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Obligation, Endemic Survival & the Complexity of Moral Judgement*

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This is a bioethical investigation into the nature of the endemic crisis, its survival, and the social construction of moral obligation during the Ebola crisis in Liberia, West Africa. The 2014 outbreak in West Africa was the most considerable, most severe, and most complex Ebola epidemic thus far. At the close of the crisis in Liberia, six thousand infected persons survived unexpectedly. The ethics of Ebola and survival is exceptionally complicated and requires a complex theoretical explanation. While a categorical analysis of ethical theory cannot cover the full scope of this moral dilemma, a single concept carried over a range of models does; and, that concept is known as moral obligation. Exploring the obligation of others toward Ebola survivors helps locate, justify, and analyze the fear-based system of morality that arose from the world's most severe endemic crisis. Examining the obligations of government, community, individuals, and foreign research initiatives toward the survivors of the West African Ebola endemic in Monrovia, this article explores the varying moralities of endemic crisis culture as it examines the complexity of judgment related to social obligation.

Keywords: Ebola virus, endemic crisis, West Africa, moral status, moral obligation

Introduction to the Problem

On the bottom half of the great northern bulge along the Atlantic coastline, three African nations bore the brunt of the Ebola Crisis from 2014-2016. Liberia, Sierra Leone, and Guinea occupy the West African shoreline sharing several common borders. The interlocking frontier of these nations formed the regional geography of this endemic crisis.

> The 2014 outbreak of Ebola virus disease in West Africa was the "largest, most severe and most complex Ebola epidemic" in history, according to the World Health Organization. More than 28,000 people were infected, and over 11,000 people (about the seating capacity of Cameron basketball stadium at Duke University) died before the international public health emergency ended in June 2016. Most of the cases occurred in three countries: Guinea, Sierra Leone, and Liberia. Without an effective early-warning system, the virus spread rapidly within the region, revealing the failures of disjointed and under-resourced healthcare systems. (*World Vision*, 2020)

Largely because of the unknown nature of the disease, EVD (Ebola Virus Disease) quickly spread between these countries, starting in Guinea then moving across land borders to Sierra Leone and Liberia. The urban capital of Monrovia, Liberia had evolved into the epicenter by the fall of 2014. This is a bioethical investigation

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into the nature of endemic crisis; it is survival and the social construction of obligation during the time of the Ebola Endemic in Liberia, West Africa.

This paper was originally presented at the ASR 82nd Annual Meeting of 2020 during a session entitled "Investigating Religious Institutions, Morality, and Conscience". The conference was based on the theme "Communicating Religion's Relevance". The presence of religious fervor can have profound impact on collective behavior, particularly for those in a culture of crisis.

While there were several instances communicating the strength of religion's relevance in Liberian culture during the earliest phases of the endemic, the most impactful emerged from the collective guilt of a citizenry in the wake of a prolonged and vicious internal conflict. Locally referred to as world war—as their entire world was indeed in violent internal, often neighbor-on-neighbor conflict. So intense was this warfare that at the time of outbreak the surviving population was only at a median age of thirty-five. Now facing the onslaught of endemic crisis, many inquired into God's role.

There is no wonder that a deeply literal and faithful people perceiving an unfathomable depth of sin could not only fear divine retribution but perceive it in the sudden onslaught of a virulent, pestilent, blatantly murderous disease. For the most literal biblical imagination, it could stand to reason that if God could send a pestilence that killed 70,000 Israelites because of David's ill-conceived census (II Sam. 24:15), if God could enumerate pestilence among "disastrous acts of judgment" against the idolatrous elders of Israel (Ezekiel 14:21 ESV), then what might happen at the hand of the Lord in retaliation for the murderous atrocities of Liberian warfare?

On August 4th, 2014, *The Daily Observer* reported that church leaders unanimously agreed "God is angry with Liberia" and concluded Ebola had been sent "as a plague" on the country. "As Christians, we must repent and seek God's forgiveness." The Liberian Council of Churches calls President to atone for the sins of the Nation. President Sirleaf arrived at the house of worship in all humility, head covered, adorning the cross. The following day, as the *Premium Times News* front page headlines blared on August 6th of 2014, *President Ellen Johnson Sirleaf has declared three days of fasting and prayer, "to seek God's mercy"*. The president then called on all Liberian citizens to enter a fasting period between 6 a.m. and 6 p.m. for the designated days of devotion.

Thereafter the perception was that God was appeased by this act of atonement and the people were relieved as the wheels of life began to spin again. Distinguishing the literal from the metaphorical became wholly indiscrete for the literalist believers who perceived the workings of a first testament God in the onslaught of pestilence—one equally as violent to a post-war world as it was at that time unknown in nature, character, or origin. Living and working in Monrovia from 2013-2016, I struggled with the relationship between ethical value, religiosity, and endemic crisis throughout the course of the Ebola Virus Disease (EVD) in West Africa.

I wondered whether the nature of endemic crisis functioned to suspend *the common morality*, unbinding the standards of action found in universally valid rules of social engagement. I also wondered whether that suspension had already been established through the atrocities of their history's most heinous civil conflict. "Obligation, Endemic Survival and the Complexity of Moral Judgement" examines the obligations of government, community, and individual Survivors of the Ebola Virus Disease as it explores the complexity of moral judgement in a prolonged death-dealing state of terror during the Liberian EVD crisis.

With respect to the ravages of internal conflict and the subsequent back turn in development that factored into the ability of a nation to take the biomedical high road, this exploration limits itself to an examination of

hemorrhagic survival in asking the following question: how do the rules of obligation stand up to endemic[1] crisis in an unrecovered, post-conflict society for the survivors of the Ebola Virus Disease (EVD)?

While none who contracted Ebola were expected to survive, the average fatality rate for the endemic turned out to be around 50% and we began to see the initial survivors in the Summer of 2014. Ultimately, there were 6,000 *unexpected* survivors of the Ebola virus outbreak in Monrovia alone. Many Ebola survivors were child soldiers ascripted into civil conflict at an early age. Reviled by the Liberian community-at-large they were highly stigmatized by their ascription as if they could have resisted the weaponry of an adult militia when their parents could not. While there were girls abducted into the fight as well, the group became known as the "Lost Boys" because they were, thereafter, *lost* to their home communities (*The Independent*, 2012).

Lost to community life as childhood abductees, child soldiers were unable to return to their homes, find work, experience social forgiveness, or find post-conflict employment. Instead, they were abandoned often to the streets to be ignored begging their daily bread. For these unfortunates, endemic crisis provided an *opportunity* to become ambulance drivers, cremation workers, and body removers. While these may have been the most dangerous jobs on the continent, those who survived the virus had also become immune making them perfect candidates for these positions.

As the stigma of ascription punished the lives of child soldiers who lived to adulthood, their militia leaders went on to become leaders of government, industry, and even the church. These are deep survivors—of the wars, of the streets, of public resentment, and now of the Ebola endemic. Lost to their communities as they were abducted into civil conflict as children, if they escaped with all their limbs intact, they would grow up to become the potential carriers of the world's most dreaded disease and then they nearly went blind in the process. The children of civil conflict would grow up to become both survivors and carriers of the world's most dreaded disease. This is the life of an average Ebola survivor; the compounded stigma is as unimaginable as it is unrelenting. However, this is not the only EVD survivor group of ethical concern.

A report by *World Vision* tells us that by December of 2015 there were over 22,000 children (about the seating capacity of Madison Square Garden) orphaned by the endemic in Monrovia alone (*World Vision*, 2020). A little known fact witnessed by those of us who remained in community during the break-out still haunts my soul. Communities so feared this bloody death-dealing disease that after the bodies of parents were removed, neighbors often locked surviving children in their homes, leaving them to starve and die alone. This was more than a startling revelation to the front-line but most of all to the ambulance drivers, cremation workers, and body removers undoubtedly traumatized by the realization of what was happening to their fellow surviving minors. Given all we now know, there can be no wonder why Liberia's moral obligation to survivors could very well have been in question.

A 1st World Perspective of a Third World Problem

Before we delve into the social and ethical concerns of moral obligation, let us first question our position as first world ethicists: Can the ethical perspective of fully developed nations be fairly applied to the situations of nations that are severely underdeveloped in comparison? *Does it matter that an American perspective*—one held within the advantage of a strong national health matrix, one held within one of the most resource rich countries in the first world, one held up by some of the most privileged assumptions of health care grounded in

[1] A pandemic is a disease with world-wide impact, while an endemic impacts one region of that world (i.e., West Africa).

one of the world's most highly advanced medical systems—does it matter that perspective *is grounded in assumptions of provision and care that lesser developed nations cannot attain?*

Should our biases somehow reduce our expectations when applied to underdeveloped nations, what would an adjustment for wildly differing contexts of provision and care entail; and what would that new level of ethical expectation look like (i.e., should we reduce expectations to compensate for underdevelopment?)? These are questions concerning a professional bias that Biomedical Ethicists should consider in the judgement of lesser developed foreign nations in crisis. On the other hand, what protections may be lost in the reduction of ethical standards? How can persons be taken advantage of under conditions of severe need during extreme crisis situations? Beware, this machete can cut both ways if we look down our noses from such a lofty perch.

Moral Obligation and The Ebola Virus Disease Outbreak of 2014

According to the World Health Organization, Ebola Virus Disease (EVD)—formerly known as the Ebola Hemorrhagic Fever—is a severe, often fatal illness affecting humans and other primates. The virus is transmitted to people from wild animals and then spreads in the human population through direct contact with the blood, secretions, organs, or other bodily fluids of infected people, and with surfaces and materials contaminated with these fluids. In the final stages, victims bleed out from the nose, mouth, ears, and other orifices as their organs begin to liquify within. While COVID has taken more souls, Ebola is a much more horrific personal experience.

While the first outbreaks occurred in remote villages in Central Africa, near tropical rainforests, the 2014-2016 EVD outbreak in West Africa was not only the largest and most complex, but the first *urban* outbreak since the virus was discovered in 1976. There were more cases and deaths in this outbreak than all others combined (World Health Organization, 2020). While none who contracted Ebola were expected to survive early on, the average EVD case fatality rate for the endemic of 2014 turned out to be around 50%. After taking 12,000 lives from Liberia, it left 6,000 unexpected survivors.

Contrary to the initial belief that none would survive contracting the disease, we began to see the first survivors of the Ebola endemic in the Summer of 2014. In a sense everyone who lived through the crisis was a survivor, but the people who contracted the disease and did not die were officially so classified by the national government of Liberia. As the survivors became *The Survivors*, an entirely new category of social indigence was borne given their social exile and across-the-board job loss.

Additionally, a new moral status was created by the government to protect Survivors from the mob violence of frightened citizens; however, the new status was unable to protect surviving children orphaned to disease. By the spring of 2015 there were 3,000 Survivors and it slowly became clear that not one of them would be allowed to return to their homes given the level of fear that emerged in community life. Survivors had become communal exiles, fired from their jobs, rejected in terror—with the support of a Liberian government desperate to stop the spread of this dreaded disease.

It was commonly known that survivors had also become carriers of the virus. There was just enough truth in these fears not only to fan the flames of rejection but to garner federal support for the separation. Soon it was brought into evidence that Survivors were the only people capable of transmitting Ebola sexually, making EVD the most internally violent STD in existence. There was no evidence to suggest the facts would ever change because there was no way of knowing how long the virus could remain in one's system post-recovery.

Unfortunately, in March of 2021 it was determined that a new outbreak, the third in the original outbreak country of Guinea, was caused by a survivor of the original outbreak that passed the virus through sexual

transmission. “The analysis suggests that a survivor of the historic Ebola outbreak continued shedding the virus at least five years after being infected” (Branswell, 2021), shocking a medical community that believed the maximum span for such transmission to be only 500 days (about 1 and a half years). Mike Ryan, who heads the World Health Organization’s Health Emergencies Program, explained that the news could lead to further stigmatization of Ebola survivors, if they are seen within their communities as possible long-term sources of the virus. “Survivors deserve our support,” Ryan (2021) said. “They’ve been to hell and back.” Ryan’s fears were quickly converted into reality.

The public fear of this very thing caused Survivors to become the lepers of Liberian communal life when it was confirmed during the original crisis that they could become carriers—for this and previously mentioned underlying reasons they have been fired, exiled, and murdered as children. At the close of the crisis there were 6,000 Survivors of the Ebola virus in Monrovia, Liberia. Given the strong nature of community life on the Continent—the African culture of community—many Survivors shared the feeling they would have been better off in death and many orphaned children were robbed of the choice to live. The ethics of Ebola and survival is extremely complicated, and its response requires a complex theoretical explanation.

The criterion for assessing moral theories brings one thing to light; the categorical analysis of ethical theory cannot cover the full scope of moral dilemma. In this case no one category can fully provide neither clarity, coherence, nor comprehensiveness for the complexity of survival. While no single model can cover the range of morality applied to the treatment of Ebola Survivors, a single concept carried over a range of models will help us locate, justify, and reflect on a system of morals that arose from the worse endemic crisis the world has ever known. Concerning moral theory, this paper relies on the evolving conceptualization of obligation to reason through the ethical resolutions to this problem. Ebola brought about an obligation to human life denied by an earlier civil conflict.

This obligation to life informs every aspect of decision making concerning the Survivors, albeit from varying perspectives on three differing levels of organization. Obligation to the lives of a Nation determined the governmental priority of stopping the spread; obligation to life in community determined the priority of neighbors to protect each other and their collective by rejecting the Survivors as communal members and employees; and obligation to personal wellbeing justified the claims of Survivors to both the positive and basic rights of survival.

Obligation to the Lives of a Nation—The Primary Moral Imperative of Government

During the Ebola Crisis, the government of Liberia was legally bound to a course of action that would reduce potential harm to the public, including mediating negative economic impacts and capping the number of lives lost to this endemic crisis. The Liberian Government’s maxim: *We survived two decades of civil conflict, and we will survive the war on Ebola*, expressed both the determination and the obligation of Liberian government for the lives of her people—the public good. The primary objective in meeting this obligation was to stop the spread of this disease. The advent of a survivor population capable of sexual transmission was an entirely new and frustrating wrinkle in the fabric of national recovery.

> *I am being honest with you when I say that at this rate, we will never break the transmission chain and the virus will overwhelm us.*
>
> —Ellen Johnson Sirleaf, President of Liberia

From the perspective of utility in public policy, *consequentialism* suggests that right action for the Government would include all acts that produce good consequences (i.e., acts that mediate public harm). This is the rule that provides the moral ground that justifies action, in this case government agency. The priority would be to protect the population from potential transmission because it is the tradition of government to produce good consequences for the people.

Because the presence of Survivors in community increases the risk of transmission, the Government acted in concert with its primary moral imperative in obligation to community life by supporting the relocation of Survivors. Having created a new social category of indigence, the Government is now obligated to care (i.e., provide services) for this newly indigent group as a specialized population and those services must include relocation and child protection. According to Kantian theory, the government became obligated to consider the full range of facts and consequences for the Survivors considering the best available information. That information could then be grounded in reason and based on empathy, rather than the tradition of governments to reduce public harm.

However, the newly formed status did could not protect surviving children orphaned by the Ebola Virus against the murderous intentions of their own neighbors. This is a moral dilemma for the ages. As communal fear breaks down into the murderous mob instinct of kill or be killed, these little ones could not protect themselves and were often left to the mercy, if not prey, of the communities in which the live—communities that became merciless mobs in the face of a rapidly spreading appallingly dreadful disease.

Case in Point: The West Point Community Riot

Early in the crisis, when the West Point Community was quarantined, the community responded violently—seeking justice through the mob. Then the military (i.e., a bigger mob) was brought to bear on this panicked community, the violence escalated, and great harm was done. The entirety of West Point was/is indigent, containing over 70,000 poverty-stricken residents. This was a highly stigmatized community way before the outbreak, which is why such extreme action was taken rather than what was truly needed beforehand—endemic education. As is the case among most of the world's poorest members of populations, they were the last to know.

> Resentment had been building for some time now. One of the most recent grievances was that the government had opened a holding facility for people with symptoms of Ebola right in the heart of the neighborhood. People were upset because the government had not explained what the purpose [of the facility] was. Officials were also bringing in suspected Ebola cases from other neighborhoods, and the facility was not providing care. It was just there to isolate people. It had become a dumping ground for people with Ebola. People were dying there.
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> Then, over the weekend, a crowd stormed that facility. They carried off supplies including mattresses covered in blood, which may have been highly infectious. Ebola is spread by contact with an infected person's bodily fluids, including blood. And now these [residents of West Point] were being put under complete quarantine—no one in, no one out for at least three weeks. They're essentially being told, "You have a deadly and contagious disease running through your neighborhood, and you can't leave." So, this place was a pressure cooker. (Aizenman, 2014)

The fact of the matter was that any Liberian who was perceived to be a threat to the community-at-large because they didn't/could not comply with the protocols or were thought to be carriers or openly violated the touch ban or refused to use hand washing stations was heavily stigmatized and socially (albeit not physically) exiled—subjected to police action at very least. For a communal society, it is difficult to imagine the psychological burden of social exile. However, the wholesale ban on touch put everyone on edge after a while.

By the time Survivor issues came into play, the lessons of West Point helped mediate the panic and anti-stigma campaigns were already in place.

Obligation to Life in Community—The Primary Moral Imperative of a Communal Society

If the moral imperative of community is an obligation to the lives of that community, then the decision to exile the Survivors was in alignment with communal morality. It was an act toward the wellbeing of the community. They were functioning under an obligation to community life and to the lives in that community. The general rule of conduct or maxim on which the community acts is together we shall do no harm but only good for each other. It is one for all and all for one, where right action is that which serves to enhance community life.

Here the love of neighbor fuels obligation and trumps duty. The moral imperative is a commitment to acts of communal wellbeing, an obligation to life in community. The life of the community comes first, just as the lives within the community come before those of the general population. People may be treated as means to other ends, but as adults they have a choice in the matter and retain control over their own lives.

> One must strive to treat every person as an end and never as means only.
>
> —Emmanuel Kant

Obligation to Personal Wellbeing—The Primary Moral Imperative of Individual Survivors

The primary moral imperative for survivors is to survive. They are obligated in this context to personal wellbeing, which not only move us into rights theory but also demonstrate the correlativity between obligations and rights, whereas the obligation to not kill, cause suffering, prevent harm, rescue lives, and speak truth correlates with the right to experience similar protections (i.e., not be killed, harmed etc.). The Survivors maxim: *I am devoted to selfcare and autonomous living*. Survivors have the right to receive goods and services from others, like governmental assistance or support from their families while in exile.

As Survivor rights entail government or family obligations to provide services or support, they are positive. Survivor rights as derived from the justice work of John Rawls that involves the right to be free from mob justice is a negative right from the development of Kantian themes of individual worth, self-respect, and equality. Christine Korsgaard suggests that interpersonal justice also involves an obligation beyond the self to the quality of relationships, a personal commitment not to treat others abusively in obligation to personal wellbeing. The commitment to interpersonal justice clearly broke down in the community life of Liberia's orphaned survivors.

Obligations of Foreign Medical Research—A Surprising Lack of Ethical Concern

Among the less discussed impacts of defeating Ebola: a host of lingering health effects, included long-term vision problems: "People who have had Ebola are losing vision..." (Brady, 2015).

The problem of becoming a carrier was not the only long term after effect of Ebola survival. It was soon discovered that the Survivors were going blind due to an intensive cataract formation caused by the disease. Rather than obtaining informed consent, the NIH approached the Survivor Network with a deal. We will prevent your blindness if you participate in this study. In other words, participate in the study or go blind.

The only way to get the treatment that would save their sight, was to participate in the study, which was being conducted by the third-party research institutions like the John Hopkins Institute who worked behind the

scenes to produce research under the National Institute of Allergy and Infectious Diseases (NIAD) and the National Eye Institute (NEI) (2021) all of whom benefited from this alternative to consent.

Having been a primary researcher and university IRB chair during the time of Ebola, I understand what it takes and how much more complicated it is to secure informed consent for human subject research in Liberia. Like most things, this is a communal process. Community leaders must be approached for consent to enter their communities and conduct research long before any data can be collected from additionally consenting individuals.

To avoid this timely and often costly process, first world researchers tend to look for loopholes. Consequently, "There has been considerable controversy about the ethics of clinical trials that are sponsored or conducted by groups in industrialized countries but carried out in developing countries" (Shapiro & Meslin, 2001, pp. 139-142). The National Institute of Health (NIH) is structured to prevent blatant research abuses. The NIH Office of Human Subjects Research Protections (OHSRP) carries out the day-to-day operations and regulatory oversight of human research activities within the Human Research Protections Program (HRPP). The OHSRP promotes the protection of rights, safety, and welfare of human subjects, and the NIH's research mandate (NIH, 2021).

The crises service community was shocked to learn that the research on Ebola and eye care dismissed all notions and methods of informed consent while employing coercive measures to gain the participation of Liberian Survivors. None could believe it, but the work around for the several researching institutions conducting the study and providing treatment, the work around that allowed them to avoid even asking for consent was provided by none other than the NIH.

Many distrustful Survivors ultimately sacrificed their sight completely (i.e., literally went blind) to avoid being coerced into treatment, especially given the persistence of rumors around the origins of Ebola and the hermeneutic of suspicion concerning the involvement of American research labs such as those at Johns Hopkins.

Analysis: The Moral Obligation to Human Life

Ebola brought into consideration an obligation to human life recently denied by civil conflict. An evolving concept of moral obligation reveals all three angles of social perception. Obligation to the lives of a Nation determined the governmental priority of stopping the national spread. Obligation to life in community determined the priority of neighbors to protect communal life. Obligation to personal wellbeing bolstered the claims of the Survivors to the positive and basic rights of survival.

During the Ebola Crisis, the government of Liberia was legally bound to a course of action that would reduce potential harm to the public, including mediating negative economic impacts and capping the number of lives lost to this endemic crisis. Here, the love of "Ma Ellen"—the nurturing of a President, motivates the moral imperative. The Liberian Government's maxim: We survived two decades of civil-conflict, and we will survive the war on Ebola, expressed both the determination and the obligation of Liberian government to the lives of her people—to the public good. The primary objective in meeting this obligation was to stop the spread of this disease. The advent of a survivor population capable of sexual transmission of the EVD was an entirely new and frustrating wrinkle in the fabric of the national recovery.

The maxim on which the community acts is together we shall do no harm but only good for each other. It's one for all and all for one, where right action is that which serves to enhance community life. The moral

imperative involves a commitment to acts of communal wellbeing. Here the love of neighbor fuels obligation and trumps duty. If the moral imperative of community is an obligation to the lives of that community, then the decision to exile the Survivors was an act toward communal wellbeing, functioning under an obligation to community life and to the lives in that community was in alignment with a communal form of morality. Ideally, in which one must strive to treat every person as an end and never as means only.

The Survivor maxim is “I am devoted to selfcare and autonomous living”. The primary moral imperative is to survive the Ebola Virus without spreading the disease. The pericope of Matthew 22:36-40 provides spiritual motivation for this imperative as it commands believers to Love thy neighbor as thyself. Survivors have the right to receive goods and services from others, like governmental assistance, support from their families; they also have the right to freedom from mob violence while in exile. As Survivor rights entail government or family obligations to provide services or support, they are positive.

Concerning interpersonal justice, Survivors also have the right to be free from mob justice and the right to not be taken advantage of by foreign interests, which are both negative rights. Interpersonal justice also involves an obligation beyond the self to the quality of relationships, a personal commitment not to treat others abusively in obligation to personal wellbeing. The commitment to interpersonal justice clearly broke down in the community life of Liberia’s orphaned survivors.

While the government has an obligation to public wellbeing, they are also obligated to the special interests and concerns of designated groups and they seem to act on most concerns of obligation, which at times can be conflicting. While the primary imperative of community in endemic crisis involves the wellbeing of that community and values community lives over the general population membership can be revoked. While Survivors are obligated to their own wellbeing, they are still apart of communal culture. The nature of African life is communal, no matter where one lives physically. Survivors tend to respect the fears of their fellow citizens if that respect runs both ways.

It seems the facts of an unrecovered, post-conflict society seem to have negligible impact on the nation’s ability to uphold the rules of obligation whether by government, in community life, or with individual Survivors under normal circumstances. In the face of immediate deadly possibilities, it all falls apart particularly in local community life. People still value the acceptance of maxims, and those maxims still provide the moral ground that justifies social action, unless there is a perception of immediate and impending threat to life.

While social obligations to protect children may seem obvious, all that broke down under the horror of Ebola as regular citizens become capable of horrific atrocities against child survivors right in their own neighborhoods. While the government has an obligation to public wellbeing, they are also obligated to the special interests and concerns of designated groups and they seem to act on most concerns of obligation, which at times can be conflicting. However, the conflict does not interfere with the fulfillments of obligation unless lives are immediately at stake.

While the primary imperative of community in endemic crisis involves the wellbeing of that community and values community lives over the general population, the status of membership is not necessarily eternal. Membership can be revoked. Members have been exiled and children have been killed when they were perceived to pose a threat to community life from endemic disease. While Survivors are obligated to their own wellbeing, they are still apart of communal culture, albeit distal. This is because the nature of African life is

communal, no matter where one lives physically. Survivors are ok respecting the fears of their fellow citizens if that respect runs both ways.

With the help of the government, EVD Survivors find the support needed to carry on in this life, even with the interruption of normal social patterns. Those Survivors could contribute greatly to public education by sharing their firsthand experiences, training people in the protocols of infection, and acquiring training to further aid in the detraumatization of fellow Liberians.

Concerning the priorities of an endemic driven society, the normative suggestion is that society does have a duty to survivors (if for no other reason than if not properly cared for they could have increased the spread) and even more so to children. Deontology is challenged for Survivors, in the case of Ebola, by the need to make sure the greater good is served *primarily*. I cannot imagine what may have happened if the Survivors had been openly transmitting. This would have challenged the ability to keep order amid the crises. The possibility clearly frustrated President Sirleaf. However, mob violence is a *communal* idea of justice. The West Point riot represents a major case in this point.

As we have seen, similar issues have been brought to bear with COVID and in the medical context of Katrina. I think the comparison may push the significance of pre-endemic issues like medical capacity, civil conflict, child protection, and a lacking infrastructure into the forefront. The impact of Communal vs. Individualistic social orientations would have to be addressed as well. America may have had more cases, even many more deaths in comparison, but she also had resources in proportion from a medical system that was stressed, but not broken as it was for these nations.

While potential patients may have been turned away, the maternity ward never closed, and women were not forced to give birth on the hospital lawn outside and alone. Many did not survive that experience—the ethics of maternity care were heartbreaking. An issue alone worthy of publication and the fact that the taboo of touch functioned to create more childbirth than before the crisis is a whole other issue—as forbidden love can be a powerful thing.

Finally, the first-world academic machine is driven by the mantra “publish or perish”. The most successful educational and research institutions in this world simply *get it done* by any means necessary. Any participant will tell you it is a vicious world that cuts corners and throats to, but only when it can afford to do so. Note that John Hopkins is three-times removed from the point of consent that puts them way beyond plausible deniability. This demonstrates how the ethics of human subject research can be wholly dependent on the circumstantial and geographical context in which it takes place.

Conclusion

This bioethical investigation into the nature of the endemic crisis, its survival, and the social construction of moral obligation during the Ebola crisis in Liberia, West Africa concludes that the rules of obligation do stand up to endemic crisis when they are applied by conscientious persons for altruistic reasons. However, it is also true that terror, trauma, ignorance, and indigence each have the potential to interrupt moral judgement. Analysis suggests that it does so in ways that increase the complexity of moral concern and cause them to break down under the various pressures of survival. Endemic terror, more specifically, begats a social dynamic that can rob local individuals, communities, and government and international institutions of the opportunity to embrace the moral concerns that influence ethical decision making.

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