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Fevers, Feuds, & Diamonds: Exploring the Ebola Epidemic

Dr. Russell:
An epidemic rages in West Africa. What are the causes beyond the virus? Welcome to ReachMD *Book Club*. I'm your host, Dr. John Russell. I'm talking today with author Dr. Paul Farmer, about his book *Fevers, Feuds, and Diamonds*. Dr. Farmer is an infectious disease doctor, Chair of Global Health at Harvard Medical School, co-founder of Partners in Health and an anthropologist. So Dr. Farmer, welcome to the show.

Dr. Farmer:
It's great to be here. Thank you for having me.

Dr. Russell:
So how did you get involved in the Ebola epidemic in Sierra Leone in 2014?

Dr. Farmer:
Well by happenstance, I happen to have been working to organize along with many colleagues a conference on surgical care in resource-poor settings. This is part of a Lancet Commission on surgical care in resource-poor settings. We had the first meeting at Harvard, the third one in Dubai. And I was saying we have to have the second one somewhere in the middle of the clinical desert, , or the report won't have the force that we would want it to have. And it's really no more than that. And we ended up not canceling the conference, even though it occurred in the very month that Ebola hit Freetown, the capital of Sierra Leone. And I'm really glad we didn't because that was my entree.

Dr. Russell:
So you and your team certainly have done a lot of work in resource-poor areas of the world. How does Sierra Leone compare and West Africa compare to some of the other places that have less resources?

Dr. Farmer:
Well it's a funny term, as I could tell you appreciate from the way you said it, resource-poor settings, there are plenty of those in resource-rich nations, of course. But I think some kind of comparative scale is helpful. After 35 years working in rural regions of Haiti, Rwanda, Malawi, Lesotho , I can say a couple of things; one is it looked a lot like those places years previously where there isn't the staff, stuff, space, systems, and support necessary to run a medical system.

But those resources can be put in place. And so even though it is possible to say it reminded me of those rural, clinical deserts, it certainly was startling to see that even in the urban areas, and in the capital city, it was also a clinical desert. I mean, there was no ICU really to speak of in the country of Sierra Leone and Liberia wasn't any better. And Guinea was a little bit better; probably not as much as we would hope. So these are among the most arid clinical deserts in the world today. Or they were in 2014. Less so now.

Dr. Russell:
As Ebola found its way for the first time to West Africa, how did the infrastructure respond to this? Did they rush to conventional medicine? Or did they seek kind of other ways to have their illness taken care of?

Dr. Farmer:
It's a great question. And one that has occasioned a lot of confusion. For example, everywhere in the world, people resort to whatever they have available in terms of a formal medical system when they feel ill or are injured. And that was true in Sierra Leone, Liberia, and Guinea. People went to what remained after war of the health systems. And so it was never the either-or option that we hear, you know, “traditional healer” versus those “sensible nurses and doctors” that staff, the formal medical system, it was never like that. And never is.

I've never seen that in Haiti, Rwanda, Malawi, Lesotho, or the United States. Right? People do what they can, they're taking in lots of information at one time. It's a very confusing situation in the midst of an epidemic. And we know that now, because that's what we all experienced in the midst of a pandemic. People did not flee our services. The real problem was that we're just too few of them.

Dr. Russell:
So you wrote about this being a disease of caregivers. Could you expound upon that a little bit?

Dr. Farmer:
Sure. A lot of diseases are diseases of caregivers. And there has to be a link to make them disease of caregivers. For example, with Ebola, it was the obvious fact that the two main sources of ongoing community contagion tend to be the act of caregiving for one's own family member or the last act of caregiving, which is burial of the dead. So those two arenas in a setting where there's very weak health systems are often largely in the hands of traditional healers and family. Right? We saw in the very early months a strong desire to be able to seek professional medical care from nurses and doctors and others. But there really was never the kind of access to that that was required to really slow down the epidemic, not until much later, in the course of it when there were more Ebola treatment units. And those Ebola treatment units, of course, had to be providing high-quality care, or people would just say, “Hey, these are death traps, let's flee them.” And that was very much the first half year of the epidemic. And it's why it didn't slow down.

And we see this control over care paradigm at work throughout the developing world. It's a much harder sell, of course, the United States, even in the midst of the COVID-19 pandemic, but we see this control over care response again, and again, in any post-colonial situation.

Dr. Russell:
So once upon a time, there were lazarettos, right? There's still one outside of Philadelphia. And once upon a time, they were the places where people didn't get so much care but were really sent to be quarantined. And who would want that?

Dr. Farmer:
That's right. And if we look at our remote history of lazarettos, and even today in Massachusetts, it's possible to detain someone against his or her will, if they have active pulmonary tuberculosis. But these are not strategies to which we've had common recourse in many years. But if you look at West Africa, and across the continent, the whole history of lazarettos, treatment units, isolation units, quarantine hospitals, it not only is much more common, but really never went away. So there's still this outmoded approach, which I've called “control over care,” which I think hampers a lot of our efforts to stem outbreaks.

Dr. Russell:
So how did you and your Partners in Health team get actively involved in the epidemic that was happening in West Africa?

Dr. Farmer:
We offered to provide clinical care. That's how we got involved. And yes, we were going to be involved in all efforts to halt Ebola spread. But how much of those efforts requires the knowledge in the general population or the broader population, that if they fall ill or injured, that someone's going to take care of them. And we believe that was a massive problem, that it wasn't at all clear for many months that Ebola treatment units were for anything more than isolation. And again, isolation is not what people are looking for when they're sick.

Dr. Russell:
What struck me is one kind of the saddest parts in your book is you had a friend and colleague, an infectious disease doctor, who took ill and passed away, whereas when there were healthcare volunteers, healthcare workers from Europe from the United States, who would have an issue they were suddenly airlifted out to be cared for. What's behind that dichotomy at least locally?

Dr. Farmer:
Well, the dichotomy itself is easy to explain. In a clinical desert, there isn't a healthcare system able to protect those who are ill or injured, so people look elsewhere. So that part is easy to explain. The hard part and the painful part, including watching Humarr Khan die rather slowly in Eastern Sierra Leone while awaiting being airlifted out, that never happened. The painful part is knowing, of course, that the only way around this for the majority of people who could never find a sponsor to airlift them out to another country is to build up and rapidly that healthcare system and allow it to be able to provide both disease control measures and care. And that's what we had to focus on. But I would add that it was something to celebrate whenever anyone was airlifted out of the medical desert. It was something to say, ‘Hey, we wish that everybody who fell ill could be taken somewhere safe, where they could recover,’ and that's really only going to happen by putting in place those stronger health systems that include, by the way, hospitals at the end of an ambulance ride and an ICU, if necessary. So we've been attending to that challenge in the years since, and even in the years of Ebola.

Dr. Russell:
If you're just tuning in, you're listening to ReachMD *Book Club*. I'm talking with the Chair of Global Health from Harvard, Dr. Paul

Farmer, about his new book *Fevers, Feuds, and Diamonds.*

One of the things I learned in reading your book, is this almost the concept of Ebola long-haulers. Right? And I certainly think that that isn't something that kind of matriculated here to the states that the people who survived oftentimes were left with great burdens from the infection, correct?

Dr. Farmer:
That's right. And one of the biggest problems with Ebola long-haulers is that we had plenty of warning. We didn't have a warning with COVID because we didn't have anybody from previous decades known to have had the disease and survived. But we had plenty of examples from Ebola and Marburg that this was a chronic disease as much as an acute one, and that the complications could include blinding inflammation of the eye, joint disease, kidney disease, et cetera. So we had some warning. And this is not talking about trauma, psychological damage, the losses that people incurred; we knew that there would be long haulers. And in fact, that explains our very first action as Partners in Health in West Africa, which was to hire every Ebola survivor we could and then find ways of working with them, not because they had immunity to a second infection they may have, they probably did, but rather because we knew that the lived experience of the disease was important, and that we could build up community trust by engaging those who had already survived that disease.

Dr. Russell:
I think there's a beautiful character, in your story, Ibrahim Kamara who who was one of the survivors. His life kind of jumped off the page in certain ways. Can you tell our audience a little bit about his story?

Dr. Farmer:
Well this was a young man who I actually didn't provide his acute Ebola care. I met him in November, right around Thanksgiving 2014, which was after we'd been there for a while. And he did something that surprised me. And he was seated next to me and I assume that that's because he's the only member of the group that night that I didn't know. And he told me that he lost over 20 members of his family to Ebola, and he was waiting for me to say something. And I was just rendered mute because I was thinking, 'My, God.' I mean, I've been an infectious disease doctor for a long time, and I can't remember any pathogen that takes out like a whole family. So he also asked me to interview him, which you know as a card-carrying anthropologist and clinician, you're always hoping people will ask you to interview them, but they never do. So this was also a kind of new experience. And then I learned a lot about his life and his losses, of course. I was reminded that every adult Ebola patient we had also survived a brutal and long Civil War, and I was reminded of the physical penury of not having enough resources to do the things that you want to do or want for your family members, like send them to school, make sure they have adequate medical care. And again, I kept on being reminded or make sure they're buried with respect when they go. So I learned so much from Ibrahim. I also have said in the book is that he really inspired me to write it.

Dr. Russell:
So you quoted Dr. Larry Brilliant. I've had him on the show, talking about his book, that "outbreaks are inevitable, pandemics are optional." Why did that quote resonate with you?

Dr. Farmer:
Well first of all, knowing him, he's a very brilliant thinker and one of the guru's behind the smallpox eradication, which all of us think of as the most successful public health intervention in history. And when I read that or heard him say it, I thought, "Well, that is so true." And there's so much we could do to limit the size of an epidemic so that it never becomes a pandemic. And of course, everybody looks back at the great pandemics, whether influenza, which I got to do in the book, or HIV, I also considered, but you know, these events are ultimately world shaping. There's so much that comes out of that quotation, you know that epidemics are inevitable, and pandemics are optional. But it's a reminder to me of the power of human agency. We get to make a decision in this and have an opinion about this. How big do we want our epidemics to grow? And do we ever want to face another pandemic, like the one we're facing now?

Dr. Russell:
And I think a big part of the book is actually talking about West Africa, and so much that you potentially have a place that is so resource abundant with regard to things that people will find valuable; diamonds and precious metals, yet it never seemed to matriculate down to the average person there. And Civil War, the slave trade, so it's a complicated soup, correct, that that led to this pandemic?

Dr. Farmer:
It's a very complicated soup, but the good news is if you start looking at all the ingredients of that soup, you start saying wait, is untrammeled resource extraction necessary? Is it necessary to take all of the resources out and put nothing back in? Is a slave trade a necessary thing? And the answers are all no, no, no, no. We can alter the shape of this. I regard the focus on the history of the place and knowledge about the place as in a way reassuring. There's nothing here that might be called essentialism, not cultural essentialism, racial essentialism, West African essentialism. These are challenges that have been seen across places and times in human history.

And they can be overcome.

Dr. Russell:
So Paul, in thinking about our listeners, they probably don't have the opportunity to really have that extraordinary career that you have had and seen so many things and places but want to help. What would be your advice for the average clinician in Anytown, USA, who wants to make the world a better place?

Dr. Farmer:
Well, I realize that I have had a lot of blessings enduring this experience, which was very difficult, or in writing the book, which I had a real sense of how lucky I am to be exposed to this. And as you said, most clinicians, nurses, doctors, social workers, psychologists don't get a chance to do this. And it's really for that kind of audience that I wrote the book. And the ways to help are just so myriad. And I think a lot of times people say, 'Well, I can't do what you do,' but that's beside the point. No one who does the kind of work that we do with Partners in Health is actually saying that. They're not saying you should do the kind of work we do. We really believe it's more of an invitation. All of us have a role to play in responding to health disparities. And certainly anyone who's a clinician, family physician, or sub specialist, a nurse, a social worker, a health administrator, a public health authority, everybody in those circles is already called to do this, right? So I think it's meant invitationally. Partners in Health certainly is called Partners in Health because we knew it back in the 80s, that any kind of significant transformation would require partnerships. So that's really the spirit that I'm extending this as an invitation for other people to get involved.

Dr. Russell:
Gandhi said to be the change you wish to see in this world, and there probably are little things that we can all do.

Dr. Farmer:
Oh, I'm sure of it. Even if you just think about the sort of professional stance of clinicians, again, nurses, doctors, social workers, et cetera, I think right now that there are more people in our fields who are aware of the need for stronger safety nets. And it's really COVID that open their eyes to that, right? But for me, you can see it very vividly whether you look at AIDS in Haiti in the 80s, or cholera in Haiti in the '00s, or the earthquake or HIV, whatever it is, there's so much that we can do, but it requires a certain stance. And that stands among health professionals, we believe that healthcare ought to be something everyone can access when they need it. Just having that as a stance empowers our work in Partners in Health, whether it's in the United States or somewhere else.

Dr. Russell:
Well, Paul, it's an honor to have spoken with you today. The book is *Fever, Feuds, and Diamonds* by Dr. Paul Farmer, one of the best people on this planet. So thank you so much for being with us today.

Dr. Farmer:
I can't thank you enough for having me and for reading it.

Dr. Russell:
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