

The Case of the Ebola Outbreak Ethics

Case Written by Sarah Lockett-Gatopoulos

Case

Dr. Sarah Lockett-Gatopoulos

Objectives:

Dr. Teresa Chan

Expert Responses

Dr. Jennifer Tang

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Curated Community

Commentary

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There were patients in the emergency department to be seen, but Katelyn, Amy, and Hamad were gathered around a computer in the back room. The three residents were whispering urgently about the patient in Acute Care Room 4. She had arrived in the department only minutes before with a fever and sore throat. Not an unusual presentation for a patient in the emergency department, except that this particular patient had flown through the Lungi International Airport in Freetown, Sierra Leone only two weeks before. With the recent introduction of the Ebola virus into North America, everyone was on high alert, and this patient had been identified immediately as a possible case.

As Katelyn searched the departmental website for an instructional video on personal protective equipment, the emergency department was kicking into high gear. The only two cases reported thus far in North America were frontline health care workers who had been exposed to the virus when infected practitioners were transported from Africa for care. Everyone working in the department had seen the frequent reports on CNN, read the headlines in the Globe and Mail, and were aware of the WHO's warnings that health care workers were at highest risk. They all now worked with urgency to collect the prepared PPE kits, review procedures, and alert the relevant authorities.

'Dr. Chen had better not ask me to see her,' Amy declared grimly, mouth set in a thin line. 'I don't know how I'd say no, but I definitely do not want to expose myself to a patient infected with Ebola. I won't risk bringing it home to my family. It's bad enough that there may be one victim; I don't want to be the one to multiply that number.'

'Are you kidding me?' Hamad countered. 'I've heard that staff plan to block residents from

seeing suspected Ebola cases. That's crazy. If there's a case of Ebola in this town, I want to be involved. I should get to make that decision.'

Katelyn chewed her lip.

'I'm not sure we have a choice in the matter, guys. We have to attend to the needs of our patients, and we've been given the resources to protect ourselves,' she pointed out.

The three turned their attention to the PPE video, refreshing themselves on the donning and doffing procedures they had practised in the department just days before. Heading back out into the acute care section of the department, they watched through the glass window of room 4 as a nurse in full protective gear attached the patient to monitors. Stepping out into the anteroom, he removed his personal protective equipment with great care. A nursing colleague kept a watchful eye to ensure he avoided contamination.

Suddenly, the patient's bedside monitor started to alarm. The patient was tachycardic at 120. Blood pressure 70/40. The residents looked to one another - what should they do?

Should residents be expected to see patients with suspected Ebola in the emergency departments or other settings? If asked to see a patient by someone in a position of power (most likely an attending physician), how and when can residents refuse if they feel uncomfortable? Should residents and other learners be blocked from seeing these patients? Is this a paternalistic strategy or a necessary protection of a vulnerable population who might not be able to refuse when asked by a direct supervisor? Should crashing patients with suspected Ebola in the emergency department be resuscitated when this might result in dispersion of blood and other bodily fluids?

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Questions for Discussion

1. Should residents be expected to see patients with suspected Ebola in the emergency departments or other settings? What about physicians?
2. If asked to see a patient by someone in a position of power (most likely an attending physician), how and when can residents refuse if they feel uncomfortable?
3. Should residents and other learners be blocked from seeing these patients? Is this a paternalistic strategy or a necessary protection of a vulnerable population who might not be able to refuse when asked by a direct supervisor?
4. Should crashing patients with suspected Ebola in the emergency department be resuscitated when this might result in dispersion of blood and other bodily fluids?

Competencies

ACGME	CanMEDS
Professional Values (PROF1) Team Management (ICS2)	Professional Collaborator

Intended Objectives of Case

1. List the ethical dilemmas presented in the case.
2. Describe the role of the learner in healthcare provision.
3. Discuss the limits of learner participation within healthcare settings.

Ethics in the Educational Setting

by Jennifer Tang ARCT, BHS, MD, MHSc (Bioethics), FRCPC

Question 1: Should residents be expected to see patients with suspected Ebola in the emergency departments or other settings?

There are strong arguments for each side of this question.

Professional duty vs. personal autonomy?

Residents are physicians-in-training; does their status as a learner exempt them from the duties and obligations of a fully licensed physician? Should physicians be obligated to see patients with suspected Ebola? By choosing the career path of a physician, one might argue that a resident accepts the inherent risk of taking care of sick patients and should be expected to see patients with suspected Ebola. Dwyer argues that much like fire-fighters accept the risk of their profession, health professionals should not be able to pick and choose aspects of their job: "individuals are free to reject this social role and choose a safer occupation, but they are not free to reject all risk within the occupation... they are not always free to separate and select particular duties that are bundled in a given social role"(1). National medical associations and specialty specific codes of ethics offer some guidance (see APPENDIX A after the references), but are open to interpretation and ultimately ask the physician to balance risks/benefits and competing values.

The counterargument, to follow the analogy, is that firefighters are not obligated to rush into a flaming building that will collapse imminently (Sokol)(2). It is unreasonable to expect residents to sacrifice themselves if the risk of treating a patient is too high. Residents, to paraphrase Daniel Sokol's description, "often wear a number of incompatible hats - doctor, spouse, parent, etc -and this plurality of roles must be acknowledged"(2). It is impossible to create a definitive order of which should take precedence: professional duty vs. personal autonomy. Definition of what professional duty entails may be specialty dependent. It might be that the residents in the scenario did not choose a specialty that would necessitate direct patient contact (example: the resident is an off-service radiology trainee)

and does not feel that they consented to accepting the current risks associated with the patient in this scenario.

How great is the risk? How pressing is the need?

In 1987, the American Medical Association came forward with a strong statement underscoring the physician's ethical obligation to care for patients with AIDS(3). This was in response to a minority of physicians refusing to treat these patients. Though there are no clear statistics on the transmissibility of Ebola, it can be spread through direct contact with infected patients, while HIV cannot be contracted through casual contact(4). If the risk of contracting the illness is low, and the morbidity and mortality are also low, residents may not be justified in refusing to treat these patients. If you changed the virus in the scenario to seasonal influenza or HIV, assuming the residents were healthy, refusing to treat patients because of a perceived fear rather than an actual one would not be justifiable.

What is the need for assistance?

If the facility is seeing a small number of isolated cases, there may not be a need for residents to be involved in care. If however, the facility is overwhelmed with ill patients, residents may need to assist. Constriction of personnel is not desirable and may not lead to good patient care (see further). According to a policy document by the Canadian Federation of Medical Students(5), there has been a proud history of medical learners assisting in mass casualty situations. Recently, medical students assisted in the identification of human remains after the September 11th, 2001 World Trade Centre disaster(6). During the Second World War, British medical students assisted in treatment of 60 000 inmates of the Bergen-Belsen death camps(7).

Reciprocity

It might be argued that learners whose education or salary is funded or subsidized by the state owe a greater duty to care for patients during a pandemic situation(8,9). However, this expectation would be unreasonable unless made explicit to the learner prior to them accepting the funded position or



About the Expert

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Expert Response

tuition subsidy. The theme of reciprocity extends to what supports a resident who cares for pandemic patients should have from society. As the Canadian Medical Association pandemic policy(10) states, this might include psychological support, vaccination, proper personal protective equipment, compensation for illness or lost time, proper accommodations in case of quarantine. In the case of residents, compensation or arrangements for educational time lost or gained should be a consideration.

An important part of residency education?

One might argue that seeing a patient with suspected Ebola or any other rare pathology is an important part of residency education. No amount of reading can replace the value of examining a patient. However, based on their specialty, not all residents rotating through the emergency department would necessarily agree or find the experience relevant. For example, the infectious risks of seeing this patient might outweigh any benefits if the resident in question was training to be a psychiatrist. Furthermore, there may be better and safer ways (high fidelity simulation) to educate residents about treatment of rare and potentially deadly diseases than direct patient care.

What's best for the patient?

Would the patient in the scenario be receiving best possible care if they are being seen by an inexperienced junior learner who is reluctant or frightened to care for them? How will their anxiety over caring for this patient affect the care of their other patients? Ethicist Daniel Sokol speaks of the concept of the "virtuous patient"(2), a patient that has compassion and recognizes the fears of his provider and "allows them to step down from their role of carers"(2). Depending on the skill level required for the encounter, it may not be appropriate for a junior resident to attend to the patient. Just as a difficult intubation requires the most experienced intubator in the room to attempt the procedure, perhaps choosing who takes care of the suspected Ebola patient requires similar considerations.

Conclusion

In this situation, the facility is not (yet) overwhelmed by an influx of suspected Ebola patients. I believe that residents should be given the opportunity to be involved in the care of the patient if all the conditions below are met:

- The resident is competent, qualified, appropriately trained to care for a critically ill patient and is comfortable with donning/doffing necessary personal protective equipment

- The resident is willing and their decision to be involved in care is free of coercion
- The resident has supervision appropriate to their level by a staff
- The resident has no medical contraindications to caring for such a patient.
- The resident will receive necessary supports in the event that they or their family members become ill

Question 2: If asked to see a patient by someone in a position of power (most likely an attending physician), how and when can residents refuse if they feel uncomfortable?

During my residency I served as a representative for our provincial professional association. In this role, I heard many stories of residents who did not feel empowered to refuse to see a patient even though they felt it was inappropriate or unsafe. This would not just be limited to the suspected Ebola scenario above, but can also extend to residents asked to see patients long after their call shift is over, residents asked to see patients they feel threatened by or residents asked to perform independently outside their scope of comfort.

Here is my advice for question 2:

1. Do you have time for a discussion?

If there is no time, the situation is life or limb threatening, and you are able to safely manage the situation, take care of the patient first. If you feel uncomfortable doing this, ask for assistance (call a response team, senior resident or staff).

If you have time:

- a) Talk to the attending staff privately.
- b) Explain why you feel uncomfortable taking care of this patient.
- c) Communicate what your needs are. If you want more supervision/training, ask for it.

If you do not find the staff to be supportive, speak to your program director or call your resident professional organization for further advice.

2. Specific to this case:

Residents should be properly educated on personal protective equipment use. If training has not occurred or the equipment is not readily available, residents should not be expected to treat suspected Ebola patients.

Expert Response

Question 3: Should residents and other learners be blocked from seeing these patients? Is this a paternalistic strategy or a necessary protection of a vulnerable population who might not be able to refuse when asked by a direct supervisor?

There may be logistical and infection control reasons for limiting who treats suspected Ebola patients. However, I do not support the "vulnerable learner" rationale for a universal block on all learners being involved in the care of a suspected Ebola patient. Firstly if the epidemic overwhelms the facility, it may prove to be impractical to run a hospital without assistance from learners. Secondly, an important part of resident training is to learn to be a professional. Part of being a professional is working through conflict and having challenging conversations with colleagues and superiors. What lessons will an automatic exclusion of all residents from this experience provide? Residents will be deprived of the experience of working through ethical conflicts that inevitably arise from care of these patients.

It would be better to focus efforts on creating a supportive, non-intimidating and positive team environment where worried residents are comfortable voicing their concerns rather than an exclusionary policy that might silence any debate. The post-graduate office or institution should instead issue a statement emphasizing the challenges of providing care in the pandemic context and encourage staff physicians to foster a supportive and educational culture rather than punitive measures for residents who feel uncomfortable caring for Ebola patients.

There is, however, a place for paternalism. Beauchamp defines paternalism as "the intentional overriding of one person's known preferences...by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences...are overridden."⁽¹¹⁾ It is the responsibility of the staff physician to assess what treatment needs to be provided and the skill sets and individual circumstances of the residents that might provide care. If the staff holds the opinion that a resident lacks the necessary competencies to provide safe care to a suspected Ebola patient and puts himself or others at risk (for example, an inexperienced resident wishes to place a central line in a high risk patient and might poke himself), the staff should intervene.

Question 4: Should crashing patients with suspected Ebola in the emergency department be resuscitated when this might result in dispersion of blood and other bodily fluids?

When considering the answers to this difficult question, the ethical lens would consider the principles of beneficence,

justice and non-maleficence. How can we best do right by the patient while protecting our staff and other patients? How should resources be allocated if there is a shortage of ventilators/staff/beds? Would blanket policies simplify procedure or result in unreasonable discrimination against a specific group of patients?

Proponents of a blanket-DNR policy argue that at best, CPR in an ICU patient has a very low rate of success (3%)(12,13). This would be even lower in a patient with multi-organ failure and hemorrhage. There is significant risk of exposure to staff which may not be justifiable by the low rate of success. An attempted resuscitation may be medically futile. Furthermore, our natural instinct as healthcare workers in the comfortable with resuscitation may be to "rush in" and neglect to be vigilant in the donning/doffing of protective equipment, thus increasing risk of transmission. The Nebraska Medical Centre in Omaha has decided not to perform CPR in patients with Ebola(14).

A unilateral "no CPR" policy may impose unfair conditions on any patient arriving from West Africa who is ill and may not necessarily have Ebola. This approach also fails to stratify based on clinical considerations; for example, the young otherwise healthy patient with Ebola who is "crashing" because of a reversible hypovolemia or hyperkalemia may be entirely salvageable with fluids and compressions.

I believe that treatment of a crashing suspected Ebola patient in the emergency room should be guided by the Canadian clinical guidelines for treatment of Ebola(15) paraphrased here:

- End-stage Ebola patients should not receive CPR because of the medical futility of the procedure and risk to healthcare workers.
- Aggressive care, fluids, vasopressors, intubation and dialysis may be appropriate for certain suspected Ebola patients based on the clinical context (reversible cause for arrest).
- Intubation, if indicated, should be considered and performed early to maximize control of the situation and minimize the need for an emergent intubation.
- Staff should continue to be vigilant and "not take shortcuts" in donning PPE despite the critical clinical status of the patient.
- Pain and symptom management is important during all stages of caring for a potential Ebola patient.

Expert Response

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Extra Reference:

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Appendix A: Professional Codes

Stage	Description
American Medical Association	Opinion 9.067 - Physician Obligation in Disaster Preparedness and Response (16) "National, regional and local responses to epidemics, terrorist attacks, and other disasters require extensive involvement of physicians. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This ethical obligation holds even in the face of greater than usual risks to their own safety, health or life. The physician workforce, however, is not an unlimited resource; therefore, when participating in disaster responses, physicians should balance immediate benefits to individual patients with ability to care for patients in the future."
Canadian Medical Association	CMA Code of Ethics (17) "Consider first the well-being of the patient" "Recognize the profession's responsibility to society in matters relating to public health, health education, environmental protection, legislation affecting the health and well-being of the community " "Promote and maintain your own health and well-being"
American College of Emergency Physicians	Code of Ethics for Emergency Physicians (18) 3d. The duty to respond to prehospital emergencies and disasters "Because of their unique expertise, emergency physicians have an ethical duty to respond to emergencies in the community and offer assistance. This responsibility is buttressed by local Good Samaritan statutes that protect health care professionals from legal liability for good-faith efforts to render first aid. Physicians should not disrupt paramedical personnel who are under base station medical control and direction"

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Keeping Perspective

by N. Seth Trueger MD, MPH

Ebola is pretty scary, but the risks of a serious outbreak in North America seem fairly overblown in the popular press. The prospect of caring for a critically ill patient who might have Ebola is enough to make even the most stoic medical student chomp at the bit – or run for the hills. The ethical issues of allowing or requiring a trainee to care for such a high-risk patient, not surprisingly, quickly get murky.

Perspective is important. While thousands of people in Africa have died of Ebola, to date only two people have contracted Ebola in the US; while both were healthcare workers, both survived (1). The current strategies for personal protective equipment (PPE) in high-risk patients appear to be quite effective (2). While there is risk to healthcare workers providing direct patient care, with proper vigilance that risk appears to be quite low (2) and the highest and perhaps only salient risk is in treating patients in the final “wet” phase of the disease(1).

On the other hand, those providing direct patient care put not just themselves at risk but those around them, potentially exposing not just themselves but also their co-workers and their other patients. However, the low rate of disease transmission while asymptomatic likely minimizes this risk, and the bigger risk is likely the prospect of the exposed healthcare worker losing their ability to care for patients in the future. Regardless, the current rarity of Ebola in North America likely tilts any public health risk calculation toward caring for more patients now, much like how travel bans or mandatory quarantines for healthcare workers returning from West Africa paradoxically increases the future risk here, as early containment offers our best chance for avoiding a pandemic (3).

Involving trainees – medical students or residents – in the care of high-risk patients raises a number of issues. First, is it coercive and unfair to demand trainees put themselves at such risk? Data from the early days of HIV suggest this coercion is real; 1 in 4 residents treating

patients with HIV in San Francisco in the 1980s reported that they would stop seeing these patients if they could, and perceived hospital administration and program leadership unconcerned about their wellbeing (4). The intervening years may have swung the pendulum, as multiple teaching hospitals (mine included) bar trainees from treating suspected Ebola patients. While I hope this is due to concerns about their trainees, I suspect fear of litigation may play a role in this protective stance.

Like Hamad, many trainees may be excited to treat high-risk patients. However, they may not be able to accurately assess their risk. In the 1980s, despite their own concerns about their safety, residents underestimated their risk of contracting HIV4; more recent data suggest surgical residents underestimate their risk of contracting blood-borne pathogens (5). Furthermore, trainees are likely worse at taking steps to protect themselves appropriately; junior surgical residents do not use PPE as effectively as their seniors, and despite a lower case load, junior residents have a higher rate of needlesticks. In addition to putting themselves at higher risk, trainees likely put others at risk through underreporting of body fluid exposure, with underreporting estimated at 50-95% (5,6).

The question of whether to aggressively resuscitate a patient at high risk for Ebola is similarly murky, particularly since the patient is now at the highest risk for transmitting the virus in conjunction with a low risk of survival.¹ At this point, however, given the effectiveness of advanced PPE, I would do what is best for the patient. If we reach truly epidemic levels of Ebola here, it would be reasonable to switch to “reverse triage”(7) in order to ration resources – focus the resources where they could be effective, and not deplete the healthcare workforce by exposing providers to high risk patients with little chance of survival. But in the current situation, caring for the sickest patients seems to give us the best chance of avoiding an epidemic, and we should do our best with the patients in front of us.

Expert Response

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About the Expert

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Curated Community Commentary

By Teresa Chan MD, FRCPC, MHPE(c)

We had fewer respondents than usual on this post, but each contributed unique and thoughtful comments. As I read, there were a number of themes that seemed to resonate the most from the comments.

The best for the patient & the workers

Heather Murray reminds us in the end that it is important to consider (especially in hyper-acute scenarios) that it may be best to keep the patient's needs as a chief consideration above all else. If a patient is critically ill, then Dr. Murray stated: "I believe that attending physicians have an ethical obligation (and possibly a legal one) to provide care in this scenario." On the flip side, Loice Swisher pointed out that the Center for Disease Control (CDC) has urged institutions to limit contact of possible ebola cases to 'essential' personnel. This is to minimize risk for practitioners, and also minimize the risk of spread to the population (since each contact point is a possible source breach for isolation procedures). Thus, if there is a moral imperative to provide the highest / best level of care, and yet limit the number of persons involved - then it may become less likely that learners would be involved in direct patient care for critically ill ebola patients even if they desired.

The Ethics of Education

The involvement of learners in medical care is not an issue unique to Ebola. As Scott Kobner (NYU Medical Student) quite aptly asked: "[H]ow does the community normally handle situations when a healthcare provider does not feel confident caring for a patient but is asked to do so by a superior?"

One learner (Michael C from Queen's University) stated:
"I don't think there's anything wrong with a bit of paternalism in educational policy. We as learners are in many ways immature to our own needs and struggle to identify which learning opportunities are most important. If the program feels that allowing us to take care of patients with possible ebola is too risky (and that those risks outweigh the educational value), they not only can, but should, forbid us from seeing those patients."

Loice Swisher used a substitution to highlight some key questions around the context of a possible 'refusal' to participate in patient care:

"Instead of ebola, try a case of a bug in the ear. What if a resident refuses to go see the patient because "they don't like bugs and it just creep them out". Does it make a difference if this is a 2nd year EM resident or a Internal Medicine resident rotating through the ED? What if

Contributors

Thanks to the participants (in alphabetical order) for all of their input:

Commenters

Michael C
Teresa Chan
Scott Kobner
Heather Murray
Eve Purdy
"Zaf"

instead the resident says that they are off in 15 minutes and the next resident can do it? Or perhaps the resident says that they can't do it because they don't have good stereotactic vision so some one else should do it? What if the patient has a swastika tattoo and only wants a white male doctor?"

Based on the expert responses and also the community responses, I will paraphrase some ethical imperatives that must be fulfilled if we are to ask our trainees to engage in patient care. Just like all other scenarios, faculty members must be will to provide:

1. Training (e.g. donning and doffing of personal protective equipment)
2. Supervision (in a graduated fashion)
3. Support when trainees reach their limits

That said, as Eve Purdy pointed out, trainees (of any level) who feel that any of the above features are not met, they should be empowered to speak up, respected and supported if they are uncomfortable.

Some learners voiced their opinions that they would like to (and feel that it would be important) to be involved in the care of patients in these scenarios. One participant ("Zaf") did highlight that it may be useful to think outside the box with regards to how learners might best learn in an outbreak scenario. As Zaf stated:

"However, the direct clinical evaluation of these patients is not the only learning the residents can receive from such situations. Being actively involved in the meetings with various stakeholders responsible for protecting the public and staff is invaluable, as there are numerous lessons that can be learned from these types of incidents, from internal planning, multidisciplinary and media communication, and addressing and setting up appropriate training to name a few. Additionally, a trainee who is involved in these things may be in a better position to "sell" their desire to participate in direct patient care when the case lands in the ED."

Curated Community Commentary (continued)

Fear & Reason

When reading the discussion around the issue of fear, a quote from Frank Herbert's *Dune* (i.e. the Bene Gesserit litany) sprung to mind:

"I must not fear. Fear is the mind-killer. Fear is the little-death that brings total obliteration. I will face my fear. I will permit it to pass over me and through me. And when it has gone past I will turn the inner eye to see its path. Where the fear has gone there will be nothing. Only I will remain."

Multiple participants pointed out the need to remember this patient was merely a 'possible' case - and one that was not yet confirmed - and thus the fear of possible exposure must be considered alongside the rational thoughts around pre-test probability and likelihood of an actual ebola-infection ongoing with this patient. As Loice Swisher pointed out, the fear of practitioners, providers and learners is a legitimate concern. She stated:

"Potential ebola situations' are significant concerns. With our first few scares, fear was quite palpable... In this patient, there is some risk of ebola and thus appropriate PPE would be called for so even with the monitors going off I wouldn't want anyone to just "rush into the room". On the other hand, I don't think it appropriate just to let a possible ebola patient die out of fear."

Preparation is key for ANY response

It became apparent to discussants for this case that a deep consideration of policies and procedures was important to do before an actual case occurs. Undoubtedly, such policies have been (and/or are being) debated at hospitals all over the world in preparation for a spread of disease.

And yet community members seemed to think it was important to actively debate these issues - since it likely helps prepare individuals for making the decisions in real time. All providers should be apprised of the risks in their practice settings, and decide their personal and institutional approaches before a scenario actually arises.

As we have pointed out before, fear can be a mind-killer. It can become impossible to think and act, or to deeply consider all angles of an issue when one is at the bedside, and thus, it is important to engage stakeholders in discussions. Most participants implied that they had engaged in similar discussions throughout the last few months at their institutions, and the group seemed to agree that such discussions were important in ensuring that EM providers were prepared to make the difficult decisions and take action when called upon.

Dr. Swisher points out, however, that this type of preparation and understanding of risk is important in all scenarios ranging from caring from a patient with TB to a violent patient.

Suggested References & Links

1. Approaches to Clinical Management for Patients with Ebola Treated in U.S. Hospitals. Emergency Preparedness and Response. Center for Disease Control. Accessed last on December 3, 2014. Available at [this link](#).
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About

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We would love to hear how you did. Please email MEdIC@aliem.com or tweet us @Brent_Thoma and @TChanMD to let us know.

Purpose

The purpose of the MEdIC series is to create resources that allow you to engage in "guerrilla" faculty development – enticing and engaging individuals who might not have time to attend faculty development workshops to think about challenging cases in medical education.

Usage

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