

*The VHA National Center for Ethics in Health Care (NCEHC) has developed the following guidance to assist VA medical facilities in Ebola Virus Disease (EVD) ethics planning and response. The NCEHC is available to address specific questions or concerns about ethical issues related to EVD. Please contact us at [vhaethics@va.gov](mailto:vhaethics@va.gov).*

**QUESTION 1. Under what circumstances, if any, would it be ethically justifiable to limit treatments, interventions or other forms of care to patients diagnosed with EVD?**

**KEY POINTS – See detailed guidance following these key points**

1. Although it is ethically justifiable to factor in concerns about staff safety when making decisions about the treatment that will be offered to patients with EVD, as a general rule, treatment that is expected to be beneficial to the patient should be provided unless it is impossible to adequately mitigate risk to staff.
2. Decisions that involve weighing the values of patient benefit and risk of EVD transmission to providers and staff have public health implications. Therefore, the decision process should not be ad hoc or the responsibility of an individual treating clinician. Rather, the weighing should be conducted through a process based on the following criteria (*see detailed guidance*):
  - a) Is the intervention anticipated to provide a proportional benefit to the patient, that is, is the benefit to the patient expected to be greater than the harm?
  - b) What is the anticipated risk of EVD transmission to health care providers and others by providing the intervention?
  - c) Are there reasonable methods that can be implemented to mitigate disease transmission risk to staff and others?
  - d) If the intervention is determined to be beneficial, can it be provided without exposing health care staff to a disproportionate risk of EVD transmission?
  - e) If not, are there other possible interventions that might achieve meaningful benefit to the patient with far less risk to staff?
3. This decision process should be formalized by updating the facility patient care response plan in advance of a local EVD outbreak to establish a standing EVD Clinical Decisions Team to ensure that decisions to limit potentially beneficial treatments to a patient with EVD are fair, transparent, and consistent.
4. Tabletop exercises should include scenarios for the EVD Clinical Decisions Team to practice using these decision criteria.

## Detailed Guidance

### **QUESTION 1. Under what circumstances, if any, would it be ethically justifiable to limit treatments, interventions or other forms of care to patients diagnosed with EVD?**

#### **Introduction**

Discussions have begun at various U.S. hospitals about limiting potentially life-saving, invasive interventions, such as CPR, for patients with EVD. For example, there has been some discussion that do-not-attempt-resuscitation (DNR) orders should be written for all patients with Ebola.

Our analysis begins with the assumption that patients with EVD are analogous to many other patients with infectious diseases, such as HCV and HIV, who require and are entitled to care. As with HCV and HIV, the available and evolving evidence base, rather than fear should inform ethical decisions regarding the diagnosis and treatment of EVD patients. Based on the best available evidence, decision makers should weigh the potential benefit to the patient of the treatment, intervention or other form of care, including potentially life-sustaining invasive interventions, with the risk that the treatment poses to the health care providers and staff providing it. Treatment should only be limited when the risks to health care providers and staff are far greater than the potential benefits that the treatment is expected to offer the patient. i.e., very high risk and virtually no benefit. Even in emergency situations, staff should never compromise safety protocols because the overall harm that could result is likely to be high (e.g., staff should always don appropriate personal protective equipment (PPE) before performing a code for a patient with EVD, even if it means delaying the code).

In addition, unless there is a clear rationale for differentiating invasive interventions (such as central line insertion, dialysis, CPR) from other potentially beneficial interventions for patients with EVD (such as basic nursing care involving cleaning the patient's vomit and diarrhea), then decision making about their use should be managed in

Unilateral decisions to limit certain interventions to all patients with EVD based solely on their diagnosis are ethically problematic because blanket statements like "Patients with EVD shouldn't receive CPR," fail to individualize care based on the relative risks and benefits to the patient and the health care providers and staff involved in the patient's care. For example, a patient with mild EVD who sustains a cardiac arrest due to hypotension from untreated diarrhea may benefit from CPR and other resuscitative measures that have the potential to restore circulatory function. This is contrasted with a patient with EVD who sustains a cardiac arrest from progression of sepsis and multi-system organ failure, and is not responding to blood pressure support medications (e.g., pressors) and is unlikely to substantially benefit from CPR. Evaluation of each individual patient is necessary to determine whether or not CPR is likely to achieve its intended goal of restoring circulatory function.

These examples also help to illustrate a decision making process based on safety to staff. For the two examples, decision makers would determine in each situation whether the resuscitation was likely to benefit the patient and the anticipated risk of EVD transmission.

Although it is ethically justifiable to factor in concerns about staff safety when making decisions about the care that will be offered to patients with EVD, as a general rule, the care should be provided unless it is impossible to adequately mitigate risk to staff.

the same way. To ensure that decisions about transmission risk are fair to all health care provider and staff, decisions about interventions and other care with similar transmission risk should be managed consistently.

### **Recommendations:**

1. Although it is ethically justifiable to factor in concerns about staff safety when making decisions about the treatment that will be offered to patients with EVD, as a general rule, treatment that is expected to be beneficial to the patient should be provided unless it is impossible to adequately mitigate risk to staff.
2. Decisions that involve weighing the values of patient benefit and risk of EVD transmission to providers and staff have public health implications. Therefore, the decision process should not be ad hoc or the responsibility of an individual treating clinician. Rather, the weighing should be conducted through a process based on the criteria provided below.
3. This decision process should be formalized by updating the facility patient care response plan in advance of a local EVD outbreak to establish a standing EVD Clinical Decisions Team to ensure that decisions to limit potentially beneficial treatments to a patient with EVD are fair, transparent, and consistent.
4. Tabletop exercises should include scenarios for the EVD Clinical Decisions Team to practice using these decision criteria.

### **Decision Criteria:**

1. Is the intervention anticipated to provide a proportional benefit to the patient, that is, is the benefit to the patient expected to be greater than the harm? This estimation of potential benefit and harm should be based on:
  - Either evidence-based standards if available, or, if not, then clinical experience.
  - Discussion with the patient/surrogate about that evidence and preferences. The shorthand term “futility” is often used when clinicians disagree with the patient/surrogate’s belief that an intervention can achieve an intended goal of treatment, or does not accept a patient/surrogate’s goal as a valid endpoint for a treatment. This term is clinically imprecise, inconsistently applied, and value laden, and therefore unlikely to be useful when conflicts arise. Discussions about the value of a treatment are separate from concerns about health care worker risk and should be managed according to existing guidance about ethically acceptable treatment limitations.
2. What is the anticipated risk of EVD transmission to health care providers and others by providing the intervention?
  - The estimation of risk should be based on evidence-based standards if available, and if not, then clinical experience or expert guidance.

3. Are there reasonable methods that can be implemented to mitigate disease transmission risk to staff and others?
4. If the intervention is determined to be beneficial, can it be provided without exposing health care staff to a disproportionate risk of EVD transmission?
5. If not, are there other possible interventions that might achieve meaningful benefit to the patient with far less risk to staff?



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