

The Doctors

The Ebola fighters in their own words

Dec. 10, 2014

Dr. Kent Brantly, 33

Physician with Samaritan's Purse

I've thought a lot about the moment when I was infected with Ebola. I will never know for certain when it happened, but I do remember one overnight shift, about nine days before I got sick, a woman came into the ER with her daughter. When I went to check on her, she was very sick.



Bryan Schutmaat for TIME

At one point, the daughter took her mother into the bathroom because she had diarrhea. We needed to get her out of the ER and into our Ebola treatment unit, but her daughter was incredibly distrustful of the situation and of us. I had to counsel her extensively to reassure her that we were trying to do what was best for her mother. To have that conversation, I took off my mask, gloves and apron.

I probably held her hands or put my arm around her shoulder, as I often do. I don't think I was infected by her mother, but since the daughter had taken her to the bathroom, there's a chance she didn't wash her hands after helping her mom. The mother died by the morning, and a postmortem test showed she did indeed have Ebola.

A little more than a week later, I woke up feeling a little warm. My temperature was 100.0—higher than normal but not too concerning. I took a rapid malaria test; it was negative—not a good sign. I called our team leader, who sent physician colleagues to my home in full protective gear. After two more negative malaria tests, I knew I would be in isolation for at least three more days. In the meantime, I grew sicker. My fever hit 104.9. We all hoped it could be dengue fever.

On the fourth day the team leader came to my bedroom window with news. “Kent, buddy, we have your results. It’s positive for Ebola.” I didn’t know what to think. I just asked, “So what’s our plan?”

This was July, and I’d been in Monrovia since October 2013. The first time I heard about the Ebola outbreak was at the end of March 2014, at a picnic for expatriates living in the area. Someone asked if I had heard about the outbreak in Guinea. I had not, but within a couple of months I was one of only two doctors in Monrovia treating Ebola patients—and at that point we had only one survivor. My wife Amber and I were both at the disadvantage of knowing how this illness can end. But even with the bad news, I felt strangely at peace. God blessed me with a peace that surpasses understanding.

At some point, I was told about an experimental drug called ZMapp. It had worked on monkeys but had never been tested in humans. I agreed to receive it but decided that Nancy Writebol, a medical aide I worked with, should get it first, since she was sicker. I wasn’t trying to be a hero; I was making a rational decision as a doctor.

Over the next couple of days, though, my condition worsened. The doctor decided to give me the drug too, and within an hour my body stabilized a bit. It was enough improvement for me to be safely evacuated to Emory University Hospital in Atlanta.

Shortly after I arrived at Emory, Amber called me from a phone outside my room. I don’t really remember that conversation, I was so delirious, but she said to me, “We watched you walk off that ambulance.” I said, “You were watching me?” and she said, “Oh, Kent. The whole world was watching you.”

I’ve had time to reflect on what happened to me. Am I the same person I was before Ebola? In a lot of ways, yes. I don’t live every moment with a conscious awareness of what I’ve been through. I still have the same flaws I did before. But I think whenever we go through a devastating experience, it’s not about there being some inherent redemptive narrative, but it is an incredible opportunity for the redemption of something. We can say, “How can I be better now because of what I’ve been through?” To not do that is kind of a shame.

When I thank God for saving my life, I am not unique in that. If you watch videos of survivors in Liberia, so many of them thank God for saving their lives. I chose a career in medicine because I wanted a tangible skill with which to serve people. And so my role as a physician is my attempt to do that. I’ll probably get tired of talking about my experience some day, but I went to Liberia because I long felt it was my vocation to spend my career as medical missionary. Deep in the core of my heart, I still think that’s my calling. I don’t want to go on with life and forget this.—*as told to Alexandra Sifferlin*

Dr. Jerry Brown, 46

Medical director and general surgeon at the Eternal Love Winning Africa [ELWA] Hospital in Monrovia and director of the ELWA 2 Ebola treatment center

I first heard about Ebola in March, when I was listening to the radio. That was late March. We had patients with Ebola presenting in Lofa County. In the counties that border with Guinea. So it was then that we really started panicking and thinking, Now that one of our counties is involved, what next? Sooner or later it might reach us, we thought.

So from then on we started thinking about Ebola.

The very first challenge I had as medical director at that time was that if we started having Ebola patients show up in our emergency room, well, “Where do we keep

them, doctor?”

The only place that came through my mind was our chapel, because we didn't have the financial capability to construct something. Our intent was not to create a treatment unit but instead to transform the chapel into a holding unit such that whenever we had a patient in the emergency room and we had the suspicion of the person being a probable or suspected case, the person could be kept in the holding unit until the patient would be transported or transferred to the treatment unit. So that was our goal for having the chapel used initially.



Jackie Nickerson for TIME

It was June 12, in the late evening after surgery. I had just left the OR when I saw a series of missed calls on the phone [from the Deputy Minister of Health] and decided to call her back.

She said, “There are two patients that we have, they are Sierra Leoneans, and they visited one of the hospitals already, Redemption Hospital. A couple of their staff have already encountered them. But their presentation, their signs and symptoms, and from where they have traveled, tell me that they are probable cases and they most likely have Ebola. And the only place I thought about that we could keep them until we can have an investigation done is at your center.”

The very first thing I felt was, this is going to be challenging to have those patients brought here. We had not attended to such patients before, so in the back of my mind I kept thinking, What would it be like, to have those patients here?

From that day onward, I always had the fear of myself or one of my staff getting infected, and what would become of me thereafter.

The first two patients were brought in an ambulance, with two of their relatives, in the back of the ambulance, along with the patients. The front of the ambulance had the driver and two health workers; one nurse and one physician assistant. What was shocking was that the nurse and the physician assistant never had any personal protective equipment. The only thing they had was gloves, and dressed in their ordinary scrubs. That was frightening. The two patients in the back of the ambulance, one had died on the way. And the other was lying there. And then a boy about the age of 13 and his brother, maybe around his late 20s, were both in the back of the ambulance. We could tell that they were Sierra Leoneans by their accents and the way they spoke.

We were shocked. First question was why the health workers allowed the patients’

caregiver to ride in the ambulance with them. It all boils down to people not knowing what a disease Ebola actually was. So no one knew what was happening. And I tell you, if we had not done some training initially, and spoke about Ebola repeatedly during our regular devotions, it would have been a greater disaster in the ELWA hospital. Through the training a few persons had some knowledge of what Ebola was all about: the mode of transportation, the means of prevention and the signs and symptoms related to the disease. So the bulk of the workers at this institution knew a lot about it. So it was a pity to see those workers in the ambulance dressed as they were. One of them is said to have died of the disease later, the nurse.

So initially, that is the situation we had. Dr. Kent Brantly and Dr. Debbie Eisenhut were the first two who were willing to dress in full PPE and took the patient down to the unit. It was very challenging to get the nurses on board the first day, though they had been trained. The patient died a few days later.

Before the end of June, the chapel, where we only had six beds, could no longer take additional patients because it was full to capacity. The initial intent of the unit in the chapel soon changed from a holding unit to a treatment unit. The chapel then became the first treatment unit in Monrovia.

So all the patients that were presenting with the symptoms [of Ebola] were all rushed here, to the chapel. [They] were dying every three, four, five days. Because of the rapid rate at which people were dying, you could easily find places to put someone else. By then the government in the middle of July created another ETU at JFK Hospital that became the second unit in Monserrado County, in Monrovia.

When the chapel became full and we could no longer take additional patients, and more people were getting ill and dying, the ELWA management decided to turn over our newly built kitchen and laundry for the new hospital under construction to be transformed into a treatment unit. Thus ELWA 2.

Within a week it was filled. We had 20 beds. Within one week we had more than 20 patients. Patients were now in the corridors and under the eaves of the building, and still patients kept pouring in daily. The outpatient department of the hospital was then turned over to be used as an extension of the unit, shutting down outpatient services to the public.

When it all started, and we had a unit set up, my wife did warn me not to enter the unit. So the first time I did enter I didn't tell her I had entered. But she knew I had been trained. I went home and said nothing to her. And the very first time she had a suspicion of me going to the unit was when Dr. Abraham Borbor, who was one of my mentors, got ill. And I had to go in and attend to him. I had been in the unit for two weeks without her knowing. And I went home one evening and started discussing a few things about Dr. Borbor. Borbor was my role model, especially when I was in medical school. How he was now ill, and how I was feeling so sorry for him, and how his condition was not improving despite what we were doing. And she paused, and asked, "You are not working in the unit. How do you know these things?" and I caught myself. And tried to change the topic. It went to something else, and she never noticed.

But then she started having suspicions. I remember her saying, "I hope you are not being stubborn. I told you not to go to the ETU." So I said, "Well, I will do my best." I formed some excuse and we just abandoned the topic. A few days later she noticed changes in the color of my boxers from the bleach or chlorine solution used for disinfection when leaving the unit. And so she said, "Ah, what is this?" and so I had no option but to finally confess. It did not go down well with her. I apologized, and we kind of talked about it for some time, and then she accepted. What she said was, "I can't stop you. I realize this is something you like, so I am not going to stop you. But just be careful. So when you are back home, change all your clothes in the garage before you enter the house. I do not want my children and I to get infected."

But before she said this, I never took any of my outfits back home. I had special scrubs that I kept at the hospital. Once I got to the hospital I changed completely into my scrubs. At the end of each work day, I changed back to my ordinary wear and went back home.

It was challenging to have her to accept this. She was afraid of me getting infected. She later realized that I was safe, and we kept trusting God to remain safe prayerfully. —as told to Aryn Baker

Dr. Mosoka Fallah, 44

An American-educated Liberian infectious-disease expert who returned to his country last year to help establish a school of public health and now leads the effort to find, monitor and isolate the contacts of Ebola victims

As an infectious-disease student [at Harvard] I studied emerging and re-emerging infectious disease, and Ebola was always what we were talking about. At the time I had come back to Liberia to work on a USAID project. It was March. Ebola was the only thing on my mind. It was already in Guinea. I understood the interaction between the people on the border, between Guinea and Liberia. And I knew that there was definitely going to be Ebola coming to Liberia.



Jackie Nickerson for TIME

It was one thing reading about a disease and then being in a disease. Maybe I could have raised the alarm, but I didn't. I regret that now. I regret that we didn't stop it in Guinea. Then the cases came to Liberia from Guinea. It was March, the 24th or 25th. I called [Assistant Health Minister] Mr. Tolbert Nyenswah: "I'm hearing about this Ebola, how can I help?" Everyone was coming in and thinking about how to mount an effective response. It was a task force.

It became much more personal for me, because one of the relatives of the [first person to be killed in the outbreak] in Lofa County had taken a taxi to Monrovia. And she slept in the Chicken Soup Factory [neighborhood]. I grew up there. My mom is there, all of my relatives are there. I said, "We've got to get our boots on the ground. We've got to go to Chicken Soup Factory." And they said to me, "This is the task force. We construct policies and strategy." And I said, "O.K., I'm going to go down to the county [level] where we can discuss boots on the ground." I led a team to Chicken Soup Factory. The index case had already left. But there were contacts like the taxi driver. I talked to him. He was frightened. He said, "I tried to help this old lady. If I do have the disease, I am going to spread it." We told the townspeople

to keep an eye on him. [We said], “Don’t stigmatize him. Don’t let him on the street.” Our contacts officer would go and take his temperature every day. And after 21 days, he did not come down with the disease.

That case had me running around recruiting and training people. And passing awareness. Then [in] April we saw the situation slow down, the number of cases drop. By the end of April, we weren’t getting any more cases. But I was a little bit worried. Given the fluid nature of our borders and the nature of Ebola, I was worried. I remember sending an email to a friend. “Very soon it will be in Liberia again,” I said, thinking of the increasing cases in Sierra Leone. Because when it hit Sierra Leone, it hit with so much force and ferocity. The cases mounted at an alarming rate. I didn’t know that was prophetic when I wrote that line to my friend.

On June 27 we had a new case. I got a call from the Ministry of Health. And it was in New Kru Town [one of Monrovia’s most crowded slums]. The population density and the denial allowed the disease to escalate. A landlady we approached [to do contact tracing] said, “If anyone says they have Ebola in this house, I will give you a slap.” I just walked out. There was so much resistance, so much denial.

As we tracked case by case, we got to know that the first index patient who died had gone to Redemption Hospital. He had come into contact with all the nurses. So we had to consider every nurse and doctor at Redemption a possible contact. Actually, I followed about 45 people that were listed as contacts. This nurse, Esther, had touched him, and she became infected. And Dr. Sam [Samuel Muhumuza Mutooro] from Uganda—he treated him, and he became infected. And then the man who took the index patient in the back of his car died, and the sister died. What we knew was only the tip of the iceberg. Even before the ambulance had gone [to take the first case for treatment], six people had died. There is a communal bathroom that all the houses use. It just blew our minds. All of a sudden we have this situation in New Kru Town, of all places. We were worried that very soon it would spread to West Point [another congested slum].

I was working to mobilize tracers, to train tracers. And there were contacts that we could not find. Contacts were becoming symptomatic and moving and exposing other contacts. Twenty-six people got infected by one person. And then the cases hit us so hard. We had contacts everywhere becoming symptomatic and generating more contacts. That’s when the tension was on. Seven days a week, 10 hours a day. And we were getting from 50 to 200 phone calls. The phone calls would come until midnight and start at 5 a.m. I couldn’t afford to turn the phone off. All through Ebola, I think I turned it off once or twice, and only when a friend said to me, “Go and rest. You look like a dead body right now. We don’t want you around reminding us of death.” And I slept for two days.

Very soon I realized that the response is not a single piece. It has to be holistic. There has to be enough ambulances. There has to be enough case investigation teams. There has to be enough burial teams. The sick will be waiting for someone to die [in the Ebola treatment centers] so we can have space. Everything we did on Ebola was dependent on the ETUs [Ebola treatment units]. And we didn’t have enough.

August and July were quite tough for us. People would die, and we were helpless. We just couldn’t do anything. I would have a contact tracer follow a family. The mother died. The sister died. The maid died. The wife died. The father died. And she [the contact tracer] would go there every day to do contact tracing on the symptomatic people. She would encourage them, but every time she came back, there would be one more body.

We were left alone. I have to say that. I always say that in July and August we lost a good window of opportunity. If they had come in with the ambulances and the tents, we could have averted a lot of death. If everyone had rushed in and built another [treatment unit]. They took such a long time to be built. Meanwhile, people were dying. The bodies would accumulate in the street. The burial teams would go

someplace for burial and they would be chased out.

I was always afraid that Ebola would be in West Point. The unsanitary conditions. The population density. The fluid nature of the population. It was Aug. 12 that I got a call. [A volunteer] called me and said, “Mosoka, you better come to West Point.” He said, “There is one dead in the house with the door locked. And the other is sick and vomiting and toileting in the street.” I left everything and I ran to West Point.

Nobody wanted to talk, nobody wanted to explain what was happening. I called a couple of leaders [from West Point], and they began to reveal to us that for the past two weeks there had been massive secret burial going on. They would take [the bodies] to an island across the bay and they would bury them. There was no investigation or contact tracing. That night I called the WHO Country Representative. I said, “Our worst nightmare has happened. West Point has Ebola.”

The decision to open a [Ebola] holding center in West Point was a desperate decision. West Point is congested. There is no way you can walk in West Point without touching. You have the sick walking around, vomiting and toileting. I said, “The best we can do for West Point is to get the sick from the population.” The community didn’t understand.

And then it was Aug. 19, the worst day of my life. It was a rainy day. That day alone we took six dead bodies from West Point. I think there was a lot of misinformation. There was still a lot of denial. And then [rioters] broke into the West Point [Ebola] center. They took mattresses. Where were those contacts? Where did they take the mattresses? There was a very big panic. The government had to deal with people running around with infected mattresses. They also knew that they had the secret burials. So the government quarantined West Point. Later, the government lifted the quarantine. The lesson we have to learn is that the government, before taking action, should consult with the community.

I’m cautious about the declining number of cases because with Ebola, a single case is an epidemic. Before we were fighting a big war. Now it’s a guerrilla war and we’re fighting little pockets. If it comes back, it’s going to be even more intense. It only takes one case, and then all our achievements are reversed.

On Tuesday, Nov. 11, we got a call that a prayer leader had died from Ebola. Thursday morning, they brought a casket to carry the body. There were people there rubbing oil on her and praying for her. Forty people. Children as young as 3, 4. All of them under a tent. So as I speak to you, three of the people that were in that room are in the [treatment unit] today. This is in New Kru Town, where it all started. That’s what I am trying to say. It came back. —*as told to Aryn Baker*

Dr. Philip Ireland, 44

Liberian doctor at John F. Kennedy Medical Center in Monrovia, Liberia’s largest hospital

We had several cases of clinicians at the John F. Kennedy hospital who have come down with Ebola. Dr. [Samuel] Brisbane [and] physician’s assistant Stephen Vincent. And then I came down next.

It was in a meeting [on July 24] when I had this splitting headache. I saw flashes of lightning. I have never had a headache like this in my entire life. And I knew something was very, very wrong.

I did my temperature; it was 38.1 Centigrade [100.58 Fahrenheit]. And I said this sounds like, smells like Ebola. This can’t be malaria because I’ve had malaria a thousand times. And I know how it is. This is completely different.

I called the chief medical officer, told him I wasn't feeling so well. I told him, "Doc, I think I have been exposed to Ebola, and I want to be tested." And he was instrumental on the next day to have me tested. The guy came in the house dressed in the entire space suit, into my room. They did the test. The next day we found out that I was Ebola positive.

By day seven I could not feel my radial pulse. I was in early shock. I was really sick. Very, very ill. My colleagues said that if we don't get him out of here [his home] today, he's

going to pass. And I felt that way for the first time on day seven. I felt I was in shock. If I didn't get IV lines going I was probably going to die that day.

So my fellow doctors, a pediatric resident at the hospital, and an ob-gyn resident, and also my wife and her brother, all of them were calling to see if they could get an ambulance. But in Monrovia there were no ambulances [available] at the time. So they found this ambulance that was having some parts replaced at a garage. They were repairing the breaks. And [one of the doctors] literally sat there and waited until this ambulance was repaired and brought to the house.

Then we got to the hospital, to the Ebola treatment unit. I collapsed on the bed and passed out. I woke up and found out that they have given me three liters of IV fluids, saline. And I felt a little better.

That night was the worst night at ETU. I had 46 episodes of diarrhea and 26 episodes of vomiting. I was in a sea of mess. The next day there was this physician's assistant—I will never forget him. His act of love towards me, to wash me, was so much so that I will never forget it in my entire life. He cleaned me totally. He dressed me, put me in a clean bed. And I felt that was so, so, so nice. I really appreciated that. I felt so relieved.

The very first night I woke up to some loud music. They had turned the SUV around and opened the doors and turned the music up very loud. Gospel music. And all the artists were singing, "You're going to make it, you're not going to die."

At that time I already had headaches; I felt like a nightmare. Like you had the speakers right [next] to my windows and boom, boom, boom. And then they had a mixture of different kind of people, like some people were in there with fever or malaria. We weren't all Ebola patients. Some people had strength, and those who had the strength will have prayer services of what we call vigils. And there was singing and praise God the entire night. They were singing and praying the entire



Jackie Nickerson for TIME

night. And that was tiring. They would sing and pray the entire night. After one night of that, [two infected doctors] said, “No, no more praying to God. If you want to talk to God, do it silently in your heart.” So they stopped the vigils.

By day three, the morning of day three, I started to do some terrible, terrible hiccups [a symptom of advanced Ebola]. That was when the clinicians taking care of me thought I was going to die. And they communicated that with one another. In fact, at one time I was hiccupping with every breath. So they thought I wasn’t going make it. They were even discussing whether I would be cremated or buried. And the news circulated that selfsame day that I had passed. I was in bad shape at that time. But after that day, day four in the ETU, I started to get better. When they came in to check on me the next morning they met me standing. And they were very surprised.

I stayed there getting better, getting better. I was actually in the Ebola Treatment Unit for 14 days. And by day 10 in that place, which was like 17 days of illness, I was feeling much better. There was no more diarrhea, I didn’t have fever. Now I did have complications. I had pneumonia, I had hallucinations of all kinds of different things. Besides the acute renal failure.

So by day 17 I was much better. So the guy did another test and the test results came back negative. And then came day 14 [in the ETU]. I was told 20 minutes before I left the Ebola Center that I would leave the Ebola Center. They said, “Dr. Ireland, you have to take a chlorine bath.” And I said, “Is the water warm or hot?” And they said, “No, it’s cold.” And then I said, “I’m staying. I’m not going anywhere.”

Where I was, you have mosquitoes flying all over the place and cockroaches. So I said, man, let me get out of here. So in the evening I mustered up enough courage to do the cold chlorine water bath. They had me strip in front of all the nurses and the physician’s assistants. And the male physician’s assistant had to ask them to leave to give me some privacy.

I had two buckets of the chlorine water. Very cold, icy water. And then I put on this T-shirt, sweatpants. And I had to go to the spray where I got sprayed thoroughly. In my ears, in my face, with my clothes on. When I left I was so wet. I was drenched with chlorine water.

And I came outside. Now you have to bear in mind I am very, very fragile and weak. I’m still sick. I’m just glad I made it, that’s all. And I walk out and there are people singing all around me. The nurses were singing with their beautiful—they were singing and so happy. I was being released at the same time as a nurse. Nurse Barbara. And we had people from JFK there, my family, my elder brother was there, my wife was there. We had a lot of other doctors that were there. We had members of the press. A lot of people had turned out. And I felt like Nelson Mandela. I always use that description. It felt like the Long Walk to Freedom. And even though it was a short walk, for me, because the energy I had to expend because I was so weak, it was like a walk to freedom.

And I walk up and I raised my hands to heaven, thanking God for saving my life. And then I noticed something also. There were a lot of crying people, people happy to see me.

And when I got close to anybody, they actually backed away. —*as told to Aryn Baker*

Dr. Bruce Ribner, 69

Medical director of Emory University Hospital’s Serious Communicable Disease Unit in Atlanta

When we knew we were getting our first patient with Ebola back in July, we said, “This is what we’ve been training for 12 years. We’ve drilled this at least twice a year for over a decade. This is what we’re here for.” We knew we had an opportunity to do something that basically had not been done before. There had been lots of people dealing with patients with Ebola virus, but never in an environment where we offered them a real chance of survival.



Bryan Schutmaat for TIME

Early on in the outbreak, I knew there were people in Africa who had Ebola virus infection, and I knew there were Americans there. I also knew that if they were transferred back to the United States, there was a high likelihood they would look at us, since we have one of the few units in the United States designed to care for patients with that kind of infectious disease. In the back of my mind I also knew there were CDC employees who were in West Africa working on the outbreak, and our primary mission is to support CDC workers. But I was not thinking about a civilian until I got that phone call [about Brantly and Writebol].

Being a hospital epidemiologist, I’ve raised the issue of building a unit like ours at every hospital I’ve been at. In most of these places, no one did too much about it, because, what the heck, that’s not really going to happen here. With the CDC being in Atlanta, it was a very real concern and mobilized many more resources.

Although I have to tell you, I felt like Noah building the Ark. The unit was open for 12 years, and we had all of two activations—which both turned out to be negative—and over the past several years, there were people questioning whether or not what I was doing was really something that had value. A part of me said, Gee, this is frustrating that we’ve had this open all these years and spent all these resources and we haven’t really been needed. I guess ultimately it turned out I was right.

When an Ebola patient presented at Texas Health Presbyterian Hospital in Dallas, we were on the phone with their clinicians two to three hours a day, getting updates and talking about appropriate medical management. When a sick physician was admitted to Bellevue in New York, we were also on the phone with them for one to two hours a day. I got a phone call about the Dallas nurse, Amber Vinson, coming to our unit at 2:30 in the morning. The facility had decided that since they now had two nurses that were ill and too many of their staff were quarantined, they really needed to transfer those nurses to other facilities.

It’s clear, unfortunately, they had not done the kind of planning they really needed for the possibility of a patient showing up at their doorstep. I’m very sympathetic. It really did serve as a wake-up call that all hospitals need to be prepared.

Our own protocols from Day 1 haven’t changed much. We came up with procedures and protocols that have really stood the test of time.

I feel greatly for my colleagues in Africa, but the bottom line is you can’t expect good outcomes when you’re treating patients that way. In the process of getting our patients better, we are learning a great deal about the virus and we are adding an

enormous amount, which we hope feeds back to our colleagues in Africa, so that they perhaps can no longer have such high fatality rates.

I'm surprised we haven't had more patients. We are prepared for more patients with Ebola, and we're ready for other diseases too. It's always the one you don't anticipate. Who knew MERS was going to come up? Who knew SARS was going to come up? And who knew that Ebola virus was going to spread to West Africa and become this hideous outbreak for almost a year?

We really take an all-cause, all-infections approach because we know that whatever comes is likely going to be something we didn't plan for. —*as told to Alexandra Sifferlin*

[TIME's 2014 Person of the Year: The Ebola Fighters](#)

[Why We Chose the Ebola Fighters as Person of the Year](#)

[Read the Ebola Nurses' Stories](#)

[Read the Ebola Caregivers' Stories](#)

[Read the Ebola Scientists' Stories](#)

[Read the Ebola Directors' Stories](#)

© 2015 Time Inc. All rights reserved.

Powered by [WordPress.com](#) VIP