

The international response to the Ebola outbreak has excluded Africans and their interests

LSE's Katherine Furman explores how ethics could have played a more prominent role in the management of the current outbreak of Ebola in West Africa.

The administration of the first doses of ZMapp, the experimental Ebola treatment, to two American healthcare workers and a Spanish priest has been met with understandable outrage. In the case of scarce medical resources, the method of distribution needs to be transparent. Given that over 1000 people have died in West Africa so far, this allocation reeks of racism.

On 12 August, the World Health Organisation (WHO) assembled a panel to assess two ethical questions in the context of the West African Ebola outbreak. Should experimental treatments be made available? If so, to whom? Predictably, and rightly, the first question was answered positively. When certain conditions are met, such as informed consent and confidentiality, experimental treatments should be made available. Unfortunately, the distributive question has not yet been addressed. Dr Marie-Paule Kieny, WHO's Assistant Director-General stated that "I don't think that there could be any fair distribution of something which is available in such a small quantity."



Medecins Sans Frontieres carry the corpse of person killed by Ebola AFP

Dr Kieny's response is obviously incorrect. Ethical questions of allocation occur precisely in situations where resources are in short supply, and ethical tools are available for addressing cases such as these. As Dr Julian Savulescu argues, in his piece on [ethics in Ebola treatment](#), there are at least three common approaches in moral philosophy for dealing with the distribution of scarce resources, and these might be brought to bear in the Ebola case.

The first is the egalitarian approach, in which everyone who requires the resource is considered equally. In order to give expression to this equal concern, something like a lottery might be held to determine the distribution. Alternatively, a utilitarian approach might be adopted, in which case the resource should be allocated in such a way that maximises overall goodness. From a utilitarian perspective, it might make sense to allocate treatment to healthcare workers first, as [Dr Kevin Donovan has argued](#). However, this would offer stronger support for treating African doctors in the field first. A third possibility might be to adopt a prioritarian approach, whereby the resource is offered to the worst off first. Deciding which principle to choose, and how to effectively realise the selected principle are difficult issues, and ones which are worthy of careful consideration by the WHO. However, none of these approaches supports the initial allocation of ZMapp to white Americans and Europeans first.

If there were no ethical reasons to allocate the treatment in the way it was, could there have been pragmatic considerations? One practical concern might have been the speedy delivery of the drug. The Americans are currently receiving treatment in the United States and Mapp Biopharmaceutical, the drug's developer, is based in San Diego. In the likely event that time was of the essence, it might just have been expeditious to give the treatment to the Americans, but this is factually incorrect. **Both the Americans received ZMapp before being evacuated from Liberia.** Another practical concern might have been that of consent. ZMapp is an early-stage experimental treatment, so informed consent would need to be strictly adhered to. While there are clear channels to achieve consent in the United States and Europe, maybe it is more difficult to do so in West Africa. Once again, this is implausible, especially if the key cases under consideration are African healthcare workers. African doctors are capable of understanding the risks associated with experimental treatments and are able to make informed decisions about whether or not to take it. To assume anything else is patronising.

Experts at the **O'Neill Institute Media Briefing** stressed that while the initial allocation of ZMapp is potentially regrettable, it was not intentional. The manufacturer just responded to a request for the treatment and was not acting in order to realise any particular distribution. The implication is that the allocation was not racist because it was not intentional. Two things about this argument should worry us. Firstly, having no allocation procedure for a scarce medical resource is cause for concern. Secondly, racism does not require intentionality. The lesson of structural racism is that power and institutions are (typically unintentionally) organised in ways that make it easier for certain people to access resources. Being in the position where one's organisation is able to contact a research group and obtain an experimental treatment is a likely indicator that one occupies an extremely privileged position.

These real-world cases are obviously messy and not open to explanation purely in terms of geographical racism. This is made clear by the **case of Dr Sheik Umar Khan**, a doctor who had been running an Ebola ward in Kenema, Sierra Leone, when he contracted the virus. Initially, it seemed as though he would be the first to be treated using ZMapp. Ultimately, it was decided not to give him the drug, both because his viral levels were already too high, and because there was a concern that if he died while being treated this would do further damage to public trust in science in the region. There is no hint that the drug was being saved for the American patients and it seems clear that the decision makers were acting with the best intentions. This case at least complicates the intuition that geographical racism was at play when treatment allocations occurred.

However, the worry that Dr Khan's death after treatment would further weaken Africans' trust in science is troubling. In many parts of Africa there is substantial distrust in science, and this has been witnessed during the **Ebola outbreak**. Another African country where there is protracted distrust in science is South Africa, particularly with regard to **HIV/AIDS science**. In the South African situation, it is clear that at least part of the reason that public trust in science has broken down is due to a history of oppression and abuse linked to western medicine. **Medical science in South Africa was used to justify early segregation policies, and by the end of apartheid laboratories were attempting to develop chemical and biological weapons to be used against the black majority.** Considering this history, the current scepticism about science that is expressed by many South Africans is premised on the reasonable belief that the medical establishment has frequently failed to act in their best interests. In the Ebola case, generating a perception that scarce medical resources are offered only to white Europeans and Americans could do as much damage to public trust as if these treatments were found to be ineffective or harmful in cases like Dr Khan's.

The perception that the medical establishment is failing to act in the best interests of Africans in the Ebola case is strengthened by the way in which the WHO's ethics panel was assembled, **in that no representatives from the affected African countries were included.** This may have been justifiable if the panel was exclusively composed of ethicists, and no West African ethicists either existed or were available for consultation (an unlikely scenario). However, given that only a few of those included on the panel have backgrounds in ethics, this justification does not hold.

The way in which the Ebola outbreak has been handled, from the initial allocation of a scarce experimental treatment to the selection of representatives on the WHO ethics panel, has excluded Africans and their interests. This is disturbing. The only hope is that there has been sufficient public outrage over this case that future scenarios might be dealt with in a more inclusive manner.

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