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The limits of medical heroism: reflections on *Getting to Zero*

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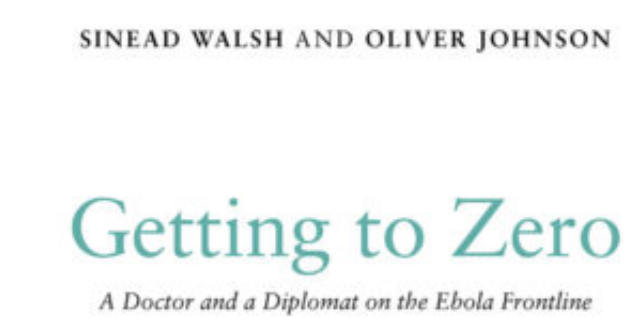

[Getting to Zero: A Doctor and a Diplomat on the Ebola Frontline]

By Sinead Walsh and Oliver Johnson

Zed Books, 2018. 352 pages.

It is midnight and my five-month-old son, who has been sick with diarrhea for two days, is finally breathing evenly beside me. I should be sleeping. Instead, I am fretting, turning over the intimate logics of medical responses to the 2014 Ebola outbreak in West Africa. The geometry of care, as Oliver Johnson and Sinead Walsh describe it in Getting to Zero, the recently published account of their time on the Ebola frontline in Sierra Leone, is simply unfathomable. I cannot get my head around it.

The enduring image I cannot get out of my mind is of small children dying alone and without physical contact inside the isolation facilities and Ebola Treatment Units (ETU) established to care for them. Early in the outbreak, such images were linked to the chaotic response at rural health facilities that were unprepared for the outbreak and quickly became overwhelmed. Johnson and Walsh cite the heart-breaking reporting of the New York Times' Adam Nossiter, who described a child at one isolation facility in the north of the country standing alone in a cot while a four-year-old girl lay bleeding on the floor nearby.

Later in the epidemic, new treatment facilities were opened in Freetown by the British government, but these were encumbered by centralised decision-making and bureaucratic protocols. On a visit to a newly opened ETU run by Save the Children for the UK, Johnson, observed that "the corpse of a small child who we were told had died during the night had been left on one of the beds" – a clear danger to the other patients in the unit – because the required burial team was taking time to assemble (259). Even the flagship isolation unit Johnson helped set up in Connaught hospital, the largest Government hospital in Sierra Leone, was locked overnight because there were no night staff and they could not risk patients leaving and infecting others. Johnson recounts how one morning he entered the room for high-risk patients at the beginning of the morning shift to find that all six patients had died (185). What desperate movement and noise went unwitnessed in the hours before he stumbled on that terrible tableau is unthinkable.

Later in the book, we learn that unaccompanied babies in ETUs were given to teenage girls with Ebola to look after, and many of the girls who survived were subsequently traumatised by the experience.

At the heart of Johnson and Walsh's book is an

uncomfortable truth: the initial failure of national and international organisations to respond to the outbreak was followed by a response that was effective in public health terms but woefully inadequate in its medical humanity.

Johnson came to Sierra Leone to establish the King's Sierra Leone partnership, a charitable arm of King's College London's Centre for Global Health. Walsh was the Irish ambassador to Sierra Leone, a role that included oversight of Ireland's aid programme. As the outbreak unfolded, both unexpectedly found themselves on the frontline of medical and diplomatic efforts to establish an effective response. For the first six months of the outbreak, medical workers, politicians, diplomats, NGO workers, donors and international response workers struggled to mobilise resources and coordinate their efforts in the context of disconnected aid, intense political distrust, and weak health infrastructure. With the World Health Organisation's (WHO) modelling suggesting that the epidemic was spiralling out of control, the mantra of reducing transmission held sway (Kelly, 2018). In the midst of a public health emergency it seemed legitimate, even obvious, that public health should take priority over individual care, and the response focused on well-tested public health measures designed to reduce the risk of new infections (contact tracing,

isolation facilities, quarantine, safe burial). Johnson and Walsh played significant roles in this effort, fighting to mobilise the resources and political will to open new beds in ETUs.

But, as Johnson and Walsh reflect in hindsight, even in these units, treatment was sidelined. The epidemiological arithmetic of crisis meant that medical infrastructure was reduced to a series of containers (gloves, buckets, beds, ambulances, isolation wards) designed to prevent the transmission of infectious substances at different scales. As Johnson and Walsh tell it, isolation wards and ETUs were neither places of treatment nor care; their tarpaulin walls, plastic sheeting, PPE (personal protective equipment) and locked doors amounted to little more than a series of fragile barriers between the sick and the healthy. This was not even the 'minimal biomedicine' that anthropologist Peter Redfield has described for humanitarian contexts where the goal of facilitating biological survival occludes fuller concepts of social, cultural and political life (Redfield, 2013). For much of the epidemic, Johnson and Walsh admit, it was taken for granted that diagnosed patients were already lost and efforts needed to be focused on preventing future infections. The absence of an effective public health response meant that critical reflection on the costs of a public health approach

and the harm it can do alongside the good – to individual patients, and to public trust in governmental authorities and health workers – was impossible.

As I join the dots, drawing out the lines of human connection and disconnection between locked doors, beds with holes in them and buckets underneath, divided by plastic sheets, and sporadic visits from spacemen in plastic suits, a terrible truth dawns on me. If my sick baby son, whose expensive absorbent nappy I am changing hourly to prevent nappy rash, who I am breastfeeding after every loose stool to prevent dehydration, had been an Ebola patient in Sierra Leone in 2014, I would have been faced with a stark choice: I could have sent him to an ETU, where he would have lain alone, a small body on a plastic covered mattress, would have received no cuddles, no frequent nappy changes, washing or feeding, and where he would most likely have died covered in his own faeces, vomit and blood. Or, I could have tried to care for him at home, knowing this would make it highly likely that I and other family members, including my other child, would become infected. As I lie in bed listening to my son's breathing, one thought repeats itself over and over: there is no way would I send my child to die alone on white plastic.

The blurred lines of emergency

For Sierra Leoneans during the outbreak this was not presented as a choice at all. In a highly militarised response, sending sick relatives to an ETU was the only acceptable thing to do, because this was the only way the authorities could reduce transmission and get a handle on the epidemic. At the time, those who hid sick relatives and cared for them at home were portrayed by government representatives as ignorant and selfish.

For the most part, Johnson and Walsh describe being caught up in this logic of containment, their discomfort with the lack of dignity afforded the sick only emerging with hindsight. On first impressions, this therefore looks like a straightforward story about the ways in which cultures of crisis can momentarily shift moral boundaries and rewrite norms for medical interaction and care. In this reading, a public health emergency is a time and space of exception in which the usual norms governing conduct are temporarily suspended in the face of an immediate threat to life. From this viewpoint, the lack of care provided to individuals at what was clearly an exceptional time of medical, political and administrative crisis looks horrible but possibly justifiable. Yet

the story is more complicated than this, because the moral tale that Johnson and Walsh weave does not follow fixed spatial and temporal coordinates.

That the emergency, and the suspension of medical norms governing how persons should be treated, had no clear territorial boundaries became a pubic scandal when expatriate volunteers who became infected with Ebola were evacuated from the country and treated with experimental drugs, raising questions in the international media about the racialised nature of the response. Later in the outbreak, Johnson fought to prevent a Sierra Leonean medical colleague being sent to Hastings, a government-run ETU that only a few pages earlier Johnson had celebrated as an unexpected success. Johnson thought the doctor would get better care at the UK run facility that had been built and recently opened for expatriate medical staff. A combination of miscommunication and a breakdown in trust led to the doctor being admitted to Hastings anyway. The doctor subsequently died and Johnson describes his continued anger at this needless death. But Johnson's moral outrage in this very personal case also exposes the deplorable conditions experienced by most Sierra Leonean Ebola patients, who would have been sent to Hastings

as a matter of course.

Throughout the outbreak it was clear that emergency measures in some cases justified the horrific conditions that existed inside isolation and treatment facilities, but not in others. Veiled racism, professional allegiances and personal ties either tightened or loosened the cordons of emergency control, in some instances dictating that medical norms of personal care and dignity be upheld and in others that they be relaxed in the name of public health. The irony, of course, is that this kind of selective treatment of friends and relatives is precisely what international aid workers brand as African corruption when it comes to political and financial affairs.

If the territorial parameters of the emergency were unclear, unpatrolled, and racially uneven, then the temporal boundaries were equally blurred. In a post-conflict country with a drastically depleted health infrastructure, the militarised response did not mark a distinct moment of emergency so much as continuity with a violent past. And in the final months of the outbreak, as efforts to "get to zero" straggled on, it became increasingly unclear whether this was still an emergency, with the necessary sense of urgency and suspension of usual rules of conduct that this entails, or whether the situation had now

become 'chronic.' Walsh describes how putting basic human rights and dignity on hold might have been justifiable in the first throes of crisis but became questionable when that crisis went on for 22 months and set a worrying precedent for the future.

Public health emergencies are not only governed by spatial and temporal boundaries that contain and justify moral compromises, they are also shaped by systematic exceptions to their own exceptionality, exceptions that run along the deep-run grooves of imperial racism and development ideologies. There are intimations that both authors experienced occasional moments of hesitation, uncertainty, guilt and confusion during the outbreak, moments in which they caught a glimpse of their future selves reflecting on their actions and judging them by the norms of a post-emergency era. Looking back, they both seem thoroughly unnerved. How did they end up becoming a part of a response that didn't meet the basic human rights they would normally take for granted? How were they part of a response that treated black bodies so differently from white bodies? The power of the book lies in the authors' growing awareness of their complicity in an emergency order that treated sick Sierra Leonean bodies as a risk posed to a global population rather than persons

deserving of love and care.

Another kind of hero

Emergencies call for heroes and a palpable sense of disappointment with the Sierra Leonean politicians and doctors they worked with runs through Johnson and Walsh's book. But while Johnson and Walsh express their discomfort at the way sick Sierra Leonean bodies were amassed and contained, their individual characteristics, relationships and lives effaced by the mantra of reducing transmission, the authors are less reflective about the demands for individual heroism and leadership they make of Sierra Leonean health workers and politicians.

Johnson, in particular, exudes a sense of frustration that the doctors with whom he worked at Connaught did not behave like the international volunteers, including himself, who were risking their lives to save others. At one point Johnson describes reprimanding a Sierra Leone doctor for resigning from his role of running the isolation ward. Johnson tells the doctor that if he leaves his post, the hospital will close and the response will collapse. "I decided to… use every argument I could think of to convince him… How his country needed him desperately and was calling out for his bravery" (137). When the families of three

male nurses give them an ultimatum of leaving the isolation unit or leaving home, Johnson states with pride and in phrasing that is redolent of glorifying war narratives, that "the three men chose to put their commitment to their country above their own interests and stayed at their posts" (287).

But the respective stakes involved in treating infected patients were very different for Sierra Leonean doctors and international volunteers. Risking one's life does not always have the same value. What a life might mean in Sierra Leone, where a doctor's salary frequently supports a large extended family and where individual educational success reflects the emotional and financial investments of many, complicates notions of medical heroism. In the view of family members, the heroic thing to do in a medical emergency may well have been to stay alive.

Moreover, for health workers in Sierra Leone, who had studied and worked through a long civil war, and for whom the depleted conditions of under-resourced hospitals were routine, the outbreak may have been experienced as an intensification of inadequate provision and a chronic lack of recognition for their work, rather than an exceptional moment deserving of a

special, energised response. This perspective manifests itself in the frequent strikes by Sierra Leonean health workers who did not receive the hazard payments promised by the Sierra Leonean government, ostensibly in recognition of the dangerous work they were undertaking.

Johnson was in Sierra Leone to establish a medical charity and his understanding of leadership is steeped in a long history of missionary medicine and humanitarian heroism that leaves no space for these kinds of personal obligations or professional disenfranchisement. Still, Johnson's words had some impact, and the doctor that he reprimanded returned to work. Later that same day, when the doctor, covered in blood from a botched attempt to inset an intravenous line in an infected patient, walked to the decontamination room to remove his protective clothing (PPE), he found that the chlorine had not been prepared and he had to remove his protective clothing without it. He began to get symptoms a few days later and died at an ETU soon afterwards.

At another point, Johnson describes how he said goodbye to a dying nurse who was being transferred to an ETU: "When I spoke, it would have to be for all of us, it felt like too much responsibility. I told her she was a hero. I told her

I loved her, that we all loved her. And I stepped back out again" (169). I wonder how much reassurance this attribution of national martyrdom from a white British doctor gave a dying Sierra Leonean woman in a post-conflict context, where distrust in government and political divisions runs deep and health workers are not treated as a valued resource?

The willingness of international volunteers to work during the Ebola outbreak deserves acclaim and the contribution they made to containing the epidemic was significant. But their willingness to accept the personal risks involved also needs to be understood in relation to a long legacy of imperial and medical intervention in other countries, to local cultural tropes of individual heroism and martyrdom, and to conditions of relative economic and social stability in their home countries that cannot be realistically transposed to workers in Sierra Leone's health system. Were the colleagues that Johnson celebrates heroes, or were they victims of medical heroism who died while trying to meet the multiple registers of familial and humanitarian obligation imposed on them?

To their credit, Walsh and Johnson are reflexive about many, if not all, of these issues. They write:

> *We frequently lacked the indignation that we should have felt about the horrendous conditions that so many people were experiencing. Consciously or not, many of us had modified our standards to 'fit' the setting of a poor country where it was 'to be expected' that people died unnecessarily all the time. We wouldn't admit it, perhaps not even to ourselves, but we didn't always prioritise every single Sierra Leonean life the way we would have if this outbreak had been affecting Irish people or British people or Americans (347).*

They also have important recommendations for future outbreak responses, including the importance of maintaining interpersonal empathy, ensuring community involvement and aligning emergency planning with health system strengthening. But the first-person narrative, which positions the authors as protagonists in a sea of incompetent WHO workers and politically motivated or corrupt Sierra Leonians, elevates their actions to a higher moral plain and has echoes of the colonial interventions that sowed the seeds of degradation in the current health system (Beisel, 2014). Like colonial authorities in the past, they are also hung up on leadership, but fail to explore what a 'good' leader might mean

in Sierra Leone and for Sierra Leoneans.

This book is gripping in a way that much historical or anthropological scholarship on the topic is not. The story unfolds apace with the epidemic itself, revealing its charismatic protagonists, villains and victims on route. But something is also lost in the conventions of a confessional genre which requires a heroic narrator(s), and that is attention to the limits of medical heroism itself.

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