Why Can't I Visit?
The ethics of visitation restrictions - lessons learned from SARS

Sharon Rogers, Director - Patient Relations (The Hospital Ombudsman),
University Health Network, Toronto, Ontario, Canada

Critical Care 2004, **8:**300-302 doi:10.1186/cc2930

Published: 31 August 2004

Abstract:

Patients want, need and expect that their relatives will be able to visit them during inpatient admissions or accompany them during ambulatory visits. The sudden outbreak of severe acute respiratory syndrome (SARS), or a similar contagious pathogen, will restrict the number of people entering the hospital. The ethical values that underlie visitor restrictions are discussed here.

Introduction

The sudden emergence of severe acute respiratory syndrome (SARS) in April 2003 caused much concern and reaction. Refereed medical journals ever since have been rife with articles about SARS. The eventual containment and treatment of SARS has seen a diminution of the massive media publicity and overt public concern. However, fears have recently surfaced about the potential for re-emergence of SARS in the near future. As we confront the potential need to return to more stringent infection control measures once again, this is an appropriate time to reflect on the ethical values that underlay the strict visitation restrictions imposed in hospitals in Ontario during the SARS outbreak and the moderate restrictions in place since SARS. This reflection will facilitate future decision making with respect to visitation restrictions.

When public health trumps civil liberties: the collateral damage associated with victims of SARS

Naming names, naming communities: privacy of personal information and public need to know

In the interests of the public good, there may be times when information must be shared publicly, thereby impinging on the rights of the individual to privacy and confidentiality. With respect to restricted visitation, an ethical argument could be made that visitation restrictions (or latitude thereof) can be instituted generally, without specifically naming names. Although the vigilant observer might be able to identify a specific person from a changed application of the rule, the organization cannot reasonably be expected to guard against every possible identification, but every effort should be made to protect the individual from easy identification. For example, if a family is allowed to visit a patient whose death is presumed to be imminent (within the next 24 hours), then the patient's identity should be protected by using privacy strategies. Efforts to protect the patient's identity are consistent with the ethical value of 'protection of communities from undue stigmatization' [1].

SARS in a globalized world

Given the risks associated with contagious pathogens and the easy mode of transmission globally, it is important that there be consistency in management. The ideal situation would be a consistent global approach to the management of each and every contagious pathogen. The notion of universal management strategies is very sensible (e.g. universal precautions with blood-borne conditions such HIV). However, given the political and economic disparities across the world as well as the lack of knowledge (particularly of newly evolving pathogens), a standardized approach is not possible.

The experience of SARS indicates that some patient populations require a level of vigilance that is more stringent than that required in others. For example, those individuals who reported recent travel to high risk areas, and those who worked in quarantined or contaminated hospitals or who exhibited clear symptoms (e.g. fever, persistent cough) were scrutinized with more vigilance and were in fact treated differently than other visitors, until they were cleared through the screening process. This type of variability in vigilance demands ethical management of differences, and there is a need to guard against overt bias or discrimination creeping into the process.

It is difficult to expect that both standardization of approach and variability in approach can easily coexist, but the operational challenge is to exercise awareness of the ethical values discussed above and the appropriate due diligence in the implementation of processes.

Conclusion

It is ethical to accept that public health protection trumps individual rights to liberal visitation. The rationale for this position must be fully outlined to patients, visitors and staff. In responding to visitors who may be deprived of visitation, it is ethical to recognize that there may be exceptional circumstances that demand exceptional latitude. A set of criteria outlining exceptionality should be developed, as should a process to receive, review and adjudicate requests. In the interests of equity, an appeal process should be made explicit and transparent to all. This information should be well publicized to staff, patients and visitors in a consistent and sensitive manner. Every reasonable effort should be made to protect the individual patient's identity and their specific health status should exceptionality be considered.

It is ethically the responsibility of the organization to enforce compliance with restricted visitation and a corporate department should be assigned this task.
Although it is recognized that standardization in the application of visitation restrictions is necessary, there is recognition that there may be circumstances that would require deviation from the corporate position.

Competing interests

The author has declared no competing interests.

Abbreviations

SARS = severe acute respiratory syndrome

Acknowledgements

Thanks to Dr Laura Hawryluck, Co-Editor of the medical ethics commentaries section of *Critical Care*, for her patient editing and insightful comments.

References

1. Ethics and SARS: [http://www.utoronto.ca/jcb/home/news_SARS.htm]
Learning Lessons from the Toronto Experience. Available from the Centre for Bioethics Website