# Treating Ebola

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As a historian of epidemics, I study contagious crises from the safe distance of a century or more. But as a physician watching the spread of deadly Ebola, I have been agonizing over my responsibility to help solve this crisis, or at least volunteer to treat its victims. It is hard, if not impossible, to criticize anyone wanting to escape from such danger, especially when so few of us are willing to go there in the first place. But it does force every doctor (and patient) to reconsider the medical profession's presumed ethical obligation to treat the ill, no matter what the risk.

In fact, the history books are filled with accounts of physicians abandoning or avoiding their patients during epidemics. In 166 A.D., the famed physician and anatomist Galen fled Rome during a bubonic plague epidemic. In the 17th century, Thomas Sydenham, one of medicine's most astute observers of infectious disease, quit London for the salubrious countryside during that city's "great plague. These legendary healers were hardly alone. Some European cities were forced to appoint public plague doctors to attend the ill patients other physicians refused to treat. A wide range of avoidance responses was also seen in colonial Philadelphia during the Yellow Fever crisis of 1793 and several cholera and smallpox epidemics that unfolded across the United States during the early 19th century. Still, many other doctors during these eras did sacrifice their lives to treat infectious patients, albeit for reasons spanning from the religious to the economic.

You won't find the duty to treat the infectious in the Hippocratic Oath or in any other oath for that matter. It was actually the American Medical Association's code of medical ethics, adopted in 1846, that first articulated such a responsibility: "When pestilence prevails, it is their [physicians] duty to face the danger and to continue their labors for the alleviation of the suffering even at the jeopardy of their own lives." Versions of this clause continued to appear in the AMA Ethics Code until 1957.

After World War II, antibiotics became widely available, revolutionizing the treatment of many infectious diseases. Between 1946 and the 1970s, a long parade of effective vaccines, medications, and support measures inspired many physicians to declare prematurely the conquest of epidemics. During this brief period, we all grew far too comfortable with the faulty notion that modern medicine was powerful enough to tame any infection. This perceived invulnerability made it especially bad form for a physician to abandon the treatment of an infectious patient.

The contemporary debate over the duty to treat reared an ugly head in 1982 when health care workers of all stripes expressed great reluctance at exposure to a new, deadly, and not even remotely curable, infection: HIV/AIDS. Even after it became clear that HIV was transmitted by sexual activity, blood contact, and, childbirth (if the mother was HIV positive), well into the 1990s, there were too many doctors and other health care workers who avoided AIDS patients. Although AIDS is now into its fourth decade of pandemic malevolence, such fears have, thankfully, quieted. But new worries and familiar avoidance patterns frequently reappear among health professionals (as we are seeing with Ebola) each time a deadly, newly emerging or re-emerging infectious disease strikes.

Today, in the relatively safe environment of conference rooms nestled in our major medical centers, health care professionals, bioethicists, and others are again wringing their hands over this conundrum: How should health care workers care for patients during an epidemic disease that modern medicine has not yet figured out how to effectively treat, especially when the disease in question holds a very real risk of killing both the patient and the health professional?

The current AMA Code of Ethics currently takes an "on the one hand, but on the other hand" approach to this dilemma. Physicians, the code explains, have an obligation to care for the sick, which "holds even in the face of greater than usual risks to their own safety, health or life." But it also acknowledges that the supply of physicians is no

"an unlimited resource" and that doctors need to "balance immediate benefits to individual patients with ability to care for patients in the future."

Striking a balance between medical or humanitarian assistance for developing nations and the hard work needed to develop a healthier future for those living there will take far more than the declaration of an ethical code or a team of idealistic doctors rushing into Africa with the hope of saving some lives.

Long after Ebola is contained, the wealthier nations (and those fortunate enough to live in them) must get to work in righting the unacceptable injustice of impoverished nations continent where health care is inaccessible for too many; where fresh, running water is scarce; and where electrification and modern roadways are inadequate. Such infrastructural problems make the overwhelming majority of epidemics worse and undermine efforts to fight them. This is precisely what we are seeing in western Africa today.

The problem with Africa's health is not just Ebola. It's the lack of adequate health care -- not enough hospitals, doctors, nurses, and medical supplies. Correcting these glaring deficits will do far more than attenuate future epidemics and the distracting side issue of protecting those exposed to them. It will significantly improve our planet's health, which is good for everyone, no matter where they live.

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