

## Health Care Ethics Advisory

*Caring for Patients with Suspected or Confirmed COVID-19*  
3/23/2020

### I. Introduction

*As CommonSpirit Health (CSH), we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.*

Today, as we respond to the COVID-19 pandemic, health care professionals at CSH find themselves in a situation similar to past situations, one whereby their professional vocation of caring for patients in need could pose risks to themselves. In addition to the multitude of clinical, public health and legal issues, COVID-19 poses ethical questions. In what follows, several of the more salient questions surrounding the ethical care of patients with suspected or confirmed COVID-19 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.

This document draws upon our ethical commitments<sup>1</sup> about the dignity of the human person, special attention to the needs of the most vulnerable members of our community, and full consideration for the common good. It also draws upon the collaborative resources available through broad academic and public dialogue on healthcare issues arising during pandemics and emergency preparedness. Of note, the CSH Ethics department, Division ethicists and local ethics committees are available for consultation as questions arise and are also willing to participate in COVID-19 discussions as appropriate. Specific questions not answered here can be directed to [ethics@commonspirit.org](mailto:ethics@commonspirit.org) or to local CSH ethics leaders and the local Chair of the Ethics Consultation Team.

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<sup>1</sup> Guidance for Catholic ministries includes information in the *Ethical and Religious Directives for Catholic Health Care Services*, (6th Ed.) and other sources of Catholic moral teaching.

## II. Health Care Professionals and the Care of Patients with COVID-19

### ***Are health care professionals required to care for patients with suspected or confirmed COVID-19?***

Ethically, as with previous infectious disease outbreaks, health care professionals are generally required to care for patients with suspected or confirmed COVID-19. 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 evidence-based care protocols, health care professionals can safely provide care to these very vulnerable patients. Literally thousands of health care professionals worldwide have met the needs of patients during this COVID-19 outbreak and previous contagious outbreaks without contracting the disease themselves.

### ***Can health care professionals opt-out of caring for patients with suspected or confirmed COVID-19?***

Yes, but only under certain circumstances. Health care professionals may opt-out if:

- They are pregnant, nursing, immunosuppressed (medically confirmed) or have some other medical condition that warrants removal from the care team; **or**
- Their physical abilities make it more difficult for them to follow precise protocols of staff protection with PPE; **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.

In addition, where personal protective equipment (PPE) is not available or maybe substandard under the clinical circumstances, a collaborative assessment and decision-making process will need to be engaged.

### ***If I am quarantined as a result of potential exposure to COVID-19 and working from home, or another remote location, will I get paid?***

Yes, employees with a non-work-related exposure/potential exposure who are required to self-quarantine based on CDC guidelines, are experiencing symptoms, or have been diagnosed with COVID-19 will be allowed to utilize their applicable EIB/Sick bank(s) and/or employer-paid short-term disability benefits without using PTO first, waiving the elimination period.

- If the employee exhausts all time off banks during the first 14 days off, CommonSpirit Health will pay administrative leave for the remainder of the 14-day period that would otherwise have

been unpaid. This would be administered outside of our normal policies and procedures, in a non-discriminatory basis.

- If a non-exempt employee wishes to take an unpaid leave for a non-work-related quarantine period, the employee may do so, even if they have hours in their time-off bank(s), as long as there is no conflicting information in the local policy.
- If the local facility has a policy that allows donation of PTO/Vacation time, we encourage them to continue to follow that policy in order for employees to support one another through this time. Normal procedures for these donations should be followed.

***Should health care professionals who have to be quarantined as a result of work-related exposure to someone with suspected or confirmed COVID-19, or who become ill as a result of caring for a patient with COVID-19 be compensated monetarily?***

Yes, employees with a work-related exposure that result in required quarantine will be placed on paid admin leave up to 14 days, and should complete an incident report per the normal workers' comp process, as well as contact Employee Central.

- If an employee is out longer than 14 days, they will have access to their available time off banks (examples of time off banks include: EIB, Sick, PTO and/or Vacation). CommonSpirit Health will help to coordinate pay with other agencies as applicable.
- If the local facility has a policy that allows donation of PTO/Vacation time, we encourage them to continue to follow that policy in order for employees to support one another through this time. Normal procedures for these donations should be followed.

***Should there be a financial incentive for healthcare professionals willing to care for and treat patients with suspected or confirmed COVID-19?***

Additional pay or financial rewards meant to incent health care professionals to care for patients with COVID-19 are not appropriate. The motivation to care should spring from the virtues that underlie the profession.

***Is it acceptable to designate a specific facility and/or select and train a limited number of health care professionals to care for patients with suspected or confirmed COVID-19?***

In past pandemic events this approach was acceptable. It could also be acceptable in our current environment if it is deemed the most effective way to reduce public health risks, mitigate the risks to health care professionals, and safely deliver quality care to patients with suspected or confirmed COVID-19.

### III. The Provision of Increased-Risk Treatments to Patients with COVID-19

#### ***Should health care professionals provide resuscitative measures to patients with COVID-19?***

Clinical evidence proposes that coronaviruses spread from person-to-person through respiratory droplets. It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads. While body fluids other than respiratory secretions have not been clearly implicated in transmission of COVID-19, unprotected contact with other body fluids, including blood, stool, vomit and urine, might put healthcare providers at risk of COVID-19.

The CDC defines high-risk exposures for healthcare providers as,

*Having had prolonged close contact with patients with COVID-19 who were not wearing a facemask while a healthcare provider's nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Being present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) on patients with COVID-19 when the healthcare provider's eyes, nose or mouth were not protected is also considered high risk.<sup>2</sup>*

Generally, health care providers have a duty to provide potentially life-saving treatments to patient such as CPR unless it is impossible to adequately mitigate risk to staff. Codes of ethics of all health care professionals include a duty to provide care for patients even at some risk to themselves. This is a primary ethical duty of the health care professional, but it is not absolute and there are ethically justifiable exceptions. Those exceptions occur when there is disproportionate risk to the health care professionals providing the care.

In considering the risks related to providing CPR to a patient positive for coronavirus disease (COVID-19) who has a cardiopulmonary arrest, we begin with the ethical assumption that patients are entitled to clinically indicated care for which they have provided informed consent. Evaluation of each individual patient is necessary to determine whether CPR is likely to achieve its intended goal of restoring circulatory function and can be provided safely. The determination of disproportionate risk must be based on the best available, if rapidly evolving, evidence about the treatment of patients with COVID-19. Potentially life-saving treatments

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<sup>2</sup> Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19) March 7, 2020 <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

such as CPR should be provided to patients unless that treatment is identified as: a) nonbeneficial/inappropriate care based on the patient's values or, b) it is impossible to adequately mitigate risk to staff.

Based on the best available evidence, decision-makers should weigh the potential benefit to the patient of CPR, with the risk that the treatment poses to the patient as well as the health care providers and staff providing it. Even in an emergency situation, such as a cardiopulmonary arrest, health care providers and staff should never compromise safety protocols because doing so results in more overall harm than benefit given the high risk of infection without PPE. Staff should always don appropriate personal protective equipment (PPE) before performing a code for a patient, even if it means delaying the code.

***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 preference, clinical effectiveness, and the safety protections able to be put in place for health care professionals. In high risk procedures with COVID-19 positive patients, additional PPE is required such as N95 masks.

Treatment should only be limited for patients with suspected or confirmed COVID-19 when the treatment is identified as: a) nonbeneficial/inappropriate care based on the patient's values or, b) it is impossible to adequately mitigate risk to staff.

***How should health care professionals respond to a pregnant patient with COVID-19?***

As stated by the CDC,

*It is unknown whether newborns with COVID-19 are at increased risk for severe complications. Transmission after birth via contact with infectious respiratory secretions is a concern. To reduce the risk of transmission of the virus that causes COVID-19 from the mother to the newborn, facilities should consider temporarily separating (e.g., separate rooms) the mother who has confirmed COVID-19 or is PUI (Persons Under Investigation) from her baby until the mother's transmission-based precautions are discontinued.<sup>3</sup>*

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<sup>3</sup> Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html>

### **How do we decide to shift to comfort care? What if family disagrees?**

This question has come up in the context of an influenza epidemic when the need for ventilators exceeds resources.

To the extent that it is medically reasonable to determine when a patient's prognosis is such that continued aggressive interventions cannot be reasonably expected to be of benefit to the patient, and/or unnecessarily increase the risk of exposure to COVID-19 to healthcare professionals and staff, it is ethical to recommend a shift to comfort as the focus of treatment. The shift to a comfort care plan will initiate the continuation of a different care plan of treatments and support for the patient.

There may be situations in which the patient and/or surrogate decision-maker/family disagree with this shift; however, given the unique circumstances related to available treatments and resources, it may be necessary to make a unilateral treatment decision (i.e., a decision with which the physician does not have the consent of the patient and surrogate decision maker). This type of unilateral decision should be done in collaboration with an assessment of a second physician. CSH ethicists and local ethics committees are also available to address the relevant ethical considerations of these decisions.

### **Are family members and friends allowed to visit patients with suspected or confirmed COVID-19?**

Per the CDC guidelines, visitors should be avoided. In some regions or counties, such as San Francisco<sup>4</sup>, Public Health Officers may have issued limitations on Hospital visitors.

Regarding nursing homes, the CDC has stated,

*Facilities should **restrict** visitation of **all** visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situations. In those cases, visitors would be limited to a specific room only.<sup>5</sup>*

For patients who do not own a personal communication device, the hospital should attempt to provide a laptop/cellphone, walkie talkie 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. An example

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<sup>4</sup> City and County of San Francisco, Order of the Health Officer No. C19-06, "Limitations on Hospital Visitors", Date Order Issued - March 13, 2020. <https://www.sfdph.org/dph/alerts/files/Order-C19-06-ExcludingVisitorstoHospitals-03132020.pdf>

<sup>5</sup> Centers for Disease Control, March 13 CMS Directive Ref: QSO-20-14-NH <https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>

of this might be patients who are at the stage of “end of life”. In these cases, visitors/family would need to wear appropriate PPE and be symptom free.

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.

***What information should be shared about patients with suspected or confirmed COVID-19?***

The ethical principle of truth-telling supports informing patients and/or surrogates that in the event of a cardiopulmonary arrest there may be a delay in responding while the code team or other first-responders don the required PPE. However, neither patients nor surrogates have the right to request that any health care professional administer CPR without PPE as this would expose the staff to a disproportionate risk.

Unilateral decisions to limit certain interventions like CPR to all patients with COVID-19 based solely on their diagnosis are ethically problematic because such decisions 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. Evaluation of each individual patient is necessary to determine whether CPR is likely to achieve its intended goal of restoring circulatory function and can be provided safely. 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 COVID-19, as a general rule, care should be provided unless it is impossible to adequately mitigate risk to staff.

Because appropriate sharing of accurate information is critical during this time, only a designated representative from the hospital should communicate necessary information with appropriate public health officials. 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 COVID-19 has become public, health care professionals should not abandon their duty to protect the rights and dignity of patients with COVID-19. 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 COVID-19 on social media. This includes a general and non-identifying statement that such a patient has presented in a CSH entity.

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