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The predicament of patients with suspected Ebola

We have concerns about both the accuracy and underlying rationale of Eugene Richardson and colleagues' Comment¹ about the "Ebola suspect's dilemma". The authors quote a nosocomial infection rate of "around 25%" for individuals admitted to Ebola treatment facilities without Ebola virus disease. However, two previous papers document rates of 3%² and 7%.³ In our previous study⁴ of over 1000 children admitted to Ebola treatment facilities with suspected Ebola virus disease, only three (0.5%) of 630 children who tested negative were subsequently readmitted with a positive test, all of whom had lost a parent to Ebola virus disease before their first admission; therefore, they were more likely to have acquired Ebola virus disease in the community than nosocomially. Furthermore, the case:fatality ratio of children who were admitted to hospital and were Ebola virus disease-negative was 9% (95% CI 8–12; 66 of 697), similar to previous inpatient mortality rates of children who were negative for Ebola virus disease at Ola During Children's Hospital in Freetown from 2013–2014, prior to the Ebola virus disease outbreak.⁵

By framing the outbreak within the trope of African subjugation or passivity in the face of international colonialists (humanitarian or otherwise), the agency is removed and the sacrifice belittled of the west African health-care workers, such as those who ran the Sierra Leonean Ministry of Health and military facilities in which our study was based.⁴ For example, far from "offering little in the way of intravenous resuscitation", the Republic of Sierra Leone Armed Forces provided aggressive parenteral fluid resuscitation from their opening in September, 2014, several months before this protocol was scaled up in internationally run facilities.⁶

Nosocomial transmission rates and mortality rates for children who were Ebola virus disease-negative appear to have been lower than those estimated by Richardson and colleagues, which is testament to the leadership of these Sierra Leonean health-care workers and their commitment to patient care and infection control. By misrepresenting the outcomes achieved by efforts of these west African health-care workers, Richardson and colleagues seem to only bolster the colonial structural determinants that they denigrate.

We declare no competing interests.

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