Feature

Do the Rules Always Apply? An Analysis of Exceptions to a COVID-19-Era Pediatric Visitation Policy

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ABSTRACT

Background

The COVID-19 pandemic abruptly reversed the long-standing practice of open visitation in children's hospitals, due to the concern that hospital visitors might contribute to the spread of disease. However, little is known about the unintended consequences of such policies, including the potential that they may disproportionately impact children and families of color and those from low-income communities.

Methods

We reviewed requests for an exception to a pediatric visitation policy made between August and November 2020 at a mid-size American children's hospital and collected data regarding details of the requests, demographics, family characteristics, and the patients' medical histories. We compared the sample to the general patient population using bivariate tests and developed a logistic regression model to explore factors associated with the receipt of requests for an exception to a visitation policy.

Results

Regression models indicated that Black families were less likely to have their request for an exception to the visitation policy granted, compared to White families (odds ratio, OR = 0.06; 95 percent confidence interval, CI 0.01-0.84; $p < .05$). The families of children who were admitted to critical care were more likely to have their request for an exception granted (OR = 28.35; 95 percent CI 1.43-562.37, $p < .05$). Two of the three reviewers of requests for exceptions were found to be less likely to grant a request for an exception (OR = 0.05; 95 percent CI 0.00-0.84; $p < .05$; OR = 0.03; 95 percent CI 0.00-0.67; $p < .05$).

Conclusions

Our findings highlight the need to reconsider the risks and benefits of highly restrictive visitation policies that disproportion-

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ately impact vulnerable and marginalized children and their families. This study also provides a model for the broader, prospective analysis of the potential for disparities in the impact of any institutional policy.

INTRODUCTION

Over the past 150 years, the general trend in pediatrics has been toward the promotion and adoption of increasingly unrestricted visitation policies, recognizing that children, families, and healthcare professionals *all* benefit when families are able to be closely involved in their child's care.[1] The COVID-19 pandemic abruptly reversed that trend due to concern that hospital visitors might facilitate the spread of the virus in an especially vulnerable setting and population. However, there was not a nationwide consensus among the facilities on how to standardize these visitation policies. Guidelines ranged from extremely restrictive (for example, no visitors permitted at any time) to mildly restrictive (for example, two adult visitors of any relation permitted at the same time).[2] The psychological and moral trauma that such policies have inflicted upon patients, families, and health professionals has been widely reported in the literature.[3]

For example, a recent "Ethics Rounds" in the journal *Pediatrics* described a case involving the single mother of a five-year-old girl who was admitted to the intensive care unit who had no close family or friends to care for the patient's younger sibling during the admission; the option of temporary childcare potentially posed new, unquantifiable risks to the sibling. At the same time, the patient's agitation in her mother's absence presented a risk to the patient, perhaps greater than the risk of the sibling being allowed to stay in the confines of her sister's room.[4] The impact of these types of situations is not equally distributed nor equitably experienced, with families who have fewer resources due to historical and ongoing structural oppression and systemic racism being more likely to be negatively affected.

To date, however, no studies have systematically described the unintended consequences of such policies, particularly the potential for them to disproportionately impact children and families of color and those from poor communities. We sought to explore this through an analysis of requests for an exception to one pediatric hospital's visitation policy. The manner in which a policy is implemented and the exceptions that are permitted to such a policy provide a lens through which to better understand the impact of structural racism and inequity. Here, we characterize the nature of requests for an exception to a pediatric hospital's visitation policy that were made during the pandemic and analyze what demographic, family, and medical characteristics were associated with making a request and with having a request granted.

PARTICIPANTS AND METHODS

Eligibility Criteria

The study was conducted at a 71-bed pediatric tertiary care facility that is part of a large academic medical center in the Northeastern United States that serves a 19-county region with a population of 1.8 million. During the time period of the study, pediatric patients were initially permitted one visitor at the bedside, with no changes in the visitor permitted during the patient's stay; the single visitor was also not permitted to leave the patient's bedside. The policy was subsequently modified to permit up to two visitors at the bedside. Although an exception to the policy could be requested, families were not formally educated regarding the exception process nor were criteria specified for the review of such requests.

Requests for an exception to the visitation policy were submitted by staff who were involved in direct patient care to one of three pediatric administrators who rotated being on call for this purpose and who made decisions independently, although they could choose to consult one another. Administrators served in this capacity for one week at a time and evaluated all requests submitted during their call block. Families were informed of the visitation policy at the time of admission but were not formally or consistently educated regarding the possibility of obtaining an exception or the mechanism to use to request an exception. Requests for an exception that were made during the study period were logged in a paper file that was stored in the department's administrative offices. All requests for an exception ($N = 157$) that were placed between 11 August 2020 and 29 November 2020 were included in this study.

Collection of Data

Data were extracted from the logbook for requests for an exception (a paper file) into a REDCap database created specifically for this purpose. The logbook included the nature of and reason for the request, the patient's location in the hospital, the staff member who filed the request, the administrator who reviewed the request, and whether and how the request was granted; identifying information

(patients' name, medical record number, and date of birth) was sometimes recorded in the logbook. The nature of and reason for the request for an exception to the policy were recorded as both narrative and categorical data. For each request for an exception that included identifying information, the patient's electronic medical record was reviewed for additional information, including the patient's diagnosis, prognosis, length of stay, age, gender, race, ethnicity, language spoken at home, place of residence, and insurance status. Qualifying factors such as smoking, breastfeeding, caregiver's health concerns, and childcare and custody issues were also documented. Identifying information was not extracted into the database.

Data Analysis

When we compared our sample population to our broader pediatric general population, we used a series of binomial tests to analyze whether there were significant differences in gender, language, and insurance status between the two groups. A one-sample *t*-test was used to examine whether our sample's mean age was significantly different from the mean age of the general population. A *chi*-square goodness of fit test was used to analyze whether the observed racial composition in our sample differed from that of the general population.

We developed a multiple logistic regression model to explore whether any demographic, family, medical, and reviewer variables were associated with whether a request for an exception to the visitation policy was granted. Missing data were removed with listwise deletion, which left 73 people who had complete data for our dependent and independent variables. The highest correlation coefficient was 0.42 between age and custody/childcare issues. There were no independent variables with a variance inflation factor (VIF) greater than 10. Specifically, the highest VIF was 1.8 for the custody/childcare issue variable, and the average VIF for the whole regression model was approximately 1.5, which indicated there was no multicollinearity. All analyses were performed using IBM SPSS Statistics version 28.0 (Armonk, New York) and, unless otherwise indicated, with two-tailed tests at a .05 significance level.

For admitting service, the most commonly granted requests for an exception to the visitation policy were for caregivers with a child who was admitted to the pediatric intensive care unit (84 percent).

For our statistical analyses, comparison data regarding the broader population served by the children's hospital were extracted from the hospital's internal database (Clarity), which is updated daily with information from the hospital's electronic medical record system (Epic). All encounters between 11 August 2020 and 29 November 2022 in the emergency department, inpatient, and surgery were included. Data extracted included visit type, patient age, gender, race, ethnicity, primary language spoken at home, and insurance type.

Variables

For our regression model, the dependent variable was whether or not a request for an exception to the pediatric visitation policy was granted. Independent variables consisted of demographic, family, medical, and reviewers' characteristics. Demographic variables included: age (continuous), race and ethnicity (White non-Hispanic, Black/African-American, or Hispanic/Latino), gender (male or female; included a nonbinary/nonconforming category but no patients identified as such), and insurance status (private or employer-based insurance or non-employment-based public insurance). Family variables included: distance from hospital (zero to 30 minutes, 30 minutes to one hour, or greater than one hour), presence of custody/childcare issues (yes or no), and presence of any caregiver's health issue (yes or no). Medical variables included: the admitting service (all inpatient pediatric units, the pediatric intensive care unit, or "other," which included rehabilitation, psychiatry, day surgery, and the emergency department), and short-term prognosis (fair, good or excellent, poor or very poor, or end of life). A variable for the reviewers (three individuals) was also included.

Ethical Approval

The study was reviewed by the SUNY Upstate Medical University Institutional Review Board and was declared exempt (project no. 1691025-1 and 1809398-1).

RESULTS

Sample Characteristics

Among 157 individuals in the full sample, 117 (74 percent) were granted an exception to the pediatric visitation policy. Most in the sample were male (64 percent), White (64 percent), and had non-employment-based public insurance such as Medicaid (69 percent) (see table 1). Most families lived zero to 30 minutes from the hospital (40 percent), did not have custody or childcare issues related to the request for an exception (63 percent), and did not have any caregiver health issues (80 percent). Slightly more than half of all of the patients were admitted to inpatient pediatrics (56 percent), most commonly with a fair, good, or excellent short-term prognosis (86 percent).

The demographic, family, and medical characteristics for those who were granted an exception to the visitation policy are listed in table 1. A higher percentage of White (79 percent) and Hispanic/Latino (79 percent) caretakers received an exception to the visitation policy than did not; slightly more than half (57 percent) of those who were Black had received an exception to the visitation policy. For admitting service, the most commonly granted request for an exception to the visitation policy was for a caregiver with a child who was admitted to the pediatric intensive care unit (84 percent). Short-term prognosis had the greatest impact when a child was deemed to be at the "end of life"; 100 percent of their caregivers were granted a request for an exception (see table 1 for more detail).

The nature of the request was stratified by the exception to the pediatric visitation policy that was granted, to determine which types of requests for an exception were most commonly granted and declined. Most commonly, caregivers requested an exception for an additional caregiver, followed by a request for an exception for a caregiver to return or leave (see figure 1). Most often, an exception was granted for an additional caregiver (81 percent), followed by an exception requested for a caregiver to return or leave (70 percent).

Comparison to the General Population

For the purposes of this study, "general population" referred to all patients who were admitted or treated at the children's hospital during the study time period, regardless of whether an exception to the visitation policy was requested on their behalf. Significant differences were noted with regard to age, gender, the language spoken at home, and race. The average age was significantly lower among our sample (mean = 7.36) compared to the general population (mean = 8.99, $t[127] = -2.86$, $p < .05$). The proportion of female patients for whom a visitation exception was requested (36.3 percent) was lower than the proportion of female patients in the general population (51.4 percent) (binomial test, one-tailed, $p < .05$). The proportion of patients who primarily spoke English at home in the study sample (88.5 percent) was lower compared to the proportion of English-speaking patients in the general population (95.8 percent) (binomial test, one-tailed, $p < .05$). The racial composition in our sample was significantly different compared to the general population ($\chi^2[2] = 9.94$, $p < .05$); the study sample included relatively more White and Hispanic/Latino patients and fewer Black patients compared to the general pediatric population treated during the study period. A binomial test indicated no significant difference between our sample and the general population with regard to insurance status (one-tailed, $p > .05$).

Regression Analysis

When looking at demographic variables, results from the multiple logistic regression indicated race was significantly associated with a granted exception to the pediatric visitation policy. Those who were Black were 0.06 times less likely to have their requested exception granted compared to those who were White (OR = 0.06, 95 percent CI 0.01-0.84, $p < .05$) (see table 2). The primary service was also significantly associated with receiving an exception. People who requested to visit a patient in the pediatric intensive care unit were about 28 times more likely to have their request for an exception granted compared to those who requested an exception to visit a patient on an inpatient pediatric unit (OR = 28.35, 95 percent CI 1.43-562.37, $p < .05$). The reviewer who was assigned to a request was also significantly associated with an exception to the pediatric visitation policy. Compared to Reviewer #1, Reviewer #2 was 0.05 times less likely to grant an exception (OR = 0.05, 95 percent CI 0.00-0.84, $p < .05$), and Reviewer #3 was 0.03 less likely to do so (OR = 0.03, 95 percent CI 0.00-0.67, $p < .05$). All of the other variables were not significantly associated with a request for an exception to the pediatric visitation policy. The logistic regression model was statistically significant ($F[15] = 25.89$, $p < .05$). Our

TABLE 1: Sample characteristics of all exception requests (*N*= 157) placed between August 11 and November 29, 2020

	Study sample		Exception granted		Exception not granted	
	Mean	Standard deviation	Mean	Standard deviation	Mean	Standard deviation
Age	7.36	6.46	6.86	6.21	9.39	7.02
	n	%	*n*	%	*n*	%
Data missing	--	--	18	2	12	3
Sex						
Male	79	7	60	6	18	5
Female	45	4	36	3	9	2
Data missing	--	--	21	2	13	3
Race						
White	83	7	65	6	17	5
Black/African American	14	1	8	1	6	2
Hispanic/Latino	14	1	11	1	3	1
Data missing	--	--	33	3	14	4
Insurance status						
Private	36	3	30	3	6	2
Medicaid/CHP	81	7	59	6	21	6
Data missing	--	--	28	3	13	3
Family's Distance from hospital						
0-30 minutes	49	4	35	3	13	3
30 minutes-1 hour	32	3	25	2	7	2
>1 hour	43	4	35	3	8	2
Data missing	--	--	22	2	12	3
Presence of custody/childcare issues						
None	84	7	68	6	15	4
Custody issues	19	2	10	1	9	2
Childcare issues	30	3	24	2	6	2
Data missing	--	-	15	1	10	3
Presence of caregiver's health issue						
No	21	2	17	2	4	1
Yes	85	7	63	6	21	6
Data missing	--	--	37	3	15	4
Admitting service						
Inpatient pediatrics	88	8	59	6	28	8
Pediatric intensive care unit	43	4	36	3	7	2
Other	27	2	22	2	5	1
Data missing	--	--	0	0	0	0
Short-term prognosis						
Poor or very poor	15	1	14	1	1	0
End of life	3	0	3	0	0	0
Fair, good, or excellent	111	10	84	8	26	7
Data missing	--	-	16	1	13	3
Visitation exception request reviewer						
Reviewer #1	40	3	32	3	7	2
Reviewer #2	69	6	49	5	20	5
Reviewer #3	42	4	29	3	13	3
Data missing	--	--	7	1	0	0
Total 1,153	1,071	372				

model has adequate model fit, indicated by 83.6 percent cases correctly classified and a nonsignificant Hosmer-Lemeshow test ($c^2[8] = 5.25$, $p = .73$).

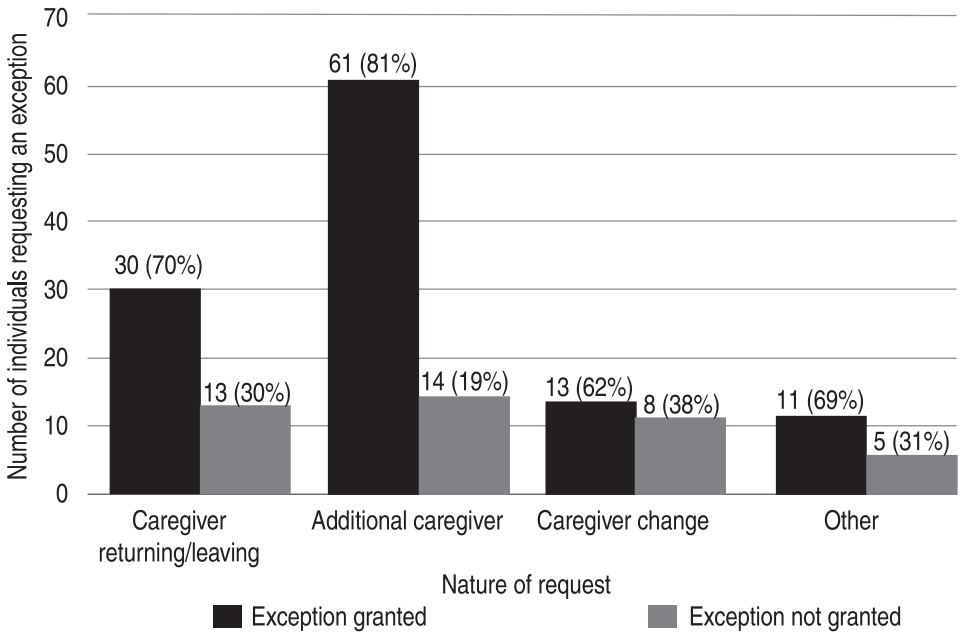
DISCUSSION

To our knowledge, this is the first study to systematically describe the nature of requests for an exception to a pediatric visitation policy and to analyze the demographic variables associated with making a request and receiving an exception. We found that the families of patients who were younger, male, White, or Hispanic/Latino and/or English-speaking were more likely to request an exception than those who were not. We also found that the families of patients who were White and/or admitted to the critical care unit were more likely than others to receive an exception, once requested.

While the latter is understandable—admission to a critical care unit is a marker of the severity of a disease and may portend a poor prognosis, or at least a high likelihood of medically complex decisions to be made—the small but significant bias against Black patients in granting an exception to the visitation policy is not. Although the policy itself was not race-conscious, and the reviewers of the requests for an exception were not deliberately informed of the patient's and family's race, there are many ways that racial bias might have inadvertently influenced the process, beginning with families' institutional literacy and self-advocacy. The process to request an exception was not widely advertised, and families with a greater understanding of how hospitals function may have been more likely to recognize the possibility that an exception to the policy might be requested. Barriers to communication between bedside caregivers and families of color and/or those who did not speak English—both of which are widely recognized in the literature—may also have contributed, leading staff to be less likely to suggest requesting an exception to Black families.[5] Further, as bedside staff were then most likely to convey a request for an exception to the administrators who evaluated them, their own biases may have influenced how requests were presented. The significant variation between reviewers is further evidence of the subjectivity inherent in this process. As Crear-Perry and colleagues have noted, merely wanting "not to be racist" does not make just policy.[6]

Some studies have reported that Black patients are less likely to self-advocate in medical encounters than their White counterparts, while other studies have reported that Black patients are more likely to be labeled as "difficult" or "demanding."[7] It is possible that Black families who made a request during the time of this study were less likely to advocate for themselves and/or more likely to have had their advocacy perceived negatively. Additionally, the reasons behind the requests and the nature of the requests themselves may have differed between Black and White families. As Black families are more likely to have lower household incomes, to work in lower paying jobs, and to be headed by a single parent,[8] they may have been more likely to make a request for an exception that was motivated by work and childcare obligations than White families would have been, and their request may have been perceived unfavorably in comparison with families with greater resources who were able to make alternative childcare arrangements, take family leave, and/or work from the hospital during their child's ad-

FIGURE 1: Pediatric visitation exception stratified by nature of request



mission and whose reason for requesting an exception may have therefore been quite different.

Such inequities, while not separable from structural racism, also affect families regardless of their racial and ethnic identities, and while our study identified systemic concerns, it is important to remember that individual families experience these injustices, and to call attention to the balance of power in such situations and question how the risks and benefits of restrictive visitation policies are weighed, whose needs are prioritized, and whose judgment is trusted. Health professionals have long noted concerns about inequity in restrictive visitation policies and that such policies are often arbitrary and unrelated to the evidence.[9] This has been particularly evident through the COVID-19 pandemic: despite passing the two-year mark, to date, no published evidence supports the most restrictive visitation measures nor has it demonstrated that more flexible policies lead to harm. Virtually all ar-

TABLE 2: Multiple logistic regression exploring the relationship between visitation exception and demographic, family, and medical variables

	Odds ratio	95% CI	*p* value
Age	0.94	0.81 - 1.11	.48
Sex			
Male		reference	
Female	0.52	0.09 - 2.94	.46
Race			
White		reference	
Black/African-American	0.06	0.01 - 0.84	.04
Hispanic/Latino	0.17	0.01 - 1.94	.15
Insurance			
Private		reference	
Medicaid/CHP	1.31	0.19 - 8.98	.78
Family's distance from hospital			
0-30 minutes		reference	
30 minutes-1 hour	6.87	0.41 - 114.79	.18
>1 hour	2.55	0.31 - 21.11	.39
Presence of custody/childcare Issues			
No custody or childcare issues		reference	
Custody issues	17.75	0.70 - 448.06	.08
Childcare issues	1.97	0.19 - 20.25	.57
Presence of caregiver's health issue			
No		reference	
Yes	1.18	0.11 - 12.76	.89
Admitting service			
Inpatient pediatrics		reference	
Pediatric intensive care unit	28.35	1.43 - 562.37	.03
Other	1.13	0.08 - 15.57	.93
Short-term prognosis			
Fair, good, or excellent		reference	
Poor or very poor	1.64	0.08 - 35.43	.75
Visitation exception request reviewer			
Reviewer #1		reference	
Reviewer #2	0.05	0.00 - 0.84	.03
Reviewer #3	0.03	0.00 - 0.67	.03
Number of observations	73		
Model significance	$\chi^2(15)=25.89$		$p < .05$

guments that support restrictions are based on studies of the transmission of other respiratory viruses, pre-COVID-19, and of seasonal visitation restrictions, which have rarely, if ever, been as restrictive as COVID-19-era policies.[10] Further, at least one COVID-19-era study has raised concerns about patients' safety outcomes in hospitals that have the most restrictive policies.[11] Such a lack of data should be viewed in light of the data we do have at this point in the pandemic—that vaccines are effective and widely available, including for children five to 17 years of age; that masking and social distancing, too, are effective countermeasures; that personal protective equipment is no longer in short supply; and that most healthcare workers are acquiring COVID-19 at home or in the community, not at work.

What would it take to create a more equitable policy? Campelia and Brown's recent commentary in the *American Journal of Bioethics* suggests some questions as starting points, including considerations of inclusivity in the decision-making process, data collection and transparency, shared responsibility, and stakeholders' feedback.[12] With regard to visitation policies, hospitals should include patients, families, and other community stakeholders in the development and review of a policy. Development should be transparent, and evidence supporting policy decisions should be made readily available to all interested parties. Data regarding implementation and impact of a policy should be collected prospectively—*not* retrospectively, as in our study—and it too should be transparent and easy to access. Responsibility for policy decisions should be shared and should not be the exclusive province of health professionals. Since such policies are designed for our benefit as well as for the benefit of patients and families, such transparency and shared responsibility are essential to mitigate the obvious power imbalance and promote equity.

We recognize several limitations of this research. First, our data were taken from a single, mid-sized, tertiary-care pediatric institution during the fall of 2020, and may not be generalizable to other institutions. Second, our sample size was further limited by the fact that not every request for an exception was thoroughly documented and linked to a medical record number, which prevented a review of the electronic medical record for some requests, although we have no reason to suspect bias in the recording of medical record numbers. Third, the cross-sectional nature of this study prevented us from establishing causality between demographic, family, and medical characteristics and the granting of a request for an exception to the visitation policy.

CONCLUSION

Crear-Perry and colleagues have called for the systematic collection of data in order to scrutinize hospital policies for evidence that they are being applied inconsistently or unjustly, and/or impacting some groups more than others.[13] This study is a call for change at all hospitals with restrictive visitation policies that are likely to disproportionately impact vulnerable and marginalized children and their families. It also offers a model for prospective analyses of the potential for disparities in the impact of any institutional policy, including policies regarding behavioral contracts, nonbeneficial treatment, and other practices: "equity as a built-in process outcome" in institutional policy.[14]

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