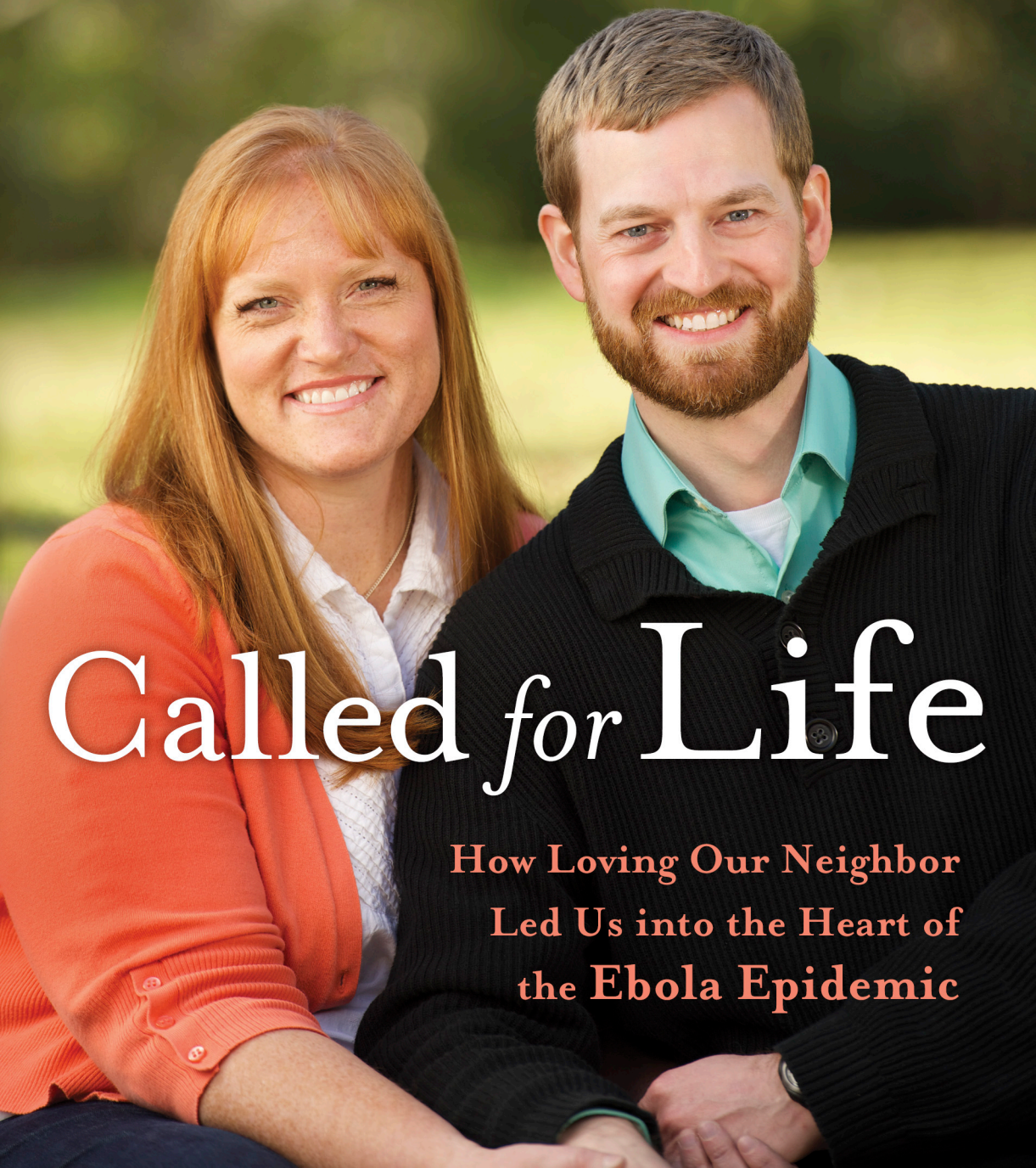
Kent & Amber
BRANTLY
with David Thomas



Called *for* Life

How Loving Our Neighbor Led Us into the Heart of the Ebola Epidemic

Praise for
Called for Life

"Dr. Kent Brantly is responsible for one of the worst weeks of my life. When I told him that, he smiled and said, 'It wasn't that great for me either!' But Kent gives God the credit for saving his life and surviving the deadly Ebola virus that infected him while serving others in the name of Jesus. Dr. Brantly and his wife, Amber, went obediently to Liberia to serve with Samaritan's Purse as medical missionaries, and were the recipients of prayers from around the world as they battled an attack that threatened their future. The world watched as Kent was successfully transported back to the United States from Africa. International media outlets captured his every step as he walked from the ambulance into Atlanta's Emory University Hospital, where he found physical restoration—a miracle from God. You will be riveted by this extraordinary couple who are called for life to serve the Lord Jesus Christ—the Great Physician!"

—Franklin Graham, president and CEO, Samaritan's Purse
and Billy Graham Evangelistic Association

"When hope seems dim, *Called for Life* reminds us of the limitless possibilities of a God-driven life. Dr. Brantly's story inspires us to stay strong in the unexpected crises of life . . . to be encouraged to recall God's promises . . . to be challenged to examine our own commitment to God's call on our lives."

—Max Lucado, pastor and best-selling author

"Compelling, factual, and emotional, *Called for Life* draws readers to reflect on their own journeys to faith in Christ and encourages them to trust God in the crises of life."

—Nancy Writebol, SIM missionary to Liberia and fellow
Ebola survivor

"*Called for Life* invites all of us behind the curtain of the news stories and press releases and into the Brantlys' lives during the most trying of times. Their love for each other, their faith and courage, as well as the strength and support they

received from their network of friends, family, and caregivers is heartwarming and inspiring. When we set out to just do what is right, this behind-the-news-flash story reminds all of us that we live in a global community, that we all have a role to play, and that all of us can make a difference, wherever we are and in whatever profession."

—Lisa Hensley, virologist and deputy director at the National Institute of Allergy and Infectious Disease, Integrated Research Facility

"As you walk alongside them on their journey, Kent and Amber's poignant story will touch your heart, move you to tears, strengthen your faith, and cause you to trust God more."

—David Stevens, MD, MA (Ethics), CEO of the Christian Medical and Dental Associations

"Kent and his wife, Amber, have truly lived by the phrase 'When the going gets tough, the tough go back to their calling.' Their great compassion for the sick and broken—choosing to suffer alongside them even in the face of possible death—has touched and saved many lives. I am thrilled to see the Brantlys share their amazing story in print, and I know it will inspire and challenge you to find your place in God's calling upon your life."

—Dr. Ravi Zacharias, author and speaker

"*Called for Life* tells the rest of the story—what went before, lay behind, and follows after the iconic images of a coverall-clad figure gently stepping out of an ambulance and into an international spotlight. Kent and Amber have given us a glimpse inside their previously private world to uncover the roots of their genuine humility, tender love for each other, and deep compassion for their neighbors. Not all readers will fully resonate with their interpretations, but all will surely appreciate their candor, sensitivity, and sincerity . . . and the beauty and suspense of a story well told."

—David McRay, MD, professor at the University of Tennessee College of Medicine

"There are many books about surviving illness, but this is a one-of-a-kind story. What happens when ordinary Christian medical missionaries are caught up in an extraordinary world crisis? Though I know the story, I found my heart pounding as I turned the pages. And it turns out to be a tale not of disease, primarily, but of calling, faith, and love. It is a story of a remarkable family, their community, and their commitment to a hurting world and to God."

—Randy Harris, spiritual director and instructor,
Abilene Christian University

"Knowing Kent and Amber personally, I can say that *Called for Life* is a deep and honest testament to God's working in the midst of suffering and crisis. Kent and Amber's voices come through the pages in a very authentic way, and you will experience all Kent's emotions as he walks through this journey. As an Ebola survivor myself, I wholeheartedly recommend this book."

—Rick Sacra, MD, SIM missionary

"Refreshingly, the Brantlys never give trite answers to complex questions like 'How does God work in healing?' or 'Why is there suffering in the world?' Instead, what they give us is a story—their story, and it's one worth reading."

—Jonathan Storment, preaching minister at the Highland Church
of Christ and co-author of *Bringing Heaven to Earth*

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This book is dedicated to Bobby, James, and the more than 11,000 other people who lost their lives in the Ebola epidemic of 2013–15.

May your suffering and your families' losses not be in vain.

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Prologue

So What's Next?

Kent, bud. We got your test result. And I'm really sorry to tell you that it is positive for Ebola."

I had not expected to hear those words despite the mounting evidence over the past three days—the worsening symptoms, the repeated negative malaria tests—that would have led me to suspect Ebola had I been the doctor rather than the patient.

Our first Ebola patient had come to our hospital in Monrovia, Liberia, barely six weeks earlier. But we had worked under the strain of a looming Ebola outbreak for nearly three anxious months before then. For the thirty-eight years since Ebola Virus Disease had been identified, every outbreak had been limited to small rural communities.

This time, however, was different. This time, Ebola had found the perfect storm of factors, quickly spreading through three countries and into major urban centers.

Our hospital of forty-five to fifty beds hurriedly converted the chapel into a small isolation unit, hoping it would never be needed. When our first Ebola patient arrived, we maintained the only treatment unit in all of southern Liberia.

In the beginning stages of what erupted into the worst Ebola outbreak the world has ever seen, I had learned to consider Ebola anytime a patient entered our emergency room with a fever and symptoms that, just a few months earlier, would have been suspected as likely malaria or typhoid fever. In fact, for the safety of our

medical workers, we treated all febrile patients as though they had Ebola until proven otherwise. It was too risky not to.

The Ebola strain we observed carried a mortality rate of 70 percent. The death rate was even higher in our hospital, where only one of the dozens of patients who had tested positive for Ebola had survived.

One.

Ebola didn't just kill our patients; it stripped them of their dignity. Ebola humiliated its victims by taking away control of their bodily functions. We constantly changed diapers and sheets and cleaned up patients, and we fed them when they could no longer do so themselves.

Unable to cure their disease, we focused on treating their sense of isolation that came from being in a treatment unit where only two groups of people were allowed inside. One group was the medical personnel always working with their own safety in the front of their minds in light of the disproportionate number of health-care workers contracting the disease. The second group was other Ebola patients, moaning and groaning in pain until their bodies could fight no longer.

For all but that one patient, a positive Ebola test had become a death sentence served out among suffering patients and cautious medical personnel—some unknown foreigners, even—outfitted so securely that only our eyes were visible through the protective goggles.

No families. No friends. No familiar faces. No human contact.

With no cure, no hope.

As the outbreak had worsened and our hospital worked to expand our capacity, I was named director of the treatment unit. I became the physician who ensured that our staff was properly trained, repeatedly reassuring them that when we followed the protocols and worked together as a team, we were completely safe. The staff had trusted me too, because for each of my patients, I had determined to display compassion over fear.

And now Dr. Lance Plyler, the team leader responsible for managing our medical response to Ebola, was standing outside my bedroom window, because he could not come into my contaminated home, notifying me that I, too, had con-

tracted the virus. Dr. John Fankhauser, my colleague and mentor in Liberia for nine busy months, stood beside my bed dressed in full personal protective equipment (PPE), just as I had stood beside the beds of too many patients in our Ebola unit, because he wanted to be with me when Lance delivered the news.

"I really wish you hadn't said that," I told Lance.

I was so sick at that point that I don't remember saying those words; that is Lance's recollection of my reaction. But I do remember what I said immediately after.

"Okay, so what is next? What's our plan? What are we going to do?"

I am a doctor, trained to respond to a bad test result by creating a plan. More importantly, I am a husband and a father, and my thoughts turned to my beautiful wife and children back home in the United States. I might not see them, much less touch them, ever again.

I stared out our bedroom window, looking to Lance.

"How am I going to tell Amber?"

Part 1

CRISIS

I

Defenseless

Kent

This is it. Everything is about to change.

Our first Ebola patient looked up at me weakly as I knelt next to her bed of blankets on the patio near the hospital pharmacy. The disease we had prepared for while praying we would never see it had, indeed, arrived at our hospital, and I realized I was about to set the tone for the rest of our time treating Ebola patients—however long that might prove to be.

Dressed in full protective gear, I offered the young woman my right hand protected by two surgical gloves. She grabbed hold.

"Felicia, my name is Dr. Brantly," I said. "This is David. He's one of our nurses."

David greeted her.

"We are going to take good care of you here," I assured Felicia.

It was Wednesday night, June 11, 2014. Our hospital had the only Ebola treatment unit in Liberia's capital city of Monrovia, and the phone call had come earlier in the evening from the country's Ministry of Health. Two suspected Ebola patients were being transferred to us from a hospital in the northern suburb of New Kru Town.

Three members of a family had died in the past week, and Ebola was the suspected cause. Two other family members had become sick and were at that

hospital. As we began preparing our Ebola treatment unit, which had been sitting empty for months, we did not know when to expect the two.

We were not even sure they would actually come to us.

Nancy Writebol came in to help. Nancy, personnel director for Serving In Mission (SIM) missionaries in Liberia, had volunteered to serve as the unit's hygienist when we ramped up our Ebola response. Nancy changed the sheets on the beds and mixed a sufficient quantity of the bleach-water solution for decontamination.

Dr. Debbie Eisenhut (known as Dr. Debbie) volunteered to stay at the hospital and said she would call me at home if anything developed. A little later, Debbie did call, telling me an ambulance had arrived at the hospital with two patients, a man in his midforties and his niece. I returned to the hospital.

As our two patients waited outside in the ambulance, we had to recruit two staff members willing to be the first to risk their lives to work in the unit with our first Ebola patients. I did not expect anyone to *want* to sign up.

I pleaded with some of the nurses: "Look, this is somebody's sister, somebody's mother, somebody's daughter. Somebody's uncle, somebody's brother, somebody's cousin. We've got to take care of them. Think if this was your family member."

Our medical director at ELWA, Dr. Jerry Brown, joined in recruiting nurses by phone.

Two volunteered for the job: Louise, an ER nurse, and David, a nurse's aide.

Preparing the unit, assembling the staff, and getting the four of us dressed in PPE required a couple of hours. Debbie made several trips outside to the ambulance during that span. Each time Debbie went outside, she told everyone to remain near the ambulance and not to get out to walk around or enter the hospital until we came to get them.

There were no ambulance services in Monrovia. The only ambulances were owned by hospitals and the government for transporting patients from one hospital to another. An ambulance was typically a modified Land Cruiser with sideways-facing seats in the back. The crew sat in the front seat with no divider between them and the patient or patients in the back.

The ambulance outside our hospital contained three crew members, the two

patients, and two family members—a man in his thirties and a boy who appeared to be twelve.

As we were preparing the unit, the uncle, who had been alert and talking, became very still and silent. The two family members helped Felicia climb down out of the ambulance and lie on the asphalt road behind it.

One of Felicia's relatives then grew angry at having to wait and stormed the entrance to the emergency room, kicking a hole in the door. He accused us of delaying care for Felicia and not being willing to admit her.

We tried to convince the family that we were not ignoring them, that we were preparing the best we could to take care of Felicia the right way and safely. He calmed down and returned to the ambulance.

Then it began raining. I do not know if Felicia walked or if she was carried, but they moved her to a covered porch in front of the hospital pharmacy and spread blankets there for her to lie on.

After we had the inside of the unit fully prepared, David and I suited up in PPE and approached Felicia on the porch. As I dropped to one knee beside her, the burden of the moment descended squarely on my shoulders, because I had known all along that once the first case arrived, working and living in Monrovia would never be the same.

"We have a stretcher," I told Felicia, "and we are going to put you on the stretcher and carry you to a place we have prepared for you."

I looked up at David. "Do you want her head or feet?"

"Feet," he replied.

I picked Felicia up by the shoulders, and we slid her onto the stretcher and placed the blankets on top of her. We carried her around the back of the hospital and into the isolation unit.

Dr. Debbie and Louise were waiting for her inside. I picked up a spray can of the chlorine solution and walked back around the hospital to the ambulance. Felicia's uncle remained curled up inside the ambulance, lying over the top of a backpack. I leaned into the truck and felt for a pulse, then looked him over. He was obviously deceased.

"I have to have that backpack," the man with him said. "It has my identification card in it."

I pulled the backpack out from under the uncle. The body fell onto the floor of the ambulance, his position unchanged. He still looked as though he were lying over the backpack. Rigor mortis had already set in.

I stood there, backpack in hand, facing a decision.

I could not give a backpack contaminated with Ebola to the man. But on the other hand, he had already been exposed, having ridden in the back of the ambulance and having taken care of the uncle and Felicia. I handed him the backpack.

The young boy started crying.

"Stop crying!" the man scolded him.

"It's okay for him to cry," I said. "You may be used to being around death, but he is twelve years old. He has lost four family members in a week. It's okay for him to be scared and to cry."

I sprayed bleach on the back of the ambulance and the road and porch where Felicia had been lying. I sprayed the door of the ER that had been kicked in and everything along the paths in between.

The leader of the ambulance team and I agreed that they would return the body to Redemption Hospital and we would take care of Felicia. None of the three crew members were wearing PPE. Not even a single pair of rubber gloves.

The man and the boy said they would ride in the ambulance back to Redemption. I didn't like that idea.

"It's fine," the man said. "It's just a dead body."

It was not just a dead body; it was a body loaded with a deadly virus.

~

The health-care system in Liberia was not prepared for Ebola.

During Felicia's first two days with us, her mental state waxed and waned. She would sit up and talk with the nurses and we would feed her, then she would lie

down and become unresponsive for an hour. Then she would sit back up and want to eat or talk.

On the third day, Felicia's condition improved. She was awake and alert more than she was out of it. Her fever came down. We hoped that she had turned a corner and would make it, that our first Ebola patient would survive.

The next day, June 14, her diarrhea increased. Her temperature shot back up. She became unresponsive, and she remained that way until she died.

Felicia introduced our hospital to Ebola.

Every shift, we would have to pull nurses away from their assignments and leave an area of the hospital short-staffed. One case of Ebola had strained our staff. I could not imagine what it would be like if we experienced an outbreak.

Our nurses who cared for Felicia were courageous and compassionate. They were the first to treat an Ebola patient at ELWA Hospital, and they took great care of Felicia.

They also encouraged their colleagues to sign up for shifts in the unit. The work had not been as bad as they expected. Their chief complaint was that it was hot inside the suits, with no air conditioning in a high-humidity environment. But other than that, treating an Ebola patient was a job that they had discovered they could do.

We had one nurse who experienced a problem with her asthma being exacerbated by the masks we had to wear. But all the rest who worked in the unit volunteered to do so again.

Everyone in the country was scared of this Ebola thing. But the nurses who went into the unit to care for Felicia realized that more than dealing with a disease, we were dealing with a person who needed compassion.

A Perfect Storm

The fight against Ebola felt like a race in which the starter forgot to say "On your mark" and "Get set" and skipped directly to "Go!"

In late March, Doctors Without Borders had launched an emergency response due to the Ebola cases that had popped up in Guinea, which borders Liberia to the north. Doctors Without Borders, which is better known internationally by its French acronym of MSF (*Médecins Sans Frontières*), was created by French doctors in 1971 as a humanitarian organization to provide emergency medical aid around the world. MSF is normally the first organization on the ground to identify and respond to outbreaks such as the Ebola epidemic in Guinea.

MSF had been successful in containing previous Ebola occurrences. There had been fewer than twenty Ebola episodes since the virus was identified in 1976 in two simultaneous events—one in Sudan and another in Zaire (now the Democratic Republic of Congo), in a village near the Ebola River. MSF's quick responses had prevented these prior outbursts from becoming widespread. The most deaths from an Ebola outbreak had been 280 in Zaire in 1976.

This time, however, MSF recognized the perfect storm gathering for a potential catastrophe with this reappearance of Ebola, which had begun in a very mobile society within a tri-border region where the virus had not previously appeared. Thus, the people in that area were not on the lookout for it. Guinea, Sierra Leone, and Liberia also were three of the poorest countries in the world, and general distrust of government caused the people to argue that Ebola was not a real virus, that it didn't actually exist.

For all those reasons, MSF knew it would be extremely difficult to bring a West African outbreak under control.

I had been working at ELWA Hospital on the south side of Monrovia for only eight months when we admitted Felicia. SIM ran the Eternal Love Winning Africa (ELWA) mission in Liberia, where it had maintained a presence since it started Radio ELWA in 1952. SIM had also opened a hospital in 1965 on its 130-acre compound that became known collectively as ELWA, or E-L-W-A. Monrovians consider ELWA like a section or neighborhood of the city.

Amber and I had signed up for a two-year term at ELWA through World Medical Mission, the medical arm of Samaritan's Purse, which offers terms in mission hospitals to young doctors like me who want to pursue medical mission work

on a lifelong basis. Samaritan's Purse, named for the good Samaritan in Luke 10 who rescued a dying man that others had walked past and ignored, was created in 1970 to offer care to the poor and suffering in crisis areas around the world.

Samaritan's Purse and SIM had been working side by side in various efforts to assist the people of Liberia in their recovery from two civil wars in the previous twenty-five years.

Liberia (meaning "liberty") began as an American settlement in the 1820s by the American Colonization Society. Free blacks and, later, rescued slaves from illegal trade ships came to the west coast of Africa. In 1847 they signed a declaration of independence and founded the Republic of Liberia, modeling their constitution after that of the United States. American settlers, of course, were not the first people to live there, so immediate tension and distrust grew between the settlers and the local tribal groups.

Perhaps it was due to this tension that, over one hundred years later in 1980, an indigenous leader, Samuel Doe, rose to power through a coup and the slaughtering of the president and his cabinet. Through fraudulent elections, Doe named himself president and began a bloody and racially charged rule. In 1989, a rebel leader, Charles Taylor, overthrew Doe's government and Liberia's civil war ensued. More than two hundred thousand Liberian lives were lost in the war, and a million more were displaced as refugees.

Finally, in 2003, largely through the courage and determination of Liberia's women and mothers, Charles Taylor was forced to resign and a peace accord was signed. Taylor was later indicted for crimes against humanity. The United Nations Mission in Liberia (UNMIL) came to monitor the peace accord. Then in 2005, Africa's first female president was elected, President Ellen Johnson Sirleaf, or "Ma Ellen" as she is called by her people.

The needs of the Liberians were many and great, and we were there not to be Westerners swooping in to do things our way or to make them like us, but to partner with the Liberians as they helped themselves. Our hospital's medical director, Dr. Brown, is Liberian and a very influential medical voice in his country. We also worked with a team of general practitioners and nurses from Liberia.

Dr. Debbie, a general surgeon from Oregon, had moved to Liberia a year earlier and headed up ELWA Hospital's Ebola response. She sent the medical staff an e-mail on March 22 informing us of a news report that up to fifty-nine people in Guinea had died from the rare and deadly Ebola Virus Disease. The article also reported that Ebola might have spread to Sierra Leone, Liberia's neighbor to the northwest.

"I thought that you all would be interested in this," she wrote. "It is a bit close for comfort. We all need to be alert to the possibility of seeing something here."

Two days later, we held our first doctors' meeting about Ebola to discuss how we would combat the disease if it made it into our country and city.

I knew about Ebola from my medical education when we studied rare, exotic viruses like Ebola, Lassa fever, and Hantavirus. I knew it was a really bad, viral, hemorrhagic fever with no cure, no vaccine, and an astoundingly high death rate.

In 2013, during my residency training, I had spent three weeks in Uganda at Mulago Hospital. They had treated a patient with Ebola the month before our arrival, and there had been other cases in Uganda. Signs around the hospital kept patients and medical personnel on alert for symptoms of the disease: "Do you have a fever?" "Are you bleeding?" "Do you have Ebola?" That level of public awareness had helped minimize the outbreak in East Africa.

But when we moved to Liberia in October 2013, there had been no documented cases—ever—of Ebola in West Africa. Ebola was not on my radar; I did not expect to see it there.

We might be overreacting a bit because Guinea is a long way from here, I thought when our discussion began. It was 282 miles from Monrovia to the city of Foya near the Guinea border. After just a few minutes of Dr. Debbie and Dr. John Fankhauser describing the situation, though, I changed my mind and agreed that we needed to take immediate action. We absolutely had to prepare for the worst.

We brainstormed where we could create a safe space to isolate a patient. That place wound up being our chapel, a small, freestanding building in the courtyard

of the horseshoe-shaped hospital. Our staff devotionals were held each morning in the chapel, along with afternoon discipleship classes for hospital employees.

Dr. Brown and Dr. Fankhauser received pushback on their decision to isolate Ebola patients in the chapel. Some were upset the chapel would be used for such a dirty job and that we would be bringing death into a sacred place.

Jerry and John explained the move by asking, historically, in times of war, where had people gone for refuge? They went to churches, Jerry and John said, and what better place could we offer than a chapel to bring sick patients who were in search of life?

Work began immediately to convert the chapel into an isolation unit, which we called the Case Management Center, with five beds and a small area for storage.

The doctors' meeting regarding the Ebola threat took place on the twenty-fourth of March, a Monday. I had recently been named physician liaison for the HIV treatment program and spent three days that week in meetings at the National AIDS Control Program for staff in all of Liberia's HIV clinics. Ebola was on my mind so often during those meetings that I downloaded the Twitter app on my phone and created an account so I could follow Ebola updates from the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), and UNMIL.

At ELWA we began implementing strict universal precautions regarding contact with potential Ebola patients based on a 1998 WHO booklet titled "Infection Control for Viral Haemorrhagic Fevers in the African Health Care Setting" that we found online.

The best science we knew at the time said Ebola was transmitted through body fluids, such as sweat, blood, vomit, and diarrhea. As far as viruses were concerned, Ebola did not spread easily. It required direct exposure to mucous membrane (eyes, nose, mouth) or broken skin (a cut or even a small scratch or scrape).

By comparison, Ebola was not spread through coughing, as with measles or influenza. When we cough, our breath contains tiny particles that can travel across

a room on air currents. Ebola was transmitted only via droplets, which by definition are larger particles. Because of the weight of droplets, gravity prevents them from becoming airborne.

Ebola may not be easily transmissible, but its greatest threat comes in needing only a small amount of virus to cause infection. The medical term *viral load* refers to the number of copies of a virus in a milliliter of bodily fluid. Ebola has one of the highest viral loads among viruses. With HIV, for example, 100,000 copies per milliliter is a high viral load. In an Ebola patient near death, the number of copies of the virus in one milliliter can reach into the billions. Additionally, it takes a relatively small number of Ebola viral particles to cause infection. I have heard estimates of 10 to 1,000. When you consider that a dying patient can have upwards of a billion particles in one milliliter of bodily fluid, it is easy to understand the danger inherent with Ebola.

To use a military analogy, most viruses would be like a nation with a poorly trained force that needs to deploy its entire army into enemy territory to complete a mission. Ebola, though, would be like a terrorist cell that only needs two or three terrorists to infiltrate to inflict deadly damage.

Health-care workers are disproportionately affected by the virus for a couple of reasons.

First, they provide care to very sick infected patients. Ebola is not easily transmitted in the early stages of the illness. But as the patients become sicker, their viral load increases.

A good example of that is the case of Thomas Eric Duncan, the Liberian who in September 2014 became the first person to be diagnosed with Ebola in the United States. He was with his family in the first days of his illness, but none of them contracted Ebola. The two people who became infected through contact with him were nurses who cared for him as his sickness worsened.

Second, health-care workers encounter patients before they are known to have Ebola. Especially early in the West Africa outbreak, patients would come into an emergency room or a clinic with symptoms commonly ascribed to malaria. The

medical personnel first seeing those patients often did not have all the proper personal protective equipment and were not able to follow certain procedures to prevent Ebola's spread.

Therefore, one of the keys to preventing an epidemic is to first ensure the safety and preparedness of medical workers.