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Evidence-Based Guidelines for Supportive Care of Patients with Ebola Virus Disease

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engineering, and maths (STEM) workplaces as “deeply misogynistic”.¹ In the UK and Australia, schemes, such as the Athena SWAN Charter have also shown that STEM workplaces cannot be gender inclusive without institutional commitment to removing unconscious bias.³ Medicine is one STEM discipline in which gender balance already exists at the undergraduate level; however, Janet Pope’s Comment in the same issue of *The Lancet*⁴ emphasised that this gender balance is not reflected at the leadership level.

Both Pope and *The Lancet* agree that the “leaky pipeline”¹ needs to be fixed to prevent wasted talent. Pope also offers practical advice to help women progress up the ladder into senior roles. But what has not been discussed in either piece is what happens once women break through the glass ceiling in a male-dominated STEM speciality. As senior STEM academics, we would argue that thought should also be given to understanding what happens next. Studies in other professions indicate the existence of a “glass cliff” effect,⁵ with women reported to more easily fall from a position of leadership because of a single mistake than a man in the same position. We are in the process of exploring whether this unconscious bias applies to women in transplant leadership roles.⁶ Our initial findings suggest the presence of a subtle rather than overt glass cliff effect in this field.

We declare no competing interests.

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Beyond vaccines: improving survival rates in the DRC Ebola outbreak

Even as an experimental vaccine is being deployed to limit the ongoing Ebola outbreak in the Democratic Republic of the Congo (DRC), provision of the clinical care necessary for improving survival among infected patients must also be prioritised. During the early part of the 2013–16 west African epidemic when intravenous fluids were not readily available, the nearly four-fold difference in mortality between patients treated in high-income countries (18·5%) compared with those managed in west Africa (70·8%) suggests that aggressive hydration, among other measures, could improve outcomes.¹

Based on this experience, WHO issued guidelines for managing Ebola-infected patients with an emphasis on early and aggressive hydration.² However, few countries in the region have received the support necessary to actually implement these guidelines. For example, less than a third of the US\$4·5 billion pledged for strengthening health systems in the three affected west African nations has been disbursed.³ DRC has chronically weak health systems and will need an influx of support to provide effective treatment for patients in this outbreak.

WHO, Médecins Sans Frontières, and others are working rapidly to establish isolation and treatment sites and should be given the resources

they need to boost survival rates. Going forward, rather than scrambling to establish capacity when there is an outbreak like this one, ensuring stronger health systems in the region must become an ongoing priority.

We declare no competing interests.

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Where is the official guidance on Ebola and surgery?

A new outbreak of Ebola is underway in the Democratic Republic of the Congo (DRC).¹ In the two years since the west African outbreak ended, we now have a vaccine, but still no official guidance on Ebola and surgical care.

During the west African outbreak, various organisations developed ad hoc protocols and guidelines.² Data showed how surgical volumes plummeted, and that many patients likely died not from Ebola but from surgical conditions such as perforated ulcers, incarcerated hernias, obstructed labour, and road traffic injuries that went untreated due to fear from health-care workers.³



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