Canada’s Ebola scare over but questions just beginning

It was 7 am on Feb. 5 when Dr. Douglas MacPherson, a tropical disease expert at the Hamilton Health Sciences Corporation, received a call from the neighbouring Henderson Hospital asking for help in diagnosing a 32-year-old Congolese woman brought to the hospital the night before. Three hours later, MacPherson walked into the intensive care unit, spent 5 minutes examining the patient and talking to doctors, and then ordered the national contingency plan for viral hemorrhagic fevers (www.hec-sc.gc.ca/hpb/lcde/publicat/ccdr/97vol23/continge/index.html) put into effect.

Although fears of an Ebola-type outbreak eventually proved groundless, MacPherson, who was moving to a new job with Health Canada the following week, says the contingency plan worked well. It was brought into play because of the patient’s country of origin — Ebola and other hemorrhagic fevers have taken thousands of lives in Africa — and the fact she was bleeding from the mucous membranes and had severe flu-like symptoms.

The contingency plan called for the introduction of a strict protocol: isolation of the patient, the introduction of precautionary measures such as contamination suits, communicating plans to health care workers and the public, and arranging for the transportation of the patient’s body fluids to the 2-year-old Canadian Science Centre for Human and Animal Health in Winnipeg for testing. Body fluid samples were also sent to the Centers for Disease Control and Prevention in Atlanta for confirmatory testing. The contingency plan also involved monitoring 70 people, mostly hospital and laboratory staff, who had come in contact with the woman or her body fluids.

“I would say it [the plan] is probably as good as you’re going to get,” MacPherson told CMAJ. He says the question now does not concern whether medical procedures were followed properly — he says they were — but what might have happened had the same incident occurred at a small, out-of-the-way community hospital instead of a tertiary care centre. He says the issues raised by this case should teach a powerful lesson to anyone diagnosing patients in what is now a global community.

“We have porous borders and high volumes of people moving within wide areas of the world. In every diagnosis we have to be thinking, ‘Where did this person come from? What [has she] been doing since [she] got here?’ This is an essential part of clinical diagnosis.”

Over the next few years, he says, more than a billion people will be travelling annually from one area of the world to another.

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