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My Thoughts / My Surgical Practice

Patient visitation – A call for standardization and liberalization

The COVID-19 pandemic has forced modern medicine to grapple with universal limitations and compromise - ventilators, vaccine distribution, novel therapies, and personal protective equipment; secondarily, shortages in blood bank supply, hospital beds, and surgical volume resulted in downstream rationing as well. Allocations of each of these resources is previously described, though historically in separate contexts and rooted in increasing health care costs. While healthcare decisions are typically based on available resources such as nursing staff, operative capacity, etc., the COVID-19 pandemic presented a uniquely difficult presentation of healthcare limitations given how sudden, massive, and complex shortages were during a time of rapidly rising healthcare demands.

COVID-19 additionally created an especially unique shortage: proximity. Social distancing was mandated, requiring people to stand at least 6 feet apart, a policy that quickly became partisan. Hospitals across the country enacted patient visitation restrictions in efforts to minimize disease transmission that have consequently neglected the concern of minimizing suffering. At the time, we lacked data on transmission, and importantly, we lacked standardization. At NCI-designated comprehensive cancer centers throughout the US, despite a large majority of cancer centers enacting visitation restrictions (83%), policies were strict and strikingly variable.[1] There were no associations between timing of initial restrictions and geographic location or severity of inpatient policies even among centers in the same city. For patients with COVID-19, visitation restriction included isolation. This reduced any amount of social interactions, as well as time spent with healthcare workers.

Visitation restrictions impact clinical care. Among adults, no-visitor policies negatively affect patient psychosocial well-being. Patients are less likely to have their preferences adequately addressed at discharge.[2] Visitation restriction has been associated with higher rates of delirium and increased sedation requirement.[3] Among hospitalized children, visitation restrictions limit family engagement in clinical decision making, a necessary component of care for children. Separation of children from their caregivers can further exacerbate health inequities with a lack of transparency in visitation policies and even reduce healthcare utilization due to the desire for families to have their children back home. Concerns for increased risk of spread of nosocomial infection in ICUs have been unfounded in professional literature[4]; data on nosocomial spread of COVID-19 among visitors wearing appropriate PPE has consistently shown that rolling back restrictions and limitations is not associated with an increase in hospital acquired respiratory viral infections.[5]

The goal of limiting patient visitation is to reduce disease transmission of COVID-19. Many guidelines have been published on the importance of supportive services but have not established guidelines for the implementation of visitation restrictions. Research on the amount of transmission from patient visitors following appropriate masking and distancing guidelines has shown that nosocomial infection is particularly rare.[6] In early August, over 80% of the country has received at least one dose of the vaccine according to the New York Times. Requiring proof of vaccination limits patient visitation may encourage vaccination uptake among those who are hesitant. However, digital literacy, healthcare access, and vaccine availability may limit uptake among populations that may desire the vaccine without the means to acquire it. Therefore, it would be appropriate for hospitals to require visitors to have proof of vaccination or two confirmatory COVID-19 negative tests within the last 48 hours while concurrently creating accessible systems within the hospital for visitors to get vaccinated. Similar policies should be enacted for patients presenting to the hospital for elective procedures that can be postponed until fully vaccinated.

Visitation for patients without COVID-19 should continue to include proper PPE, including surgical masks for patients and family members. Even among vaccinated populations, breakthrough infections have been associated with increased transmission of the Delta variant that has been found to be more contagious. Adherence to proper PPE donning and doffing can be assisted by patient care technicians and nursing staff. Current success with masking has shown the risk of transmission to be unlikely,[7] and more likely far outweighs the social and clinical costs of limiting visitation. In systematic review, the pooled percentage of healthcare workers infected during epidemics (including the COVID-19 pandemic) has been estimated at 6.2%,[8] similar to the national positivity rate. Exposure is largely within the community and not within hospital settings. For patients with active COVID-19 infection, resource availability and local infectivity rate can guide whether families can visit with sufficient PPE. More routine visitation policies can be enacted as patients become convalescent. Just as visitors have previously served as partners in preventing transmission of C. diff and MRSA, so too can they participate in the prevention of transmission of COVID-19.[4]

Visitor restrictions affect the postoperative experience as well. Patients are more likely to have delays in receiving medications, experience greater social isolation, have greater difficulty getting in and of bed, and are less likely to have their discharge preferences adequately considered compared to patients without visitor restriction policies.[2] Postoperative management is complex and often requires the assistance of multiple caregivers after discharge given the acute change in health status for the patient. Learning how to manage an ostomy is difficult in the immediate postoperative period as the confusion of multidisciplinary teams, lack of sleep,

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and pain control medication prevent patients from being the best students. Involving caregivers can help ensure that patients can manage their postoperative care at home, where they'll be discharged to a setting where they will be exposed to these caregivers regardless.

End of life care is particularly distressing without the presence of family. Sense of self and existence is largely rooted in our existence among a community, whether on the smaller scale of a family unit or on the larger scale of our workplace or neighborhood. In our final moments, the culmination of these experiences without family and loved ones to support us is a lonely and terrifying experience. It is additionally distressing for loved ones to not be able to participate in the processing of loss, as well as for healthcare workers who are expected to become surrogates for families at the end of life.

While some may argue that modern compassionate care in the COVID-19 pandemic necessitates in-person visitation, others have found that televisits can help supplement difficult conversations and facilitate difficult conversations between patients and providers, with largely positive experiences for patients and their families. Rationing may often feel like an either-or decision,[9] but focusing on the true burden of harm can help alleviate an artificial scarcity. A combination of evidence-based visitation allowance policies and robust televisit infrastructure for patients to continue to receive support and care from their loved ones is imperative as the burden of the COVID-19 pandemic waxes and wanes. Arbitrary and harsh restrictions are not without downstream effects for patients and their families, whether directly for their clinical outcomes and psychosocial experience, or later with resentment and mistrust of the medical system.

Individual states have been increasing visitor allowance, but consistently without guidance on best practices or more liberal policies beyond more than one or two visitors per patient. The CDC has adjusted masking recommendations for those who have been fully vaccinated but has not yet released guidance on hospital visitation policies. The pandemic is often described as "unprecedented", but widespread, debilitating viral spread is not a new phenomenon. With standardization of visitation policies incorporating local vaccination status and test positivity rate, we can stand prepared for the next wave of restrictions while keeping healthcare humane.

Conflicts of interest

I have no conflicts of interest.

References

1. Yeh JC, et al. Visitation policies at NCI-designated comprehensive cancer centers during the COVID-19 pandemic. *Support Care Canc.* 2021.
2. Zeh RD, et al. Impact of visitor restriction rules on the postoperative experience of COVID-19 negative patients undergoing surgery. *Surgery*. 2020;168(5):770–776.
3. Kotfis K, et al. COVID-19: ICU delirium management during SARS-CoV-2 pandemic. *Crit Care*. 2020;24(1):176.
4. Adams S, et al. Visitation in the intensive care unit: impact on infection prevention and control. *Crit Care Nurs Q.* 2011;34(1):3–10.
5. Wee LE, et al. The impact of visitor restrictions on health care-associated respiratory viral infections during the COVID-19 pandemic: experience of a tertiary hospital in Singapore. *Am J Infect Contr.* 2021;49(1):134–135.
6. Rhee C, et al. Incidence of nosocomial COVID-19 in patients hospitalized at a large US academic medical center. *JAMA Netw Open*. 2020;3(9), e2020498.
7. Leung NHL, et al. Respiratory virus shedding in exhaled breath and efficacy of face masks. *Nat Med*. 2020;26(5):676–680.
8. Lee Y, et al. Impact of hospital lockdown secondary to COVID-19 and past pandemics on surgical practice: a living rapid systematic review. *Am J Surg*. 2020.
9. Shao C. The COVID trolley dilemma. *Am J Surg*. 2020;220(3):545–549.

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