Frankfurter shows us how the epidemic played out on the ground. Practitioners relied on local networks of intelligence. Health workers in dedicated vehicles drove into villages where there were unattended cases of Ebola, entering houses to dispose of the clothing, beddings, and other items of those who had died, and washing corpses to confirm cause of death. Sometimes they neither explained nor gained consent for these procedures and protocols from family members. They left with dead bodies, again without appropriate consent, disposing of the corpses in body bags—white for children, black for adults—ignoring the conventional use of white for all corpses. Ambulance drivers and body handlers suffered the most collateral damage. Colleagues from WHO working in Sierra Leone at the height of the epidemic in 2014 reported that para-medics were excluded from entering the hospitals to which they delivered those who were ill, instead, they were secluded in sheds in hospital yards, subjected to extreme stigma from other health workers and from their own families. Reduced transmission and the potential end of the present epidemic have occurred, and this has been facilitated through extensive community engagement, the provision of health information so that people understand how transmission occurs, and social mobilization to support communities where emergency responses might be required. The experience of Ebola emphasizes the need for consultation between epidemiologists, health workers, and communities and the significance of local traditions in the care of the dead both in relation to disease transmission and in regard for the dead and bereaved.

15.5 Doctors Without Borders and the Global Emergency

Peter Redfield

For the contemporary aid world, the category of "humanitarianism" commonly designates short-term relief work—actions intended to rescue people from immediate peril and promote their survival. Perhaps no organization exemplifies this emergency orientation more fully than Médecins Sans Frontières (Doctors Without Borders or MSF), which casts itself as a central actor of frontline medicine in crisis settings worldwide. Rushing breathlessly from site to site, the group has expanded from a ragtag French alternative Red Cross of the 1970s into a well-established multinational NGO known for both a combative tradition and excellent logistics. Moreover, it largely funds itself through private donations, with a budget now in the order of $1 billion a year. Relatively rich and independent, it can chart its own course to a greater degree than most aid actors. In conceptual terms the group identifies more strongly with humanitarian than development, defining in commitments through present states of crisis rather than future goals. While its projects encompass a wide range of medical activities, many well beyond urgent care, MSF's sheer existence extends an imprimatur ethos on a worldwide scale. The group's trajectory thus outlines both the possibilities and the limits of emergency medicine as a response to economic inequalities and political violence. To illustrate its mode of urgent action, below I sketch a day in the life of one project, combating a minor epidemic among civilians caught in a conflict zone.

A Case of Cholera

Near the end of 2004, I visited a cholera treatment center run by the Swiss branch of MSF in northern Uganda. The outbreak, focused in a displacement camp outside of Gulu, appeared to have run its course. Although the treatment center counted as an emergency project in the lexicon of the organization, the threat had subsided enough that there was little anxiety. Instead pressure came from...
an internal source: in a few days MSF planned to close the center and move the equipment back to a local hospital, as we urged that it be relocated to a more secure and less crowded hospital. The staff then decided not to make this decision.

Indeed, for MSF cholera treatment had become something of a routine. Over the second half of the twentieth century, the disease proved a common scourge of human displacement, regularly appearing in refugee settings where people crowded together with contaminated water and poor sanitation. Cholera outbreaks had helped inspire the group’s development of an “on-demand” treatment system in the 1980s, with the goal of providing pre-packaged equipment ready for deployment in emergency situations. Once on site, the cholera kit provided any medical team with the essential means to set up a safe and efficient treatment zone and provide medical care to patients. Most of the time, the approach proved quite reliable in quelling an outbreak and dramatically reducing mortality. The combination of preventive public health and basic clinical care transformed an exceptionally deadly disease into a relatively ordinary problem.

This particular case appeared a success as well. The compound, where we finally treated it, stood largely empty. Surrounded by a tall reed fence, with chlorine sanitation units geared toward its entrance and a large MSF flag flapping overhead, it resembled nothing as much as a minor colonial fort. Once through the sanitation barrier, we entered a set of large tents with beds set up for patients. Only a few were still occupied, and the patients and caregivers looked more bored than distressed. As the doctor explained, it was the case: such cases continued to trickle in, including a few cholera patients, but the records for the last few weeks indicated the epidemic had run its course. Since this structure was a temporary outpost, they would refer patients to the local hospital and discourage the center before the equipment started to disappear.

A bit later in a nearby government health center, we attended an impromptu presentation by a Ugandan doctor from the nearest hospital. The MSF team and the health center staff (along with a curious patient or two) gathered around his laptop computer as he shared a slide show he had just prepared on the outbreak for an upcoming workshop. The slides told a triumphant story. Over the past two months the area had seen well over 200 cases of cholera, most from the camp we had just visited. Testing showed all the springs and borehole wells were contaminated, and early projections suggested as many as 3,000 people potentially at risk. However, once MSF staff had set up their center and authorized hold an emergency camp meeting, the infection rate plummets. In contrast, the number of cholera cases went down.

Finally, the history of the medical emergency reveals that the many ways to distinguish maladies in the human society is more than one which is immediately and every moment counts. Others feature a slower rate of progression, whether positive or negative, and care becomes a long-term proposition. By definition emergency medicine—in its conceptual framework to its tools, techniques, and principles—is a more urgent form of care than any other. The care can operate on a variety of human diseases, and this does, it uses a different set of techniques and principles to statistical, subjective knowledge. Action, rather than dialogue or contemplation, remains paramount in the act of care. All of these points grow significant when extended to the realm of emergency medicine.

How Biomedical Logics Travel

The Medical Emergency

Poplar media attests to the degree of entanglement between contemporary health care and dramatic moments of life-saving intervention. The heroic figure of the medical emergency is very much an action figure: a master not only of diagnosis, but also of administration, of medical care, and of the administration of medical care. All of this is not to imply, however, that these moments do not exist. Indeed, the popular frame of the medical emergency, like the capacity to respond so quickly, is actually a relatively recent development.

Michael Nuss (2003) has convincingly shown how terms like “accident,” “resuscitation,” “surgery,” “abortion,” “drugs,” and “trauma” only combined into their now-familiar “epistemological alignment” by the late twentieth century, partly catalyzed by the First World War. The component parts of emergency care—trauma, first aid kits, and ambulances to emergency rooms staffed by dedicated specialists, emerged into the landscape of wealthy countries in stages between the late nineteenth century and the late twentieth century, with a particular boost in the decades after the Second World War. Details vary by national context, but at a general level—the level at which anthropologists usually engage the past—one might say that the medical emergency appeared alongside industrial society and modern medicine itself. Older stories extend deeper into traditions of experimentation and surgery, particularly forms associated with war.

This background history matters for these reasons. First, it reveals the extent that medical emergency reflects a particular cosmology of time and technology—one that assumes human doctors can act and should influence outcomes at an immediate material level. This cosmology is formally unattractive, at least in the sense that it prioritizes a technical rather than a divine set of human actors. It also assumes a world of machinery, risk assessment, and accounting, compounded commercially and electrically. The balance between life and death has moved away from a spiritual management of good or bad or toward the ethical issues of biological existence, purifying the value of caring lives.

Second, the conceptual lineage of the medical emergency underscores the importance of exception and time, a time outside of ordinary life when special equipment might be deployed and actions taken.

Finally, the history of the medical emergency reveals that one of the many ways to distinguish medical problems is to divide the time of their potential treatment into categories. In some cases the sense of crisis is immediate and every moment counts. Others feature a slower rate of progression, whether positive or negative, and care becomes a long-term proposition. By definition emergency medicine—in its conceptual framework to its tools, techniques, and principles—is a more urgent form of care than any other. The care can operate on a variety of human diseases, and this does, it uses a different set of techniques and principles to statistical, subjective knowledge. Action, rather than dialogue or contemplation, remains paramount in the act of care. All of these points grow significant when extended to the realm of emergency medicine.

Life During Wartime

Like all other human groups, nongovernmental organizations have their histories and habits. In the case of Médecins Sans Frontières, emergency plays a prominent role in both. Although not all forms of humanism have emphasized immediate response, MSF descended directly from the Red Cross lineage of responding to war and disasters. By the end of the 1950s, its patent movement had expanded from its original concern with the battlefield suffering of wounded soldiers to encompass the plight of civilians. It had also moved well beyond its original focus in conflict zones, such as the civil war in Algeria, to include the world in which all war is seen as a conflict in which no one is safe. This was a world in which no one is safe. This was a world in which no one is safe.
born from war. Although it would never limit itself to responding to conflict, conflict established its most defining norms. The group likewise appeared in the wake of fast transport, global communication and standardized emergency care, which in the French variant provided doctors straight to the scene of the accident.4 Imagining an organization of "borderless" doctors, in other words, required more than humanitarian sentiment. It also required a particular configuration of possibilities, and a problem around which they might cohere. For MSF that problem was what its 1971 charter termed "populations in distress"—or in a formulation used in later publications, "populations in crisis.

In operational terms MSF realized this classic notion of refugee work in camps on the border between Thailand and Cambodia in the late 1970s. For some key members, that experience stoked their ambition to provide more efficacious care, as well as to develop a logistics system that would support moving rapidly from site to site. In rhetorical terms the organization's first publicity campaign had already provided a revealing slogan for such ambitions, suggesting that for MSF there were "two billion people in their waiting room." Given that the group was then in a tiny French initiative, hardly capable of delivering much to anyone, the slogan bore little relation to actual practice. Nonetheless, it both defined a problem, and established an expansive frame of potential response. If populations experienced distress worldwide, then care should adapt accordingly. The medical emergency had found a global scale.

By the time I began conducting research in the early 2000s, MSF had greatly expanded in size and scope beyond these earliest beginnings. The name now represented a factional family of national sections, undertaking a shifting range of projects and initiatives around the world. Many of these extended well beyond the most immediate frame of emergency in medical terms, including such things as vaccination programs, psychosocial counseling, health education, pharmaceutical advocacy, and the provision of AIDS drugs. In Uganda, where I did much of my fieldwork, the organization was involved in all of these; in one fashion or another, as well as conducting epidemiological studies of drug protocols and responding to emergent diseases like Ebola (which surfaced in the same general setting a few years after the cholera outbreak described above). It launched a spinoff NGO involving traditional healers and a network of volunteers for the wider region. In practice, the concept of crisis proved elastic. From the perspective of MSF that was precisely one of its values in the formulation "populations in crisis," permitting a greater degree of latitude than was true with "emergency." Still, the group regularly frettet over the limits of its mission, alternating launching new experiments and drawing back from them. What should it try to do, and what should it leave alone?

A Global Band-aid

A humanitarian organization like MSF often encounters the question of why it does not address root problems. Is its crisis response—particularly the theatrical, media-saturated international variety—like applying a band-aid rather than treating the underlying pathology? MSF's standard reply is staunchly defeatist. A crisis response remains limited by definition. Taking the medical metaphor seriously would make a band-aid, like an ambulance, seek only to stop the bleeding, nothing less or more. For better or for worse that is precisely the temporal logic of emergency. To address chronic or future problems would require other equipment. It would also risk overlooking immediate needs, even as it might produce dependencies on new forms of domination, intended or not. Few MSF lives cannot be exchanged, and a population should not be determinately its own care. Thus while the project of saving lives might have political implications and effects, it cannot substitute for a political plan or obscure political possibility. From this perspective humanitarianism appears as a liminal and political endeavor, analogous to urgent care.

But the wide problems of scale and inequality pose other challenges. A billion dollars only goes so far, and charitable donations are not the basis of a viable, or sustainable, health care system. For this reason, the group has formed regular moral justifications and occasional denunciations aimed at these deemed responsible for the health of a given population. Governments and international agencies should do more; pharmaceutical corporations should charge less; governments should solve their woes. With this last point medical power reaches a limit. Violence, whether overt or structural, lies beyond a purely technical remedy. As MSF bitterly observed with regard to Rwanda in 1994, "you can't stop genocide with doctors."

Twenty years after the crisis in Rwanda, and a decade on from the cholera project described above, concerns about MSF fills medical headlines worldwide. Although the total number of dead has yet to reach the annual toll of cholera, and new onus of AIDS, the disease is extremely deadly and inspires fear in the manner of nineteenth-century outbreaks. Due to the mode of its transmission, the virus is unusually dangerous for health care workers, and evokes health care systems. Experimental treatment aside, biohazards often no cure for Ebola, only a reduction of mortality rates through supportive care. Amid the growing disaster in West Africa, MSF has received a new wave of attention, often cast in a heroic role as it struggles on the frontlines. Although overwhelmed and unable to offer treatment to those seeking it, the group recognized and proclaimed the severity of need earlier than most others, and in call for reinforcements have helped define a state of emergency. Its protocols for protective equipment have recently featured in discussions of shortcomings in the preparedness of US hospitals. As much as any official government body or intergovernmental agency, here an NGO defines a standard of action, however erratically and uncertainly life-saving. Yet at the same time, MSF has limited ability to actually solve the larger problem or rebuild health systems. An Ebola treatment center, just like one for cholera, is an immediate response, not a solution.

For all that emergency might offer humanitarians the allure of moral clarity—action as pure reaction—that clarity wanes when the frame widens. MSF continually opens programs in response to perceived crises, and closes them when conditions return to a more ordinary state. In doing so, it confronts the fact that what counts as normal varies considerably from place to place, and that it cannot respond to all problems. Being "without borders" the group continually struggles to define limits. The choices it makes factor in the work of other organizations and the larger realities of poverty and inequality, as well as its own relentless need to move on. Within the frame of a global emergency, there are always more lives to save.

Notes

1. MSF International Financial Report 2013 gives the group's overall income as just over 1,000 million Euros in 2013, up from just under 700 million the year before. Of this amount, 90.5 percent came from private sources, the rest primarily derived from nearly 5 million contributing worldwide.


Reference


Unexceptional Moments

While groups such as MSF provide care to those in need during 'exceptional moments,' anthropologists often work at the other end of the spectrum of excitement—that is, they usually dwell in the most unexceptional of times and places—places like the aftermath of the Ebola epidemic. It is unexceptional in many ways: most volunteers and their attendant medical equipment have packed up and left West Africa for home; the press has moved on to other topics. It is unexceptional because the after-effects of the epidemic are chronic in nature and their care is uncertain. At this writing (September 2015), we are just beginning to understand the long-term effects of having lived through the 2014 Ebola epidemic; survivors of the disease caused by the Ebola virus are now, six months to a year after the infection, suffering from intense joint pain, headaches, and PTSD-like symptoms of depression and anxiety. A quarter of the survivors suffer from eye problems and blindness as the virus continues to survive in the eye long after it clears from the rest of the body. Ebola virus also seems to survive in semen,