VIEWPOINT

Labor and Delivery Visitor Policies During the COVID-19 Pandemic
Balancing Risks and Benefits

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In times of a pandemic, the primary responsibility of health care professionals shifts from maximizing the best interests of individual patients to prioritizing the health of the community. Given the surge of patients with the novel coronavirus disease 2019 (COVID-19), their clinical needs, and thus, resource utilization, the ongoing pandemic has amplified the duty of physicians to responsibly steward health care resources. Additionally, the well-being of health care professionals, both as scarce resources and as members of the community, must be safeguarded. Given this shift in ethical and clinical goals, policies have been implemented to limit the number of visitors accompanying patients in virtually all clinical settings. Such policies stem from balancing the benefits to the individual patient with the duty to reduce infectious exposures to visitors, other patients, the community, and the health care team. Notable exceptions to many of these policies exist for visitors for children, persons with disabilities, end-of-life care, and labor and delivery units.

Although variation exists in visitor policies, many hospitals have instituted a limit of 1 adult visitor for each patient in labor and delivery units. As recommended by the Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists, this visitor should be afebrile and screened for symptoms prior to entry.[1,2] Other hospital systems have further limitations based on geography (no visitors from the New York City area) or patient location (visitors are not permitted to postpartum units). In an attempt to reduce exposures, several hospital systems in the New York City area announced policies prohibiting all visitors to labor and delivery and postpartum units.[3] Given earlier guidance from the New York Department of Health that 1 support person was "essential," Mayor De Blasio issued a statement articulating that city hospitals would not be following suit.[4] On March 27, the New York Department of Health reissued guidelines. The following day, the governor of New York issued an executive order specifying the right for a pregnant woman to have a support person with her during labor and the immediate postpartum period.[5]

> Implementing a labor and delivery unit visitor policy necessitates balancing risks and benefits in the face of uncertain and evolving information.

Apart from the emotional rationale, ethical and clinical reasoning supports excluding labor and delivery units from visitor prohibition policies. As noted by the World Health Organization, continuous companionship during labor is recommended for all pregnant women to potentially improve labor outcomes.[6] This support may be especially important for women of color considering differences in maternal health outcomes, such as higher maternal mortality for black women compared with non-Hispanic white women.[7] For example, doula support for black women has been associated with increased rates of vaginal delivery and breastfeeding initiation.[8,9]

Additionally, alternatives to in-hospital birth exist, including birth centers and home birth. In a harm reduction model, policies that prohibit visitors to labor and delivery may dissuade some women from in-hospital delivery and could potentially result in an increase in-home births. The difference in health outcomes between in-hospital birth and out-of-hospital birth (such as higher rates of perinatal death) may be even more pronounced during the COVID-19 pandemic, as the concomitant stress to the emergency medical system may lengthen response times in the event that complications occur during home birth.[10] In addition, assuming a partner gains equal legal rights to make decisions on behalf of the infant once born, prohibiting visitation could create barriers to the partner's participation in such decision-making.

Ethically, the benefits of exempting labor and delivery from visitor restrictions is clear. A healthy visitor, in agreement with the patient and through shared decision-making with the health care team, can ethically choose to accept increased risk to confer benefits to the patient, for their own emotional well-being, and to assist in decision-making for the infant. The increased risk of exposure to other patients, the community, and health care professionals depends on the rate of asymptomatic severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) carrier status. But in low prevalence areas that rate is most likely low and potentially is counterbalanced by the benefits. These additional risks can be minimized by prohibiting the visitor's reentry to the hospital during the patient's admission, encouraging frequent handwashing, and providing the patient and the visitor with masks.

What is less clear, however, is whether such policies should be modified for pregnant women who are considered persons under investigation or those have tested positive for SARS-CoV-2. Given visitor screening guidelines (such as those from the CDC), visitors permitted entry to labor and delivery units will either be negative or positive but asymptomatic. In the case of a noninfected visitor, the visitor would assume increased risk given the

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proximity to the pregnant patient, who is infected or is a person under investigation. A surgical mask would not offer the same level of protection to the visitor as the N95 mask recommended to health care professionals, nor can the hospital system be responsible for conducting visitor fit testing. There is no increased risk to other parties if the visitor is negative for the virus. Thus, just as visitors of healthy laboring women can choose to incur additional risk through shared decision-making, so too can virus-free visitors of women who are or maybe infected while they are in labor.

However, given the high rate of infectivity prior to symptoms, there is risk that the visitor of the pregnant patient could also be SARS-CoV-2 positive though asymptomatic. In this scenario, there is probably no additional risk to the positive patient nor to the community, although isolating the visitor during the hospital admission may decrease risk of presymptomatic transmission to the community. The increased viral load in the labor and delivery unit and postpartum room does confer additional risk to the infant, other patients, and health care staff. As the relationship of viral load and symptomology remains unclear, the implications have yet to be fully elucidated. Some infants will be exposed to the visitor, especially if they are the pregnant patient's partner, upon hospital discharge. Therefore, risk to the infant is not effectively lessened by prohibiting the visitor.

Although guidelines to physically distance infants are evidence-based, they are not pragmatic. Many families, especially if both the patient and visitor are SARS-CoV-2 positive, lack the resources to isolate from the newborn for 14 days. Furthermore, risk of harm to bonding and breastfeeding initiation exists. The risk to other patients and health care staff can be reduced by requiring that the visitor not leave the patient's room. While higher viral load increases spread in the community, it is unclear if it does so in the health care environment with appropriate protections in place. Given that the patient either is a person under investigation or is known to have a positive status, the limited health care staff inside the patient room should already be protected by appropriate personal protective equipment (PPE). If PPE is unavailable, the increased risk to the health care team is no longer justifiable, and visitors should not be permitted.

Policy development should account for local resource availability to ensure visitor policies are enforced in terms of limiting visitors to 1 healthy person, prohibiting reentry, and ensuring isolation to the room of a visitor who is or may be infected. Minimization of room transfers, provision of food for visitors, and the availability of and requirements for appropriate PPE may also vary between hospitals. An individual hospital's ability to conduct universal SARS-CoV-2 testing for patients and ultimately their visitors may also result in modifications to visitor policies.

After infant birth, policies may also reasonably differ between postpartum units vs neonatal intensive care units (NICUs). Given the potential decreased ability to isolate infants, policies may ethically prohibit NICU visitation by mothers who have either tested positive or are persons under investigation and their support person. However, while variation is necessary, ongoing dialogue between hospital systems is crucial both to minimize the utilization of health care resources in creating novel policies and to ensure fairness and transparency across hospitals. Pregnant patients who travel in pursuit of a hospital system that has a less restrictive visitor policy increase their risk of adverse maternal and fetal outcomes given the lack of continuity of care and increase the risk of viral transmission to another community. Unique clinical situations will require flexibility and individualization in application of policies.

Implementing a labor and delivery unit visitor policy necessitates balancing risks and benefits in the face of uncertain and evolving information. Ideally, such policy making balances the benefits and risks to the patient, the visitor, the community, the health care team, and perhaps above all, to the infant, in an evidence-based, nonreactionary, and compassionate manner.

ARTICLE INFORMATION

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