



Opinion by letter No 16 on visiting rights in hospitals

*Request for opinion dated 15 December 2021 from the President
of the Medical Ethics Committee of AZ St. Elisabeth*

*Admissibility of the request: Committee plenary session of
25 April 2022*

*Adoption of the opinion by letter: Committee plenary session of
17 April 2023*

Preliminary Warning:

The committee's opinions are drafted in Dutch and French. Please consider these two language versions as official, even if translations in other languages are available.

30 May 2023

To Dr. Lorré Els
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Your request for an opinion dated 15 December 2021, regarding visiting rights in hospitals

Dear Dr. Lorré,

On 15 December 2021, the Belgian Advisory Committee on Bioethics (hereinafter, the Committee) received your question which was worded as follows (freely translated): *"Currently, there is a strict ban on visits in our hospital. Exceptions are made for the paediatrics, neonatology and maternity wards, medium and high care, and for palliative patients. The situation is currently assessed by the hospital hygiene service as high risk and the patient's visiting rights may currently be overruled. In the ad hoc situation, how do we respond to this in the uncertain Covid-related future? What is your advice in this regard? You referred to the document (freely translated) "Ethical compass for choices regarding visiting arrangements during Corona" published in April 2020 and drafted at the request of the Covid-19 task force"*¹.

In consultation with the authors of the Ethical Compass for choices regarding visiting arrangements, the Committee would like to provide a response in the form of the present letter opinion. To start with, we would like to express some reservations.

- A long time has passed since the time the question was asked and now, when the present response has been finalised. The consultation with the authors took place in

¹ Denier, Y., Vlaeminck, M., & Devisch, I. (2020). Ethisch kompas voor keuzes omtrent bezoeksregeling in tijden van corona. In: Brussels: Covid-19 care task force, Department of Well-being, Public Health and Family. See: <https://www.vlaanderen.be/publicaties/ethisch-kompas-voor-keuzes-omtrent-bezoeksregeling-in-tijden-van-corona>

November 2022, when the Covid pandemic was past its peak and virologists and epidemiologists predicted that there would be further minor waves, increasingly less intense.

- Nevertheless, in our judgment, the question is still relevant for three reasons. First, other pandemics or epidemics may occur in the future. It is useful to learn from the Covid-19 experience and have a position ready for the future. Moreover, we will have to learn to deal with Covid-19 as endemic in our daily lives. Second, the person asking the question implicitly brings up the question of for whom, and on the basis of what arguments in the event of a crisis or disaster, decisions are made in terms of restrictions, and above all, what ethical framework is used in this regard. Third, we receive information from residential care centres, hospitals and other care facilities, via informal channels and still now in 2023, of locally imposed restrictions regarding visiting. Questions are then raised in this regard which deserve ethically-substantiated responses.
- The Committee also refers to its comprehensive Opinion No. 78 of 9 June 2021, on the equal treatment and autonomy of residents of residential care centres (RCCs) in the context of the Covid-19 pandemic.²
- The Chamber of Representatives passed a resolution in December 2022 regarding amendments to the Law on Patients' Rights of 2002. This called for "(...) *examining whether it is advisable to guarantee visiting rights for patients in healthcare facilities and what the best approach is in this regard. Nevertheless taking into account the necessary autonomy of healthcare facilities to ensure the safety and health of their patients and staff, and also taking into account the possible alternatives to physical visits*"³.

This brings us to the question of how decision-making is organised in hospitals. The Law on Hospitals provides for a number of elements. The chief physician has a lot of powers in this regard, including as regards hospital hygiene, in addition to the hospital hygienist. The Hospital Emergency Plan⁴ is under the authority of the chief executive officer (CEO) and must be approved by the provincial governor. The Covid pandemic was a rather exceptional

² www.belgiumnationalbioethicscommittee.be

³ Resolution of the Belgian Chamber of Representatives of 12 December 2022 on a fundamental reform of patient rights, Doc 55, 2969/005, Recommendation 10.

⁴ Emergency Plan, cf. Royal Decree of 23 October 1964 laying down the standards to be observed by hospitals and their departments, Annex, III Organisational Standards, 14°.

situation. Indeed, there was no Hospital Emergency Plan but a new legal framework for health facilities with very strict rules on visiting rights. Consequently, the situation was generally clear for hospitals at the time, and no internal measures needed to be agreed upon. All that was needed was for the measures imposed by the competent authorities to be correctly implemented. In addition, the medical council also has a role. This participatory body provides advice and has an important say in the decisions of the administrator on matters relating to medical assistance.⁵ In the event of disputes, the matter must go to court. There is also a provision annexed to the Royal Decree of 23 October 1964, laying down the standards to be observed by hospitals and their departments that provides as follows: "*Visits to patients must be regulated by internal regulations. Restrictions will be imposed, by decision of the physician. Suitable measures must be taken to avoid too many visitors being in a room*"⁶.

Despite the strict procedures provided for in the Law on Hospitals and its implementing decrees, in practice every hospital has its own decision-making process, often with unwritten rules and agreements. Consequently, there is limited transparency on how the measures are implemented in practice. In addition, as mentioned above, various decisions have been imposed from above by interministerial conferences and various competent government bodies, and implementation was organised on an ad hoc basis.

The Committee believes it is important that the democratic and legal guarantees in our society be respected. The reflections and assessments currently underway at many levels will provide more insight into this.

Against this complex organisational and legal background, the Committee decided to make suggestions for an update of the "Ethical Compass," which is based on a deliberative approach to these issues. As such, it intends to formulate in advance five basic principles based on the experiences of the Covid-19 period.

1. The "**do no harm principle**" is still important.

Panic reactions, that sometimes give rise to decisions that are difficult to justify and may seem arbitrary, must be avoided. The individuals involved (staff, patients, residents, clients, citizens) then no longer understand why the measure has been

⁵ Zakboekje voor het ziekenhuis, Kluwer, 2012, pp. 114-154.

⁶ Royal Decree of 23 October 1964 laying down the standards to be observed by hospitals and their departments, Annex, III Organisational Standards, 4°.

taken. This can lead to non-compliance by all parties involved, resulting in conflict and unease.

The principle of 'Do no harm' also implies, as the *Deutsche Ethikrat* suggests⁷, conducting risk assessment based on available scientific evidence. This means considering what risk of infection spreading we are willing to accept in the event of a pandemic, and applying balanced risk management on that basis.

2. The **context** in which measures are taken is important. This relates not only to the infectious-epidemiological context, but also the care and living settings in which measures and restrictions are proposed or imposed. For example, a residential care centre is a setting that replace a home, and is not a hospital. A psychiatric nursing home is a different environment than a psychiatric hospital. This requires flexibility, practical wisdom and a critical but non-polarising approach. The experiences in maternity departments, for example, showed that, by restricting and even banning visiting, there was a calmer environment and more well-being for new mothers. An adapted, proportional version of this measure was kept in place in many care facilities after the acute Covid period. What was different was the experience on palliative departments and units. For example, in the depths of the Covid-19 crisis, a separate visiting arrangement was devised to this end⁸.
3. The measures and restrictions on visiting must be **proportional and reasonable**, i.e., understandable to all concerned. We must not forget that many older individuals underwent major suffering during the Covid period due to isolation and loneliness. Proportionality and reasonableness can be important elements in ensuring that the proposals are acceptable and therefore implementable. A proportional decision must always be anchored in a specific context.
4. An additional factor in making implementation and follow-up more likely is that significant attention is paid to **communication and participation**, more so than has been the case during Covid. Communication that clarifies the how and why for all involved: staff, patients, residents, clients, citizens and the institutions. The actual

⁷ Deutsche_Ethikrat (2022). *Vulnerability and Resilience in a Crisis - Ethical Criteria for Decision-Making in a Pandemic*. See: https://www.ethikrat.org/en/publications/publication-details/?tx_wwt3shop_detail%5Bproduct%5D=159&tx_wwt3shop_detail%5Baction%5D=index&tx_wwt3shop_detail%5Bcontroller%5D=Products&cHash=dda23996b2e07a9c7790d7e2ef405d40

⁸ Zorgnet_Icuro. (2020). How do we organise the farewell of a terminal resident (RCC) with (possible) Covid-19 infection in the most dignified way possible? (October 2020).

participation of all these stakeholders in establishing the measures is essential in this regard. If there is participation, the measures taken can be better understood.

5. The Covid-19 crisis and its approach highlighted the importance of the "**public health**" perspective: measures must always take into account the impact on 'the community'. When a general practice implements a patient freeze, this affects other GPs and the nearby emergency department. If a hospital autonomously decides, e.g. on account of staff shortages, to close its geriatric department, this can have a serious impact on the referral potential of residents from a residential care centre.

Below, we reprise the key messages from the above-mentioned Ethical Compass that are also more broadly applicable, in other words, outside the Covid context. We want to offer ethical frameworks when making decisions regarding visiting arrangements in the well-being and care sectors.

Adapted synopsis of the Ethical Compass

Below, we summarise the text of the "Ethical Compass", focusing on visiting arrangements.

The compass offers insight into

- (1) the general aspects of an ethical consideration,
- (2) the three levels of context,
- (3) the ethical consideration as a weighing scale,
- (4) the ethical principles and tensions relevant in this context, and
- (5) the different steps of an ethical care decision-making process

In conclusion, we propose several general recommendations regarding good cooperation on this question between governments, organisations, patients/residents/clients and their families.

As such, this compass is an overarching tool for concrete decision-making.

(1) General aspects of an ethical consideration

An ethical consideration is essentially a balancing act in the context of a specific problem based on a set of ethical values and principles of action.

Key question

The key question posed in this ethical compass is as follows:

"How do our choices promote the well-being and dignity of each individual (this includes all stakeholders: patients, residents, clients, their family, the staff) balanced against the common good of society?"

(2) Three levels of context

The context in which this key question must be asked each time is at three levels: micro, meso and macro.

1. The micro-level is that of the individual and relational care context: patients/residents/clients, carers, staff, family and loved ones.

Here the question is, "What does this person specifically need here and now, and what can we do to fulfil this in the most humane and safest way possible?"

2. The meso level is that of the teams and the organisation: directors and managers, administrators, etc.

Here the question is, "How can we, as those creating the context of care, ensure that the people for whom we are responsible can give (i.e. staff) and receive (patients/residents/clients, their loved ones) care in the most humane and safest way possible?"

3. The macro level is that of broader society and policy: policy makers and advisory bodies.

Here the question is, "How can we shape the guidelines and contexts in such a way that they promote the dignity of those involved as much as possible, ensure safety and guide society as a whole in the right direction?"

(3) Ethical consideration as a weighing scale,

Any ethical decision process involves weighing up values such as, e.g., autonomy and freedom of choice, do good, do no harm and social justice. Ethical answers are rarely black and white. They are not "yes" versus "no", but the result of searching for the right balance between multiple values.

It is useful in this regard to think of the decision process as a weighing scale.

The key question is, **"What values do you put on the weighing scale and what do you let weigh most in that consideration?"**

Specifically, "What values are at issue when it comes to the visiting arrangements we want to modify?"

(4) Ethical tensions in balancing well-being and safety with regard to visiting arrangements

During the corona crisis, we saw four major areas of tension emerge:

1. The tension between the **societal interest** (public health) and **individual interest** (individual well-being and autonomy).
2. The tension between **do good** ('Beneficence') and **do no harm** ('Non-Maleficence').
3. Respecting **people's autonomy** (individual freedom of choice) and restricting the space for this freedom of choice in the context of the **public interest**.
4. Ensuring **social justice**, not only in the distribution of benefits, but also in imposing restrictions.

In all this, particular attention should be paid to the most vulnerable and to the specific locus of their vulnerability. Where is this situated? Is it biomedical (e.g., physical vulnerability)? Is it social or relational (e.g., loneliness)? Is it psychological (e.g., anxiety)? Or existential (e.g., loss of meaning)? Or something else?

(5) Steps of an ethical care decision-making process regarding visiting arrangements.

Various elements can help in making the concrete consideration regarding adaptations to visiting arrangements within individual organisations. We offer them in the form of concrete, guiding questions. We adhere to the four dimensions of care ethics in this regard.

1. What are the needs?

We want to be attentive to what is going on, by asking the question, "What do the patient/resident/client, family and loved ones, staff want in terms of visiting? How do they see that? How do they want to do it? Who wants it? When?"

2. How can we fulfil this?

Specifically, how do we organise it? What specific questions arise?

3. Professional expertise

How can we competently meet the needs and wishes of patients/residents/clients and their families and staff regarding visiting arrangements?

4. Receptivity and reception/aftercare after visit

Throughout the process, we verify that our decisions relating to visiting actually meet the needs and wishes of the patient/resident/client and family and staff, taking into account the specific circumstances.

A lot of clear communication and information is essential

A good measure hinges on good communication and clear information. These include the following points to bear in mind:

Throughout the process, it is important to maintain good contact with patients/residents/clients and their families by providing clear information, explaining the situation clearly, what is possible regarding visits and what, unfortunately, is not (yet) possible. This also applies to internal communication and agreements with staff and volunteers.

In this regard, it may be helpful to consider the above-mentioned ethical tensions between (1) the societal interest and the individual interest; between (2) beneficence and non-maleficence; between (3) respect for autonomy and people's individual freedom of choice and the necessary (partial) restricting of this freedom; and (4) a fair distribution of the advantages and disadvantages of restrictions.

The core, guiding ethical question in this regard is:

"How do our choices promote the well-being and dignity of each individual (patients, residents, clients, their family, the staff) balanced against the common good of society?" This question is specifically answered proportionally and incrementally. Continuing to think together and look for good ways out, in the spirit of cooperation and consultation with all concerned in order to achieve the most humane outcome in sometimes difficult circumstances.

CONCLUSION

In response to your question, the Committee believes that the "Ethical Compass" *mutatis mutandis* is an ethical framework against which ethical considerations surrounding decisions such as visiting can be made. It must be verified to what extent the measures reflect a

balance between individual versus societal well-being, taking into account the specific context (micro, meso, macro) in which the measures apply.

The Committee suggests that a hospital's medical ethics committee can issue adapted opinions as long as they are well-reasoned. Exceptional situations such as Covid-19 may warrant exceptional measures, but these must be critically assessed on a permanent basis. Coherent arrangements within a region also help increase transparency and clarity.

The Committee also refers to its Opinion No. 21 of 2003 regarding forced treatment in forced admission. Recommendation No. 5 of this opinion states that vulnerable persons must be informed of their rights, that a roadmap must be drawn up under the responsibility of the physician-head of service, which must be approved by the medical and administrative directorate. As regards ethical issues, it is advisable to seek the advice of the local ethics committee.⁹

The concrete framework and tools formulated in the Ethical Compass are a valuable resource to ensure ethical consideration with all involved.

Outside the context of your request for an opinion, the Committee states that for primary care, where there are not always ethics committees, or they cannot be consulted, it may be useful to examine whether at the local level, for example at the level of the primary care zone in Flanders and Brussels as well as the primary care in Wallonia, putting in place an ethics advisory body is possible, or at least whether guidance can be provided on ethical issues.

Kind regards,

Paul Cosyns, President

This letter opinion was drawn up by the "visiting rights" working group consisting of: Jan De Lepeleire, Chris Gastmans, Ignaas Devisch in cooperation with Yvonne Denier and Herwig Van Dijck as external experts.

⁹ www.belgiumnationalbioethicscommittee, see p. 18 of the opinion.