

# Ethics Advisory

## *Caring for Patients with Suspected or Confirmed Ebola*

### I. Introduction

SSM Health Care seeks to continue the healing ministry of Jesus and further the legacy of our founding sisters, the Franciscan Sisters of Mary. Throughout their history of healing, the sisters responded to the most urgent health needs within the communities they served, including, at times, caring for the sick during mass epidemics such as smallpox, cholera and tuberculosis. Despite threats to their own safety, the sisters cared courageously for the afflicted and remained undeterred in service to their mission of revealing God's healing and reconciling presence to those in need.

Today, as we face the possibility of an Ebola outbreak in the United States, health care professionals at SSM find themselves in a situation similar to that which our sisters experienced numerous times, one whereby their vocation of caring for patients in need could pose significant risks to themselves. In addition to the multitude of clinical, public health and legal issues, Ebola poses numerous ethical and pastoral care questions. In what follows, several of the more salient questions surrounding the ethical and pastoral care of patients with suspected or confirmed Ebola are outlined and ethical responses for each are offered. Because of the complex and changing nature of this situation, the responses provided herein are advisory and subject to further study and revision. Of note, System Ethics is available for consultation as questions arise and is also willing to participate in Ebola preparedness discussions as appropriate.

#### **Summary of this Ethics Advisory:**

- Caring for patients who carry infectious diseases is a responsibility that health care professionals accept as part of their profession. With few exceptions, all SSM health care professionals are expected to effectively carry out Ebola preparation and screening procedures as part of their professional role.
- Treatments that pose heightened transmission risks to SSM health care professionals (e.g., resuscitation) should be evaluated on a case-by-case basis in light of patient/family preferences, benefits and burdens, clinical effectiveness, and employee safety.
  - If safety protocols adequately protect health care professionals, if the patient/family desires the treatment in question, **and** if the treatment holds a reasonable hope of success given the patient's condition, it may be provided to the patient.
  - However, if the treatment does not offer a reasonable hope of benefit to the patient, if the safety of health care professionals cannot be adequately ensured, **or** if the risk to staff outweighs the potential benefit to the patient, it is ethically acceptable to withhold the treatment.
  - If there is disagreement among the clinical team or uncertainty as to the benefits and burdens of a certain intervention, Ethics should be consulted and Administration should be notified.
- Pastoral care is an essential component of the care team. Pastoral care and the administration of sacraments will occur at the request of patients/families with Ebola in ways that are safe and feasible.
- Employees should be reminded about the importance of patient privacy and confidentiality.

## **II. Health Care Professionals and the Care of Patients with Ebola**

### ***Are health care professionals ethically required to care for patients with suspected or confirmed Ebola?***

Ethically, as with previous infectious disease outbreaks, health care professionals have a general professional responsibility to attend to patients, including patients with suspected or confirmed Ebola. In choosing their vocation, health care professionals knowingly and willingly commit to undertaking risks, including those posed by patients with infectious diseases. Although they need not care for patients at all costs, health care professionals are expected to deliver care to patients with infectious diseases when safety measures and procedures can reasonably mitigate the risk of disease transmission. With adequate training, access to and proper use of personal protective equipment (PPE), and adherence to established care protocols, health care professionals can safely provide care to a patient with suspected or confirmed Ebola. Literally thousands of health care professionals worldwide have met the needs of patients during this and previous Ebola outbreaks without contracting the disease themselves.

### ***How does this ethical requirement apply to health care professionals at SSM facilities?***

Health care professionals at SSM facilities, whether Level 1 or 2, are required to screen all patients for indicators of Ebola exposure, isolate patients suspected of having Ebola, and subsequently notify their manager and/or Infection Prevention of this suspicion. They must also understand how to use PPE appropriate for their work environment so they can fulfill this critical task of identifying patients and preventing the potential spread of the disease. Patients suspected of having Ebola will be transferred to a Level 2 SSM facility, where they will receive care by health care professionals who have volunteered for the assignment, have access to additional PPE, and have been specially trained in Ebola care.

### ***What's the difference between an Ebola Level 1 and Ebola Level 2 SSM facility?***

SSM hospitals, physician offices and ambulatory care sites have been designated with either an Ebola Level 1 or Ebola Level 2 status. The majority of SSM facilities are Level 1. Health care professionals in these facilities are being trained to provide basic screening, isolation and employee protection. If a patient is identified with suspected Ebola, health care professionals at Level 1 SSM facilities will work with Infection Prevention and public health to prepare that individual for transport to a Level 2 SSM facility or another appropriate site of care outside the system.

At least one Level 2 SSM facility has been identified within each region, as outlined below, and will have additional capabilities for providing short-term inpatient care (3-5 days) until an Ebola diagnosis can be confirmed. These facilities will have infectious disease doctors and nurses on-staff, a dedicated team of health care professionals who will receive intensive training, a negative pressure room, appropriate point-of-care testing, and the ability to safely clean equipment and dispose of contaminated materials. If a patient at a Level 2 SSM facility is confirmed to have Ebola, health care professionals will work with the CDC and public health to transfer that individual to a specially designated facility (e.g., Emory University Hospital in Atlanta) with capabilities for providing continued acute care.

**Which SSM entities have been designated as Ebola Level 2 facilities?**

SSM has designated the following entities as Ebola Level 2 facilities in each region:

<b>Region</b>	<b>Facility</b>
Oklahoma	St. Anthony Hospital, Oklahoma City
Southern Illinois	Good Samaritan Regional Health Center, Mount Vernon
Mid-Missouri	SSM Health St. Mary’s Hospital, Jefferson City
Wisconsin	St. Mary’s Hospital, Madison
St. Louis	SSM DePaul Health Center SSM Cardinal Glennon Children’s Medical Center

**Can health care professionals opt-out of screening or caring for patients with suspected or confirmed Ebola?**

As indicated above, health care professionals at SSM facilities, whether Level 1 or 2, are required to screen all patients for indicators of Ebola exposure, isolate patients suspected of having Ebola, and subsequently notify their manager and/or Infection Prevention of this suspicion. They must also understand how to use PPE appropriate for their work environment so they can fulfill this critical task of identifying patients and preventing the potential spread of the disease.

Under certain circumstances, however, health care professionals at SSM facilities may opt-out of the screening process if:

- They are pregnant, nursing, immunosuppressed or have some other medical condition that warrants removal from the care team; **or**
- PPE is not available or is sub-standard under the clinical circumstances; **or**
- They have not been adequately trained in safety measures to mitigate transmission risk **and** another qualified, properly trained health care professional is available to provide the care to the patient without compromising the safety of the patient.

The American Congress of Obstetricians and Gynecologists (ACOG) emphasizes the poor maternal and fetal outcomes for obstetric patients with Ebola. As a result, ACOG advises that caregivers who are pregnant not treat patients with Ebola. Thus, while pregnant caregivers at Level 1 facilities may electively decide to decline screening responsibilities that involve direct patient contact, a caregiver at a Level 2 facility who received the specialized Ebola training and later becomes pregnant should be replaced by an alternate employee.

**Should health care professionals who are forced to take a leave of absence to rule out Ebola exposure or who become ill as a result of caring for a patient with Ebola be compensated monetarily?**

Yes. Given the unique circumstances of Ebola and the elevated risks health care professionals undertake in caring for patients with Ebola, they should receive paid time off when asked to take a leave of absence to rule out Ebola exposure and receive free care and paid time off when incapacitated by the Ebola disease. However, financial rewards meant to incentivize health care professionals to care for patients with Ebola are not appropriate. The motivation to care should spring from the virtues that underlie the profession.

### **III. The Provision of High-Risk Treatments to Patients with Ebola**

#### ***Should health care professionals provide resuscitative measures to patients with Ebola?***

Because of the proximity and likely exposure to bodily fluids, resuscitative measures for patients with Ebola pose increased transmission risks to health care professionals. These risks heighten the need for explicit training and cautious protocols. If health care professionals at an SSM Level 2 facility are faced with the decision of whether to initiate resuscitative measures for a patient critically ill with Ebola, they should consider several factors, namely: patient/family preferences, benefits and burdens, clinical effectiveness, and employee safety. If safety protocols adequately protect health care professionals, if the patient/family desires resuscitative measures, **and** if resuscitation efforts hold a reasonable hope of success given the patient's condition, resuscitative measures may be provided to the patient. However, if resuscitation does not offer a reasonable hope of benefit to the patient, if the safety of health care professionals cannot be adequately ensured, **or** if the risk to staff outweighs the potential benefit to the patient, it is ethically acceptable to withhold resuscitative measures. The clinical team that reviews the risks and probable benefits of resuscitation should follow the patient and adjust the resuscitation plan according to changes in the patient's condition.

Of note, if there is disagreement among the clinical team or uncertainty as to the benefits and burdens of resuscitation for a patient with Ebola, Ethics should be consulted and Administration should be notified so the unresolved issues can be addressed.

#### ***Should other treatments that heighten transmission risks to health care professionals be offered and provided?***

Resuscitation is not the only intervention that provides heightened safety challenges for health care professionals. Other invasive treatments may also dramatically increase such risks. Ethically, they should be evaluated in the same way as resuscitation, that is, based on patient/family preferences, benefits and burdens, clinical effectiveness, and employee safety. Again, if there is disagreement among the clinical team or uncertainty as to the benefits and burdens of the treatment in question for a patient with Ebola, Ethics should be consulted and Administration should be notified so the unresolved issues can be addressed.

#### ***How should health care professionals respond to a pregnant patient with Ebola?***

Due to factors related to the geographical distribution of Ebola, relatively little data exist on pregnant patients with Ebola. Pregnant women with Ebola have increased rates of spontaneous abortion and increased mortality rates due to pregnancy-related hemorrhage. Moreover, although some babies have survived for days or several weeks, the long-term survival of a child born with Ebola has not been reported. (See "What Obstetrician-Gynecologists Should Know About Ebola: A Perspective From the Centers for Disease Control and Prevention." *Obstetrics and Gynecology*, 2014). In treating pregnant patients with suspected or confirmed Ebola at SSM facilities, the following guidelines apply:

- All pregnant patients should be screened, and those with suspected Ebola should be isolated while staff inform their manager and/or Infection Prevention. Whether at a Level 1 or 2 SSM facility, the clinical team should work with the CDC and public health

to transfer the patient to a more advanced site of care equipped to address the patient's clinical needs.

- If transfer is not an immediate possibility and obstetric care must be provided at an SSM facility:
  - Pregnant patients with suspected Ebola or those who are not highly infectious should receive standard obstetric care under the safety protocols required for patients with Ebola.
  - Pregnant patients who have confirmed Ebola and are highly infectious should be evaluated on a case-by-case basis and treatment limitations may apply. In this case, a team comprised of high-risk obstetricians and infection prevention specialists, Ethics representatives, and administrators should evaluate treatment options in light of the risks to employee safety, the feasibility of providing care, and the probable effect on maternal and/or fetal outcome.

***Could a Cesarean section and other obstetric procedures be offered to a highly infectious patient with Ebola?***

Cesarean section delivery, especially in women with hemorrhagic manifestations, could compromise maternal well-being and poses an extremely heightened safety risk to health care professionals and everyone involved in the procedure itself, post-operative care, and room cleaning. Consequently, Cesarean section should only be considered as a last resort, when less invasive, safer options of caring for the patient and the fetus are not available. This same standard applies equally to other advanced obstetric procedures, such as induction and surgical repair of lacerations. When deciding whether to offer these treatments, the clinical team in consultation with Ethics and Administration should consider patient/family preferences, benefits and burdens, clinical effectiveness, and employee safety.

#### **IV. Visitors, Chaplains, and Religious Rituals for Patients with Ebola**

***Are family members and friends allowed to visit patients with suspected or confirmed Ebola?***

Per the CDC guidelines, visitors should be avoided. For patients who do not own a personal communication device, the hospital should attempt to provide a laptop or other device to communicate remotely with family members and friends. Exceptions regarding visitors may be considered on a case-by-case basis, based on the needs, values and clinical circumstances of the patient. In rare cases and with their informed consent, CDC guidelines permit consideration of visitors when deemed “essential for the patient’s wellbeing.” Potential visitors should receive thorough counseling about the safety precautions they will need to take as well as the risks and consequences of visiting the patient.

***Are hospital chaplains a core member of the care team of patients with suspected or confirmed Ebola?***

SSM's history, mission, and values call for recognition of the emotional and spiritual dimensions of health care. These dimensions can have a tremendous impact on the patient's ability to endure and recover from illness. Thus, the pastoral care of the emotional and

spiritual needs of the patient, in addition to the physical care of the body, is essential to SSM's mission of revealing the healing presence of God. As such, chaplains are an essential part of patient care, and they should be presumed to be part of the core team of caregivers for a patient with suspected or confirmed Ebola. SSM clinicians should make referrals to pastoral care as they would with any other patient, and chaplains should be included in safety training on the care of patients with suspected or confirmed Ebola.

***How should pastoral care be provided to a patient with suspected or confirmed Ebola?***

While the provision of pastoral care is an essential component of SSM's mission, chaplains and administrators maintain discretion about how that care is offered. A chaplain who receives a referral for a patient with a suspected or confirmed case of Ebola should visit with the patient via phone or videoconference to address her or his spiritual needs. The chaplain should strive to offer adequate and appropriate prayer, conversation, and/or counseling through one of these modes of communication. In most cases, ongoing and quality pastoral care will continue as needed through one of these modes. When possible, the chaplain might speak to the patient via phone from the external side of a door or window, such that the patient can see the chaplain as they converse. One of these remote modes of providing pastoral care is highly preferred.

If the patient requests an in-person visit or if the chaplain feels an in-person visit is necessary to promote the patient's well-being, the chaplain should discuss the patient's pastoral needs with other members of the care team and hospital administrators. An exception to allow an in-person chaplain visit might be justified if:

- The patient and chaplain believe that pastoral care will aid the well-being of the patient and, in the judgment of patient and chaplain, cannot be adequately provided from a remote setting; ***and***
- The chaplain has been adequately trained in safety measures and is aware of and accepts the risks to her or his health; ***and***
- Clinicians and administrators are confident in the efficacy of safety protocols given the present condition of the patient.

In the event that an exception is made and a chaplain makes an in-person pastoral visit, the chaplain should not touch the patient or stand closer than four (4) feet from the patient and the chaplain should follow all other clinical guidelines of care. In the majority of instances, however, pastoral care will be offered to patients who have or may have Ebola only through a laptop, phone, or other communication device.

***May non-employed religious leaders or hospital volunteers provide pastoral care or engage in other religious rituals for patients with suspected or confirmed Ebola?***

Hospital volunteers should not be involved in the pastoral care of patients with suspected or confirmed Ebola. However, non-employed religious leaders may under specific circumstances. In the event that (1) a patient requests a priest and there is not a priest fully employed in the SSM hospital or nearby SSM hospitals, or (2) a patient requests contact with their own religious leader who is not employed by the SSM hospital, they should be considered as having the same status as other visitors. In most cases, they are not permitted

to visit patients with suspected or confirmed Ebola. The hospital should strive to provide technological accommodations that facilitate communication between the religious leader and patient.

***How should requests for the administration of sacraments or other religious rituals be handled for patients with suspected or confirmed Ebola?***

Catholic patients may request the sacrament of reconciliation. Confession and absolution can be given without the need for physical contact. If a patient requests this sacrament, the care team should consider the safety and logistics of administering the sacrament. If it is feasible to offer reconciliation, the priest should remain at least four (4) feet from the patient and should not touch the patient. Catholic patients may also desire the sacrament of anointing of the sick. This sacrament is more challenging because it requires touching the patient and anointing with oils. In this case, other Catholic prayers for the sick or dying might be offered to replace the sacrament with no touching of the patient allowed. The System Vice President of Mission and local Ordinary may be contacted for guidance on the provision of sacraments to patients with suspected or confirmed Ebola and the possibility of administering sacraments with the aid of communication technologies.

## **V. Confidentiality and Patients with Ebola**

***What information should be shared about patients who contract Ebola?***

A designated authority from the hospital should communicate necessary information with appropriate public health officials but beyond that the privacy and confidentiality of the patient should be maintained to the fullest extent possible. Although much of the personal information of patients in the United States who have contracted Ebola has become public, health care professionals should not abandon their duty to protect the rights of patients with Ebola. The ethical importance of privacy and confidentiality should also be emphasized to employees. In responding to media inquiries, the hospital should strive to maintain the confidentiality of the patient and avoid releasing the patient's name or other identifiers if at all possible. Employees should be reminded that they are not permitted to post any information about suspected or confirmed cases of Ebola on social media. This includes a general and non-identifying statement that such a patient has presented in an SSM facility.