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Should Families Be Allowed To Visit Dying COVID-19 Patients in the ICU?

COVID-19 has drastically changed how end-of-life care is practiced in the intensive care unit. Safety concerns for society limits family visitation but is contrary to patient and family-oriented care. This article provides an ethical analysis of the pros and cons of having family members present at the death of a COVID-19 positive ICU patient and provides a framework that can be used in future surges.

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The Ethical Dilemmas Involved in Restricting ICU Visitation at the End-of-Life

End-of-life care for ICU patients is highly variable in practice, even prior to the COVID-19 pandemic (Curtis et al. 2012; Kruser et al. 2019). A large proportion of patients who die in the hospital do so in the ICU, especially during the current COVID-19 pandemic due to severe organ dysfunction (Mularski 2006). However, with the rapid advent of the pandemic and the accompanying large scale ICU admissions and mortality, family visits were prohibited to ensure that relatives did not infect other family members, patients, or healthcare professionals. Family members could no longer be at the patient's bedside and the ICU team was unable to communicate and support family members. Involvement in decision-making was also compromised, and it was felt that this situation was harmful both for patients and family members (Robert et al. 2020).

Is it ethical to deprive families from being present at the bedside of a dying COVID-19 ICU patient? This article will argue that the considerations that point towards a more relaxed policy of family visitation simply outweigh those that point towards a stricter policy, when scrutinised in the context of what is at stake in the context of decision-making. The following sections are divided into the current strict visitation scenario, our own arguments against this policy, and finally proposed solutions.

Reasons for a Strict Policy of ICU Family Visitation at EOL

COVID-19 mortality is highest in those 85 years and older (10-27%) followed by those 65-84 years (3-11%) (Zhou et al. 2020). Many of these patients have died in the ICU without their loved ones close by. Hospitals and physicians have managed these difficult conversations via telephone or video chat, which remains erratic and sub-optimal, but the best that can be done under the present circumstances. Modern technology has allowed families to say goodbye to their loved ones through electronic devices, sometimes from all over the world (Etkind et al. 2020). This has become necessary due to i) a shortage of the personal protective equipment (PPE) required for interacting with a COVID-19 patient. Giving these to the family members may be considered a less optimal use of precious PPE that could be better used for frontline healthcare workers, ii) even with sufficient PPE, infection control issues play a big role in these decisions as the ICU staff may become exposed to family members who may be symptomatic or asymptomatic COVID patients, and who may not follow infection control instructions appropriately, and iii) another clinical and ethical premise is that allowing family members into COVID ICUs would expose them to the threat of hospital acquired COVID infection [primarily from their dying loved one] (Arabi et al. 2020). These choices can be justified by aiming to provide a safe environment for healthcare workers to practice and also to allocate resources fairly (Rodríguez-Prat et al. 2016). The strict policy adopted by most COVID ICUs across the U.S. is generally framed in the argument that we could impart harm through broad visitation due to lapses in the strict infection control and

the multi-faceted PPE use and complex management requirements of the COVID-19 pandemic containment (Goh et al. 2020).

The first concern relates to the use and availability of PPE to prevent infection of families visiting infected loved ones. There is a worldwide shortage of PPE, which is essential for protection of the healthcare workers. It is imperative during pandemics that healthcare workers have adequate protection to decrease personal harm and the spread of disease. This is especially true when limited availability of testing masks the true prevalence of COVID-19. It is therefore essential to preserve PPE. Using it for family members of ICU patients may be considered an unnecessary waste (Seibert et al. 2018). Secondly, the use of PPE to prevent infection relies on proper training and fit-testing (for N-95 masks) for the donning, doffing and PPE use to ensure adequacy of protection against infection. This would be a large burden to accomplish for all family members, especially those who are emotional and likely not thinking clearly, wishing to visit their loved ones to ensure the fit and use of PPE was done properly.

To mitigate the concern/risk that allowing family members in COVID ICUs would expose them to the threat of hospital acquired COVID-19 infection, some hospitals are buying iPads and other devices to allow virtual visits. There is no data that would support this premise, as strict visitation policies at times seem to be implemented on an ad hoc basis. Even if allowed to visit under special circumstances, the instances are inconsistent and therefore confusing to the public, and very often families are left to call patients when the patient is on his/her last breath and unable to interact at all. Very often this is a failure of following the policies in place, which advocate early virtual visits with the patient and in-person visits as the patient's death becomes more imminent.

The second concern is that the ICU staff will become exposed to infected family members who may be carriers of COVID-19 infection, and potentially lead to health care worker infections. A high proportion of healthcare workers (HCW) in Italy and a third of NHS healthcare workers in the U.K. have become COVID-19 positive. Over 9,000 U.S. healthcare workers contracted COVID-19, and 27 have died. A majority of those who tested positive (55%) think they were exposed while at work (Chu et al. 2020). Allowing family members to visit may bring in members of the public who may be COVID-19 carriers and pose a risk for staff and other patients. The Center for Disease Control (CDC) has issued guidance that visitors to healthcare facilities should be limited during the COVID-19 pandemic (Smith and Fraser 2020).

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Why We Should Allow Visits by Families at the EOL in the ICU

The ethics of end-of-life care rely on empathy and emotional responsiveness. Getting families through the difficult stage of acceptance of the prognosis, building rapport and trust and progressing through the stages of grief to let go peacefully takes time and multiple interactions between the teams and family members (Oczkowski et al. 2016). The presence of family members at the bedside of a dying patient in the ICU is not only comforting for the patient, even if they are minimally conscious, but is comforting for the families, and enhances the quality of the end-of-life care being delivered (Rawal et al. 2017). This experience can provide closure and acceptance in ways which any amount of communication alone may not offer (Hartog and Reinhart 2018). Families also feel some sense of participation and control when they are able to offer solace to the patient, even if the patient is unconscious (Osborn et al. 2012). This compassion for the family members comes from an active regard for another's welfare with sympathy, tenderness and emotional involvement. Good clinical care requires this insight, and a physician who acts according to clinical norms without aligned concern and sympathy for the suffering person and their families may seem non-compassionate. We owe something to the families without a direct duty of care in this unique context. This obligation arises from current constructs of justice and commitment which encapsulates patient-family-healthcare provider relationships (Holmvall et al. 2012). These difficult decisions are traditionally made face to face and with family members having access to the patient (Lautrette et al. 2007).

Studies have shown that the quality of death is significantly improved with the family present at the bedside (Nelson et al. 2010). Good end-of-life care is regarded as one where the family is present irrespective of the time of day. This presence is also of immense benefit for the families. Here justice also encapsulates the value of benefitting what is essentially a third party in the medical encounter. Families feel a sense of closure and control if they are allowed to participate in shared decision making at the end of their loved ones' life, which is the norm in non-pandemic times. This sense of control can emanate from the decisions

made regarding transitioning from a 'full code status' to 'comfort measures only' or 'do not resuscitate' status; or decisions regarding withdrawal of life sustaining therapies (Wong et al. 2019). Trust, which is inextricably bound to respect for human dignity, is an expectation that physicians will act for their patients as they would for their own families. This trust often requires visual and audible cues that families experience when they visit the loved one at the time that the patient is dying (Hutchison et al. 2016). However, the larger question is whether these advantages of family presence outweigh the danger of exposure for vulnerable families, other patients, and staff. Emotional distress of HCW when adequate EOL care is not delivered is not only a source of anxiety, but also burnout (Dodek et al. 2019). If families aren't allowed to be present at a patient's bedside as they die, optimal care is not being delivered, and may produce emotional turmoil among bedside staff. If this form of work-related stress builds to a level where a staff member's emotional wellbeing is seriously compromised, it is likely to have an impact on the quality of care of patients, as well as on unit morale and staff turnover. Given the pre-existing wide variability in EOL care for dying ICU patients, such a policy would provide uniformity and provide better patient and family-centred care (Davidson et al. 2007).

Proposed Solutions for Family Visitation

This discussion will present a practical strategy for proceeding with visitations of a certain kind, in light of the following arguments and in the context of additional evidence: i) this is necessary for delivering good clinical care; ii) it presents minimal risk to family members, iii) it does not present additional risk to other patients and staff if done with care; and iv) it is reasonable and justified, and an essential source of solace for family members of dying patients. A recent cohort study of 1,536 ICUs in the U.S., within a national quality improvement collaborative, showed that family presence at the end-of-life is a minimum standard of care (Kruser et al. 2019). For various notable reasons, this standard is maintained to promote patient and family-oriented care. The aim of this article is not to expound on the benefits of family presence at the EOL, but to argue that such a policy is not only ethically sound but a moral obligation of physicians and healthcare teams. The Center for Disease Control (CDC) has stipulated that "visits of family members should be scheduled and carefully controlled. Hospitals should also institute safety procedures; facilities must provide instruction on hand hygiene and use of PPE accord; visitors should not be present during aerosol generating procedures; visitors should be instructed to only visit the patient room and not go to other locations in the facility". With these restrictions, family visitation at their loved one's end-of-life, is permissible. These carefully orchestrated visits (with expert escorts, personal protective protection, and limits on numbers of family members) can prove to be extremely meaningful for families, patients as well as HCWs. In some reported cases, physicians and nurses perceived the visits as 'fulfilling and moving and gave them a sense of delivering dignified and compassionate end-of-life care for their patients (Bansal et al. 2020). Therefore, the argument can be made that individual hospital policies are aimed at protecting families from the threat of the infection from their loved ones or from other COVID-19 patients. Adopting such solutions, therefore, preserve respect for individual dignity and relationship at the end-of-life (Van Orden et al. 2020).

> **"having families present to say goodbye to their loved ones is simply the right thing to do, and it is the responsibility of the health care teams and organisations to make this possible"**

The risk of exposure to family members is reduced if they are provided with adequate PPE and proper instruction. The CDC recommends normal face coverings in the absence of aerosol generating procedures. This can avoid wastage of N95 masks which may be in short supply. If the EOL visit is carried out in a private room within the ICU (especially important for surge ICU space such as post-anaesthesia care units that are generally more open spaces that have been used for ICU space during the pandemic surge), the risk of this exposure is further reduced. Similarly, staff members are already adequately protected within COVID ICUs where policy dictates masks be worn in all areas of the hospital and hence, HCW are not at extra risk from families who may be COVID positive. In times of a pandemic, allowing families to be present at a dying patient's bedside is ethical, if done in a careful and thoughtful way. An underlying commitment to compassionate care for the patient also includes justice and consideration for the patient's family members.

The threat of another wave of SARS-CoV-2 infections or similar catastrophes is very real now. In such a scenario, institutions and hospitals must remain prepared with infection control policies in place. These should include family visitation in general and presence during EOL care in particular. If such a policy precluded family visitation, there would be much greater grief for countless people. Having families present to

say goodbye to their loved ones is simply the right thing to do, and it is the responsibility of the health care teams and organisations to make this possible.

Conclusion

COVID-19 has shaken the delivery of healthcare across the world. The ethically sound clinical policies with respect to end-of-life care are seemingly in conflict with public safety and resource allocation. In these times, when death becomes commonplace, the deep core of humanity must underscore our actions and deeds. Welfare based on principles of compassion and virtue must be valued, whilst maintaining an emphasis on safety and care. This article makes an argument for allowing families to visit dying COVID-19 patients in the ICU by describing how this encapsulates humanity, fairness and compassion for them although they are not directly under our care.

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Conflict of Interest

None of the authors have any competing interests or conflicts of interest. ■

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