Ebola and Beyond

During the summer and early fall, as the country became increasingly alarmed by the failure to contain the current Ebola outbreak in West Africa, the Centers for Disease Control and Prevention (CDC) issued statements reassuring the American people that Ebola is “unlikely...[to] spread if imported into the United States” (July 28), and that it “poses very little or no risk to the US community at large” (Aug 13). The CDC also called for vigilance and measures to ensure the US healthcare system was prepared to rapidly manage cases to avoid further transmission (Sept 17). Nowhere in these statements were there guarantees that there wouldn't be isolated cases of Ebola in this country, but in light of subsequent events, the public perception of what was said has seriously undermined the credibility of one of the strongest and most effective public health agencies in the world.

Why were actual events seemingly at odds with the initial risk assessments? In part, it was because the statements appear to have been based on several unrealistic premises. They presumed that everyone, from airport personnel to emergency department physicians and nurses, to hospital staff and administrators, would do everything right, every time, for every patient. More importantly, hospitals underestimated the staff and resources that would actually be needed to care for Ebola patients.

The CDC statements also seem to have included a leap of faith: if the spread of Ebola among healthcare workers could be minimized in one of the most medically underserved regions of the world, surely the most advanced healthcare system in the world could do even better. This belief, however, did not take into account that any deaths among patients, close contacts, or healthcare workers would never be considered acceptable in this country, and that intravenous transfusions, hemodialysis, and other advanced treatment measures unavailable in Africa, would expose a greater number of healthcare workers here to the risk of infection.

With absolutely no margin for error in the plans to prevent the spread of Ebola, ED triage professionals, nurses, and physicians have been placed under an enormous burden to get everything right, 100% of the time—a standard that is clearly beyond human capabilities. Should EPs and nurses be blamed for the failure to diagnose the first case and the inability to subsequently prevent two nurses from becoming infected?

I am virtually certain that every EP reading this has had at least one patient encounter that he or she wishes could be done over. Sometimes no harm results from a serious or potentially fatal omission or error; sometimes we are not so fortunate. Have you ever failed to notice an important piece of information in the EMR because it was not entered into the place where you are used to finding it—especially during and after EMR “downtime” periods? Have you ever experienced the pressures resulting from too many patients and too few beds, or the federal regulations calling for reduced lengths of stay and reduced short-term admissions, or of not having all of the resources you need to treat a patient just when you need them? If not, you are indeed fortunate. But to assume that none of these factors—and others—could possibly compromise efforts to diagnose, treat, and contain Ebola is almost “magical thinking.”

Afterward, when not everything goes as well as the public had believed it would, our ability to continue basing sound medical practice on scientific facts instead of unsupported fears, is undermined.

As a result of the widespread reporting of early missteps in managing the first Ebola cases in the United States, we are in a much better position now to prevent, manage, and contain new cases, and to avoid the mind-numbing effects of the huge numbers of cases we witnessed with the spread of HIV and AIDS in the 1980s and 1990s. With everyone’s full attention, and more than a small degree of luck, we can successfully prevent or limit the number of future cases—efforts that hopefully will be furthered in the next few months by at least one effective vaccine and/or antiviral agent.

But, there will always be new and emerging infections that the world has never heard of to challenge us. So now would be a very good time to think of the training and resources necessary to deal with future contagious diseases and epidemics, and to plan on avoiding the use of words that may later come back to haunt us.