Against visitor bans: Freedom of association, COVID-19, and the hospital ward

Abstract:

To ban or significantly restrict visitors for patients in hospital could seem to be simply a sensible and easy precaution to take during a pandemic: a policy that is unpopular, perhaps, and even unfortunate, but not something that wrongs anyone. However, I argue that in fact such restrictions on visitors infringe upon a fundamental right, to freedom of association. Whilst there may still be permissible restrictions on visitors, making the case for these becomes highly demanding. One common way to understand the purpose of the fundamental liberties is as protecting us from interference in a core set of freedoms, even when such interference would be to our benefit or would promote the general good. This reframing of the importance of visitors in terms of a right also has implications for how to run hospitals beyond the pandemic era: it supports a rapid expansion of visitor access and suggests that any decision to significantly restrict visitors ought not be left in the hospital, or hospital trust's, hands.

1. Introduction: COVID-19 and visitors

Under Covid-era restrictions, on hospital wards, some died without a chance to see loved ones and loved ones were unable to say goodbye. Other times, just a single visitor was permitted, say only one parent or one of one's children, and generally only for brief periods. Some recovered from life-changing accidents or endured serious illnesses and accompanying treatments without friends, lovers, or children allowed in to see them often, or at all, to do things like help them eat, get dressed, or check with doctors about treatment options.

In maternity units, some gave birth, and some had stillbirths, without partners or another birthing companion being permitted to be present. Others were left to care for their babies without support from companions or partners shortly after birth, some with limited

movement following c-sections, or whilst recovering from traumatic birth injuries. Some women discovered they had lost their babies during scans without anyone they knew there to support them.

In consultation rooms, people received life-changing and terminal diagnoses without companions there to hold their hands or ask doctors questions that are hard to think of when you receive such a diagnosis. Only one parent was permitted to accompany a child to such meetings, even where the news might be grave.

Rather than stylised philosophical examples, the above cases describe the real-life results of visitor restrictions. Nor are these cases outliers. Across the UK, and in many other countries, hospitals or hospital trusts have imposed sweeping restrictions on visitors over the last two years as a response to the COVID-19 pandemic. My focus is not on the ethics of quarantining those with infectious diseases but, rather, the wider bans and restrictions introduced on visiting. In some hospitals, all visitors were banned, with a few exceptions for end-of-life care. People were, and are, required to go to appointments and scans alone. At points in the pandemic, women were made to labour alone, or left without support from family or partner very shortly after birth [1,2].

Most of these restrictions lingered even during periods of low prevalence of Covid, and while restrictions were lifted in other settings, such as bars, restaurants, and theatres. Indeed, many hospitals still have significant restrictions on visitors in place, far beyond what was usual pre-pandemic, even as COVID-19 cases decline.[1] These sorts of restrictions, too, now seem to be in the toolkit for future outbreaks of COVID-19, or even during flu epidemics. Some medical

[1] To give one case, UCLH banned partners from the postnatal ward during the pandemic, and at the time of writing, restricts visits to 4 hours: pre pandemic, partners were welcome even overnight.

professionals even defend continued restrictions. One recent piece, for instance, calls for some restrictions to continue in order to let doctors work unimpeded, without being interrupted or questioned [3]. Visitor restrictions were once the norm. In the early days of the NHS, for instance, parents were banned from visiting, let alone staying with, their sick children [4]. As such, it is important to examine the justifiability of such restrictions. In so doing, I urge a reframing of the issue in terms of a moral right to have visitors. This provides a strong argument against radical restrictions and bans on visitors, with implications for hospital policies beyond the pandemic era.

2. The costs of banning visitors

To make the case against significant visitor restrictions, one could point to the resulting cruelties, harms, and indignities. One aspect of visitors' importance that one might miss without experience is that, at least in the UK, visitors often provide basic care in understaffed and busy wards. They aren't only there for entertainment and emotional support; rather, they might carry out caring duties that otherwise may not be done at all, or not in a timely manner, like helping a patient to wash, eat, or change dirty clothes. Or take banning of partners or other supportive companions from post-natal wards where they'd assist the new mother to care for her newborn baby or deal with the birth's physical consequences. There can be serious costs to patients' dignity and well-being, then, from banning visitors. In one survey of pregnant women in the UK, 90% reported a negative impact on their mental health from visitor restrictions [5]. The potential harms, however, are not only to wellbeing and dignity. While I focus on hospitals, some claim that there were thousands of additional deaths amongst people living with dementia in the UK resulting from the increased isolation and lack of support produced by visitor bans in care homes [6].

Another important objection to visitor bans and substantial restrictions observes the visitor's role in advocating for patients to ensure that standards of care are met, the right

treatments are offered, and adequate pain relief is provided. That is the source of many of the 'interruptions' that the doctor keen to continue on his ward round may experience. Advocacy is crucial as patients are often in a poor position for self-advocacy. Some patients might be on drugs that compromise their facilities or be too unwell. Consider, too, the power imbalance that in-patients experience, with their doctors in charge of pain relief and treatment.

Visitor bans also have an unequal impact. Against a background of significant racial disparities in outcomes for, and treatment of, patients, for some advocacy is of crucial importance. Having an advocate present can help ensure that the concerns are heard of those whom, as a result of background racial injustices and biases, medics tend to be less likely to believe regarding their symptoms and whose pain they are less likely to treat [7,8]. This case has been made for maternity care, where it is argued that the absence of advocates threatens to worsen the already unacceptable inequalities in outcomes for black women and Latinx women [9,10].

Defenders of hospital bans may grant the existence of these costs but are likely nevertheless to insist that such costs are worth incurring for the sake of a crucial benefit: namely, infection control, to 'protect lives' [11]. Such claims cannot be accepted at face value. Strikingly, bans on visitors have tended to continue where infection rates are low.[2] Further, the costs to patients' dignity and care, and especially the unequal impact of this, ought not be underweighted where we carry out such cost/benefit assessments. Visitors, after all, *always* present an infection risk. They might carry in bacteria, or the flu, and various other illnesses to often vulnerable patients. What motivated the restrictions was the *degree* of risk that the COVID-19 pandemic created. That level of risk diminishes with widespread vaccination, improved care for serious

[2] There may yet be cost-benefit style justifications of restrictions, perhaps, say, that there is some value in not chopping and changing restrictions, with thanks to a referee. These, though are precisely the kinds of justification that are s too weak to justify infringing rights – as I shortly elaborate.

cases, better understanding how the virus spreads, falling rates of infection, and the ability to test visitors before admission. Hospital bans and restrictions, then, may not always have been based on a careful enough assessment of the benefits of permitting visitors, against the risks of infection given its possible mitigations.

Even so, one cannot deny the possibility of cases where a careful assessment shows that the benefits of infection control outweigh the costs of disallowing visitors. The various peaks of the COVID-19 pandemic may have been such cases, and we see this cost-benefits style of assessment of permitting visitors in discussions [12,13]. However, a cost-benefit analysis, as presented so far, fails to settle the question of whether visitor restrictions have been, or can be, justified. That is because it misses out a significant reason against visitor bans: their impact on our freedom of association. I argue that reframing the issue in terms of our moral rights in this way renders policies disallowing visitors substantially more difficult to justify. I also argue that a focus on rights changes *who* ought to be making the decision about visitors, taking it out of the hands of individual hospitals and hospital trusts.

3. Freedom of association and hospital visits

Freedom of association is one of our fundamental or basic liberties, along with freedom of speech [14,15,16]. In the liberal tradition, this right protects our intimate relations, where we associate as friends, lovers, or family, as well as political organisations and formal associations like unions or the Scouts [17]. As Larry Alexander describes it, following in J.S. Mill's footsteps, free association is: "the liberty a person possesses to enter into relationships with others—for any and all purposes, for a momentary or long-term duration, by contract, consent, or acquiescence" – or to refuse to do so [14, 18]. The right protects us from interference with whom we associate, and how.

On the grounds of this right, I suggest that there is a strong case to be made against general bans on, and extensive restrictions to, visitors to hospital wards. Banning or limiting

visitors restricts an inpatient's freedom of (intimate) association.[3] It also restricts the would-be visitors' ability to associate. That restriction might be short lived, where the hospital stay is short, or longer term if the patient receives more extensive treatment. But patients, given their right to free association, should be thought of as *entitled* to have visitors. Visitor bans might be regarded as merely temporary restrictions – at least for those who make it out of hospital – and so as insignificant. However, this would be to ignore the fact that illnesses, deaths and births are crucial moments in our intimate associational lives. To be unable to be present during the birth of one's child, or the hours after birth, to be unable to hold the hand of a loved one facing serious illness, to be made to be absent when an intimate's life draws to a close, are not small, insignificant restrictions on our associational life. Rather, these are significant and go to the core of the values and purpose of the association: values like care, intimacy, and closeness [17]. The hospital, then, is an especially important site in which to protect our free association interests.

Here, I adopt a broad understanding of this right, familiar from discussions of other fundamental rights like free speech, on which it has some application to non-government institutions and individual and can be infringed upon in ways other than through legal restrictions. It is not only the law that can undermine our freedom. For instance, J.S. Mill argues social stigma, and not only legal restrictions, can undermine free speech [14]. Of course, to apply the argument to U.K. hospitals, given that these are public institutions, requires only accepting that a state's interference in our freedoms can be carried out through its institutions, and not only its laws.

[3] Some might prefer to ground this argument on a right to a family life, with thanks to referees. However, that would not ground an objection to visitor bans in general, only bans on visits from family. Further, my project is philosophical and not legal: the right to a family life might be useful as a frame in certain legal jurisdictions but, following the liberal tradition, I treat our freedom of intimate association, including family life, as one element of free association.

In the light of our freedom of association, any substantial restriction to hospital visitation rights will thus be hard, though not impossible, to justify. Some understand our fundamental rights as a way of indicating a very weighty consideration, one that requires proper justification for any serious infringement [17]. Others think they cannot be captured as one more part of a wider weighing up of costs and benefits at all [15]. Either way, to appeal to the right to free association makes it substantially harder to justify visitor bans and extensive restrictions. To most, we cannot simply trade off protecting someone's rights in order to promote other goods – including public health goods [19].[4]

Clearly, this isn't to argue against *all* restrictions on association for patients. Other liberties, too, permit limited restrictions in how and when they are exercised. We can have freedom of speech whilst still being forbidden from marching down a residential street shouting into a loud-speaker at 3am. Likewise, it may be unreasonable to visit a ward at 3am and make noise, since that would disturb other patients. Nor would it be reasonable to demand visitor rights during surgery if that substantially compromises the ability to deliver care; nor can people visit if they have a serious infectious illness, since we have a moral duty not to inflict lethal harm on others.[5] There will be some necessary and justified visitor restrictions. But to frame the issue in terms of freedom of association urges a shift in how we conceptualise visitor restrictions. Rather than weighing the costs and benefits and coming up with some policy on what seems a reasonable amount of access to visitors, *every* single restriction to one's having visitors must be

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[4] Sometimes, in special circumstances, we might make such trades: quarantine is a good example, of a limited restriction on free movement. However, to justify such trade-offs is hard: adverting disaster may sometimes, to some, justify trading off rights, but not just any infectious disease will do, let alone the mere possibility of infectious disease. I return to whether (or when) the outbreak of Covid-19 counted as a disaster-type scenario later.

[5] However, a mere possibility of having some infectious illness can't suffice to make visiting unreasonable *in general*, especially if there are tests: that risk is always present. Still, in *particular* cases such a risk might make visitor bans reasonable, e.g. on wards with severely immune-compromised patients. With thanks to a referee on this point.

justified; restrictions, after all, threaten the interests that ground a basic moral right. Further, extensive visitor bans are very different from the limited kinds of restriction regarding the precise manner and timing of our exercise of our rights, of the sort that could be justified.

One could object that physical visits are unnecessary: won't phones or video calls do, in providing *some* contact [13]? Yet for many of us, that is not the way in which we desire to associate, and a virtual presence will not suffice to satisfy our need to connect with intimates at times of need and profound life changes. Nor do virtual alternatives make space for the physicality of our expressions of care and affection.

Another objection is to observe that infringements on intimate associations are commonplace in public institutions. Take restrictions on prisoners having visitors, or the fact that one cannot just walk into schools to see children whenever one likes. But these are telling comparisons. A hospital patient has done nothing to render herself morally liable to such restrictions, where part of the punishment of imprisonment is precisely its limits on one's freedom, especially of movement and association. Indeed, despite that, some think that prisoners have a right to visitors, given the significance of intimate associations [17, 631]. Schools are closed to spontaneous visitors, one might think, for reasons that do not translate to the hospital case: to meet safeguarding duties by removing the risk of visiting adults having unsupervised contact with others' children, without background checks, and to avoid significant disruption to education.

Still, in the hospital case, could one make similar arguments by appeal to the institution's disrupted activities or on the grounds of safety? On the former, take David Oliver's thought that visitors hamper the doctor on the ward round [3]. Given their role in delivering care and support, and in advocating for patients with doctors, however, I would argue that visitors are not best understood as intruding into the running of the hospital and the delivery of care. Rather, they are a crucial part of the life of a well-functioning hospital. Further, while it is hard to see how a school could function with parents dropping in and out of classrooms at whim, it is not

hard to see how hospital wards could function that way: pre-Covid, a great many did function with visitors permitted extensive access.

On the latter, the safety of patients and medics are, of course, important considerations. But here, not just any risk to safety will do. Considerations of safety in the hospital context are not as weighty as the safeguarding considerations for children in schools: we lack a general obligation to make adults as safe as possible of the kind that schools may bear towards their pupils. When it comes to children in hospital, mostly, they are safer and more secure with their parents there, rather than alone. The idea of making adult patients as safe as possible by banning them from having visitors also proves too much: we'd then always ban visitors, given that there is always some risk of unruliness or indeed infection.

One last objection to raise in this vein. Shouldn't we make hospitals as safe as possible for medical professionals, given that they are workplaces? People should be protected from serious risks to health at work. In response, of course: we should all have safe workplaces and hospital workers should have safety equipment provided. But the goal can't be to make a workplace safe in a way that is inconsistent with the activities and nature of that workplace. For instance, cafes have customers, even if banning customers would be safer, given diminished risks of infection. Hospitals have patients and their visitors, and these visitors deliver essential care and support for patients and permit in patients to continue their associational lives as best they can, in the face of illness or the need for medical care. Even where the risks are significant, as during a pandemic, still, to protect free association, one should look first for ways of mitigating safety concerns, like testing, protective gear for staff, ventilation, or having outside spaces patients can access with assistance to meet visitors, rather than automatically restricting visitors.

4. Who decides, pandemics, and enabling visitors

Banning visitors, then, turns out not to be simply a sensible and easy precaution. Rather, it is a potentially rights-violating restriction. Implications follow for the decisions made during the

pandemic, and also beyond. First, in some places, including the UK, individual hospital trusts or hospitals chose their own visitor restrictions. If the question of admitting visitors is conceptualised in terms of a cost-benefit analysis, that makes sense. Individual trusts likely have the best sense of the costs and benefits to their particular local communities and hospitals and this nuance will change our calculations on what to do [11]. But, if conceptualised in terms of moral rights, on the ground local knowledge has far less significance and so the case for variation across hospital trusts is substantially weakened. That is because small or even moderate local fluctuations in the costs of permitting visitors, or benefits of banning them, of the kind that on the ground local knowledge provides, cannot outweigh the very weighty consideration of protecting a fundamental liberty.[6] Worse, it would create a new variety of a postcode lottery, this time in how secure is our exercise of our right to associate. Further, when it comes to restrictions on our rights, one ought to prefer the processes of a democratic state over relying on the whims of local health administrators. Local administrators are not held to account in the way that democratic states are at the ballot box, and their decisions tend to be subjected to less scrutiny and to fewer checks and balances than are a democratic state's. Visitor restrictions, then, are better decided at the level of state policy, rather than by permitting hospital trusts to introduce additional restrictions unilaterally, at least in public healthcare systems.

Second, given the importance of permitting visitors – given the care that they deliver, their advocacy for patients, and in allowing patients to exercise their freedom of association at crucial moments – hospitals and hospital trusts have good reason to make more space for visitors. For instance, more hospitals might create rooms for patients to meet with visitors. They might also consider more permissive visitor policies in areas where visitors have usually been restricted. As one example, Berwick and Kotagal argue against limiting visiting hours in ICUs

[6] Again, philosophers differ when conceptualising clashes between fundamental rights and other considerations. For some, the bar will be higher still.

[20]. In general, shifting to a rights-based approach means that visitor restrictions must be more carefully justified: each is a potential infringement, and the case needs to be made that the infringement is either insignificant, or that there are weighty reasons for this particular restriction, of a kind that overrides the right.

Third, rights infringements might sometimes be justified, especially in times of disaster. The COVID-19 pandemic likely counted as such in the first wave, where we faced limited knowledge about the disease, less effective treatment options, and no vaccinations. But alternative options which would not substantially infringe upon our free association ought to have been considered first and, likely, adopted. These could have included prioritising access to protective gear for visitors, once immediate shortfalls for healthcare workers were resolved; setting up testing stations to check visitors before entry; even creating safer spaces (outdoors, ventilated) for visits. Further, as we move out of a 'disaster' situation, visitor restrictions ought to be retracted. As COVID-19 infections decline, and as we live with the virus, it is troubling that many visitor restrictions have remained. Restoring access for visitors should be a priority. People have a right to sustain their valuable intimate associations, and to do so even when they are patients. Indeed, hospitals are often the site of deeply significant, central moments in our intimate associational lives: our births, deaths, and illnesses.

No competing interests. [Acknowledgements removed for blind review].

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