, especially when knowledgeable and trained, has been associated with improved outcomes separate from a patient's happiness and sense of well-being.
- They can contribute to decision making, especially as parent-couples work to align choices with shared values. A partner-visitor can often help patients process information and choices, serving as a valuable second set of ears, articulating questions the patient may struggle to offer and explaining key points in ways that are more readily heard and understood.
- They provide help during the process of labor and delivery, whether lifting a leg, obtaining water or other appropriate hydration and nutrition, and in the postpartum unit, assisting in newborn care and maternal recovery. Among other realities, removing these invited "assistants" would challenge nurses' time and nursing staffing needs.
- As attendants, they experience the joy of welcoming a new child, whether as a genetic or intended parent, other relative, or a friend.

In short, not having a partner present during labor seems both detrimental and unkind. Yet we must acknowledge that the same could be said for end-of-life circumstances, and COVID-19 in some settings has left patients dying without the comfort and presence of loved ones. That said, these are extraordinary times.

Some have raised concerns that having visitors present risks the visitor's health by reducing physical distance and exposing visitors to many in a hospital's halls and rooms, including the patient herself. As noted above, the process of labor and delivery requires close quarters, but it is difficult to estimate the true incremental risk that comes with accompanying and supporting a patient, especially if members of the healthcare team are symptom-free and wearing appropriate personal protective equipment (PPE). It also should be recognized that most patients and their visitors will soon be sharing similarly close quarters at home as they recover and care for a newborn.

The healthcare worker

Both for the sake of their own well being, and so they will be available to care for current and future patients with and without COVID-19, healthcare workers (HCWs) have an interest in decreasing their chance of unprotected exposures to those who are infected. The infectivity (R0) of COVID-19 is approximately twice that of influenza, and the mortality rate is apparently much higher as well.

- Decreasing the risk of exposure may be accomplished by screening patients and visitors (using a questionnaire regarding symptoms and travel, and taking temperatures), but transmission from asymptomatic but infected individuals has been recognized as a key avenue for spread both in China and in US labor and delivery units.[2] Furthermore, screening for symptoms relies on the honest and transparent reporting from a visitor who, eager to be present, may consciously or unconsciously fail to disclose an early tickle in the throat, waning sense of smell, flushed feeling, or other early and subtle symptoms of infection. The risks of transmission from visitors will clearly diminish if and when viral or serologic screening of partners can be instituted. The former is already in place at some sites.
- The use of appropriate hand hygiene, distancing, and other health practices (not touching one's face) are important in limiting the risk of infection, but keeping one's physical distance is difficult in most labor rooms, particularly when supporting a woman during the second stage. All who have managed the second stage have experienced the tight huddle of the provider at the perineum, a nurse on one side of the mother, and the partner on the other: the diameter of that circle is often much less than 6 feet.
- Appropriate use of PPE is an important step in mitigating the risk of close exposure, but in many places, the individual elements of PPE have been in short supply. In many settings, it is not possible to approach every patient and

visitor as if they were COVID-19 positive and use enhanced PPE (gown, gloves, mask of at least some kind, and face shield). Although supplying and requiring visitors to use masks themselves would limit their risk of their spreading infectious droplets, even that may not be possible in systems with limited supplies. In such situations or if providing PPE for visitors would compromise access to PPE for frontline workers, then the ethical balance shifts away from supporting visitors in labor and moves toward honoring the societal commitment to protect the health of physicians and other HCWs.

Limiting the number of people in the room would as a matter of simple math, limit the potential exposure of HCWs. For example, there are certainly other situations in which we accept limitations to a patient's right to have visitors or limit their autonomy in choosing them. Individuals who are verbally or physically abusive of staff or otherwise risk a provider's well-being are not permitted to attend their partner's delivery. It is also difficult to imagine that someone symptomatic with active tuberculosis (TB) would be welcomed. When risk is manifest, whether as a cough or verbal challenge, the chance to exclude provides an opportunity for keeping HCWs safe. When risk may be present without symptoms or other warning, the risk is more insidious, and there is not such a ready opportunity to identify and exclude those who bring risk.

Although in all these considerations, it is important not to dismiss these risks to those providing care, it may be useful to contextualize them. When the HCW leaves work and goes to shop for essential goods in the local grocery mart, they will stand 6 feet away from someone who has not had their temperature taken or filled out a questionnaire and is likely not be wearing the type of PPE that would be distributed in a hospital. In the delivery room, when the provider, patient, and partner have donned appropriate garb and make good faith efforts to maintain a distance, the risks would have to be considered substantially reduced.

What is to be done? Where does the best balance lie?

As laid out above, the dilemma here seems to be of conflicting interests and outcomes: the unhappiness, potential trauma and other challenges of giving birth alone for the patient, and the risk of exposure and possible infection for the HCWs. But this simple sketch ignores the shared goals important to each: navigating the process and events of labor and delivery with a healthy mother and child at the end. Moreover, eliminating risks by banishing all visitors is likely to discomfort, at least in some regard, most providers, who would be asked to serve as agents in inflicting this unkindness. Separately, eliminating visitors may impede the process of labor and delivery and postpartum recovery. Accordingly, instead of pushing to eliminate all visitors and their support we suggest 2 menus of measures: the first is designed to limit the chance that a visitor presents a risk, and the second, recognizing that all visitor-risk cannot be eliminated, is designed to moderate any residual impact on HCWs.

Limiting the possibility, a visitor presents a risk

A first step in limiting the risk of exposure is to screen all visitors for the symptoms of COVID-19 or a known ongoing infection and only allow those who are asymptomatic and infection-free in labor and delivery units. This is consistent with hospital practice during times of other infections (influenza season) and the approach to individuals who at other times have highly communicable illness (eg, active TB). The utility of visitor screening, as with screening of the patient herself, relies on honest answers from the individual screened. Some will see this as a key weakness, but appealing to the virtue of truthfulness while emphasizing the implications for the health of the individual HCWs and the other patients who require their continued health and care should find traction with many. Verbal screening can also be supplemented by objective criteria, such as checking a visitor's temperature at intervals (once a shift might be a practical option) and monitoring for readily observed symptoms such as cough.

Ideally, the screening process will yield to viral or serologic screening in the not-too-distant future. When testing becomes more readily available, screening might include testing a visitor for viral RNA either at the time of admission (tests that allow for rapid results have already been rolled out in some clinical settings) or at some point in the final weeks of pregnancy as the time for delivery nears (although the latter approach cannot preclude incident infection subsequent to testing). Serologic testing (ie, testing for COVID-19 antibodies) can also identify individuals who had a positive test result in the past but are no longer shedding virus and are therefore considered appropriate to accompany a patient. Testing may also be useful in reducing the risk from a visitor who, although asymptomatic, has had an identified significant exposure to an individual known to have COVID-19.

If a planned visitor or partner needs to be excluded, whether owing to symptoms or concerning test results, a patient should be permitted to turn to an asymptomatic substitute: mother for husband, sister for partner, second best friend for best friend. Discussing or otherwise communicating visitor policy and restrictions in advance will allow patients to understand when such substitution will be needed and to prepare accordingly.

The spread of coronavirus from those not undergoing aerosol-generating procedures is through droplets. As such, requiring visitors to wear an appropriate mask supplied by the healthcare facility for as much time as possible can be part of a visitor contract. Requiring visitors to remain with their patient-partner in their room throughout the course of labor and delivery and postpartum recovery should be another key stipulation in limiting staff exposure. In addition, limits on the number of visitors should also be instituted. Given the extraordinary current circumstances, and the work and resources involved in the measures proposed above, allowing just 1 visitor who cannot be swapped for another throughout the course of labor and delivery seems appropriate and is, in fact, where many have settled. Some have argued that a policy

of 1 visitor affects those who have planned to use a doula or an experienced family member or friend to provide support that a partner or father may be less able to offer or comfortable offering. Allowing exceptions and extra visitors for some, however, would push against the virtue of providing care that is equitable, and, as just noted, allowing more for all would be a significant additional strain on resources. An appropriate solution may be to encourage additional support and participation by using phones and other technology to share conversation and images. Facilities should consider relaxing any rules limiting live communication and streaming during the process of labor, delivery, and recovery. Equity in this virtual solution might be facilitated by loaning needed devices and technologies to interested families who do not have such access.

Moderating the risk of a healthcare worker becoming infected if exposed

As is true when an individual provider is caring for a woman with known or suspected COVID-19, the risk for being infected by a visitor-partner will be mitigated by the appropriate use of PPE. The availability and type of PPE have varied widely across healthcare settings. Some require and provide masks for continuous use by HCWs and may be able to provide similar masks to patients and their partners and require that they use them continuously as well. Other facilities may limit use to the partners of patients with symptoms or known COVID-19. In cases in which masks are not worn, encouraging or even requiring distancing of the partner may offer another route of mitigation. Such distancing may be undertaken, as room architecture permits, by assigning a visitor a space appropriately distanced from where a nurse, midwife, or physician will be stationed for needed clinical care. Clinicians will recognize the limits of this latter approach given the close quarters of the labor room and, especially, the huddle of patient, providers, and visitors that often is the reality of the second-stage pushing. Given these concerns and real-world limitations and, as suggested above, some may judge the overall balance of adding a labor support person to be unacceptable when PPE cannot be available to visitors.

None of the suggestions above are perfect, and admittedly, there may be chinks in the armor of protection. As with medical care and protocols in general, all will need to be tailored thoughtfully to individual circumstances, including the circumstances of individual facilities where supplies, space, and staffing may limit implementation of some proposed steps for risk mitigation. Used in combination, however, the measures suggested here will contribute to promoting the goals that patients and providers share and hold paramount: promoting healthy maternal and neonatal outcomes, protecting the safety and health of all involved in patients' care, and creating an experience of childbirth as satisfying as possible to all. A recent article[3] discussed intrusions on civil liberties in times of rampant infection noting that, "To respect civil liberties, courts have insisted that coercive restrictions must be necessary; must be crafted as narrowly as possible—in their intrusiveness, duration, and scope—to achieve the protective goal…."[4] With appropriate PPEs and screening, we believe that in most settings and circumstances, that mandate would allow women to have a chosen partner, spouse, or support person present with them without posing undue risks to their providers. ■

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