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Original Article

Pastoral care of patients with Ebola Virus Disease: A medical and canonical opinion about pastoral visits to patients with contagious and highly fatal diseases

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The Ebola Virus Disease is a contagious and highly fatal illness that up until recently had been geographically limited to remote areas of Africa. In 2014, Ebola patients have been transported to the United States for care or have been newly diagnosed in the United States. With the intensive medical care and isolation policies usually needed by these patients, we inquired whether pastoral care would be possible.

Using clinical and canonical considerations, we analyzed the permissibility and logistical challenges pastoral care presents to the priests and lay ministers, as well as the healthcare system.

We conclude that with the approval of local, state, and federal health officials, pastoral care, including provision of the sacraments, is possible. It would require proper training, proper equipment and policies, and a significant commitment of time. While the risk to the pastoral team is difficult to define, it seems low in an Ebola-capable medical system. These risks to priests and ministers seem reasonable given the inestimable benefits of receiving the sacraments during critical illness.

Lay summary: *Traditional pastoral visits to hospitalized patients might prove difficult or impossible for diseases that are contagious and highly fatal. This inquiry examines the feasibility, challenges, and logistical solutions to these visits. With input from bishops, priests, a canon lawyer, an epidemiologist, a physician, the CDC, and others, we conclude that pastoral visits are possible. Visits will require permission of health authorities, commitments of time, training, and a small but significant risk to the health of priests and others who volunteer for this ministry.*

Keywords: Ebola, EVD, Pastoral Care, Confession, Reconciliation, Holy Communion, Holy Eucharist, Sacrament of the Anointing of the Sick, Infection Control, Personal Protective Equipment, Funerals

Introduction

Ebola Virus Disease (EVD) is a contagious infectious disease with a high fatality rate. As of December 2014, Ebola is causing an unprecedented outbreak in West Africa, and several patients have required care in the United States. The physical, psychological, and spiritual stress of this illness extends to all involved. With the advent of EVD care in the United States, it is incumbent on the Church and healthcare officials to consider the implications of pastoral care of these patients.

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Our mandate, "Heal the Sick" (Matt 10:8) permeates Christian life. The Catholic community strives to integrate the sick into the full life of the Church by caring for all patients with prayer, personal human presence, the provision of sacraments, the eventual reintegration of the healed patient back into the Christian community, and at times providing funeral services.

This manuscript will consider the medical and canonical aspects of pastoral care of Ebola patients and will provide logistical recommendations.

As new information becomes available, these recommendations need to be re-evaluated and updated. These principles may have applications to other diseases with similar characteristics.

The Ebola Virus Disease (EVD)

EVD was previously called Ebola Hemorrhagic Fever and has been causing localized outbreaks since 1976. The latest outbreak in West Africa has a case fatality rate of about 70 percent (WHO Ebola Response Team 2014). In the United States there have been four newly diagnosed cases diagnoses as of December 2014. Of these one patient has died.

Transmission

EVD is usually spread by human-to-human contact. It involves a direct contact with the virus through an exposed mucus membrane, or broken skin (CDC 2014c). In general it is not spread by air, water, or in gene-ral by food. The exception to this is in Africa where people became infected with EVD from eating or touching infected wild animals.

During the illness there is a window of time during which the patient is considered contagious. In the early phase of the illness when viral load is low, the risk of transmission to others is low. As the viral load increases and as the symptoms progress, so too does the risk of transmission. This risk is potentiated by a patient's prostration and their inability to control their secretions, thus the need for more frequent cleaning of the patient and changing of the bedding.

The length of time that the virus can be detected in bodily secretions varies with the body fluid. Feces may have the virus persist for 29 days after onset of symptoms. Semen may harbor the virus for up to 101 days (CDC 2014c). This type of information will have a bearing on how soon the recovered patient may re-integrate into his community.

The remains of the deceased EVD patients are also high-risk reservoirs of disease.

Clinical features

The prodrome may begin between 2 and 21 days after exposure. At first onset, symptoms are non-specific such as fever, headache, and malaise. They will progress to more severe prostration, profound fluid loss through diarrhea and vomiting, and bleeding. Even in severe cases, survival is possible with intensive care.

Diagnosis

If someone has a risk factor such as travel to West Africa or exposure to an EVD patient and then develops characteristic symptoms, they are considered a *person under investigation*. If the laboratory tests find evidence of EVD in their blood, then they are considered a *confirmed case*.

Treatment and prevention

There are no currently available FDA-approved treatments for EVD. Experimental treatments are being developed. While the initial vaccine studies hold

promise, it will be months or longer before these are widely available (Kanapathipillai et al. 2014).

Infection Control Considerations

A detailed description of current infection prevention and control recommendations for hospitalized patients with EVD can be found on the Centers for Disease Control and Prevention (CDC) Website (CDC 2015b). For pastoral issues, it is understood that the key feature of infection control is to isolate the patient, both physically and operationally. The physical isolation relates to the hospital room and the personal protective equipment policies. The operational isolation relates to the traffic of hospital personnel and visitors, and the handling of waste.

There will be a limited number of nurses, doctors, and support staff that are caring for the patient on a day-to-day basis. Non-essential visitation will be restricted. The CDC does provide an exception though:

> Exceptions may be considered on a case by case basis for those who are essential for the patient's wellbeing. (CDC 2015b, 4)

An email correspondence on November 26, 2014, with a representative of the CDC's Division of Vector Borne Diseases inquiring about the feasibility of conferring the sacraments in patients with EVD, they confirmed the above, and added:

> [The] CDC has no guidance on this specific question. Decisions should be made on a case-by-case basis through discussions between the clinical team, the hospital administration, the local health department, and the CDC. However, current guidance for hospitalized Ebola patients is that visitors should not be present in the patient room; exceptions may be considered on a case-by-case basis for those who are essential for the patient's wellbeing. (CDC 2014a)

Personal protective equipment (PPE) for pastoral care

At odds with a traditional face-to-face pastoral interaction, are the appropriate infection control policies that call for careful isolation of these patients with stringent PPE procedures to limit the risk of spreading disease.

If the local health officials give permission for a face-to-face pastoral visit, then the pastoral visitor will need to undergo rigorous training and demonstration of competency in these procedures before making a visit. During subsequent pastoral visits, reinforcement of these procedures will be provided.

There will likely be a separate unit for the EVD patient(s). The visitor's name and pertinent demographics will be recorded. The visitor will need to change into surgical scrubs and will be provided non-porous shoes.

The current CDC guidelines for PPE involve at least fourteen steps to don (put on) the gear, and at least twenty-four steps to doff (remove) the equipment (CDC 2014b). A basic principle is that no skin is exposed to virus.

In many cases the PPE will include an N-95 respirator mask that is fit-tested. For this to be effective, there can be no facial hair or other impedance between the sealing surface of the mask and the skin. The person must be able to breathe adequately through the mask and not be subject to the potential claustrophobia. Under optimal circumstances, the mask will be worn under a surgical hood that extends to the shoulders. Other aspects of PPE include a fluid-resistant or impermeable gown, shoe covers, and lower leg coverings. Two pairs of examination gloves are worn.

There will be one attendant assisting the visitor in this meticulous process and one person with a checklist giving guidance. The local health authorities will

likely require several flawless donnings and doffings of the PPE prior to the visitor being cleared for entrance into the patient's room. Expect to spend twenty minutes putting the PPE on, and thirty minutes taking it off. The visitor will then take a shower prior to putting on his or her street clothes. Subsequent pastoral visits will involve reinforcement of these procedures.

Visitor movement within the facility will be restricted to the patient care area and to the immediate waiting area.

When a diocese designates a priest or an extraordinary minister of holy Communion (EMHC) for this ministry, the authors recommend that these ministers be volunteers. They should be able to limit their other pastoral or social duties if requested by the local health officials.

Quarantine information

Visitors and healthcare workers who have followed the isolation procedures with the proper equipment and no breaches in protocol, should have no need for quarantine. If a breach has occurred quarantine may be necessary and will generally be determined on a case-by-case basis by the local health authorities. The duration of the quarantine is currently twenty-one days after the exposure with twice daily temperature monitoring and symptom surveillance (CDC 2015b).

Medical waste information

Depending on how the sacramental items such as anointing oil or other vessels are handled, the disposition of medical waste may be relevant.

The basic rule is that waste should never be removed from the room except by the strict policies leading toward incineration.

From a canonical point of view, incineration is the preferred method for these items. A given hospital may not have an incinerator that is approved for biohazardous waste. Thus it should be confirmed with the hospital that they have contracted with a medical waste company and that the waste is destined for an approved incinerator.

Pastoral and Sacramental Considerations

While the risks of caring for patients with EVD are significant, with proper preparation, practice, and equipment, these risks seem reasonable compared with the benefits of pastoral care.

In *Christifideles laici*, Saint John Paul II describes elements of pastoral care and its benefits:

> This activity must be capable of sustaining and fostering attention, nearness, presence, listening, dialogue, sharing, and real help toward individuals in moments when sickness and suffering sorely test not only faith in life but also faith in God and his love as Father. Such pastoral initiatives find most meaningful expression in sacramental celebrations with and for the sick, as a source of strength amid pain and weakness, hope amid despair, and as an occasion of joyful encounter. (John Paul II 1988, n. 54)

The Pontifical Council for Health Care Workers expounds on these statements further:

> In giving priority to the celebration of the sacraments over any other form of expression, pastoral care in health affirms that its fundamental purpose is to make Christ present so that everyone, above all sick people, can encounter Him as the Physician of the body and the spirit. (The Pontifical Council for Health Care Workers (For Health Pastoral Care) 2013, 28)

Pastoral visits and prayer

When a patient with EVD (or any other contagious and highly fatal disease) is

brought to the attention of a Catholic parish, as a general rule the diocesan Chancery should be notified and participate in designing the plan of pastoral care. In some situations of severe illness, the local bishop will discern the suitability of conferring Holy Communion and other sacraments to a specific patient.

Prayer and communication

Even in situations where pastoral care may be limited by the circumstances of an illness, the church community can and is encouraged to pray for the sick, both remotely and inside the hospital (within limits). The priest and lay ministers, even if prevented from entering the patient's room, might be permitted to visit the hospital care area and will likely be visible to the patient through the glass doors. A telephone or other intercom system should be available for prayer and conversation.

Sacrament of Confession

The traditional elements of confession such as telling one's sins to the priest in a face-to-face setting or separated by a fixed grille, can prove challenging in a hospital setting.

While absolution cannot be given by remote phone or other live imaging technologies, with a bishop's permission, absolution may be valid if the priest is on site, visible to the patient (and vice versa), and audio enhancement such as a phone is used.

A greater barrier to a valid confession by the Ebola patient may be privacy. There will always be a nurse in the room and others in the area proximate to the priest. If there arose a situation where despite lack of privacy, it was necessary to discuss specific sins, a nearby nurse, might be viewed as the Church views an interpreter, who is obliged to observe secrecy (*Code of Canon Law* 1999, c. 983 §2). If the confessor discerns that the secrecy obligation of those in the room is in doubt, he may decide not to hear the specific sins.

Sacrament of the Holy Eucharist

The Holy Eucharist is "the source and summit of the Christian life" (Vatican Council II 1964, n. 11) and therefore reception of Holy Communion has paramount importance in pastoral care of the sick.

In normal hospital circumstances, receiving Holy Communion will require either a priest or an extraordinary minister of Holy Communion to enter the room of the patient. Therefore they will need to undergo the rigorous isolation training described previously.

Nonetheless, receiving Holy Communion appears feasible if an exception to the visitor restrictions is granted for the well-being of the patient. The judgment on this exception will be made by health officials.

For receiving Holy Communion, the authors recommend the following:

(1) The pyx (the vessel containing the host) should not enter the room, as it would then need to be purified and remain in the room until the patient recovered or died.
(2) After the volunteer minister has donned the PPE, they should take a small host in their gloved hand and enter the room.
(3) Avoid breaking the host once inside the patient's room in order to avoid creating Eucharistic crumbs.
(4) The priest or EMHC should be prudentially certain that the patient is

able to swallow the Host. This might be assured if the patient has taken food and water satisfactorily in the past few hours and that there has been no vomiting in the last twelve hours. Needless to say, having to retrieve a host that is not swallowed and not dissolving in the patient's mouth will challenge the norms of handling this situation. Under non-Ebola circumstances the Host would be allowed to dissolve in water, and then poured into a sacrarium (a special sink found in the sacristy of most Catholic churches that drains directly into the ground). Since no sacrarium is available in the hospital room and since waste cannot leave the room, the norms would necessarily be compromised.

(5) Having discerned that the patient may receive Holy Communion, at the appropriate time, the Host is received in the hands and under one species.

(6) Under normal circumstances, the choice of whether to receive Holy Communion on the tongue or in the hands has traditionally been the choice of the recipient (*General Instruction of the Roman Missal* 2003, n. 161). The bishop may restrict this choice under these special circumstances. While receiving Holy Communion on the tongue is feasible, it would seem to pose a higher risk of contaminating the minister's gloved hand. As long as proper doffing of PPE is done, this should pose minimal additional risk.

(7) In cases where the patient is judged to be unable to swallow the Host, Holy Communion may be administered under the species of wine alone (*Code of Canon Law* 1999, c. 925 §1), even if in the form a one small drop (in a disposable dropper), provided that the patient is able to receive the Consecrated Wine in the mouth without dripping. The Consecrated Wine should be transported in a sealed vessel. A second disposable vessel with purification water is also brought to the hospital. Using a new dropper, a small amount of Consecrated Wine is removed from its vessel. The minister of Holy Communion would transport only the dropper and the disposal vessel into the room. After conferring Holy Communion to the patient, a small volume of the purification water should be drawn into the dropper in order to purify the dropper. This water is to be given orally to the patient as well. This purification step should be repeated as necessary in order to purify any final traces of the Consecrated Wine from the dropper. Once this is done, the dropper would be placed in the disposable vessel with any remaining water, and placed with medical items destined for incineration.

Holy Communion: Special situations

If the ordinary ministers of Holy Communion are unable to bring Holy Communion into the room, it is possible that a Catholic member of the medical team could be designated as an EMHC. As described in the *General Instruction of the Roman Missal*, "In case of necessity, the priest may depute suitable faithful for this single occasion" (*General Instruction of the Roman Missal* 2003, n. 162).

If no Catholic members of the medical team are available, at the discretion of the bishop, it might be permissible for a non-Catholic to function as a transporter of the Eucharist on a paten. The patients are not permitted to take consecrated bread off the paten by themselves (*General Instruction of the Roman Missal* 2003, n. 160) but it may be permissible to have the transporter tilt the paten and have the

communion host slide into the recipient's hands from where it is consumed. The paten would remain in the room.

Sacrament of the Anointing of the Sick

> By the sacred anointing of the sick and the prayer of the priests, the whole Church commends those who are ill to the suffering and glorified Lord, asking that he may lighten their suffering and save them. (Vatican Council II 1964, n. 11)

Unless a patient with EVD is well on the way to recovery, he or she is considered seriously ill with the potential for death and therefore may appropriately request the Sacrament of the Anointing of the Sick.

This sacrament must be conferred by a priest and involves an in-person interaction. In its complete form, this sacrament in a hospital setting involves two parts: an introductory rite, and the liturgy of the anointing. The anointing involves the laying on of hands on the head of the patient, anointing the forehead and hands with oil, and saying the prescribed prayers. The rite closes with a blessing. Depending on time and circumstance, this format may be shortened or altered (Pastoral Care of the Sick 1983, 126–33).

Although the normal manner of anointing requires a priest to use his own hand, in grave circumstances, an instrument can be used (*Code of Canon Law*, c. 1000 §2).

For receiving the Sacrament of the Anointing of the Sick, the authors recommend the following:

(1) The blessed oil stock does not enter the patient's room.
(2) After the priest has donned his PPE, he can either place oil on his anointing hand or could take a piece of cotton that has been soaked with blessed oil for anointing. If he chooses the latter, then a disposal vessel should be used in which the oiled cotton is placed for incineration.
(3) If a continuous rite is appropriate (Penance, Anointing of the Sick, and Holy Communion) then the priest will also be carrying Holy Communion in his other hand.
(4) He will enter the room and greet the patient.
(5) The rite(s) are then performed as allowed by the circumstances of the illness.
(6) When the priest has completed his visit, he leaves the oiled instrument in its disposal vessel in the room and then exits to begin the doffing procedure of PPE.

Recovery From Ebola and Re-Integration of the Patient into the Parish Community

In the West African experience, survivors of Ebola can face the stigma of having the disease, income loss, grief over loss of ill family members or friends, and even survivor guilt. In outbreak situations, governmental and nongovernmental organizations have emerged to assist patients in reintegrating with their community. The Church should also be sensitive to these needs and may be in an optimal position to help with the re-integration of parishioners. By welcoming Ebola survivors back into day-to-day parish life, the Church will set an example for the surrounding community.

Funerals

The Christian funeral "seeks spiritual support for the deceased, honors their bodies, and at the same time brings the solace of hope to the living" (*Code of Canon Law* 1999, c. 1176 §1). It is usually celebrated at the parish church of the deceased (*Code of Canon Law* 1999, c. 1177 §1).

The CDC has provided guidelines for safe handling of human remains of Ebola patients in US hospitals and mortuaries (CDC 2015a). Since human remains are infectious, the body is contained prior to exiting the room in which the patient has died. The body is wrapped in a shroud, and then double-bagged in a leak-proof and puncture-resistant set of bags that are zipper-closed before leaving the room.

No autopsies or embalming are recommended as risks outweigh benefits. The remains in the containing bags are either cremated or buried promptly in a hermetically sealed casket.

A hermetically sealed casket is a casket that is airtight and secured against the escape of microorganisms. The casket is accompanied by valid documentation that it has been hermetically sealed.

The CDC states that once a body is placed in a hermetically sealed casket, no other cleaning is necessary and no PPE is required when handling the casket (CDC 2015a).

The CDC recommends that transportation of human remains of Ebola victims be minimized (CDC 2015a).

If these guidelines can be achieved in practice, then a funeral in a church should be safe for all concerned. If the person has died outside the area of his or her parish, it may be necessary to have the funeral in the parish church near the hospital where the death occurred.

As in other causes of death, the Church does not prohibit cremation unless chosen for reasons contrary to Christian doctrine (*Code of Canon Law* 1999, c. 1176 §3).

Conclusion

Guided by prudence and charity, efforts should be made to provide pastoral care to patients with Ebola Virus Disease. The patient's needs are weighed against the contagious nature of the virus, the high fatality rate, and concerns of further transmission of the disease to the community at large. Nonetheless, with the approval of healthcare officials, availability of proper isolation equipment, and strict adherence to PPE procedures, priests and lay ministers may be able to provide pastoral care including sacraments. They must be willing to assume the small but serious personal health risks. They must be willing to spend hours of time for each visit. They should be able to limit other pastoral or social duties, and be able to comply with a quarantine order in the event that a breach in isolation protocol occurs.

By doing so the Church community participates in Jesus' healing ministry and allows those with severe illness to participate in the life of the Church to the fullest extent possible.

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