Abstract:
The Ebola virus disease (Ebola) outbreak in West Africa (2014-2015) prompted domestic planning to address the scenario in which a traveler imports Ebola into the United States. Parental presence at the bedside of a child with suspected or confirmed Ebola emerged as a challenging issue for pediatric health care providers and public health practitioners. At the heart of the issue was the balance of family-centered care and appropriate infection control, which are not easily aligned in the setting of Ebola. In the following dialogue, pediatricians, who participated in discussions about parental presence during the evaluation of pediatric persons under investigation, and a public health ethicist discuss the interplay between family-centered care and appropriate infection control. Reaching a balance between the 2 ideals is difficult and may require the facility and providers to engage in a deliberate conversation to determine how they will handle parental presence for such high-risk scenarios, including Ebola and other high-consequence pathogens, in their institution.

Keywords:
Ebola virus disease; infection control; family centered care; bioethics

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SPECIAL ARTICLE

Parental Presence at the Bedside of a Child with Suspected Ebola: An Expert Discussion

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The Ebola virus disease (Ebola) outbreak of 2014-2015 in West Africa prompted widespread domestic planning in the United States focused on the possible importation of Ebola from a traveler arriving from an affected country. Travelers from West Africa included children, and guidance was developed to address infection control considerations in school settings[1] and during pediatric patient transport by emergency personnel.[2] However, parental presence at the bedside of a child

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suspected of having Ebola emerged as a difficult issue for pediatric health care providers, as they sought to balance the goals of family-centered care with those of appropriate infection control. In a family-centered care model, maintaining the integrity of the family unit is paramount. The family serves as a source of strength and support for the child's recovery, and the child is a source of strength and resilience for the family.[3–5] Infection control protocols, however, specifically focus on preventing the spread of disease; the safety of health care workers (HCWs) and patients, other family members, and the community takes precedence.[6]

To explore parental presence at the bedside of a child with suspected Ebola in the United States, we invited subject matter experts to discuss a fictional case study from the perspective of family-centered care or infection control. The subject matter experts are pediatricians who participated in discussions about parental presence during the evaluation of pediatric persons under investigation and a public health ethicist. The intent of the expert discussion is to explore the issues surrounding parental presence that were identified during the domestic response to the 2014-2015 Ebola outbreak, not to identify a standard of care.

THE CASE

A family returned from a country with widespread transmission of Ebola during the peak of the outbreak. The family had no contact with a known individual with Ebola and did not attend a burial or funeral while in-country, and all family members were asymptomatic when screened at a US airport. A 2-year-old male becomes symptomatic 1 week after returning to the United States; the parents are asymptomatic. The parents transport their child to a pediatric hospital that is a designated Ebola treatment center. The local and state health departments are notified. His symptoms include a fever of 103°F, nonbloody diarrhea, vomiting, and moderate dehydration. The parents wish to remain at his bedside during his evaluation and also insist that they will remain at his bedside even if he tests positive for Ebola.

INITIAL EVALUATION OF THE CHILD

Steven Krug (SK), Pediatric Emergency Medicine: Upon presentation to the emergency department (ED) triage desk, I would hope the patient's presenting complaints, parental concern, and screening questions that are now part of our standard triage assessment would prompt recognition that this child (and any accompanying family members) may have been exposed to Ebola, with the presenting complaints potentially representing early symptoms of disease. The patient and family would be moved immediately to one of our ED isolation rooms or, if no room was available, to an empty consult or conference room. Once placed in an appropriate exam room, the index patient and immediate family (1 or 2 parents) would be asked to remain in that room, with additional family members and others accompanying the patient placed in a nearby family room, and staff would be assigned to ensure compliance. Hospital infection control and the Department of Public Health would be immediately notified.

In this scenario, a patient brought by a family to the ED, the parents would be permitted to remain in the examination room until it became time to move the child to the location in the hospital (pediatric intensive care unit [PICU]) where she/he would remain until cleared of having Ebola or until treatment of actual Ebola disease was complete. Of note, patients being transferred to our hospital with advance notification by the Department of Public Health would bypass the ED and go directly to the PICU treatment area. This bypass was created in an effort to limit the number of staff exposed and exposure risks for patients and families in public areas.

Susan Hocevar (SH), Pediatrician, Infection Control: An ill toddler with vomiting and diarrhea can be difficult for health care workers to care for under the