Case Discussion

Cholera and Nothing More

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This is a personal account highlighting some of the difficulties in dealing with a contagious epidemic in a resource poor setting. It shows a situation where you are limited in what you can do and asks what you should do when the interests of the population and of the individual conflict.

It seemed simple.

> So the plan is, if someone comes in to our Cholera Treatment Centre with anything other than cholera, you just transfer them to the hospital nearby. And if they have cholera plus something else you can keep them . . . depending on how bad the other thing is, otherwise transfer. The reason being that we are just here for the cholera and don't want to take over the work of the Ministry of Health. Oh yes, and we generally don't provide transport. The hospital has lots of ambulances that they do not use.

The reality of course was much harder as almost everyone had another medical condition.

This is Juba in South Sudan, the capital of a semi-autonomous region of the country. While an outbreak of cholera would be unthinkable in the UK, in a stark example of the inequalities of the world, people still suffer and die from it here. Juba was never meant to be the capital. It only gained popularity when John Garang, the former leader of the Sudanese People's Liberation Army (SPLA), died mysteriously in a helicopter accident. Following a 22-year civil war, South Sudan finally gained 'independence' from the north 3 years ago. The SPLA then took charge of the region and in honour of Garang the capital was moved to Juba. It therefore saw impressive expansion with a huge influx of people, including those returning to Sudan from neighbouring countries. The infrastructure of the city was never meant for such large numbers leading to an environment where cholera can flourish.

The theory was understandable. Should we provide basic health care for everyone, when we just went to help out with the cholera? Where would this end? If the word got around that we are treating any medical condition, we would be flooded with patients. And if we were not there, the patients would have to go to the local hospital.

There is also the need to 'encourage' the normal health system to take care of the public. It was made clear to the health minister and the hospital officials what we would and would not do. We were there to treat people with cholera, while another non-governmental organisation was cleaning the water sources. By treating other patients would we discourage the government to provide healthcare themselves? There is no need to put valuable resources into health when someone else is doing it. By creating a reliance on foreign NGOs could be detrimental to the country's health system in the long term.

The situation with cholera was also complicated by it being a contagious epidemic. We also had a duty to protect the population who did not have the disease. Patients who came to our unit with other illnesses would be at risk of contracting cholera and they could then spread it to others.

The counter-argument is that we had a duty of care to our patients. Most agreed with this sentiment, but we were splitting hairs as to who we were defining as patients. If they only get to our Admissions tent, were we obliged (both legally and morally) to treat them?

Rather than trying to treat a patient holistically, we were confining ourselves to one of their ailments; like doing medicine with blinkers on. 'I don't care about your cough, I just want to know how much diarrhoea and vomiting you have.' In many ways it was easy to ignore chronic conditions. They would probably need long-term solutions, which we could not provide anyway. And of course there were interventions, like performing surgery, which we were unable to do. In these cases it was

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obvious that it was in the best interests of the patient to transfer them.

The acute illnesses were much more complicated. Will this infant who has presented with a likely pneumonia be better off with us? We always kept a limited stock of drugs for emergencies, including antibiotics, so we could have treated him. If I knew he would get better treatment then the decision would have been easy. But the paediatric department of the hospital I was referring to received around 700 admissions a month with only one paediatrician (and he was only part-time). Despite the risks of being in our unit he would probably have got better care with us. In reality, most cases of pneumonia and other illnesses were referred unless they were unlucky enough to have cholera as well.

As with other things, epidemics can come in threes and Juba was also facing meningitis and measles. Not having read our 'Memorandum of Understanding', many meningitic patients would come to our cholera unit seeking help. I was always concerned about transferring them without treatment as I knew how difficult it was to find a doctor in the hospital. They would also have to go and purchase their own treatment before it can be administered. Also, however nearby the hospital was, it is difficult to get there when you can barely walk and cannot find or afford the transport.

The reality of the situation meant that you do not have much time to make complex ethical judgements but I did consider the people who turned up to be my patients and I was concerned as to whether I was doing my best for them by transferring? Surely, in scenarios like this our initial duty of care is to our patients, before political or national/international issues. I would generally treat first and then transfer.

A common scenario involved patients with gastroenteritis that was not cholera. It could be difficult to get a good description of the type and severity of the diarrhoea, so we would often admit them for observation. We could then see what kind of stools they were passing and refer them on to the hospital if needed. If they were severely dehydrated then they would be admitted for intravenous fluids and then transferred later if found to not be cholera. This usually occurred with children and was very common at the end of the epidemic.

When a very ill patient arrived at our door we would arrange the transport ourselves. This occurred with someone with severe breathing difficulty and a couple of patients who were drifting in and out of consciousness.

If there were two illnesses, the decision then became which illness is worse? The local hospital did have some ability to look after patients with cholera and were doing this long before we arrived. So if someone was suffering from another illness that was more severe, we would transfer them. An example of this was with malaria. As we were starting to enter the malaria season, we were seeing many suspected cases. Our very limited diagnostic ability did allow us to test for malaria. Most patients with cholera and uncomplicated malaria were treated in the unit but complicated malaria cases were usually transferred.

This dilemma can be examined using ethical principles. Should we take a consequentialist approach that by not treating patients for other conditions, our ends will justify our means? We would help the entire population, the health system and even our organisation. Or are we to adopt a deontological (duty based) approach, whereby we have a duty of care for our patients; they are the means and the ends in themselves.

I suppose, like most discussions, the answer lies somewhere in between and depends on the patient, condition and situation. I would transfer most patients, but treat some as well.

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