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Research

Physician perceptions of restrictive visitor policies during the COVID-19 pandemic: a qualitative study

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Abstract

Background: Little is understood of the consequences of restrictive visitor policies that were implemented in hospitals to minimize risk of infection during the COVID-19 pandemic. The objective of this study was to describe physician experiences with these policies and reflections of their effects.

Methods: We conducted semistructured phone interviews from September 2020 to March 2021 with physicians practising in Ontario hospitals, recruited via professional networks and snowball sampling. We audio-recorded, transcribed and analyzed interviews to describe and interpret overarching themes by thematic analysis.

Results: We interviewed 21 physicians (5 intensivists, 5 internists, 11 specialists in palliative care). Four main thematic categories emerged, including provider, system, patient and caregiver effects. Provider-related factors included increased time and effort on communication with a need to establish limits; increased effort to develop rapport with caregivers; lack of caregiver input on patient care; the need to act as a caregiver surrogate; and the emotional toll of being a gatekeeper or advocate for visitors, exacerbated by lack of evidence for restrictions and inconsistent enforcement. System effects included the avoidance of hospital admission and decreased length of stay, leading to readmissions, increased deaths at home and avoidance of transfer to other facilities with similar policies. Patient-related factors included isolation and dying alone; lack of caregiver advocacy; and prioritization of visitor presence that, at times, resulted in a delay or withdrawal of aspects of care. Caregiver-related factors included inability to personally assess patient health, leading to poor understanding of patient status and challenging decision-making; perceived inadequate communication; difficulty accessing caregiver supports; and increased risk of complicated grief. Participants highlighted a disproportionate effect on older adults and people who did not speak English.

Interpretation: Our study highlights substantial negative consequences of restrictive visitor policies, with heightened effects on older adults and people who did not speak English. Research is required to identify whether the benefits of visitor restrictions on infection control outweigh the numerous deleterious consequences to patients, families and care providers.

Caregivers play a fundamental role in ensuring patients' well-being, both at home and during admission to hospital. The presence of caregivers at the hospital bedside has been associated with numerous benefits, including reduced delirium and anxiety, and improved patient and family satisfaction.[1] Over the last few decades, health care institutions have recognized the importance of caregivers. Many institutions have made the presence of caregivers a part of the inpatient experience with the help of flexible visitor policies. However, widespread implementation of policies to limit visitors during the recent COVID-19 pandemic, in hopes of decreasing transmission of SARS-CoV-2, occurred with little understanding of the indirect or unintended consequences to patient care. To date, little research exists about visitor restrictions during the COVID-19 pandemic; it is mainly focused on outlining implementation of various policies around the world and hypothesizes about potential effects on patient care.[2–4] Thus far, it is unclear whether these policies have been successful in decreasing infection rates in either acute care hospitals or long-term care facilities.[5,6]

Canadian hospitals started to implement "no visitor" restrictions in March 2020, and most did not differentiate between visitors and essential caregivers until much later in the pandemic. In May 2020, the province of Ontario, one of

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Canada's most populous provinces and the first to be affected by COVID-19, outlined strict policies allowing the presence of essential caregivers as essential visitors (care partners), defined as those allowed access to the hospital in certain situations, such as for compassionate care; for visits that are paramount to the patient's fundamental care needs, mental health and emotional support; for enabling processes of care and patient flow; and for discharge from the hospital.[7] Since that time, hospital visitor policies have varied depending on regional infection rates and continue to remain in effect 2 years later.

Previous literature has shown that essential caregiver presence is associated with improved patient safety, improved outcomes (e.g., decreased delirium, shorter length of stay) and improvements in communication.[8,9] Recognizing the important role of caregivers during a patient's hospital stay, the consequences of their absence at the bedside during the pandemic is unclear. We sought to describe the experiences and reflections of physicians on the unintended effects of restrictive visitor policies that were implemented during the COVID-19 pandemic.

Methods

We conducted a prospective qualitative study with intensivists, internists and palliative care physicians in Ontario who provided care to patients admitted to hospital during the pandemic. This study is a secondary analysis of work done to explore the barriers to the provision and integration of palliative care in hospitals during the pandemic.[10] We targeted these physicians as they were working in hospitals during the pandemic and were likely to have sustained relationships with patients and caregivers. Specific research team member roles, experience and characteristics are found in Appendix 1, available at www.cmajopen.ca/content/11/1/E110/suppl/DC1. We used the Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist to promote explicit and comprehensive reporting.[11]

Setting

Participants completed a demographic questionnaire virtually and participated in a semistructured, open-ended interview conducted over the phone.

Recruitment

We recruited physicians in practice during the pandemic from September 2020 to March 2021 (over a 7-month period that corresponded to the peak of Ontario's second wave of COVID-19 through to the peak of the third wave). We identified potential participants by professional networks and snowball sampling. We included intensivists, internists or specialist palliative care physicians who worked in a hospital environment during the pandemic and who had adequate fluency in English. We excluded physicians who did not speak English, intensivists or internists who did not provide care to patients with COVID-19, and specialist palliative care physicians who did not work in a hospital environment. Eligible participants were approached and provided with an electronic study summary and consent form that the study team reviewed with the participants before the interview. Interviewers reviewed the study consent form with participants and answered any questions.

Data collection and measures

We developed the interview guide with insight and guidance from clinicians and researchers, and then piloted it with a physician who met the inclusion criteria (Appendix 2, available at www.cmajopen.ca/content/11/1/E110/suppl/DC1). Questions were designed to gather information on the participants' practice, and how their practice and the care they provided to patients changed during the COVID-19 pandemic, including their provision of palliative care. For example, the guide included, "How did visitor policies change your practice?", "Do you have a role in determining visitor access to patients with COVID/without COVID?", "How has this affected your practice/you?" and "How has it affected others/the system?". We amended the interview guide after each of the first 4 interviews. Interviews were scheduled to be 45–60 minutes long, audio-recorded and transcribed verbatim. Three researchers (K.W., A.W. and L.H) who did not have a close relationship with the participants conducted interviews. We confirmed thematic saturation when continued coding of interviews did not produce further data, which was reached by completion of the 21 interviews.

Data analysis

We used thematic analysis to describe physician experiences of working in an environment with restrictive visitor policies.[12] We chose our methodology and process to improve reflexivity and trustworthiness through frequent debrief meetings among interviewers and coders; to reflect on the content of the interviews and their personal biases; and to adhere to the core principles of credibility, transferability, dependability and confirmability.[13–15] Using a postpositivist approach to analysis,[16] 4 team members (K.W., K.T.W., L.H. and A.W.) first reviewed more than 50% of the transcripts and then worked collaboratively over a series of meetings to compile a list of high-level concepts inductively.[13,17,18] After the finalization of the codebook, 2 team members (K.W. and K.T.W.) consensus-coded all 21 transcripts using NVivo version 12. Themes were further refined by team members (S.I. and C.Z.) who had not conducted or coded interviews but who had content expertise.

Ethics approval

This study was approved by the University Health Network Research Ethics Board (no. 20-5933).

Results

We interviewed 21 physicians, including 5 intensivists, 5 internists and 11 specialists in palliative care. Two additional clinicians agreed to participate but were unable to schedule a convenient time to do an interview. Participants' mean age was 36 (standard deviation 1) years and 62% were female

(Table 1). All participants worked in a hospital setting, but 7 palliative care physicians also provided care in the community or a palliative care unit or hospice outside of the hospital. All 21 participants were from the province of Ontario and were employed at 16 unique health care institutions.

During the interviews, participants described 4 main thematic categories, including provider, system, patient and caregiver consequences. They also outlined what they believed to be a disproportionate effect of visitor policies on older adults and non-English-speaking populations.

Provider-related consequences

Participants indicated that visitor restrictions forced providers to spend more time and effort to support caregiver communication. This included not only an increased daily time commitment and additional efforts to build trust and rapport with caregivers, but also the need to set limits to how much communication could be provided (Table 2). Providers were unable to benefit from caregivers' input on patient status or their perceptions of response to treatments. Anecdotes illustrated that providers were required to act as surrogate family members, including being a presence to provide comfort at the bedside, communicating final words or messages between patients and caregivers, and being present for intimate conversations to support virtual communication between patients and caregivers.

Many participants articulated the emotional toll on providers when they were required to enforce visitor policies or act as a gatekeeper for visitors. Participants felt the need to work around the policies and advocate for flexibility for their patients; they described feeling powerless when they were unable to do this. The role of gatekeeper was seen as particularly difficult, contributing to poor morale, burnout and an element of trauma for staff (Table 2). This was further exacerbated by the lack of evidence to support restrictive policies and their inconsistent enforcement. Some participants challenged the usefulness and the evidence behind restricting visitors during the pandemic; they highlighted their negative consequences in situations in which these policies had no potential gains. Providers also found it difficult to explain and justify restrictions when they were not uniformly implemented. This made it challenging to anticipate and inform patients and caregivers of what to expect when transitioning between units or institutions. Participants saw the flexibility provided to patients in allowing more permissive visitation as a sign of compassion or a reflection of their own values and beliefs.

Table 1: Participant demographic characteristics

Characteristic	No. (%) of participants *n* = 21
Age, yr	
Mean ± SD	36 ± 1
Median (range)	37 (32–58)
Gender	
Female	13 (62)
Male	8 (38)
Specialty*	
Critical care	5 (24)
Internal medicine	5 (24)
Palliative care	11 (52)
Time since training completion, yr, mean ± SD	6 ± 4

Note: SD = standard deviation.
*Several participants had mixed practices but were identified by their primary practice; 2 internists also acted as palliative care consultants, and 1 palliative care specialist also worked as an intensivist.

System-related consequences

System consequences of visitor policies were illustrated by examples of patients who prioritized visitor presence in their decision-making, which resulted in changes in occupancy, length of stay and place of death. Participants highlighted that patients wanted to avoid hospital stays and, if admitted, would ask to be discharged quickly. This, at times, led to patient readmissions. It was felt that patients also expressed their preference to die at home rather than be moved to a palliative care unit because of similar visitor restrictions (Table 2).

Patient-related consequences

Participants shared their perceptions of specific consequences of restrictive visitor policies for patients. Participants felt that visitor restrictions resulted in patient isolation, and that many patients were forced to die alone (Table 3). Patients were believed to lack family caregiver support, comfort and advocacy. Many providers offered examples in which patients and caregivers made care decisions that they would not normally make to prioritize visitor presence. These decisions included delaying or forgoing medical care to avoid hospital admission and withdrawing aspects of care to ensure death was more predictable so that family presence could be permitted.

Caregiver-related consequences

Participants perceived several caregiver-related consequences of visitor restrictions. Participants felt that caregivers were no longer able to participate in care or provide comfort to their loved ones. Participants believed that caregivers' ability to assess clinical status of patients was hindered; caregivers were not able to provide collateral information regarding patients' status to the health care team (e.g., provide context on the patient's status in relation to their baseline status, interpret patient behaviour to infer level of comfort). Participants expressed that caregivers were unable to adequately communicate patient status virtually, and with caregivers unable to assess clinical status at the bedside, they therefore had a relatively poor understanding of the patient's illness or status. Thus, caregivers struggled to make care decisions. Participants described how this difficulty was highlighted when providers were

Table 2 (part 1 of 2): Provider and system consequences of restrictive visitor policies

Subtheme	Participant quotes
Provider consequences	
Increased time and effort on communication and need to establish limits	“I think that the main thing with families was that we would essentially have daily conversations with families, going over clinical status and changing it in accordance with just daily conversations of 15 to 30 minutes, multiplied by the number of patients that we have. So it was really just a huge increase in the work volume. And I think for family members there was just such a need to have that dialogue because they couldn’t see or participate in the care in any other way.” — GIM3 Male “I did notice at the beginning, families were just very happy to get any communication at all. But as months went on that changed from gratitude to just anger and not being able to come in and not getting daily updates and I would perpetually explain to the families that my practice is to update them multiple times a day at the bedside and to talk to anybody who’s there, but because … if I’m on the phone all day and this takes me away from the patient’s bedside, I’m not able to always promise to call every single day even though I want to because I can’t be in 7 places at once and if their loved one needs me or needs resuscitation or anything like that … I can’t be on the phone to someone else’s family. And I think once I framed it like that — I want to call you and I want to be on the phone with you, but it’s taking me away from them if they need me. Then that helped change their mind frame, but I did my best to try and set expectations with that family member.” — ICU5 Male
Increased efforts to establish trust and connection to family	“I mean, there’s no substitute for being in person with someone. When you’re with someone and they’re not there, you’re basically doing it blind when you’re on the phone, you’re robbing yourself of one of the most important senses, which is your visual, your body language. And body language gives off an energy where you can connect with someone you. It’s easier to empathize with someone when you can see what they look like and over the phone you just can’t, it’s a voice. It’s impersonal. You can say any … it’s almost like a conversation on the internet, your username. But when you’re in someone’s face, when you’re sharing a space that are 4 walls around you’re together, you’re present. So it makes a huge difference.” — GIM3 Male “Very difficult to establish a relationship because they were not in the unit. I usually, in normal times … I advocate for patient presence during patient rounds because I think it’s saving me time. It is creating trust. It is transparency. They realize that we don’t hide information or whatever. There is a lot of information communicated during the rounds so they are aware of changes, minimizing the time and spending on phone calls and updates and when we have a more rearranged family meeting, they already [have] a lot of information already incorporated. So it’s think there’s only benefit to have the family presence during rounds and the pandemic cancelled all of it. Horrible. Honestly it’s horrible.” — ICU2 Male
Decreased input from family on patient status and response to treatments	“I think that this has been so used to having family as people who help with identifying symptoms, quantifying, improvement with treatment; being able to have them nearby and easily accessed so that the ongoing psychoemotional spiritual support can be provided them and their families. And in their absence, that that became a little bit more difficult from the point of view of assessing the severity of symptoms, the effectiveness of treatment and certainly being able to provide the emotional support is necessary”. — PC5 Male
Supporting patient–caregiver communication and being a surrogate for family	“Sometimes we … I would go, and I and our nurses would go into the rooms because these people are alone and it was ... didn’t … it was not the best that they were alone for their last hours and days all the time because, again, the nurses were going less frequently and the MRP wasn’t going in at all at that point.” — PC9 Female
	“I called his family and to say, you know, he’s awake, he’s interacting and he’s articulated that he wants to stop. This is too much for him. And so we’re purely just going to focus on symptoms and comfort and pain, and they said they weren’t going to come in, but then they gave me all these messages to tell him and so that aspect … most of the patients we’re palliating with families that come to the bedside; they are comatose, likely can’t have awareness of what’s going on. But in this situation, there was kind of the anguish associated with me having to portray the final thoughts of their loved ones and then me not knowing what he’s thinking … like maybe he understood why they weren’t coming in, but I didn’t know that and it’s enough for him to realize that he’s dying and I just didn’t want to ask the questions of … So that was awful … that was probably the worst experience of anything.” — ICU3 Female
The emotional toll of being in the role of advocate, gatekeeper or enforcer of visitor policies, which was exacerbated by lack of evidence and inconsistent enforcement	“It’s like there is this inhumanity to the whole interaction where you are speaking to someone who you’ve never met over the phone. And telling them and you’re acting as the gatekeeper, you no, no you can’t come in. No. No, yes. Only one son can come in but the other no.” — PC4 Female “There was one patient on one unit and they had 6 visitors at one time, and then they would go to another unit and be told no visitors allowed. This would be 12 hours apart. It was incredibly difficult. Some units would say no visitors whatsoever, some would say one at a time, some would say one per day, some would say no one under 18. So it’s incredibly inconsistent and when patients who moved from unit to unit, that was so challenging to try to tell families why there’s no visitors.” — PC12 Male

Table 2 (part 2 of 2): Provider and system consequences of restrictive visitor policies

Subtheme	Participant quotes
System consequences	
Changes in occupancy, length of stay and place of death	"Everyone wanted to be discharged yesterday. Patients wanted to stay home to die there." — PC12 Male "I think that was one of the biggest, not COVID but COVID-related, shifts was people dying at home. I know this happened everywhere. I think we had an extra 100 people die in Q1, or Q2 I should say. In [region], when compare[d] to the year before, Our PCU had been 15 beds, we are now 10. We gave up 5 because we couldn't fill them. Oncology needed isolation and private rooms. And even the 10 that we had there was a reasonable balance. There was a while it was hard to fill even 10 … So that shift of people choosing to go die at home. Really. I mean, it was driven by people's strong desire to be with the family. To be able to have visitors." — PC8 Female "I guess it also changed how, you know, about disposition planning, especially at the peak of COVID because we were mindful of what other services would have been impacted by COVID. So, you know, some families were concerned about going to hospice because they wouldn't … the visitor restrictions would still be in place versus they may be more motivated to get home for end-of-life care." — PC6 Female

Note: ICU = intensivist, GIM = internist, MRP = most responsible provider, PC = palliative care physician, PCU = palliative care unit.

able to bring caregivers to the bedside. When caregivers could assess a patient's status in person, participants perceived that they were more likely to be amenable to options such as withdrawal of life-sustaining therapies or a comfort-focused approach.

Participants expressed that, because caregivers were unable to be at the bedside, caregivers were overly reliant on providers both to communicate patient status and support their communication with patients. Participants indicated that caregivers were sometimes unhappy with the amount of communication provided to them, with some participants indicating they had received formal complaints concerning inadequate communication, something they had not previously experienced.

In addition, participants believed that family caregivers were unable to access or be provided with adequate family supports owing to their absence from the bedside. In participants' clinical opinion, these circumstances led to increased risk of complicated grief and trauma for caregivers.

Perceived populations at greatest perceived risk

Participants also identified factors that influenced the impact of visitor restrictions on specific populations of patients and caregivers. Visitor restrictions necessitated a shift to virtual communication, not only between providers and caregivers, but also between caregivers and patients. Older adults were perceived as being at a disadvantage in working with virtual technologies. When patients were unable to work independently with phones or computers, they depended on providers to support their communication with those outside the hospital. Patients and caregivers who did not speak English were also identified as being at a heightened disadvantage. Patients who relied on English-speaking caregivers to communicate with the team when in hospital, or non-English-speaking caregivers who normally relied on hospital interpreters, were believed to have struggled to get virtual updates from team members (Table 4).

Interpretation

Many health care facilities enacted restrictive visitation policies in an effort to limit institutional transmission of SARS-CoV-2. We found that physicians identified provider-, system-, patient- and caregiver-related consequences of these policies. Our findings also suggest that these policies may amplify existing health care disparities as they disproportionately affected older adults and non-English speakers.[19,20] These patient populations face numerous barriers to quality care, including difficulties with coordination and access to care, as well as understanding treatment-related information,[21,22] and are more likely to require caregiver supports to overcome these barriers while admitted to hospital.

Isolation and the risk of dying alone have been highlighted as potential patient consequences of infection control practices and restrictive visitor policies early in the pandemic.[4] Participants witnessed this in practice and felt that, in response, patients re-evaluated their goals to prioritize caregiver presence. Participants described patients who chose to forgo or withdraw aspects of care to ensure they could remain at home, leave hospital or be given leniency to have visitors at the bedside. Many international studies have identified decreased visits to the emergency department, acute care admissions, and length of hospital stays during the pandemic,[23,24] and we found that, in theory, visitor restrictions may be a potential driver of this behaviour.

Previous research has highlighted the role of visiting caregivers in providing support or care, providing a voice for patients and contributing to patient assessment.[25] Physicians similarly described these roles in our study. However, in our study, participants hypothesized that difficulties in virtually communicating patient status and caregivers' inability to independently assess patient status at the bedside may have led to a poorer understanding of patient illness and limitations in providing ongoing care. Participants believed that restricting visitors led to delayed treatment decisions, especially in

Table 3: Patient and caregiver consequences of restrictive visitor policies

Subtheme	Participant quotes
Patient consequences	
Isolation and dying alone	"The constant conversations around visitor policies is heart-wrenching. The number of people that I have watched die alone because we didn't get the timing right on the end of life." — PC8 Female
Lack of caregiver support, advocacy and care	"Patients would benefit the most from having families around when they are able to interact with them, where they can advocate for them … And again the need to gain comfort from their family." — PC13 Female
Prioritization of family presence over other aspects of care	"Thinking of the one who had a new diagnosis of cancer, it became very complicated to try to ascertain what kind of … what she wanted … She really wanted to see her family and her kids were not being allowed to visit in the hospital. So I think she decided to be discharged home. She subsequently came back with symptoms but she wanted to see her family and she figured, you know, this is maybe the only way to do it is just go home. You know, I'm not sure if that goal would have been different had her family been allowed to visit." — PC1 Female "There was a case … where essentially a decision was made to remove a patient's oxygen in order for the family to actually be virtually present for end-of-life because otherwise they were concerned that they wouldn't be able to predict when that would happen and they would miss the moment and … they really wanted to be there for the final breath and it just really struck me that it was a decision that … I mean, maybe they would have made in different circumstances that maybe not and it may have just totally drastically changed what this person's end-of-life looked like and even their length of life and the end of life because of just the circumstances around COVID." — PC3 Female
Caregiver consequences	
Caregivers were felt to be unable to provide care or personally assess patient health, leading to difficulty with decision-making	"The other aspect is usually in discussions about … how someone is declining … I commonly ask patients' family what they have seen in like the last days … in the last week … and getting them to explain that as a sort of a way to advance the conversation … But in these situations they haven't seen the decline. They have not been able to see their loved one who is dying and so it made it a little bit harder, and so they sort of have to trust what you're saying because they are not there." — PC11 Male "I think it was difficult for them to appreciate the patient's clinical status without seeing them… knowing how short of breath they were or how sick they appear to us clinically. I think it was harder for them to have a grasp on that. Whereas other family members that are able to see, you know, family members suffering right in front of them. It's easier for them almost to make that decision. In that, you know, my family member is suffering and this is not an appropriate quality of life for them. I feel like it was a little bit more challenging to have families really appreciate how sick patients were." — GIM7 Female
Perceived inadequate communication	"Probably the greatest challenge for us was COVID related to communications and I just, to put it into context that all of the patient relations complaints that I received — and I've never received patient relations complaints before COVID — but all of the ones that I received were related to communication and a perceived inadequate communication." — ICU1 Male
Family access to supports	"When I would call all the families at the end of the day. I was concerned about the support that they had, so when their loved one was kind of sedated and paralyzed and probably … hopefully had minimal awareness of what was going on. I've heard there was like so much anxiety and grief and PTSD associated with being at home and terrified like not actually knowing what's going on." — ICU3 Female
Increased risk of complicated grief	"So much more challenging largely because of the 2 factors I already outlined — the rapid deterioration with lack of preparation for sort of an end-of-life course, which is a risk factor for complicated grief, and also the inability to be present with their family members." — PC3 Female

Note: ICU = intensivist, GIM = internist, PC = palliative care physician, PTSD = post-traumatic stress disorder.

withdrawal of care. This seems to align and add context to a recent quantitative study that evaluated outcomes among 940 patients who died in the intensive care unit (unrelated to COVID-19) before and after the implementation of institutional visitor restrictions.[26] Length of stay was found to be 2.9 days longer after the implementation of visitor restriction; in addition, the time to first order to not resuscitate, to not intubate or to provide only comfort care order was signifi-

Table 4: Populations at greatest perceived risk of being disproportionately affected by restrictive visitor policies

Population	Participant quotes
Older adults	"I mean many of these patients had older partners who don't use computers and know … You can't see them and they can't see you and they're just hearing another voice on the other side, you know, as you're standing there and telling them like, you know, like this is the choice … the choice is you know, that they're gonna die. You have to say goodbye and your loved ones dying and no you can't come into the hospital." — PC4 Female
Non-English-speaking patients and caregivers	"Some of the patients who are admitted couldn't speak English or were elderly and patient families were absolutely terrified. So keeping patients updated on COVID was exceedingly difficult during this time." — GIM2 Female

Note: GIM = internist, PC = palliative care physician.

cantly longer after visitors were restricted. This potential association should be tested in future studies.

Decreased visitor presence required providers to spend additional time and effort to establish relationships with families. They highlighted their inability to use nonverbal cues to display compassion and empathy, and found that their limitations to communicate with caregivers led to distrust and complaints to the hospital. Providers were additionally expected to act as surrogate caregivers, providing support but also bridging communications between patients and their families. Participants outlined the substantial emotional burden of acting as an enforcer or gatekeeper of visitor policies, or as an advocate for visitor presence. A recent study of visitor restrictions in Dutch long-term care homes also indicated that providers felt a profound emotional impact when acting as gatekeepers and working in the absence of family members.[27] These role extensions may lead to further psychological burden and moral injury from the moral–ethical dilemmas encountered by health care providers throughout the COVID-19 pandemic, which can negatively contribute to their personal well-being.[28,29]

Limitations

Given funding and resource constraints, we only interviewed intensivists, internists and palliative care physicians that have been in practice during the COVID-19 pandemic in Canada. Their experience may not be reflective of those in other regions, from other practices or from other health care provider groups. Despite differing practices, all 3 physician groups described similar experiences, although their illustration of impact at times differed. For instance, the burden of being a gatekeeper for visitors was highlighted as a serious stressor by internists and palliative care specialists, but was less evident for intensivists who often rely on nurses or other structures to enforce visitor presence. We also acknowledge a potential bias in that we used the same coding team for both the primary and this secondary analysis of data. Finally, we relied on provider perceptions of the patient and caregiver experience. To better understand the consequences of visitor policies on other stakeholder groups, we should also collect data on the experiences of patients, caregivers and other members of the health care team directly from these groups.

Conclusion

Visitors who act as essential caregivers serve a critical role in patient health and the health system. The restrictive visitor policies implemented during the COVID-19 pandemic have had a negative effect on patients, their caregivers, providers and the system. Further research is required to identify true benefits of visitor restrictions on infection control to be able to strike a balanced approach to minimize these numerous deleterious consequences to patients, families and care providers. If these visitor restrictions continue in the future, institutions need to ensure consistent enforcement (including clear communication to patients, caregivers and providers), provide additional communication supports to older and non-English-speaking populations and ensure an appeals process is in place for caregivers and families.

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