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Responses to Hospital Restrictions on Family Visits during the COVID-19 Epidemic in Mali and France

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ABSTRACT

Few studies have focused on the presence of families in the hospital in the context of an epidemic. The present study aims to contribute to filling this gap by answering the following question: How did professionals, patients and their families cope with more or less drastic restrictions to family visits and presence during the COVID-19 pandemic in a French and a Malian hospital during the COVID-19 pandemic? Data were collected during the first two waves of the pandemic through 111 semi-structured interviews (France = 55, Mali = 56). Most of the interviews were conducted with staff (n = 103), but also with families in the case of Mali (n = 8). The investigators also conducted 150 days of field observations, 44 in France and 106 in Mali. Thematic analysis was applied using an inductive approach. Interviews were content analyzed to identify passages in the interviews that were relevant to these different themes. The study highlighted the difficulty for the medical-clinical system to provide appropriate responses to the many emotional needs of patients in a pandemic context. Families in France benefited from a support service to reduce stress, while in Mali, no initiative was taken in this sense. In both countries, families often used the telephone as an alternative means of communicating with relatives. The results showed that in the two contexts, the presence and involvement of the families contributed to a better response to the patients' psycho-affective demands and thus promoted resilience in this field.

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Introduction

The role of families and their involvement in the negotiation of care has been particularly well documented in the West[1] and in the African continent.[2,3] Some of these studies have addressed the role of the family entourage in therapeutic relationships.[4,5]

Family visits are not conducted in the same way everywhere, nor do they meet the same needs of patients. African hospitals are accustomed to the strong presence of families around patients.[5] This intensive presence of the family circle around the patient helps overcome the feeling of loneliness.[5] The food of African patients depends largely on dishes brought by the family. In France and Europe, families visit patients without being expected to provide care and food.

Few studies have focused on the presence of families in the hospital in the context of an epidemic.[6,7] The COVID-19 pandemic[8] raised questions about the place of family visits in hospitals and the functions associated with these visits. The impacts associated with family presence in hospitals have been studied in the literature. In intensive care units, family presence has been associated with better patient outcomes.[9,10]

In the COVID-19 pandemic context, studies have highlighted the negative impacts of visiting restrictions on health workers, patients, and families.[8]

The strategies implemented by care providers and patients' families in response to restrictions on family visits or the institutional responses to psycho-affective difficulties are resilience strategies. Resilience strategies mobilized in specific areas, including family visit management, contribute to the overall resilience of the hospital.[11]

These resilience strategies have seldom been contextualized in the studies conducted on this topic. This article aims to fill this gap by comparing the resilience strategies mobilized during the COVID-19 epidemic by staff and families in a French hospital and in a Malian hospital. The study is part of a larger program on hospital and health

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workforce resilience covering five countries.[12] The analysis focuses on the relationship between caregivers and families when faced with restrictions on family visits.

Methods

Framework of the Study

We conducted an inductive qualitative analysis largely based on the approaches of hospital ethnography. This approach emphasizes the dynamic and negotiated character of social interaction, where the course of the interaction is never fixed but constantly readapted, reinvested, and negotiated.[13–15] The social interactions analyzed in this paper are composed of interactions between caregivers and patients (France and Mali), interactions between caregivers and families, and interactions between patients and their relatives (Mali).

In Mali, the University hospital center (UHC) where we conducted our investigation during the pandemic period was considered one of the main sites for the management of COVID-19 patients, with nearly 100 inpatient beds. It had a triage unit for suspected patients and a treatment unit. As of June 16, 2020, Malian UHC had received 431 COVID-19 patients.

In France, the study was conducted in one of the main referral hospitals for managing COVID-19 in the north of Paris. We call this hospital ESR (Etablissement sanitaire de reference). During the first wave (between March and May 2020), this 900-bed hospital transformed its activities to manage up to 323 COVID-19 patients in the peak period. The two hospitals were infectious diseases reference hospitals and the sites where the researchers gathered data regarding family visit restrictions.

Data Collection and Samples

Data were collected during the first two pandemic waves in 2020. The qualitative approach was based on semi-structured interviews and on-site observations. A total of 111 semi-structured interviews were conducted with staff (France = 55, Mali = 56). Most of the interviews were conducted with staff (n = 103) but also with patients in the case of Mali (n = 8) (Table 1). The research protocol was approved by ethical review boards in both Mali and France, as indicated at the end of the article. In France, data collection focused only on staff, in accordance with pre-established research protocols. During the interventions, the staff talked about the process of interactions with the families and thus did not extend to visitors, as was the case in Mali. The scale of this phenomenon in Mali prompted us to examine it. We applied a convenience sampling technique because the interviews were conducted with the people who were most available and accessible.

We used a comparative approach in this study, to capture the elements of similarity and difference in generating new knowledge through the processes of comparison and contrasting.[16] In each epidemic wave, numerous interviews gave us sufficient data on all our questions, allowing us to reach saturation threshold.

According to the context of each country studied, the questions asked to caregivers and families dealt with the attitudes of staff, relationships with caregivers, the roles played by caregivers in the context of an epidemic, and the strategies used to adapt the restrictions imposed. We addressed the topics that provided a sufficient understanding of what was done, how it was done, and why.

The observations took place in or outside the wards —depending on the opportunities offered to the investigators to describe the interactions (what is said, what is done) between the staff and the patients or accompanying persons, depending on the context, or the interactions between the family members and the patients, particularly in the Malian context (triage unit).

The investigators conducted 150 days of field observations, 44 in France and 106 in Mali (Table 2).

Each COVID-19 unit was an observation site for patient-care provider interactions and patient attitudes and practices. Each unit could be visited several times a day (Table 2).

Table 1. Number of interviews conducted per country according to pandemic waves.

		Period		Number of interviews									
Country	Wave	2020	2021	Managers	Doctors	Nurses	Social workers	Laboratory workers	Hygiene workers	Nurses' aides	Other staff	Visitors*	Total
Mali	1	April—May	-	1	6	7	2	5	2	-	3	4	**30**
	2	December	January	6	4	6	-	1	4	-	1	4	26
France	1	March—June	-	13	9	12	-	-	-	8	1	-	43
	2	October—December	-	5	1	4	-	-	-	2			12
Total				25	20	29	2	6	6	10	5	8	111

*Includes family members and other accompanying persons.

Table 2. Distribution of observation days by country and pandemic wave.

Country	1st wave	2nd wave	Total
Mali	32	74	106
France	27	17	44
Total	**59**	**91**	**150**

Data Processing and Analysis

All interview data were transcribed in full. Thematic analysis was applied using an inductive approach. To facilitate a comparison between the two sites, we focused on certain areas where the data most often showed similarities or differences (e.g., family visit management, family/patient communication). Interviews were content analyzed to identify passages in the interviews that were relevant to these different themes.

Results

Different Models for Family Visits in Hospitals in the COVID-19 Context

In the two hospitals studied, various measures were taken from the outset to restrict the presence of families because of the risk of contamination. The strategies applied on a daily basis in the hospital were initiatives of the hospital's management or staff.

At the Malian UHC, only access to the triage unit was possible, and even that was subject to attempts at regulation in the second wave (entry authorized for only one visitor at a time). Access to the rooms of the treatment unit for patients hospitalized after positive PCR test results was strictly forbidden to patients' families from the outset. "It is forbidden for parents to accompany the patient to his hospital ward." (Nurse, Care Unit).

In the French setting, families' presence in the hospital was also very limited (one visitor per day), with visits authorized on a case-by-case basis:

> Regarding visits, in fact, the ESR [reference hospital] has adopted a stance that is extremely restrictive . . . authorizing visits only in situations of patients at end-of-life, and spouses coming to attend their wife's delivery. In fact, [Hospital P] has taken a somewhat different stance. (Head of infection control, May 2020)

The presence of a family member was considered an exception. It was not aimed at ensuring presence with the patient, as was generally the case in the Malian setting. In the French case, the biosecurity measures implemented did not deprive families of space, but it was very limited, unlike what happened in Mali. In fact, at the ESR, in exceptional cases they were accommodated in a dedicated space with some amenities (chairs).

Thus, these cases present two models of regulation of family visits. In France, despite restrictions, the hospital developed a model of family involvement in the accompaniment of patients at the end of life and in childbirth situations. In Mali, there was no official strategy for family involvement.

Accompanying Institutional Measures to Control Biosecurity Measures

Whether in France or Mali, the strategies applied fall within the scope of the national COVID-19 plan (e.g., measures to protect the individual), the hospital (e.g., specific measures to restrict family visits) or the staff (tolerance of family visits). Both hospitals took several measures to provide institutional support, which consisted of a series of strategies to alleviate the effects of isolation on patients or to reduce families' stress.

In France, where the severity of the pandemic was much greater than in Mali, the surge in deaths and intensive care cases drove the ESR to organize a support service specifically for patients' families. Starting in April 2020, the infectious and tropical diseases service (SMIT) set up a telephone line dedicated to the families of hospitalized patients to help relieve their stress and worries. In the departments where a significant number of patients died—emergency and intensive care—a secluded space was set up to accommodate family members of dying patients, who were often given extended visiting time with attentive support from physicians who answered their questions.

In Mali, this kind of institutional support for families was absent. Instead, the institution tried to exclude families from this process and replace them with various measures to help patients cope with the isolation measures.

> At one of our meetings, they said it was quite possible to take care of patients 100% and that this COVID-19 pandemic had just proved it to us. (Hospital manager, Mali)

As relatives were not permitted to access hospital rooms, nurses had to perform all the basic hygiene tasks. Other measures were also taken to minimize families' involvement in the hospital. For instance, the Ministry of Health hired a catering service to provide three daily meals for the patients. The hospital's social workers were tasked with distributing food in addition to their mission of providing psychological support. To help patients overcome feelings of loneliness at the beginning of the first wave, the hospital installed a TV screen in a room that served as a dining room. However, the use of this social space was discontinued following a burglary.

Table 3. Staff practices and families' strategies regarding restrictions on family visits.

Country	Institutional measures to enforce family visit restrictions	Staff attitudes and practices	Families' strategies to circumvent restrictions	Attempts at institutional support
Mali	• Strict no-entry rules • Hiring of a security guard	• Tolerance of families in the triage unit • Adoption of the one-visitor-at-a-time rule • Delivering food brought in from home • Involving the family in various tasks, including basic hygiene care	• Intrusion of families into areas reserved for healthcare staff • Use of mobile phones to communicate with patients	• Providing rest/refreshment areas • Attempts by the hospital's social services to provide psychological support to patients • Basic hygiene care by nurses • Hiring of a catering service • Allowing food to be brought from home
France	• Prohibition of visits was strict at the beginning, then relaxed over time	• Refusal to apply strict rules • Case-by-case authorization with agreement of the department head • Application of the one-visitor-at-a-time rule	**N/A (no data)**	• Family support service • Authorization to communicate between patients and families via tablets

Thus, in response to restrictions on family visits, two different models of institutional support were implemented in the two countries. The Malian model focused on patients, while the French model focused on families (Table 3).

Re-involving the Family in the Care Relationship

In France, a principle of banning visits was advocated in Paris hospitals. Care providers almost always reported that it was extremely difficult and painful to have to prevent families from coming to see their hospitalized relative, especially in cases of severe COVID-19 and death. Families were also missed because their presence kept patients occupied and reassured them.

Some departments, such as infectious diseases, more than others, refused to apply a strict no-entry policy. They consistently allowed more family visits than one person per day.

> It's complicated. We always left it open, because it wasn't right for them not to be able to come and see their loved ones, but there was some carelessness: the families had to be gowned, the hospital's preventive measures, [but] we've had difficulty marshalling the medical teams, who don't follow the rules, they don't get it. (Health executive, SMIT, France)

In Mali, this kind of tolerance led families to resume their traditional functions of supporting their relatives. It was the dysfunctions in the institutional system that prompted the return of the family to the bedside.

> I said, if the caregivers can't handle cleaning the patient, I'll go in and do it. (Close relative of a confined patient)

In the beginning, care providers tried to meet the many nursing needs of dependent patients. This momentum soon waned, however, as many were reluctant to perform basic hygiene care (e.g., cleaning up waste, feeding dependent patients); also, cumulative delays of several months in salary payments had led to frustration. Leaving these tasks to the families gave care providers a way of avoiding this extra work:

> We can't prohibit the companions [family members]. They're the ones who feed the patients, take care of them, change the sheets, etc. If they're chased away, who will do these tasks? (Doctor, triage unit, Mali)

The findings showed that family visitation was characterized by ambivalent attitudes and practices that consisted in keeping families at some distance while at the same time tolerating their presence.

The Key Role of ICTs in Carrying Out Family Functions in Hospitals

In France, during the first wave, care providers used digital tablets provided by the hospital to support conversations between patients and their families. Respondents referred to the use of tablets as a positive adaptation. However, the professionals pointed out that this was not a substitute for actual presence with the patient, particularly in the event of a serious episode or death. This was reported in particular by the geriatric services, where the use of tablets was not suitable and family visits were more frequently arranged.

In Mali, families contacted their relatives directly without going through the care providers, mostly by using mobile phones. These telephone connections enabled them to talk with their hospitalized relatives and check on their health status regularly.

> We talk to him [on the phone] and it's based on that that we can inform the caregivers. (Relative of a confined patient)

Many families engaged in the common practice of negotiating favors after hearing complaints from their hospitalized family members. Thus, some families did not

hesitate to pay care providers for services rendered to their sick relatives:

> A patient gave me 50,000 francs, in one shot. Another gave me 30,000 francs. By the time I got off [my shift] I had 120,000 francs. (Doctor, care site, Mali)

The contextual analysis highlighted similarities and differences between the two countries. The restrictions on visits were circumvented by staff who partially tolerated them. In France, they were welcomed and supported, while in Mali, they were kept away or encouraged to care for their hospitalized relatives. In both cases, communication between patients and families took place by telephone, which allowed families to support their loved ones or to report their complaints to staff, as in the case of Mali.

Discussion

Circumventing, Negotiating, and Reinventing the Presence of Families

The forms that family visits take are linked to specific settings, but the fundamental question of families arises in all settings. In Mali, the institutional responses implemented to mitigate the restrictions on visits actually compelled families to want to be more present because of numerous shortcomings in the strategies implemented. In France, these responses were less obvious, as there was no real policy to mitigate the ban on visits, aside from the provision of tablets.

Despite measures intended to establish a hospital model that excluded families, family presence was asserted in both Mali and France. Strategies to circumvent those measures were adopted by staff (in France and Mali) and families (in Mali). The clashes between families' adaptation strategies and the biosecurity and surveillance precautions reflect a conflict of logic.[17] These clashes between institutional logic and family logic are often part of an adversarial relationship between family "tactics" and institutional "strategies."[18] The actors in the care relationship tolerated the presence of families, while at the same time deploying strategies to take charge of visitors' mental health (France) or having families replace them in many tasks (Mali).

Thus, the presence of families creates power relationships with several poles of influence, including medical authorities and families. One source of influence is the influence exerted by a social category which manages to impose dominant norms of attitude and behavior. The poles of influence are not entirely opposed to each other, but rather build a negotiated order in the hospital. The encounter between these two poles of influence, families and medical authority, defines a context of negotiation within a broader institutional framework.[19] Negotiations take place between the rules of control laid down by a hierarchical authority and the rules produced by actors who take liberties with the rules laid down.[20]

Managing family presence is a difficult challenge.[21] These negotiations, which are not based on any pre-established program, take the form of "random management of areas of uncertainty."[22] However, many obstacles prevent the care relationship from being a fully negotiated relationship (e.g., the absence of families from care units, limited lay knowledge about the disease). These difficulties, which limit the capacity of patients and their families to engage in any negotiation process, have been documented by research in other settings.[23] Due to the particularities of the study in France, where families could not be interviewed, the negotiations discussed here refer more to the results from Mali.

Absorptive Resilience and Return to the Previous Order

In response to the crisis, several innovative measures were put in place in both countries, in particular institutional arrangements to support patients. The innovative measures discussed here are institutional measures to help patients better cope with the emotional difficulties associated with isolation. They may support or oppose staff strategies. Specific innovations were also noted, such as the dietary services provided to patients in Mali. These measures were aimed at minimizing families' role in care relationships, which were intended to move from a tripartite relationship model to a bipartite one based on the singular caregiver-patient relationship.

Despite efforts to anchor themselves in this redefined model of care relationships, both hospitals were in the process of resilience marked by a return to the old order, i.e., a tripartite care relationship involving the care provider, the patient, and the family. This adaptive, or even re-adaptive, capacity was conducive to absorptive resilience rather than transformative resilience based on long-term systemic changes.[24] It contributed strongly to the humanization of care (France) and even the maintenance of care (Mali).

The restrictions on family visits had several impacts. One significant impact was the increased use of mobile phones by families in Mali and tablets by families in France. In Mali, opposite the patient's room, which was controlled by the medical establishment, a virtual

communication space controlled by families was set up that enabled them to resume traditional functions in the hospital. It also allowed families to have a say in the quality of patient care, as care providers were regularly confronted and reminded of the ethics of care. Elsewhere, such as in the United States, it was care providers who gave families the possibility of seeing their loved ones hospitalized in the COVID-19 intensive care units by means of telephone applications.[25] Thus, depending on whether or not the patient was in the intensive care unit, ICTs made it possible either to see their loved one even without being able to talk with them, or to communicate and act as their spokesperson to the care providers.

The experiences of Mali and France could be mutually beneficial. In Mali, the lessons from COVID-19 should support the institutionalization of conditions needed to reduce family involvement in certain tasks such as basic hygiene care and a resumption of these tasks by the hospital. In addition, in the Malian context, psychological support programs for care providers are missing. Our study could nevertheless be very useful in view of the many stressful situations experienced. In France, it is first important to acknowledge that care without the visit of family members is inhumane not just for end-of-life moments. It would also be important to push for institutional measures internally to help patients better cope with isolation. In intensive care units, where visiting restrictions are prevalent, strengthening this institutional role would promote a patient-centered care model. This model should be based on the availability and training of care providers and on values such as compassion and willingness to communicate.[26]

In terms of methodological limitations, the analysis relied heavily on data from interviews with staff (the targeted category in the research protocol). The lack of data collected from families in France did not allow for a cross-sectional view of this category of respondents, which was targeted only by the Mali surveys.

Conclusion

In this study, we have analyzed the strategies adopted by staff and families confronted with sudden restrictions to their visits and presence. These drastic measures imposed by healthcare institutions led to patients' isolation but this isolation was always relative. In the face of institutional measures imposing restrictions on family visits, healthcare staff were less rigorous or even tolerant in their application. They circumvented the official norms on multiple occasions. Aside from many contextual particularities in the two cases, this polarization was a constant contradiction in the two hospitals studied. However, in the face of prohibitions and restrictions on family visits, compromises specific to each social context were put in place. In both France and Mali, the strategies mobilized by families and staff helped patients feel less isolated. Data from both hospitals suggest that the mechanical application of national or hospital protocols leads to a dead end. These protocols need to incorporate a much more humanizing dimension that can be achieved with the involvement of patients' families.

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Ethics Statements

Mali: The research protocol was approved by the National Ethics Committee for Health and Life Sciences (Decision No. 120/MSAS/CNESS).

France: Ethical approval was granted by the Institutional Review Board -IRB 00006477- of HUPNVS, Paris 7 University, AP-HP on April 15, 2020.

Participation in this study was voluntary. All recordings and interview transcripts were anonymized, as were the names of the hospitals studied.

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