I had the privilege of serving as a short-term Ebola clinician in Sierra Leone. I went as part of a team with the nongovernmental organization Partners in Health in January and February 2015. Sierra Leone is a country of 5.9 million people, with 41.7% <15 years old. Sierra Leone has a ratio of 0.022 physicians per 1000 people, or 1 physician for every 45,000 people. Pediatric care is provided by general practitioners and community health care workers. There is no pediatric specialty training available for physicians in the country. The most common causes of death for children <5 years old in Sierra Leone are pneumonia, diarrhea, and malaria. Against this background of an insufficiently equipped health care system, the Ebola epidemic hit West Africa, and cases in Sierra Leone peaked at 13,406 cases, the most of any country afflicted with Ebola.

I trained as a combined internal medicine and pediatrics physician, and while working in the Ebola treatment unit (ETU) I was quickly assigned to the pediatric patients there. I was not the first or the only pediatrician to work in the ETU. I had the pleasure to meet excellently trained and compassionate pediatric providers, as we served side by side in this epidemic. This is my personal perspective. This experience was the most difficult to date in my career as a pediatric provider. I write this brief report to bear witness to the suffering of the children I cared for in the ETU.

Many of these children were wet when they came to us, meaning they had vomiting, diarrhea, and bleeding. Part of caring for them was cleaning them up, which meant cleaning up vomit, diarrhea, often bloody, and other secretions. This is a particularly high-risk part of providing care for Ebola virus disease (EVD) patients in the high-risk zone of an ETU. Most of us as pediatricians are used to dealing with body fluids from our pediatric patients: changing diapers in an office visit or sometimes being the unwitting target of an infant who urinates while we examine them. This part was not new. However, the awareness that even in full personal protective equipment (PPE), prolonged or greater exposure to virus-laden body fluids was a new challenge. We did it anyway.

Intravenous access was a bigger challenge than it normally is. Many of our pediatric patients presented in mild to severe dehydration. Trying to get intravenous access in dark-skinned, dehydrated patients with 2 or 3 pairs of gloves on and in full PPE (with a facemask or shield) multiplied the challenge. I put in more intraosseous lines in 2 weeks in an ETU than I had until then in my time as a pediatrician.

Time spent in the “hot zone” (the high-risk zone of the ETU, where patients with confirmed EVD were) was limited. In the heat,
temperatures in full PPE were often >100°F, with 100% humidity. Under these circumstances, time in the high-risk zone was limited to 30 to 90 minutes. That was never enough time to do all that was needed for each patient. It was hard to leave a 3-year-old with a burning fever lying alone on a mattress on the ground and walk away because our time was up. Human touch, skin to skin, was impossible. I could hug or hold a child but only with several layers of protective coverings between us. They could not even see our faces, only our eyes.

The hardest part by far was the death. Death is a grim reality in every physician’s practice and never easy, especially when it comes to a child. We worked in a resource-poor setting with limited access to medication and the means to deliver it. This, coupled with limited diagnostics due to cost and the impediments of isolation procedures, made it that much more heartbreaking and, in most cases, senseless.

Data on rates of EVD in children are only just becoming available.5–7 Children <16 years old make up ~20% of the total number of EVD cases. The estimated case fatality rate for confirmed and probable cases of EVD in children varies with age. As opposed to the case fatality rate for adults (age ≥45) of 83.8%, the rates for children range from 55.8% (for 10- to 15-year-olds) to 91.2% (for children <1 year of age).

During a 2-week period of working in the ETU, I took care of 6 children with confirmed EVD. They ranged in age from 3 to 16 years. The only survivor was an 11-year-old boy. His 16-year-old sister died in the same unit during that time. There were survivors, though not many. To encourage both the community we served and the health care workers in the ETU, we had a Tree of Life outside the unit. It was a tree to which each EVD survivor had tied a piece of cloth when he or she was discharged from the unit.

During our last working day in Sierra Leone, most of my cohort of short-term clinicians chose to go to the cemetery to pay our respects. I was not prepared for the sight of numerous graves of children who died in this Ebola epidemic. The sight of simple dirt mounds with signs, especially those of the children I had cared for, will haunt me for a long time. To me, these graves and the grim outcomes of EVD in children they represent send a clear and compelling message: We need more research, better treatment options, better avenues for care, and more pediatricians in the fight against this disease.

**ABBREVIATIONS**

ETU: Ebola treatment unit  
EVD: Ebola virus disease  
PPE: personal protective equipment

**REFERENCES**


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