June __, 2026

To Members of Congress

We write as physicians, nurses, public health professionals, humanitarian responders, scientists, military personnel, government employees, contractors, aid workers, journalists, and concerned individuals. Many of us have direct experience responding to Ebola outbreaks; others support the principle that Americans serving abroad should have access to the highest standards of medical care.

We are deeply concerned by reports that the United States government is pursuing a policy under which American citizens with Ebola exposures requiring quarantine, isolation, or medical care would be transferred to a facility in Kenya or countries in the European Union rather than repatriated to specialized treatment centers in the United States.

This policy raises profound clinical, ethical, operational, and legal concerns.

For decades, the United States has maintained the capability to safely transport, isolate, and care for Americans exposed to or infected with highly hazardous communicable diseases. Following the 2014–2016 West Africa Ebola epidemic, substantial taxpayer investments were made to establish and sustain a world-class network of biocontainment and high-consequence infectious disease treatment centers. These facilities were specifically designed for situations such as this and include highly trained multidisciplinary teams, specialized transport systems, advanced laboratory capabilities, and critical care expertise developed through years of preparation, training, and real-world experience.

These capabilities cannot be recreated in a matter of days or weeks through the rapid establishment of an overseas facility.

The management of Ebola requires specialized expertise, infrastructure, and operational experience that may not be readily replicated in a newly established facility.

The care of patients with Ebola is extraordinarily complex. Survival depends not only on the ability to safely isolate patients, but also on access to advanced supportive and intensive care delivered by multidisciplinary teams with expertise in infection prevention and control, intensive care, and the management of high-consequence infectious diseases. We know such care saves lives.

The United States has successfully managed this challenge before. During the 2013-2016 Ebola epidemic, multiple Americans infected with Ebola and those with high-risk exposures were safely repatriated to the United States and treated in specialized biocontainment units. They survived because they had access to high-level supportive care unavailable in many outbreak settings at the time. Importantly, these controlled medical

evacuations and treatment operations did not result in secondary community transmission in the United States when proper protocols and trained personnel were utilized.

This experience demonstrated that safe repatriation is both feasible and effective.

The current approach also raises serious ethical concerns. Individuals who deploy to assist during outbreaks do so at enormous personal risk in service of global health, national security, and humanitarian response efforts. They do so with the expectation that, should they become ill, they will have access to the highest standard of care available. Policies that deny or limit access to the very systems the United States has spent years building and maintaining undermine that commitment.

Such policies risk undermining the outbreak response by discouraging qualified personnel from deploying to the affected regions. If responders believe they may be denied access to optimal medical care should they become ill, many will understandably reconsider whether they can safely serve.

At a time when outbreak response efforts are already strained, this is a dangerous precedent.

We are equally concerned about the diversion of resources toward establishing ad hoc quarantine, isolation, and treatment infrastructure overseas rather than directing urgently needed resources toward controlling the outbreak at its source. Efforts should focus on strengthening local clinical care capacity, supporting surveillance and laboratory systems, protecting healthcare workers, improving infection prevention and control, expanding access to vaccines and countermeasures when available, and supporting affected communities.

Finally, there are profound legal, ethical, and human rights concerns associated with preventing American citizens from returning home for care or diverting them to third-country facilities. The lack of transparency surrounding these policies only deepens those concerns. Fundamental questions regarding standards of care, clinical responsibility, medical evacuation, access to investigational therapies, and patients' rights remain unanswered.

We respectfully urge Congress to:

1. Require transparency regarding any plans to quarantine, isolate, or treat Americans in third-country facilities, and ensure that a facility in Kenya or any other country operates under clearly defined quality and safety standards comparable to U.S. biocontainment units.
2. Ensure that Americans serving abroad retain access to medical evacuation and treatment within the United States.

3. Protect and sustain the U.S. high-consequence infectious disease treatment network and related preparedness capabilities.
4. Assess the potential impact of these policies on recruitment, retention, and deployment of outbreak response personnel.
5. Conduct appropriate oversight of policies that affect the care of Americans responding to global health emergencies.

Americans who volunteer to serve on the frontlines of outbreaks should not have to wonder whether they will be able to return home if they become ill. The United States possesses the expertise, infrastructure, and clinical capacity to safely care for these patients while protecting healthcare workers and the public. We should utilize and strengthen these systems—not bypass them.

Protecting those who place themselves in harm's way to respond to outbreaks is both a moral obligation and a matter of national preparedness.

Leadership of this Effort

Krutika Kuppalli, MD, FIDSA is an infectious diseases physician with experience on emerging infectious diseases and outbreak response. She previously served as Medical Director of an Ebola Treatment Unit in Sierra Leone during the 2013–2016 West Africa Ebola epidemic.

Debra Houry, MD, MPH, FACEP is an emergency physician and public health leader and former Chief Medical Officer and Deputy Director for Program and Science at the Centers for Disease Control and Prevention (CDC), where she helped oversee responses to major public health emergencies.

Anne Schuchat, MD is a physician, epidemiologist, and former Principal Deputy Director of the CDC. She has played key leadership roles in numerous public health emergencies, including Ebola, Zika, pandemic influenza, and COVID-19.

Craig Spencer, MD, MPH is an emergency physician, global health expert, and Associate Professor at the Brown University School of Public Health. He treated patients with Ebola in Guinea during the 2013-2016 West Africa epidemic and is both an Ebola survivor and advocate for evidence-based outbreak response, public health preparedness, and equitable access to medical countermeasures.

Signatories

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