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EDITORIAL

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Restricting family presence due to COVID-19: The harms we do not see

Policies that limit family presence during acute illness, such as the widespread visitation restrictions enacted during the COVID-19 pandemic, are harmful to patients, family members, and clinicians.[1] These consequences have not been balanced by evidence that these restrictions have accomplished their intended goal of limiting COVID-19 spread, nor that such restrictions reduce staff distress or improve their efficiency. While we continue to accumulate evidence of the negative impact of policies restricting family presence, the absence of family members in the hospital most often leads to invisible harm. Health care systems do not regularly measure or document the impact of their clinical practices and policies on family members. Therefore, the consequences of family separation during an acute illness can be difficult for inpatient clinicians to recognize because many of the individuals affected are not physically present in the hospital. Although clinicians may be aware of the downstream consequences of visitation restrictions for patients, including an increased risk of delirium and delayed decision-making, they may not always attribute these challenges to the absence of family members.

In this issue of *Journal of Hospital Medicine*, Fenton et al.[2] leverage a mixed-methods design to explore how visitation restrictions affected communication with family members, focusing on potential mechanisms through which restrictions on family presence cause harm. At Maine's largest health system, the investigators reviewed the electronic health records (EHR) of 200 adult patients hospitalized before and during hospital visitor restrictions in March 2020. They identified evidence of communication between the medical teams and caregivers based on EHR documentation, finding that visitation restrictions were associated with decreased frequency of communication, lower rates of discharge counseling, and more caregivers who had not received any contact with the medical team during their loved one's hospitalization. The investigators then analyzed the EHR-documented communication content to guide interviews they conducted with a subsample of nine patient-caregiver dyads. These interview data provide insights into the complexity of restricting family presence beyond what appears in clinical documentation. Patients and family members shared their feelings of isolation, demoralization, helplessness, anxiety, and confusion, resulting in heightened emotional distress and perceptions of lower quality of care.

The narratives of suffering from patients, family, and caregivers that Fenton and colleagues report echo those others have shared when separated from their loved ones during medical crises.[3] Although family-centered care is widely acknowledged as important in theory, the execution of routine health care often falls short of achieving true family-centeredness. While the COVID-19-era visitation restrictions are an obvious—and now persistent—example of health system policies that separate families during an acute illness, there are also many other structural contributors to the physical distancing of the family from their hospitalized loved one. Such barriers may include other family caregiving duties, work responsibilities, physical distance, transportation requirements, restricted visitation hours, and lack of coping support for families experiencing the crisis of having a hospitalized loved one. For example, Fenton and colleagues highlight that rural populations are at particular risk for geographic distancing from major medical centers, which may make it more challenging to maintain a physical presence in the hospital. Shift workers or those without the ability to pay for childcare may also be excluded from being at the bedside due to health system policies governing visitation hours or visitor age restrictions.

Even describing family members as "visitors" diminishes their crucial role in a patient's short- and long-term health as well as the interdependence of family members' and patients' well-being.[4] Reorientation of the inpatient health care delivery model to integrate and center family members requires movement toward a social-ecologic framework of health.[5] Such a model emphasizes flexibility and adaptability to meet the unique needs of patients, families, and communities, recognizing that health encompasses far more than physiology. To achieve both quality and equity, Fenton and colleagues highlight the importance of regular, high-quality communication with family members who are not present at the bedside. Such communication and engagement among the family, patient, and clinical team are critical to harm prevention. But how might we move to radically reinvent and redesign our inpatient care systems to better recognize the harms we do not see, while honoring the inseparable family unit during an acute illness?

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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