no one is talking about an early end to the outbreak. The international community will need to gear up for many more months of massive, coordinated, and targeted assistance. A humane world cannot let the people of West Africa suffer on such an extraordinary scale.

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A Good Death — Ebola and Sacrifice

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A friend of ours, Dr. Sam Brisbane, died recently. He was a Liberian doctor, and he died from Ebola, a horrible, nightmarish disease.

Information coming out of Liberia has been scarce. Since Dr. Brisbane's death, we've learned that other doctors and nurses with whom we've worked have also contracted Ebola and have died or are being treated in the types of rudimentary facilities we see on the news. As we live in dread of each phone call, questions about how we die and what we're willing to die for have been weighing on us.

The ancients had a concept of a "good death" — dying for one's country, for example, or gloriously on the battlefield. Solon, the sage of Athens, argued that one couldn't judge a person's happiness until one knew the manner of his death. The Greeks recognized that we're all destined to die and that the best we can hope for is a death that benefits our family or humanity.

For emergency-medicine clinicians like us, the concept of a good death can seem too abstract, intangible. Rarely are the deaths we see good or beneficial. We see young people who die in the throes of trauma; grandparents who die at the end of a long, debilitating illness; people who kill themselves; people who die from their excesses, whether of alcohol, food, or smoking.

Last year, as part of a new disaster-medicine fellowship program, we developed a partnership with John F. Kennedy Memorial Medical Center in Monrovia, the only academic referral hospital in Liberia. We collaborated with the hospital administration to develop disaster-planning and resilience programs and teamed up with the emergency department (ED) staff to enhance medical training and establish epidemiologic studies of trauma. It was there that we met Dr. Brisbane, the ED director. He immediately struck us as a genuine ED doc — at once caring and profane, lighthearted one minute, intense the next. A short, bald man with weathered skin and thick glasses, he spoke openly and easily; his laugh was best described as a giggle, and he swore frequently.

When we conducted an initial vulnerability analysis for the hospital, we discussed our concerns about severe supply and personnel shortages, regular power outages, and occasional electrical fires. Dr. Brisbane replied that what scared him the most was the potential for an epidemic of some viral hemorrhagic fever. He was right to be scared. We encountered rationing of gloves, a limited supply of hand soap, and an institutional hesitance to practice universal precautions, probably because of the limited resources. The hospital was not prepared for the kind of epidemic it's now facing — nor was the city of about 1.5 million people.

During our time at JFK, we became friends with Dr. Brisbane. We learned that he'd trained in Germany in the 1970s, had returned to Liberia to work, and had chosen to stay through the civil war and during Charles Taylor's despotic rule, continuing to see patients despite the bloodshed around him. He had welcomed the country's new democratic leadership and a new female administrator at the hospital — a first. He ran a successful coffee plantation and gave us bags of coffee every time we visited him. He was the father of eight biologic children and six adopted children, and he had numerous grandchildren around the world.

Within a few days after our return to Monrovia in June 2014,

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the city's first patients with Ebola presented at Redemption, the county hospital, and we soon got word that a doctor and some nurses there had died. Rumors were rampant, and staff quickly abandoned that hospital. At JFK, our colleagues grew nervous. There were tensions between the hospital administration and the public health ministry. There was no clear plan for what to do if a patient suspected of having Ebola showed up at the hospital. How would staff members protect themselves? How would they isolate the patient? How could they move the patient to one of the ministry's isolation centers? Dr. Brisbane was a wreck. He chattered nervously, his smile disappeared when he thought we weren't watching, and he openly wondered how he could protect himself. He told us bluntly, "Leave Monrovia."

Then one morning, we arrived at the hospital at 7 o'clock and ran into Dr. Philip Zokonis Ireland, one of our young doctor friends. He was agitated, his fear evident in his face: there was a patient in the ED with suspected Ebola. The patient had lain in a bed in one of the small, crowded treatment areas for 6 hours, surrounded by nurses and other patients, until someone recognized his symptoms. We rushed to the room and met Dr. Brisbane and Dr. Abraham Borbor, the head of internal medicine. Others were sensing that something was wrong. Patients and their family members quickly disappeared, and nurses hung far back in the hallway.

The first priority was to get the patient out of the common room and into an isolation room, but the bed he was lying on was too wide for the doorway. So Dr. Brisbane, Dr. Borbor, and two custodians hastily donned gowns, gloves, and masks, then lifted the patient — mattress and all — and carried him into the isolation room, nearly dropping him in the process. The man had begun gasping for breath, and despite their efforts, within 5 minutes he was dead. Later that day, laboratory tests confirmed that he was indeed infected with Ebola virus. His body stayed in the now-otherwise-empty ED until it was retrieved hours later by the health ministry.

During the world's worst Ebola outbreak to date, clinicians like Dr. Brisbane are on the front lines — and are dying as a result.

We remained in Monrovia for the next week and helped however we could. Dr. Brisbane brought his own thermometer and checked his temperature religiously, fearing the telltale sudden fever. He wore a fedora in the hospital as a protective talisman. And yet he still joked with us, displaying a sort of gallows humor.

A few days after we'd returned to the States, we got a call from a friend in Monrovia saying that Dr. Brisbane was in isolation and had tested positive for Ebola. The next call informed us of his death and hasty burial on his plantation. By late August, Dr. Ireland and one of the nurses we knew had contracted Ebola and were fighting for survival, and Dr. Borbor and a physician assistant who'd worked in the ED had died from the virus.

Dr. Brisbane didn't have to stay at JFK and continue to care for patients. He could easily have retired to his coffee plantation with his wife and children and grandchildren. He was terrified of Ebola, and yet we knew that every morning when we entered the ED, we'd find him there, seeing his patients.

Doctors and nurses have a duty of care toward their patients.[1] We're expected, on the basis of our training and an unwritten social contract, to fulfill that duty even in less-than-ideal circumstances — in the face of depleted resources, for example, or undesirable patients. But we also have a duty to ourselves and our families, and when our work becomes life-threatening, we have to decide what benefit we will be to our patients and what cost it will exact from us. In such circumstances, we cannot be expected to uphold the same duty of care. But during the world's worst Ebola outbreak to date, clinicians like Dr. Brisbane are on the front lines — and are dying as a result. They care for patients despite the risks to themselves, despite the inadequate supplies and infrastructure, despite their insufficient training in infection control.

Dr. Sam Brisbane's death diminishes us as a people. But with apologies to his wife and family, who saw him die horribly and un-

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justly, and despite the deep loss we feel, we believe our friend died a good death — as did all the nurses and doctors who have sacrificed themselves caring for patients with this awful disease.

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INTERACTIVE PERSPECTIVE

Ebola Virus Disease — Current Knowledge

An interactive graphic is available at NEJM.org

This interactive graphic provides information on past and present Ebola outbreaks, as well as on the current understanding of the Ebola virus and its effects in humans. The graphic will be updated and expanded as more information becomes available.

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