Ebola virus disease has ignited some of our worst fears in a globalized world. The disease spreads quickly, with high mortality, and is crossing borders. More than half of infected persons have died (1). The confirmed cases include 2 Americans who have become the focus of public attention because of their heroism and for the extraordinary measures taken to ensure that they received optimum medical care.

With this attention, 3 ethics questions are being asked: Should the 2 Americans have been airlifted out of Liberia when others were not? Should they have been given a highly experimental treatment? And if treating them was appropriate, should the hundreds of Africans with Ebola also be treated?

Despite codes of ethics requiring physicians not to abandon sick patients (2), few health professionals would probably volunteer to care for patients with Ebola in West Africa today. Sound medical ethics is one thing, but traveling to help patients with an illness both highly contagious and usually fatal is what ethics calls “supererogatory”—above and beyond usual norms of good ethical conduct.

When a health care provider is willing to work amidst Ebola (or the severe acute respiratory syndrome or pandemic influenza), we, as a society, must fulfill our end of the bargain. It would be unconscionable to send physicians and nurses to Africa now without hazardous material suits, and it would be equally unconscionable not to assure them that, should they contract Ebola, they would be airlifted home to receive the best care available. It would clearly be better for persons in at-risk areas if they, too, had access to protective equipment and airlifts. The tragedy of people dying in Africa from this killer virus does not make our special treatment of the physicians and nurses who fly in to help them unfair.

The 2 American health care workers with Ebola were given a highly experimental treatment (3, 4) that was previously tested on monkeys and never before given to humans, not even in small clinical trials. Some ask whether it is ethical to give such treatment to humans, especially those whose judgment may be clouded by desperate circumstances. Yet, when a patient’s chances of dying exceed the chances of surviving, when significant symptoms have set in, and when recipients are health care workers whose potential to understand risks is probably high, such a decision seems more reasonable. These 2 patients have had the visibility of few other cases of public health, medical care, or research investigations. As such, experts from the Centers for Disease Control and Prevention, U.S. Food and Drug Administration, and National Institutes of Health probably weighed in on the pros and cons of releasing the experimental serum, and through such collective deliberation of experts, some of the protections ordinarily provided to participants in research trials may have been realized.

Which leads to a final question: If it was reasonable to treat these 2 Americans, shouldn’t the experimental treatment also be provided to the Africans? Callous as it may seem, the answer is no—or, at least, not yet. The threshold for determining that an individual patient receive access to a highly experimental drug on a compassionate-use basis (5) does, and should, differ from the threshold for rolling out a treatment program to an entire community, even one facing a life-threatening epidemic.

Drug testing requirements are designed to ensure that drugs are sufficiently safe and effective to be recommended to the public. No such evidence exists for these drugs. Moreover, U.S. researchers have been accused many times of exploitation (including of poor people in Africa) when testing new treatments during devastating public health outbreaks (6–8).

The visibility of the 2 treated Americans, however, has been a catalyst for debating whether, or under what circumstances, distribution of experimental drugs in Africa is warranted. The World Health Organization will convene a panel to address this question (9). In addition to considering the safety risks of untested treatments, the risk that they will be ineffective must also be considered. A top priority in this, and any, public health emergency is public health cooperation: The affected people must be willing to follow directions from international and local health authorities with regard to, for example, whether to assemble and how to handle the bodies of those who are sick or have died. What is at stake in a decision about using experimental treatments may be far greater than the risks to the individuals who take them.

Thus, risk and benefit must be evaluated expansively. A well-orchestrated public communications strategy must be a component of any rollout to reduce rumors and misconceptions (10). Any rollout must also proceed with caution. It should include small numbers of individuals and ones selected for their—or their families’—ability to provide meaningful informed consent. Starting with small numbers is itself a protection, as is an unwavering commitment to ongoing data collection. Ultimately, such data will be our best ethical guide.
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Disclosures: None. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M14-1864.

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