CDC Ebola Response Oral History Project

The Reminiscences of

Anne E. Purfield

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

2016

Anne E. Purfield

Interviewed by Samuel Robson
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Interview 1 of 3

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Q: This is Sam Robson here today with Dr. Anne Purfield. Today's date is July 1st, 2016, and we're in the CDC [Centers for Disease Control and Prevention] recording studio at the Roybal Campus in Atlanta, Georgia. I'm interviewing Anne today about her experiences regarding the Ebola epidemic, her response to it. [I'm] just so happy to have you here. Thanks, Anne, for being here.

Purfield: Thank you.

Q: Yeah. Would you mind pronouncing your full name for me and telling me your current CDC position?

Purfield: My name's Anne Purfield. My current position is the clinical and laboratory research coordinator for the Clinical Research Branch in the Division of Tuberculosis Elimination.

Q: Thank you for that. Can you tell me when and where you were born?

Purfield: I was born in Peoria, Illinois in 1977.

Q: Did you grow up in Illinois?

Purfield: I grew up in rural Illinois, Eureka, Illinois.

Q: What was that like?

Purfield: It was like growing up in rural Illinois. [laughter]

Q: Sorry. I'm from Iowa, so I can laugh.

Purfield: It was a small town of about 4,500 people. Everybody knew everybody. My mom went to high school there, my grandfather went to high school there. We lived in the family farm that was built several generations ago. My family migrated up from Kentucky in a covered wagon in the 1800s and was part of the founding group of the town and county. It was kind of amazing that I escaped all that. [laughs]

Q: Were your parents farmers, then?

Purfield: No, my mom drove a school bus for Eureka, and my dad dug utility lines. He would repair gas lines for a utility company.

Q: How did you keep yourself occupied in rural Illinois?

Purfield: I swam. I was on the swim team, and I did summer swimming. And read a lot, and worked a lot. That was back in the days where children were free-range, and you could go explore and kind of have your own adventure every day.

Q: Were there subjects in school that interested you more than others?

Purfield: I originally wanted to be an architect. I liked design and art, but then in high school, I switched over to science. It was actually an article in Time magazine I read, probably in the early nineties. It was about CDC and antibiotic resistance, and that kind of was what set me on the track for where I'm at now. Then I had a great high school biology teacher.

Q: Upon graduation, where did you go?

Purfield: I went to MacMurray College. It's a tiny, little, small liberal arts college in rural Illinois. But it was free. [laughter] Yeah, I majored in biology and chemistry. I left halfway through my senior year because at the time, the only two schools you could go to and have an internship at CDC were Agnes Scott College or Emory University. I did my last semester of college at Agnes Scott so I could intern here at CDC.

Q: I currently have an intern from Agnes Scott right now. She's wonderful. Shout out to Lola. Hello, Lola. [laughter]

Purfield: You go, girl.

Q: Yeah, yeah. She's great. What were you doing at CDC?

Purfield: What can a college student do at CDC? I pretty much occupied a chair in a cubicle at the [National Center for Chronic Disease Prevention and Health Promotion], and people were nice to me. I helped to write an IRB [institutional review board protocol] for a trial looking at seroconversion for women and their partners with HIV [human immunodeficiency virus] in Thailand in the Division of Reproductive Health. Wasn't what I thought—I wanted to be in the lab [laboratory]. It wasn't really what I thought I wanted to do, but I guess that was my first taste of clinical trials.

Q: What came after that?

Purfield: After that, I did an emerging infectious disease training fellowship [EID Advanced Laboratory Training Fellowship] at CDC in atypical pneumonias. Got to go on an outbreak investigation, just really enjoyed myself in the lab with the group I worked with. Then I went to grad [graduate] school at [the University of] North Carolina, got my PhD in microbiology and immunology. Worked on malaria parasites, and then short post-doc [postdoctoral], and then after that, I went up to work at FDA [Food and Drug Administration] as a microbiology reviewer for anti-infective drug products.

Q: Was there anyone in that time, while you were getting your PhD, who you'd say had a special influence on you?

Purfield: Sadly, probably not. I think it was all mainly in high school, and after that and through grad school, it was just a matter of survival. Just getting through it, and finding your way. It wasn't really a particularly—I don't know—enlightening time. It was just work [laughter]—without any of the inspiration that you had earlier in life.

Q: How did you like the South? I don't know if you guys ever went back to Kentucky or anything like that when you were growing up.

Purfield: No, no. Well, Kentucky was like 1800s. I loved the South. I thought I would really hate it, moving down here. It's kind of the butt of many of my friends' jokes when I said that I was moving to Atlanta and moving to the South. Of course, they all thought that I was—just the Northerners' perception of what the South is like is different. Growing up in high school, you learned that the North won the Civil War, and that was it. It was based on slavery, and go [Abraham] Lincoln, especially as a kid from Eureka, or from Illinois. In the South, I was amazed that all these—everybody knows battles and generals, and the true politics. It was completely different.

I loved the winters. I came down with my triple fat goose down parka, because it was nineteen degrees below zero when I packed up my car and moved on Christmas Day, 1998. When I got down here, I remember there were pansies in the ground. I remember

calling my mom and saying, “Oh my God. They have flowers. It’s Christmas Day, and there are flowers in the ground.” I adapted pretty quickly, and I haven’t been above the Mason–Dixon line since.

Q: I kind of joke that I don’t think we’re supposed to live above it. I think we’re supposed to be down here, right?

Purfield: Yeah, yeah.

Q: Come down and see the pansies. “Oh, this is right.”

Purfield: Yeah. This is our winter.

Q: Yeah.

Purfield: You know, ninety-five degrees, you just stay inside. It’s air conditioned. It’s forty degrees, and we’re all wearing cardigans.

Q: Yeah. It’s kind of ridiculous.

Purfield: Yeah.

Q: Can you tell me more about your doctoral thesis?

Purfield: My work in grad school was on malaria parasites, and I was looking at molecular mechanisms of drug resistance. Then I was looking at mechanisms of action for—we had a new novel drug for sleeping sickness, but [that] also had activity against the malaria parasite. I was looking at the mechanism of action of that drug against the malaria parasite. It was both molecular [biology] and microbiology, but also very public health-focused. It was about as applied research as you could get in a basic science PhD program.

Q: I'm sorry, and I'm blanking. You probably said, but what subject was the doctorate in?

Purfield: Malaria. Malaria drug resistance and drug mechanisms.

Q: I'm sorry, you got your do—

Purfield: Oh, microbiology and immunology—

Q: Microbiology and immunology.

Purfield: —is the department.

Q: Okay. Yeah, that's the department.

Purfield: Yeah, but I really didn't leave my little world of malaria parasites.

Q: Tell me about your work at FDA.

Purfield: At FDA, I was a primary reviewer for all anti-infective products for tuberculosis, anthrax, parasitic diseases, fungal diseases, and then some specific bacterial diseases—fluoroquinolones and some random things. I would review all of the data. I would review the protocols. When drug companies come to the FDA with a protocol to do a clinical trial, I'd review that and determine whether or not their methods were appropriate to evaluate the efficacy of the drug based on microbiology. Then we would get the data after a trial was performed. We get all the data, patient-level data—and we'd look and basically do a very critical analysis to determine whether or not the drug was efficacious or not.

Q: Did you like that work?

Purfield: It's a unique type of work. A certain type of person really, really excels at this job, and I was probably not that person. You think it's science-based, but really, it's more law-based, and you're in this really tight box. You have to make sure all of these scientific protocols fit these regulations, and you don't have a lot of room for creativity or problem-solving because everything is already prescribed for you by Congress or by standards. After about four years, I—what I did love about it was learning about all kinds

of different drugs, different places, different trials, different bugs. I learned a lot about parasites and fungus and tuberculosis, anthrax. I learned about the challenges of dealing with diseases like Yersinia pestis, with plague, or anthrax, where we can't do human clinical trials. We have to do them in animals. And trying to understand how you evaluate the natural history of a disease that you can't study in humans. There's just—we don't have that much plague. We don't have that much anthrax. So we really don't know what the natural history of that disease in humans is. When we evaluate the drug in an animal model, are we on target? Are we even comparing apples to oranges?

Those are some of the kind of fun things I did at FDA. But for the most part, it was kind of writing the introduction to your dissertation every day. I joke that it was like being a good mother-in-law, where all you do is criticize. You're very, very critical of—and you have to be. It's for the health and safety of everyone. I have great respect for everyone at FDA, because they're the reason you can take Tylenol and you understand about the risk to your liver disease. There's a reason you can take your Lipitor, and all your other drugs. And sometimes it may take ten or twenty years of a drug being in a population to amass enough data to really understand what the risks are. But we're putting chemical entities into our bodies that are manipulating our function, and so you want to look at that closely. I appreciated it, but I was very happy to leave.

I came to CDC to do EIS [Epidemic Intelligence Service] in 2012 directly from FDA. I was really excited about doing EIS. It was something I'd wanted to do since I read that article in high school in the mid-nineties about the disease detectives. It's so corny.

Q: Can you tell me about some outbreaks that you were involved in that kind of stood out to you?

Purfield: I moved down in June of 2012. I'm not an epidemiologist. I can pretend I am one. I've taken a few epi [epidemiology] courses, but I'm a molecular parasitologist, if you really want to narrow it down to one thing that defines what I know. But the thing about being a scientist, and especially a bench scientist, is that you're really like an expert in problem-solving. It doesn't really matter that I'm not working with a pipette and moving small volumes of liquid from one tube to another. It's all about, how do you answer a question? How do you define a question? How do you answer a question? What data do you need to amass? And are the data good enough to answer the question? So even though I wasn't an epidemiologist, I felt like EIS was a culmination of all of these things that I'd done at FDA, and my post-doc, and grad school.

I got here in July of 2012, and you do your summer course. The first thing I did after that was an evaluation of the national cryptococcal surveillance program. I was with the mycotic disease group, the fungal group, and they sent me off to South Africa. For two weeks, I dug through data, and I evaluated their national cryptococcal surveillance program. The day I left for South Africa, for this two-week trip—and I'd been to Africa once before, so this was still kind of a pretty big international trip for me—I met with a contractor to redo my kitchen, and I found out my dog had cancer—my dog, my precious twelve-and-a-half-year-old golden retriever-ish dog, who is the four-legged soulmate of

my life. Spoiler alert: he's still alive, okay. But when I left, I just took him into the vet to—and this is way off-topic—I took him into the vet to deal with his allergies, because he had a dermatologist. [whispering, inaudible], and she's like, "Oh, he's got this oral melanoma." I was like, "Oh my God. I'm leaving for two weeks. I'm going to South Africa." She's like, "You need to get him in for surgery as soon as possible." So that was Friday. My housemate at the time took him in for surgery on Tuesday, and in the meantime, I'm reading everything I can about oral melanoma and golden retrievers. The prognosis is like two weeks. Two weeks. I had no idea if it had metastasized, I had no idea if she'd be able to get the margins, so I was totally mentally prepared to come home to my four-legged soulmate being gone. The entire time I was in South Africa, I slept with a pillow on my bed, because he sleeps on the bed with me, just like, you know—so then I was in South Africa.

Then the day I got back, I remember I was on the plane coming back, and there was something on the news. We were boarding in Johannesburg, and there's something on the news about a contaminated something. I saw that it was a fungal contamination, and I got all excited, because it's what I just signed up to do. I come back, and it's the day the Emergency Operations Center opens for the fungal meningitis outbreak, which turned out to be the largest healthcare-associated infections outbreak in US history. My contractor started demolishing my kitchen, and I took my dog in for his first cancer treatment. It was just like, whoosh. Everything whooshed over me. That was the beginning of what I felt like was my two years in EIS is, that whole—it's just a crazy scramble of you're trying to figure out what to feel, what to think, what to do.

The EOC was opened for fungal meningitis. We had fourteen thousand people, we found out that day, that had possibly received injections of a steroid contaminated with Exserohilum—excuse me—rostratum fungus into their spine or into their joints. To that point, the mortality was extremely high. At that point, we may have had eleven cases. Nine had died. So what we didn't know was whether this thing had a mortality of 90%. What was going to happen? How many people got injections? Who got injections? What we did know was that the sooner you probably told people that they were exposed, and—because there's—this is a population of chronic pain. So there's a lot of symptoms that they may think are associated with their chronic pain. They may not go to a physician and say, "Hey, you know what? I feel worse." We had this massive effort to contact fourteen thousand potential people. We had fourteen thousand doses. I think, in the end, we think we found eight or nine thousand people who could have received those doses, because some received multiple doses. Then for six weeks, I was just manning these desks, trying to get accurate case counts every day. We ended up with more than 750 cases. Less than one hundred deaths, but still a very significant number of deaths. I think it was around sixty-nine, seventy-one deaths at this point. That really consumed, pretty much, my EIS experience every day for a year. It was just getting these case counts and talking to these people and trying to figure out where we were with that.

Did a couple more outbreaks. One, there's a fungal disease in the Central Valley of California that's in the soil. It's called Coccidioides, and it just is in the dust, and it's airborne. Out in the prisons in the Central Valley, there's a lot of dust. We were trying to

figure out why the prisoners—or the inmates—in two prisons had rates about one thousand times higher than in the local community. We went out there on an Epi-Aid [epidemiologic assistance] investigation to interview them to see if the inmates who had gotten—we did a case control study to see if the inmates who had gotten sick were more likely to have worked outside, were more likely to have a certain profession. If they spent more time out in the prison yard. Then we did some mathematical modeling to see if we could test the prisoners, to see if they had had valley fever or cocci before they came into the prison system. If we could keep all of them at the prison and move anyone who is susceptible, not immune, to a different prison in northern California where this fungus isn't in the ground—I did that.

Then there was another outbreak of random, strange fungal infection in cardiothoracic surgery patients. We thought, when we first found out about that—it was multiple hospitals. They were all cardiothoracic surgery patients. Suddenly we had that moment where we all looked around at each other, and our eyes flew up on a conference call. We were just like, oh, this is fungal meningitis all over again. We could have a contaminated product that's killing people. It wasn't. Figure—solve that one. Not really, but [laughs]—could not find a contaminated product. So, yeah.

And then that was pretty much it. I finished EIS in 2014. In March of 2014, we started to get calls about an Ebola outbreak in Guinea. There had been kind of an astounding number of Ebola outbreaks during my two years in EIS, and one of my friends was matched with the Viral Special Pathogens group. I think for the first, probably six or

eight weeks of EIS, she was out back-to-back on three different outbreaks of Marburg or Ebola. When this popped up in Guinea in March of 2014, we were kind of like, oh, Ilana [J. Schafer] is going to be busy again. A lot of times during any type of big event, they kind of try to roster up the EIS officers. They send out a query and say, if you're interested in potentially deploying, send us back. Let us know if you have supervisory approval, and send us back this—whatever information they wanted. I asked my supervisor, and he's like, "Oh, they're not going to want you," because I'm not a medical doctor, just a parasitologist. I sent them, and I didn't hear anything back from them. I had a couple friends who spoke French. I wasn't a medical doctor, and I didn't speak French. A couple of friends who spoke French, medical doctors who had had some experience in this before—they went out in March. They came back in June, or late May, and just shaking their heads like, this is not going away. This is so much worse than we thought it was. But it's still in West Africa. We still didn't—and this was Mary [J.W.] Choi. This is not anything that we think that they're going to roster up a thousand people for. I still, at that point, thought my chances of going over there—I wouldn't go, because I don't speak French. At that point it wasn't in Sierra Leone yet.

Then I bumped into someone, since I spent so many weeks in the Emergency Operations Center, and I got to know everybody who just normally worked in the Emergency Operations Center, either through polio or because they're just staffed there. One of the women who I'd known—we just casually chit-chatted every day because I pretty much lived there—she's like, "I was thinking of you the other day, because we're looking for more people to go for Ebola." I bumped into her in the Building 16 parking lot. I was

like, "Oh, yeah, I'd love to go." I had just finished EIS I think, or maybe it was—yeah, I think I had just finished EIS, and it was July. I was transitioning. I took a little vacation, went to Thailand, transitioned to the new job in TB [tuberculosis]. It was one of those things where I didn't know anything about TB, [I was] just starting from ground zero. I didn't think I'd ever get picked: don't speak French, not a physician. Then randomly, a week later maybe, she called me up on Wednesday and said, "You're leaving on Sunday." I was just like, "Uh, what?" [laughs] because I hadn't really gotten permission from my new group. I was like, "Yeah, I'd love to go! Let's get coffee. [laughs] Ebola, sure! It sounds like a good time. Sign me up!" [laughs] I figured it was like that, because I'd been—my name was in, and we'd been in for four or five months, and I'd wanted to go. I get the call, and I am over in my new job, and I'm kind of like oh, um, okay, I'm not in EIS anymore, so it's not like they'll just—when you're in EIS, you kind of get a free pass to just go explore the world. Go. Save people. Do things. Suddenly, this new group was hiring me, and I didn't know anything about what I was doing there. I asked, kind of timidly. "Well, um, they kind of asked if I could go for an Ebola deployment. What do you think are the chances of that?" They're like, "Oh, how long?" and I'm like, "Um, like four weeks? [laughs] I know I've just been here for a couple weeks." But they were extremely supportive, didn't even bat an eyelash. It was actually amazing that my supervisor, or my branch chief—who I'd never actually worked with, because he'd been out the entire time I was there—we called him, and he was very concerned about my health and safety. Very concerned about if I wanted to go, if I felt like I was being pressured into going. He was concerned that I would just be exposed to Ebola, but also, at the same time, concerned that this is something that would be great for my career. This

was an experience that I may never get ever again. I mean, we had no idea how big this was going to get. So that was Wednesday.

Q: Who was your branch chief?

Purfield: Andy [Andrew A.] Vernon. Yeah, so that was Wednesday. I spent all day Friday running around, trying to get in for a health screening visit and stopping by the EOC, trying to get things. This was before they had the go-bags. I remember they didn't have my size face mask in stock for my respirator fit test, so they're like, "Sorry, you just got to go without one." It's like, do you have another one that may kind of fit? Do you have a surgical mask? Do I just go to CVS and buy surgical masks? I want some type of protection in case—I don't know where I'm going to be. There were quite a few things, like there was no real deployment briefing to get you out the door. In the emergency operations DEO [director of emergency operations] logs [logistics] office, they gave us like two little packets of PPE [personal protective equipment]. That was it. I got gloves, and I got a box of gloves from my lab. [laughs] because I wanted to make sure I at least had gloves.

Q: What was in the PPE packet?

Purfield: It was basically two bunny suits, two Tyvek bunny suits, and I think that was it. There may have been some gloves and some shoe bunnies or something. That was it. Honestly, I didn't open it up and look at it. At the time, we got this two-hour PowerPoint

to get out the door. Most of it was, like, the JIC [Joint Information Center]. It was just ridiculous. I remember sitting there, and they're showing us maps of Sierra Leone. "Here's a map of Sierra Leone. Don't worry, you can get this stuff later. We'll send this to you. We'll give this to you on a thumb drive." We had no idea. At that point in time, it was an outbreak where there were twelve people in-country. This was not the polished thing that [it] had become. Probably in the four days that I knew—probably from the time I got the call to the time I went—I mean, the case count in Sierra Leone probably doubled in those four days. At first, they were going to send me to Liberia, and then at the last minute switched and sent me to Sierra Leone. It was a time where—again, nobody is to blame. It's not like we were unprepared. It's just that [pause] we just didn't know. We had no idea. After two hours of learning who we can take photos of and where we can exchange cash at the embassy—there was some logistic things that we learned about.

In terms of learning about what our role was, what the current situation was like, nobody had come back. There was nobody, really, that we could talk to that said, look, this is what to expect. I don't want to say there was no—because this could be a very dramatic statement. There's nothing that I remember in terms of mental resiliency. If there was, it may have been like, look, there's long days—the same thing you get, you know—make sure you get some rest, make sure you drink plenty of water. If you need to talk to anyone—more, like, just mental health, as if I'm going to a hospital in Texas to investigate the *Bipolaris* outbreak. It was not like, your friend Nancy's going to die in the next three weeks, and you may have a hard time dealing with that. You're going to share a toilet with Ebola patients. You're going to wake up with a headache in the middle of the

night and wonder whether or not this is the first symptom of what will be the end of you. Those were the things that they didn't prepare you for, because we didn't know. The people who had come back were very, very isolated. There were very few people who were embedded into that type of environment where I ended up being embedded into, where you know the staff, you know their children's names, you know their history, you know where they live. You know all these things about them because usually when you go to these things, you're staying in a relatively nice hotel and you may be traveling from site to site to site to meet with the head official, shake some hands, give a tour, give some preliminary recommendations after talking to people for some few hours, and then you move onto the next site. You don't go out and stay in one place at the ground level like we did. You're not in the war zone. You're in the buffer zone. The green zone, so it was just a different situation than I think what we'd done before.

Q: Yes. When you look back, when you think about the training that would have been the most useful for you to have received, is it the mental resilience training or—yes?

Purfield: Yes. Again, they couldn't have. This was fresh snow. Nobody knew how deep it was. It wasn't until a few people walked out and then came back and said, yes, it's up to my knees. Or up to my eyeballs. [laughter] Probably the mental resiliency, but it's just more of knowing—situational awareness. It's very comforting to know what you're getting into. If you're diving into a pool that's really cold, or if you're diving into a hot tub, you want to know. If I would have known I'm going to be at this hospital, and I'm going to be there for four weeks, it prepares you differently than—My second

deployment, or even my friends who were there at the same time or at other districts where they were just working in the logistics center and dealing with data management, but there were so few patients, and all the patients were anonymous, and they were loaded up into an ambulance and sent somewhere else. Or, you're driving through the streets and you see people and you're like, oh, I think that person has Ebola—but you're not sitting next to them on a bench.

Q: Right.

Purfield: You're not talking to them about their family and about all the stories that they had.

Q: Right, wow. How close is it to your actual departure when you're told, oh no, not Liberia, sorry, it's going to be Sierra Leone?

Purfield: It may have been two days? Yes, yes. I think I found out on Wednesday I was going. I had to get back to her within a day. She's like, "Let me know if you can by the end of the day." I was like, I have never met my branch chief, really. [laughter]

Q: Yes.

Purfield: I have to ask this guy for permission to leave for a month? I had to track him down and have that conversation. By the end of that Wednesday, I knew I was going.

Then on that Thursday, it was still kind of shocked, like oh yeah, I'm going. But in EIS sometimes, you have these deployments where you're like, I'm out the door in four days. After the earthquake in Haiti, the Commissioned Corps deployed me down to Haiti, and I was out the door in a couple days. That wasn't that surprising. I went to Goodwill, I bought some clothes, because I imagined things would be covered in bleach. From what I had heard from Mary Choi was there were bleach stations everywhere, and everything gets covered in bleach. I learned that.

I also know, sometimes when you're in those situations, you just want to leave everything there. You want to leave your clothes there. You don't want to bring it back. I can remember I spent half a day trying to find rain boots because I knew it was rainy season. I know Africa's got open sewage. From everything that I can imagine, it's a bad situation, and you don't want to be traipsing around a hospital or anywhere in open sewage in the rainy season in Africa, but let alone in an Ebola outbreak. So I remember I drove to Tractor Supply Company, because it wasn't enough time to order anything online. I had to do it old school, and I drove down to—it was outside the perimeter. It felt like I was driving to Alabama [laughter] to Tractor Supply Company, and I bought my cute little polka-dot rain boots [laughs], which were like a symbol of happiness and joy for the nurses. They loved my polka-dot rain boots. It was kind of funny.

My friend Leigh Ann Miller, who ended up deploying shortly after I did—I think it was Leanne, I don't know, maybe I'm—yeah, we went to Goodwill. I'd try to buy things that you could wash in the sink that would be cool and would dry very, very quickly in a

tropical, humid environment. Limiting it to two to three pairs of pants and two to three shirts, just knowing that I'd be doing laundry every single night and washing it out every two or three days was what I was thinking. I didn't realize how disgusting you'd feel after working in an Ebola hospital all day long. My attire was wearing pants that were too short for me and [laughter]—what else? It was these shirts that were way too big and pants that were too short and navy blue pants with a baby blue top. Fashion-wise, it was horrendous, but I was going for functional rather than comfort or style and fashion. The ironic thing is—have you been to Africa?

Q: Yes.

Purfield: They dress up. You go to a meeting and it's 110 degrees, and I feel like a washcloth that has been dipped in a bucket and hung out in a moldy room or something. I'm dripping with sweat, my hair's a mess. They come in their starched, ironed, pressed, beautiful clothes. I'm just, like, I'm the frumpy American. [laughs] When I go to, like, meet with government officials and evaluate a national cryptococcal surveillance program, yes, I try to look nice.

Q: Right.

Purfield: But when I know that I'm going into an Ebola outbreak, and there's a chance that I could be in the middle of it, I did not. I wanted to make sure I brought things that were dry, cool, wash-wear, and could even leave there if I got things on them.

Q: Right. So, tell me what happens next.

Purfield: Friday, I came into CDC, here, for my health screening and we had the two-hour deployment briefing, where we learned all about the JIC and everything. Saturday, I just was busy preparing: doing my laundry, packing my stuff, going—word was, coming back, I did have a friend, Erik Reeves—he'd just gotten to Liberia, and he said, "There's no food." You can't get food in the restaurants. The trucking and the shipping and moving industry, like, transport—that's the word I'm looking for—transport is shutting down in the country. This was when Monrovia was really at its absolute worst. There was a story of an EIS officer who jumped in a boat—people were rioting, and he jumped in a boat and paddled downstream to get to safety. I went and I bought a giant thing of peanut butter and crackers. I know when you're over there, you have a hard time getting fresh vegetables and fruit, so I bought some little fruit strips, little fiber strips, you know, some type of diversity. I bought eight pounds of M&Ms.

Q: Wow.

Purfield: Peanut M&Ms, which are fantastic in Africa because they don't melt. They got a little bit of protein in there. [laughter] At least get a peanut. When you're over there, and you're working sixteen-hour days, a little bit of chocolate treat, it's amazing how much it can do for morale. I brought a lot of candy for my team. I had no idea what my team would be. It might just be me and fifteen pounds of candy. So, I basically had a

giant duffle of food and then my clothes and a small backpack. I packed tons of Ziploc bags, flashlights and books and a water filtration kit, and all these things that the Emergency Operations Center was throwing at me—permethrin to spray my clothes.

I'm waiting on Sunday for my ticket to come through, waiting, waiting—waiting for my visa. I had to rush my visa. They said—I think my flight was Sunday evening—"We'll let you know if you have to go to the airport, and you pick it up at Delta DASH on Sunday and fly out." [laughs]

I didn't hear anything, and there was no one to contact. Sunday came and went, and I'm still here. Then, the next flight out was Tuesday, so I ended up flying out Tuesday night. I was all ready to go on Sunday, and then—[sighs] I think I spent that Sunday with my friends, which was really surreal. I'm here, we're having a cookout or a dinner or something, and then, "Yes, I'm going to Sierra Leone in two days for the Ebola outbreak." But all my friends are EIS-ers, so they—Mary had been. Little did I know, they would all go, eventually. It wasn't a big deal. It was just like any of us had another trip. We had friends leaving for international trips on a daily basis.

I didn't know what to do with myself on Monday, so I went into work. [laughs] Didn't do anything because I'm about ready to leave for a month. Tuesday, I flew out. I put on one of my nicest Goodwill outfits. [laughter] I was wearing—I remember, because I wrote this from the airport to my friends. I brought my crappy tennis shoes that I mow my lawn with, figuring bleach couldn't hurt them, and they were just crappy tennis shoes. I could

always leave them there if something happened to them. Here I am, had status, so I got upgraded to at least economy comfort, and I am looking like an absolute bum on my flight. At the same time, I'm flying with this other woman, Michelle Dynes. We were meeting up in the airport. I think we were both on the same flight, but I didn't necessarily know who she was. We get to Paris, and I go to the Air France lounge and was drinking Perrier and eating chocolate croissants. Here I am amongst all these people who—these are status people who fly all the time, they all look very nice. These aren't exactly the backpacking crowd. Here I am, guzzling as many Perriers as I can. I'm like, oh, I may not get some sparkling water, I'm not going to get a chocolate croissant for a while. Eating because there was another long flight ahead of us, and we were going to get in late at night. Well, we were getting in not late at night, but I figured by the time we got to the hotel and I got my next meal, it'd be a while. Airplane food is horrible. Air France is some of the best.

Q: Oh!

Purfield: British Airways is my favorite, actually. They have horrible food, but they always give you Cadbury chocolate.

Q: Oh, yes. I like their accents.

Purfield: Yes, yes. I did practice my, "Merci, merci!"— the only French phrase I know— on my Air France flight.

Q: That's good.

Purfield: So we land, and I'm trying to remember now, I think it was a direct flight to Sierra Leone. It was fairly empty. No, we had a stop in Senegal. Pretty much everybody got off the plane in Senegal. It was maybe 40% full from Senegal to Freetown. I think it's August 19th, maybe August 17th. I can't remember my dates really well, but it was before the world took notice, but enough to the point where—usually, the people who fly to and from Sierra Leone are businesspeople who are doing business there from Europe, or people who are just traveling to visit family and back. There was a notable absence of those two groups of people. Most of the people on there were—you could tell they were us. Any white person on the plane, you could tell, was pretty much an aid worker. There's Michelle and I, and we were the only two from CDC, which is kind of astounding because now it's pretty much a shuttle, or at least the year that followed, that flight and the other flight in and out was really a CDC shuttle of getting ten, fifteen people in and out every day, it seemed. But it was the two of us, and we were met by the embassy folks. The first thing I noticed when we got off the plane is—you know, it's Africa. You have the tarmac, you're not going off into one of those air—what do you call those things? Whatever they are that meet you at the plane as you—

Q: The little chute thing?

Purfield: The little chute thing where you never actually touch the tarmac.

Q: Right.

Purfield: No, this is Africa, and you go down the steps. I remember the first thing—it was still light out when we landed, and it was beautiful. It was kind of flat where we were, but it was that time in the evening where, in the rainy season, you have these giant, big, heavy, full clouds, and you just see all—the horizon is filled with nothing but these layers of grey and white and these long strips of clouds. You know rain is imminent, and you know rain just happened. You know you're just in that lull. I also remember it was just humid, but it wasn't hot. I mean, it was hot, but it wasn't miserable. It was humid. It was windy, too, and that could have been because you're in an open area in the tarmac, and it always seems windy in an airport. At the bottom of the stairs to get onto the tarmac, there were a couple people with the thermometers. Bam, bam, bam, and it just struck me that they weren't even looking at the temperature. They're just hitting—

Q: Is it kind of like a gun to your forehead, almost?

Purfield: It is really—and it's an unsettling feeling when you first get there, because it is almost like a—there's a guy with a semi-automatic weapon standing there, because that's what they do, you know? They're security, and they have large guns. But it is, yes. You get used to someone putting something to your temple, essentially, or your forehead. It's in the shape of a gun. Everybody that was getting off the plane was kind of—it was this weird little nervous excitement, almost like farm animals right before a thunderstorm. We

don't know whether or not to be—is this kind of novel? Do we take a picture of this? Are we really scared? Suddenly you put your feet on the ground in Sierra Leone and you're like, where is Ebola? Do you see it? [laughter]

Then you had to wash your hands with bleach, and then we walked to the actual terminal. Everybody's in this giant cluster, trying to wash their hands with bleach again. There are the giant Gatorade buckets with the spigot. You have to just sit there and wash your hands and shake it off. I thought this is the beginning of some [Jackson] Pollock painting of bleach splatters all over my clothes. [laughter] Then we walked in, and I think we had to fill out a form. It was very casual, your immigration—fill out a form. I don't actually remember if there was a form that asked if we were sick at that point in time. If it wasn't, then that was instituted within a couple of days. I think there may have been, because I think CDC folks were already there at the airport, working on immigration. I think we had to just check a form. But again, no one's really looking at it. You had your temperature taken one more time. We get through, and we pick up our luggage. There's somebody from the embassy waiting for us and takes us.

To get to the hotel, this really nice hotel, which I'm sure you've heard a lot about, you have to take a water taxi across. We were standing for the water taxi, and there are three other white people at that water taxi. It was one of those things where you all look at each other, and you realize you're going to the same party. [laughter] One of them was CDC, Steve [Steven] Wiersma. He was coming from Tanzania, and he was supposed to be the epi team lead, but I think immediately, kind of like me, they switched. As he was getting

there, as he was arriving, they moved him over to be the liaison for USAID [United States Agency for International Development]. He explained his role as the “cash and prizes” guy.

We’re waiting for maybe twenty-five minutes for this water taxi, and the other two people were there. There was a man and a woman. The man was probably in his late fifties, then a woman who was younger, maybe forty-five. They kind of had the deer-in-the-headlight looks of, we’re so ready for this, we volunteered for this, yay, this is an adventure! I started talking to them, and the man’s name was George [Risi] and the woman’s name was Kate [Hurley]. They were two clinicians from Montana who had volunteered for WHO [World Health Organization], and they were heading off to a hospital.

We rode the water taxi across. I remember the water being really choppy. I remember it just storming. It was just raining and it was pelting, and you’re in this long speedboat. If you go over waves, it’s—[wave sounds] it’s very choppy. There’s the little plastic flaps tied around to keep you dry, but of course you get all this spray and water around you. You’re wearing this disgusting life jacket, and all I could think of was, I’m putting this life jacket on me, and who has this life jacket been on? There’s an Ebola outbreak, and where’s the Ebola? Where’s the Ebola? [laughter] From what you expect, you’re like, “It’s got to be everywhere.” My understanding of geography and where Ebola really was—I mean, we didn’t get that lesson before we left. You didn’t know if the driver of the car had Ebola.

When the water taxi pulled up and we put our luggage—we got off and we got into a car, and it was another embassy driver. You're twenty hours into your trip. You just stop caring at this point, and just get me somewhere. I always feel like it's a sensitive subject. "I'm a white person, I am here to save the day! We are CDC!" We get into the car with him and introduced ourselves and asked him how he was. "How is your family?" It's just the general. He just very sincerely said, "I'm so grateful you're here." He's just like, "We need you," which felt really good, because, again, it goes against the whole, "I'm the white person, here to save the day," you know? I'm very cognizant of colonialism, I'm very cognizant of the fact that we have incredibly competent people and they just need some help.

Q: Yes.

Purfield: And how to deliver that help without coming in and saying, "Move aside, little people. Let me take this." You know?

Q: Right.

Purfield: Just hearing it from him, that was the first dose of earnest, like, "This is more than we can handle. This is affecting everything, and this is affecting my family, and this is affecting my country, and I'm worried. I'm worried for my country, I'm worried for my family, I'm worried for myself. Thank you so much for coming to help us."

Then he took us to the hotel. We get to the hotel, literally ready to roll up our—you're tired and you're exhausted and you're hungry, but at the same time you're, like, okay. When you do an epi aid, it's, like, every minute counts in the field. You're rolling up your sleeves, you stay up as late as my poor old body can stay up, and you're like, let's go. We got something to eat. There are a couple people. At the time the hotel was empty, completely empty. They just remodeled it, and I think actually while I was there the next morning, eating breakfast, the manager was coming around from some super-regional area. They were doing the tour and talking about all the renovations and the improvements and what that was going to do for them. I think that night I had, I don't know, pizza. Basically, it's like frozen pizza there. Eat something and just go to bed, and the next morning we agreed to meet.

In the morning, I think we met Leisha Nolen, or we met somebody who [was] there already and said, who is the base there? I also remember Bex, Bex [Rebecca] Levine. She was in the deployment briefing with me. We were supposed to go out at the same time—but then my flight got delayed—so she was coming back right when we were coming in from being out in the field and still didn't quite know where she was going to be. For those first few days, she was going to Freetown. She was the first epi [epidemiologist] to be in Freetown and to stay in Freetown and to liaise with the Freetown health professionals. There was discussion, I remember, that night about when to send her out in the field, because Freetown wouldn't need anyone. [laughs] "I think you're done here, and we can send you into the field. You need to go into the field." I remember that, not

even understanding the situation, just thinking, I feel like we should not leave the large city.

The next morning, come down, breakfast, fresh, ready to go. Didn't unpack anything. I'm ready, let's go, get me out in the field. Then it was just the timing. We didn't have drivers. We didn't have all the logistics that were put in place after that, and so couldn't get out into the field that day. But there was somebody who was leaving the next day to go out in the field, so we were going to go out in the field the next day.

First day, we went to the Ministry of Health [and Sanitation], met with the minister of health, met with a very small group of eight to ten people who are trying to manage this for the government. I don't even remember who it was now. It was some NGO [nongovernmental organization] and the government. We spent the rest of the day sitting on a patio with the ocean behind us, in a breeze, drinking coffee, tea, soda, cappuccino, whatever, and trying to familiarize ourselves with the data management system. It was very surreal to be, like, beautiful ocean and palm trees and trying to load up the Epi Info system. Trying to load that onto our computer, trying to dig into the database to see what was really there. Some of it, we're just pulling things from Excel and trying to get that. It was like suddenly trying to learn French in one morning with somebody else's computer files. [laughter]

So it took us a while. Everything is so much slower there. If you just try to open up SAS. We were just trying to do some basic demographics on what data we had and then review

some of the PowerPoints, the flowcharts, the case report form—the case report form was just changing or had just changed—trying to understand the history of what had happened in the month previous. The first folks were on the ground for three weeks, I think, when we got there. Dr. [Sheik Humarr] Khan died in late July, and I think it was right around July 30th, August 1st, they sent the first group over. They'd been on the ground for two to three weeks when we got there. I can't even imagine, because they must have been mostly in the dark. My cohort were the first ones to get there and to start to really see light, really understand more fully what the situation was. I almost feel like before that, there wasn't enough communication in place. You're scrambling to figure out what's going on. You can spend three weeks doing that.

That was the first day, and then the second day we knew we'd go out in the field. We stopped at the embassy, exchanged cash—wrote a check to the embassy, and—giant stack of money. It wasn't even that giant of a stack of money because our hotel was being paid for. We had to pay for our food, and that was it. There really is nothing you can do or buy in Kenema. We knew we were going to Kenema at that point. I think I had like two hundred dollars cash that I changed. It was still a big pile. Then we finally got going, and it was maybe around ten in the morning that we finally got on the road. It's a four-hour drive to Kenema.

By the time we get there, it was about four o'clock, so it was later than that. It was about four o'clock in the afternoon, because it was too late for anyone to turn around and drive back. You couldn't drive in the dark. The logs person who went out with us stayed

overnight, took us to the hospital. It was four thirty. Things were starting to wind down. We went to the evening meeting. Every night, there's a meeting. It was six or six thirty and sometimes lasted until nine. I remember walking out of that meeting and just thinking, holy shit.

Q: Who's in this meeting?

Purfield: There was kind of a lead from WHO who was there. The clinicians weren't there, but the head matron nurse from the hospital—or, she was usually there. Then it was some Ministry of Health folks, and there was another NGO who was just always on the ground there and was amazing.

Q: Do you happen to remember the name right now?

Purfield: Laura—I can't remember Laura's last name.

Q: That's okay.

Purfield: Yeah, I can find out. What would happen is you'd go around the room and you'd get reports from the burial team. All these were mainly local hospital staff, or some public health ministry staff who just were—this is, again, like deer in the headlights. But you'd get reports from the burial team, from the nurse staff about the patients that were in the hospital. There's a community liaison, there's the epi team, talking to case managers,

the people who are going out into the community and finding things. I don't even know how to explain it at the time. It wasn't organized, but it wasn't chaos. It was just the best we could do. We walked out of that meeting and Michelle and I were just kind of like, holy shit. This is not what EIS prepares you for. This is not going to be easy. I think after that first night, you have both this, like, I can make a difference. Okay, we need to do this, this, this, and this. You have this energy that you think you can change things, and you think you can make it better. But then, at the same time, you have this—what's that cliff at Yosemite that, like—

Q: Oh, Capitan?

Purfield: Yes, and two guys just climbed up it for the first time in its history. You have that same feeling of, I can do it! I can be the one that fixes this! Then you get to the base of it and you're like, can this be fixed?

The first day we got there, it was four, four thirty in the afternoon. We shared the office with one Ministry of Health person—was helping out with data entry, or he was a hospital person, I don't remember now. Then the CDC lab team—Ute Stroeher was there. That day, when I got there, they literally just got the first result from the CDC lab that was set up. They set up this makeshift BSL-4 [biosafety level 4] lab. The first result was Will [William] Pooley, who was a British nurse who'd been volunteering there for several weeks, and he tested positive. My very first twenty minutes of being there was realizing that there's someone who looks like me, who was here helping out, who got

sick. I think when we all went over there, we were like, we know how to protect ourselves. The expats [expatriates] don't get sick, it's only the locals because they don't know how to protect themselves. We know how to protect ourselves. I think for the first fifteen minutes of, like, this is—I'm not safe. Any shield that I thought that I had, any protection I thought I had because the color of my skin or my nationality or the fact that I was with CDC or because of my extensive training—all of it was gone when Will tested positive. Then I was there for the huddle. What do we do?

Q: Right.

Purfield: How do we tell people? Where's Will? Someone needs to be with Will. Will is in his hotel room, and you need to tell Will. We need to know the person who spent the most time with Will. It was just shocking to see that ripple go through. But also at that time, I remember being in there, and the physician that I'd been on the boat with, he walks in. We were kind of like, hey! I know you! He walked in with this other physician. They're wearing their blue scrubs, and they were coming down to get the lab results, because we knew the lab had come down. This tall, beautiful man walks in with these amazing blue eyes. Of course, everyone who sees Ian [Crozier] for the first time is just, like—every man or woman is just like, oh, wow! [laughter] That's a tall glass of water! [laughs] He came in, and he has this way about him, this calmness in the midst of chaos and tragedy. His presence, being there—he was bringing George, the other physician, down to show him around and show him this is where we're going to get the lab results. Ute just got there. She came on the flight that I was supposed to come on. They had just

gotten there and arrived, and so there were no real relationships established between any of us. I remember distinctly that was the first time I met Ian, just thinking, wow, he looks like he's been here forever. He'd only been there for like two days, but he had this amazing, commanding—not commanding. That sounds wrong. It was just this amazing, graceful presence of calmness, like he's the person who's always going to know exactly what to do in every situation. I remember immediately feeling grateful that we had Ian and George there as our clinicians. I remember talking to the people who had worked with Will—or not talking to them, because I was just some stranger. I was the interloper who just showed up. They didn't know me. But being very obtrusive and being in the room when other people were having those conversations about, how could Will have gotten sick? What happened? "Must have been the baby" was kind of the conversation that we'd heard. It was the baby, because he couldn't—and I didn't meet Will. I never met Will. Someday, I hope I can meet Will, because he's an influence in my life. But from what I heard, he's—childlike enthusiasm for being there, like, this is my job, this is what I do. He volunteered, you know? He came of his own free will to do that. He wasn't one of those people—I mean, a lot of people who we'd see would "volunteer," with my air quotes. Would get over there and they want to be in the pristine bubble. They heard about the cappuccinos at the Radisson Blu [Mammy Yoko Hotel], and they heard about the carvings you could get, and they wanted the experience. Have their clothes made without getting their fingers dirty, without ever being at risk, but to be able to drive around in a car with a driver and take photos of this horrible tragedy unfolding.

So there's that type of person. Then there's Will Pooley and Ian Crozier, who raise their hand and say, this is what I do. These are my people. I'm here to help and to make this better. The fact that Ian and Will both got sick, you just have this incredible admiration for someone who does that. CDC won't let us go in. I both wanted to, and that's probably my biggest regret in the rest of my life was not caring for my friends when they were sick and alone, or not going in and caring for those patients that I felt like I knew so well because of a paperwork connection, when there was no one else to care for them—knowing just how scared they must be, how scared a woman must be watching her child die after her entire family dies. Or the children, when their mother doesn't want anything to do with them because everybody else in their family has died. "I'm not going to get close to you, because you're going to die, too." That was just the first day where I realized that this was not going to be me sitting in my pristine little office, clicking away at the data management center. It would get real. I would know people, and I would know people like Will who would get sick. That was day one.

Q: Wow, day one. Can I pull back for a minute and ask, when you're told that you're going to be going to Kenema, are you also told what you're going to be doing there? What's your perception right—like, at this point of—

Purfield: Yes.

Q: —your role?

Purfield: No, I knew I'd be doing epi, which is pretty much it. I thought that that meant doing contact tracing and case management. I thought that would be the whole thing, because in a normal—"normal," air quotes—Ebola outbreak, it's twenty, fifty people.

Q: Right.

Purfield: That's what the database, the Epi Info database, was set up for, was to do contact tracing so that you can find people who may have been exposed and you can stop the spread of disease. I thought that's what I was going to be doing. I knew there was a hospital, and I think they told us that our office would be at the hospital, but I thought a hospital that had a few Ebola patients. It also had TB patients and a peds [pediatrics] ward and surgery and, you know, everything else, because this was the big district hospital.

There was nothing. It was just Ebola. There were some TB patients who were still there because they lived there, because they got direct-observe therapy there. They were the only patients at the whole hospital. When I first got there, for the first few days, I think there were still a few people in the men's and women's ward. Then one of the nurses from the women's ward, she'd been sick. I think I'd been there for just a couple of days. I didn't know her, and this was to be—because my perception of Kenema is that there's no one in any of the wards. But in the first few days, there were. There was a physician who got sick while I was there. He had not treated Ebola patients, but he'd not protected himself. He got sick, and he passed away. There was another nurse I didn't know from

the female ward. I think I got to Kenema on Thursday, and I think it was Saturday at night or early in the morning. She'd been sick and a couple other people had been caring for her in the women's ward. She just didn't go home, but she wasn't a patient. She was still working, but sick, and they were helping care for her. Finally, they convinced her that she should go over to the Ebola ward and get tested. She literally collapsed and died on the walk over.

It was just these little fires pop up. So, now there's more people. Now the entire women's ward was potentially infected, and the other nurses were infected. Those first few days, we would walk through the women's and men's ward. It was a cut-through. You'd walk through there to get to the hot zone, the Ebola ward. Then one morning we came and there were these beds stacked up that wouldn't allow anybody to walk through. Then you see the decontamination and then the next thing you know, it's a ghost town. There's no one in there. There's no one in the men's ward. Walk the very circuitous route around, try to avoid that at all costs. I don't remember what your question was, I'm sorry. [laughs]

Q: Oh, I don't either, anyway. That's okay.

Purfield: Oh, I—yes.

Q: Are they implementing that plan that I associate with MSF [Médecins Sans Frontières], where you go toward the dirty area and then don't come back through the—

Purfield: Yes. A couple days before I got there, MSF came and gave them—or maybe it wasn't the day I got there. It was all happening. Everything was happening. It was clustered around a few days of things changing. MSF came and helped them set up: like, this is where you need to do your water, with the hot zone and with the security fence where they'd have somebody who checked your—basically let you in or not, not like real security—into, I guess you could call it an orange zone before you get to the red zone, where you actually had to gown up and go in. They helped them with those zones, and it is going from clean to dirty in the sense that—so, there was the Ebola ward, which was some tents and a surgical ward. Then there was the men's and women's and peds ward. They're long, open buildings. Windows are open, and you can walk through, and there's courtyards between the buildings. This is where—when someone is sick, the family member comes. They cook for them, and they do their laundry. These little courtyards are kind of where the family members live while their loved one is being treated. They were all empty. It was all completely empty. We would walk through that hospital to get to the orange zone. The first thing you do is—there was a wooden frame with a piece of plastic sheeting. It was kind of the material that rice bags are made out of.

Q: Sure, yes. It's kind of—

Purfield: The woven plastic?

Q: —viscous kind of thing?

Purfield: Yes. Around where all the Ebola patients were staying, there was basically a four-foot plastic sheeting all the way around, and then four feet away from that, there was another. There was a barrier between the patients. There's four to maybe six feet between the patients and anybody else who could come up there. To get to the Ebola unit, we would walk from our office, which is actually closer to the Ebola patients because it's down the hill, so we were closer to that four-foot barrier. We walk up the hill and through the hospital and around the women's ward. You'd be hopping over open sewers, and then you'd hop over to the platform that goes around the men's ward. Then we'd walk around the men's ward, and then you'd be walking on these little raised sidewalks that had a roof kind of like a little canopy that connected all the buildings. We'd walk under that, so in rainy season, you'd stay dry, and it'd be shaded when the sun was out. Then we walked to the building where the surgeries took place and the pharmacy was. There was an office at the end where the physicians and the WHO office was. Initially, I think we may have started off up there and then moved down in the beginning, when it was just maybe one person. Then the lab and everybody, they moved down to another office that had actually been occupied by Tulane University because they ran the Lassa fever program. We were in the Lassa office after that.

We would walk up the hill and around to the hospital, and we'd walk past this swinging door that was covered in plastic sheeting to get into—if you went with red, orange, yellow, this would be the yellow zone. This is the first barrier. Within that first barrier was a WHO office, and that's where the clinicians were, which was very close to the ward. So they'd come back. They'd go in and they'd come back. That was usually my

first stop. I would stop in there and talk to them and try to get any peripheral updates on what had happened, what was going on. Not an official meeting, but just to kind of touch base and see how they were, say hi. Then you'd walk past that office and around, and then you'd leave the building. You'd walk across a little gravel yard, I guess it is, just an open gravel area. That's where the ambulances would go along that gravel road, and they would be let directly into the zone. I'd walk across that gravel and then a man, Ishmael, was there, and he worked security. Ishmael had this floppy hat and was really kind of funny. It was like a fisherman's floppy hat. I remember the first day I saw Ishmael, he had this Harvard t-shirt. I just love finding the t-shirts—that's one thing I do when I go abroad is I kind of play Kenema bingo or Freetown bingo. You try to be like, oh, look what I saw! I saw a man in a pink puffy coat on a motorcycle, or I saw a dog on a leash. I was amazed to see that. I saw five people on a motorbike, or I saw a t-shirt of my alma mater.

Q: Right.

Purfield: You see Harvard t-shirts —I did not go to Harvard, by the way. [laughs] But saw him in this Harvard t-shirt, and it was just kind of funny. All he does, all day long, he sits under this tree, which is cut down—it no longer exists now—sits under this tree and—you know that orange construction fence you can roll up? He would take a loop of the orange fence off and move it aside so that anybody could pass in. I'm not sure there was any type of, are you worthy of passing in or not? Then he would put the orange fence back. Then I'd pass by another gentleman named Thomas Smart, who also did security.

He just sat there, but I would talk to him. The next stop, ten feet further down the road, was a little hut maybe four times the size of an old-fashioned phone booth. A man named Solomon was there in the morning. Lansana was there in the afternoon. They would sit there. I remember Solomon, he always seemed to be in this coat that almost had a little bit of faux sheepskin or something. Mind you, it's hot. It's really hot there. He had pants on and this apron on over him. He had a mask, an N95 mask that was never really on his face. It was always around his neck, but it was always just on his neck there. Then he had on these green gloves. He had one of those pressurized spray bottles like you have when your exterminators come. You pump air into it and then you spray fine mist. He would spray my boots. It's big gravel, so it's kind of like the gravel's almost so big that it's hard to walk in, because your ankles tilt and turn, and I'm wearing my polka-dot boots that are really—I think they're garden boots. I don't even think they're rain boots. They had no traction on them whatsoever, which was probably yet another safety issue. Then I'd wash my hands with the bleach in the giant bleach bucket, and then I walked past. The next stop, I walked past a couple trailers, small trailers, close in. Then the next stop was where the nurse's station was.

I went up there the first day with Emily Pieracci. She took me up the first morning. She had been in Bo, which was another area. Her objective was to get the log book, the admissions log book, and to try to capture who was actually in the hospital every single day. There's no electronic system, there's no—the WHO physicians don't know. They're in there for a minimal amount of time to provide care. The nurses were the ones who were supposedly keeping a record of everyone who was in there and what their status

was. That ended up being my job for four weeks. I thought I would be doing case management, but it was hard enough just to find out who lived and who died every day.

Q: Wow.

Purfield: After about a week—there's myself and Michelle. Michelle Dynes came with me to Kenema, and she ended up doing health communications right off the bat. She did a phenomenal job. She's got the best story. You ought to talk to Michelle because she was in the community, and she met this artist like on day two and basically commissioned him to draw up a picture book, so that the village health workers could—because language is an issue. The village health workers would have this picture book to show what would happen if someone cared for a sick person, or what to do at a funeral. This artist was amazing. He had one arm. [laughs] My gosh, I can't remember his name at the moment, but we ended up buying, had some paintings that we bought from him, too.

Immediately, Michelle was out the door, out with the social mobilization team, working on health communications. Then Emily was there. She had been there. She came, she finished EIS July—or she finished EIS summer course July 30th, August 1st. Same day she finished, she was picking up her go-bag. She was out the door August 1st. She'd been not in Kenema, but she'd been in Sierra Leone for about three weeks when I got there, mainly in Bo, which was a town between Freetown and Kenema—it was about forty-five minutes from Kenema. It was the next town over. They had some issues, but it wasn't

quite like—Kenema, again, was the only hospital, so everybody was coming to Kenema. She came to Kenema for her last week there, and [it] had been a rough week. There was also this public health analyst who had come from Washington State. I don't remember what she was doing there, but her—sorry, I'm getting out of order here.

Q: It's okay.

Purfield: I was at the hotel in Freetown, and she was flying out the next morning. I had just flown in, and we had dinner together. My first impression of her was that she was reserved, but now I know it was probably just PTSD [post-traumatic stress disorder], just may not have been reservation. There's only so many things you can talk about when you're coming back, but she'd had some challenges. There were personality issues, they were just—she was literally probably the first one there with this other woman, Tara [Perti], just, again, forging the trail in new snow. Emily was essentially the second epi that was there, because first was Tara and this other woman who'd just left. She was very young, too. Then Emily came from Bo and she came to Kenema. I remember there was a day, it may have been two days in. This may have been when the nurse died, and just everyday, so many wrong things happened. Emily just broke down. She just lost it and started crying. I was still bright-eyed and optimistic. I told her, "You're going to be home soon. It's not that bad. This could be a lot worse than it is." She just gave me this look, and I said, "In three weeks, I want you to email me and tell me it's not that bad, it's going to get better. Right now, I want you to just tell me to go fuck myself, [laughs] because I haven't been here for three weeks, going through what you've been through. I have a

different perspective. I'm, of course, more optimistic. I know, in three weeks, I'm going to be exactly where you are. I'm going to be sitting there with my head in my hands crying, thinking this cannot possibly get any worse. So I want you to remind me [laughs] in three weeks, and then I'll tell you to go fuck yourself." It was just one of those situations where everyone knew—you saw, just had this sense of, I don't know, resolution that it can't get any better. My gosh, we used bad language. We talked about dead bodies all the time. Dead bodies. Body bags. You'd talk about it almost with humor, and we talked about bowel movements. I mean, there's things that you don't talk about, and the only thing I can relate to is that I dated this guy once who'd had two tours in Afghanistan and Iraq. I remember the stories he told me. Of course, this was long before I experienced any of this. I tried to be empathetic to some of the stories he told me about just the language and the things you think and the things you talk about when you're in that situation. That's what started coming to my mind when I was there. I was like, this is like war. All social norms are out the door. You're just trying to do what you can do to get through the day, and to not end up with your face in your hands, and letting it wash over you.

Q: Right.

Purfield: But yes, there were many moments like that, where we just lost all professionalism. You joke about how you started eating a diet of candy, and we had this trick about—you drink in the morning. We'd get up, and I think we had breakfast at seven. We left at seven thirty for the hospital, or seven fifteen. Or maybe we left at seven,

and we got up at six thirty. Oh, I'm sorry, I was telling you about who was there. Emily was there, and this woman Tara [Perti] was there. She was an EIS officer, second-year EIS officer. Then Michelle and I got there, and then there were three people from the lab: Tara [K.] Sealy, Mike [Lo], and Ute were there. All of us had just gotten there except for Tara and Emily. They'd been there and they were on their way out. We only overlapped with Tara and Emily for a couple of days. But Emily was the one who showed me how to get the book.

It was really stressful, I think, for her. Because she hadn't been in Kenema the entire time, she didn't have the relationships she had by the end, the last week in Kenema. She would go out there and she'd just want the book. "Where's the book? Can I get the book? I need the book." Very quickly we realized, you can't just go up and get the book. It's, oh, their friend died overnight. Another one of their family members is in the unit. It's not like going to Grady [Memorial Hospital] and having a nurse deal with a gunshot victim. It's going to Grady and having a nurse deal with a mass shooting at her own church. You couldn't have this level of anonymity or professionalism. It became very clear like day two.

I went back the first morning after we'd gone up there and I'd try really hard to remember their names, try really hard to try to—I don't want to say ingratiate yourself, because that sounds very insincere—but [I] tried to befriend them. I went back that afternoon, and I brought them a little baggie of Peanut M&Ms, just, you know, to share with them, thinking that they would enjoy that treat in the afternoon, those Peanut

M&Ms. They stashed them, and they'd take them home to their kids because their kids never get chocolate. They just don't get chocolate. That became my thing. Every day, I would go up, and I'd bring them a little bag of candy or a little bag of M&Ms. Then I started bringing them cold sodas, just trying to do whatever I could do. "What do you need? What can I get for you?" My role went beyond—I mean, getting this admissions log was part social work for the nurses and part getting the data. Every day I would go up, and I'd get the admissions log. Every day, there was a different tragedy that occurred. There was no such thing as a random Tuesday. [laughs] The staff was on strike, someone else got sick, someone else died. An orphan showed up, we were out of body bags, four people came in the middle of the night and we didn't know their identification. There were four case report forms, and there were four bodies. Two of them were in a coma, and two of them were dead, but we had no idea who was who. All four of them die, and we still don't know who was who. Dealing with case report forms where either the information is illegible, you know it's wrong, or you get two case report forms on the same patient and they have different names, they're telling you different symptoms. It's a lot of teasing things out, and sometimes you have questions, and we would go to someone in WHO who's case management, Mikeiko, and she would go and she'd try to help tease out what really happened.

In the beginning, we thought oh, we can do this. This is going to be like one funeral, twenty-five people exposed. We contact everybody that went to the funeral. We tell them about their risk. We teach them a little bit about infection control, and then we monitor them with our community monitors. This is no problem, we can do this. Then within the

first day, you realize that you have twenty-five funerals with twenty-five people that attended, and they all attended multiple funerals. Then they went back to different villages, and then they have sick people, and they buried people. There are secret burials. Contact tracing was—then we'd get these calls from headquarters. "You've got to work on contact tracing." It was just like, you've got to be kidding me. There were two of us. Emily left and Tara left after a few days—I'd been there. Then Melissa Rolfes came in. She was a first-year EIS officer, brand spanking new, like Emily. Melissa and I were the epi team. There was just the two of us at the only hospital treating Ebola patients in Sierra Leone. Then Michelle did health communications, and there were three lab people. There was a decent cadre of CDC folks, of team members there, but what we really needed was five more people. We needed one person who just worked on contact tracing, one person who just worked on case management, one person who worked with the community health workers. We needed more people, and so much of our day could be sucked up in going to these meetings. Oh my God, these meetings where—at the time, I just felt like we are not moving anything forward. We're just talking. But with time and reflection, you realize that there was no capacity to move anything forward. There was no playbook. There was no SOP [standard operating procedure]. We were doing the best we could, and nobody knew what was happening.

Yes, there were personalities that were difficult, and you're dealing with—I remember one time, I was maybe a week in, and the head of the epi team in Kenema—he was someone from Kenema, and he looked to us, and he wanted capacity building. We're just like, we can't do capacity building. We've just got to put the fire out. Unfortunately, this

isn't the time where we can sit down and teach you about how to do things, maybe the best way. We're just constantly chasing our tails.

We had meetings, and quickly, we decided that I would try to deal with the cases. I would try to deal with updating the database and getting accurate information, because in addition to getting all the people who were currently in the hospital or currently buried, we were trying to go back and fill in gaps and holes, dating back to when the first patient walked in the door at Kenema on May 13th, before they even knew it was Ebola. We didn't know names, we didn't know outcomes. Then, when people got sick, when Dr. Kahn got sick, nothing was recorded for two or three weeks. A lot of staff fled, some staff stayed. It was just this incredible mind-bending game of trying to figure out both your history, your present, and your future, all at the same time, and all while every moment you feel like this is one of those commercials where, "Every second, four people die of a car accident." It was literally—we could do that math. Every hour, 1.2 people died in our hospital of Ebola. It was that much going on. I didn't even know where to start with the Kenema experience because it was—yes, yes, we tried little things to implement. I hear people getting awards for, I don't know, coming up with something in the ambulance. One of the biggest things—differences—I think we did—and this had no effect on solving the outbreak or fixing anything—but we gave Orlee, our illiterate burial team member, a notebook, so he could try to write down or at least copy the names that might have been on a case report form that was with the body, so that we could copy down a name into a book, so we could try to identify who died.

We didn't have the capacity to notify family members that their loved one died or their loved one was just discharged from the hospital with twenty dollars, a mattress, and a fifty-pound bag of wheat. We didn't have that capacity. But if we could just get their name into a database, then maybe someday, two months down the road, somebody calls up the hospital and says, "What happened to my loved one?" we could give them some sense of peace. "Oh, they died on this day." I mean, that's dignity, knowing that someone died. It was just assumed. This is what was happening in the community was that people were afraid to come to the hospital because you wouldn't find out what happened to them. Some were in the hospital for three weeks, and they recovered and they were discharged, and they were not allowed to go back to their community. The family still didn't know if their family member had died or not, what happened to them, where did they go? That was my daily struggle, and it was just a disco ball of all these different reflections of how to try to accomplish that, trying to figure out every day who died. I remember one night we argued in the hospital for an hour about whether or not ten people died or eleven people died that day. We argued for an hour. The burial team said, "I buried eleven people." The nurse said, "Only ten people died." [laughter]

Q: Oh, no.

Purfield: They were having the same argument back and forth. As both an outsider and an insider, you try to figure out what's going on. It was because he was counting from 7:00 am, she was counting from 9:00 am, whatever. Things like that. Yes, there was—yes, I don't know. You have any questions?

Q: Yes.

Purfield: I don't—

Q: Oh, no, of course I do. [laughter] Of course I do. I think it says something that this kind of comes out stream of consciousness a little bit, too, the intensity and the chaos and everything. One question I have is just how you were going about trying to learn these things from the past. Reconstructing the past of the epidemic at the hospital.

Purfield: This is something that Emily had done, and this other woman who had just left when I had gotten there: they started getting the hospital files. When you think of a medical chart from the U.S., you think of something that's two inches thick and it's got the little metal tabs in there, and there's a lot of papers. But here, it was just a file folder with—so, every patient's—back up a little bit. Every patient that would come in, when they came in, they'd sit and wait in a tent. It was like a Red Cross tent. Then they'd go through a triage tent, which is just a giant, half-cylinder tent where you would walk through like you're walking from one end to the other. That tent was staffed by Red Cross nurses. I think they're mainly local nurses, Red Cross nurses. They did the triaging. They would take a patient's temperature, they would ask them about their symptoms, they would fill out the case report form. If there was any doubt that they met the symptoms, they would go into the suspect ward, which I think—there was training and

retraining and training and retraining. You can train all you want, but this amazing level of fear probably skewed everything to the very conservative side.

There was also a level of fear on the patients'—they may have been forced to go there. They may have come there and thought, "I've just got malaria. I've just got malaria. I'll tell them I have malaria, and I'll be on my way. Then my family will let me back in the house." I don't know how many people really met the case definition who went into the suspect ward and how many people may have just gone in because of a fear of letting them back in the community. That wasn't something that we really had any participation or control with. But I know there were people who went in who didn't have Ebola and got Ebola. I know there were people who went in who never got Ebola, but were there for a very long time, and their risk was astounding for getting Ebola. When you write an SOP and you think of the best practices—I'm a scientist. I think of the steps and the order.

Q: Right.

Purfield: You know? You don't think of the psychological aspect. You try to do a study, and you don't want to have bias. You can't take bias out of the situation.

The patients would come through the triage tent, and then, essentially, Ishmael would open up an orange fence, and they'd be swallowed up into the Ebola ward. The first thing they did was they would go to the phlebotomist, and they'd get their blood drawn. They'd get a G number. That's a general hospital number. The G number was really only used

for the people who went in through this Ebola system. It was not used for the hospital. I think there was an L number—[there] was a Lassa fever book, if they had Lassa. So they'd get a G number and that was identification, and they got a wristband. It was written in pen—usually pen on the wristband. Their blood was drawn. The first day I got there, there was a phlebotomist who died that day—same day Will Pooley was diagnosed. Then, by three or four days in, the seventh phlebotomist had died.

Again, there's so much potential exposure when you think about the case management issue of trying to figure out how they were exposed. It could have been drawing blood, or it could have been in the community. It could have been that they all hung out together. Could have been that they shared the same facilities. One got sick and got the rest of them sick. Could have been that they shared food from the same container. Water. But seven phlebotomists died, and the phlebotomist would draw the blood. You can imagine, as phlebotomists are getting sick and dying, there's disruption. Nobody may be there to draw blood that day. The phlebotomists went on strike, and they would stop, or they would all go to their colleague's funeral. There were these intermittent periods where people might get into the hospital, and they may not have a wristband. They might not have had blood drawn, which means it wasn't being tested. They were in the hospital, they were in the Ebola ward, and we didn't know who they were. There was no number, so there may have been a case report from—we had a stack of case report forms that didn't have any G numbers attached to them. We didn't know if they were duplicate forms that came with the patient in the ambulance, because in the community the patients were sent to Kenema from all over the country.

When I got there, Kailahun [District]—there is an MSF facility in Kailahun that had—I think they had twenty-five beds. Within my first week I think it was, an epidemiologist named [name withheld], who was a WHO epidemiologist in Kailahun, he got sick. That was my first week. It was my first three days. He got sick and he went and he asked to be tested, and he wasn't tested. He had himself tested. They told him it was malaria, had malaria. He either tested himself, drew his own blood or something, and he ended up having Ebola. He was medevacked out. He passed away, but he shared a very small office with two CDC employees, and those two CDC employees got medevacked out, just as a precaution. It's such a small space, and when you're talking to someone and there's spit that flies, and you are sharing doorknobs. You try to be very careful and conscientious about all this, no touching or anything. But it's still shared, intimate space, bathrooms and just breathing space. I know it's not transmitted that way, but once you think you've got an exposure, you can't do anything else. It's like Friday of a three-day weekend. [laughs] You're not going to get any work done after three o'clock. You know you're going on vacation, you're done. I think it's something similar. Once I think you start to have that seed of doubt and that you've been exposed, there's no going back.

Q: Are you talking about this from experience?

Purfield: In part, yes. Rationally, I knew that I never had an exposure, but once—there are people that you've shared meals with, facilities with, you work close to, you talk to, and once they get sick, if they can't say, "This was my exposure," then it's like, well,

what was the exposure? What don't we know about this disease? Convention tells us you can't get it through casual contact. But when you wake up with a headache—

Q: Did you do that? Did you wake up with a headache?

Purfield: Yes, it was about four or five days in. I woke up with a migraine. It wasn't—I get migraines all the time, I hadn't been there long enough, hadn't had any exposures. But I went and I couldn't eat breakfast because I was so sick to my stomach. I took Pepto-Bismol to help with my stomach, and I took a migraine pill. Then I got in the car, and it was like a kidney-busting ride to the hospital. It was nothing but potholes and potholes. You're rolling around in the—the key is to try to keep your body as loose as possible because if you try to have any sense of rigidity in your body to control against the potholes, then it just ends up basically bruising your kidneys almost, and, you know, you get sore and stiff.

We had this very wild ride into the hospital every day. Normally, it's a bad ride, but when you have a migraine and you're nauseous, it put me over the edge. I get to the hospital and I'm in my office. Sometimes, if I can just stop and put my head down and be quiet and still for a little bit and let the medicine kick in, I'll be fine. But I wasn't fine, and I ended up going out into the open sewer and I threw up. Someone from the hospital saw, one of the lab members saw that somebody was throwing up, which is one of the symptoms of Ebola. When you have any of those symptoms of Ebola, you immediately go into the unit. This is four, five days after Will got sick. It's no longer, you know, white

people are immune, which is one of the ideas that people had, was that you're white, you can't get it.

I immediately called the driver, and I drove back. I was just in bed all day long. I remember taking my temperature every hour, rationally thinking I don't have Ebola, but what if? What if? There were a couple other times, too, especially after Ian got sick. It's just that you're—by then, I think I had become almost so disconnected, emotionally disconnected, that I almost—"I have Ebola, it is my destiny."

Q: Wow.

Purfield: That's what the nurses would say: "If it's my destiny"—they all thought that they were going to get sick and die. I think it was after Ian got sick that I was kind of like, yes. Rationally, I don't have an exposure, but you just start seeing everyone going down, and it's day after day of these horrible stories. I don't have Ebola. I don't have an exposure. I'm not in with the patients. But it's so easy for anyone to get around here. Again, where's Ebola? [laughter] You know?

I think those two epidemiologists were medevacked out, just as a precaution, which I think was the right thing to do. Then another nurse at that MSF facility in Kailahun got sick. MSF is very infection control. "We don't get sick. Our patients don't get sick," and if they do, they shut it down. That's what happened, is they shut Kailahun down. They were then shipping patients from that district, which is the only other district that was

treating Ebola patients, to Kenema. Then Kenema was the only hospital in the entire country with Ebola patients. I think that's when our census shot up to about a hundred patients. We'd get patients trucked in from Port Loko, and also way out of sequence. I remember the first day I got to Freetown was the day the first Freetown patient died. It was so early. I was just like, oh, we can control it. It was a patient who came from Kenema, but then he ended up getting his family sick, and his family got other people sick. Then the next thing you know, we have nine thousand cases in Freetown. Yes, that was the beginning. It was just like that first domino that went in Freetown.

Q: Oh my gosh.

Purfield: One theory was—in part was because in March of 2014, this very nice highway was finished between Freetown and Kenema. One theory was that that made the trek from a kidney-busting, eight-hour trip to a four-hour zip-zip trip. Things could be transported to and from, and people would go home for the weekend. They would go to Kenema and work, and then they'd go back to Freetown to visit their wife and children for the weekend. The thought might be that that road was what helped facilitate and fuel this outbreak.

Q: Right.

Purfield: That's what some of the locals thought.

Q: Yes.

Purfield: But—

Q: Can I ask—this may be taking us in a different direction, I don't know. How much of your work involves interviewing?

Purfield: Patients?

Q: Patients.

Purfield: None.

Q: Okay.

Purfield: I didn't—

Q: Staff?

Purfield: I didn't interview any staff. I didn't do case management, which was—you're interviewing with the case report form.

Q: Right.

Purfield: The role that I had was either to fill out a case report form—

Q: Right.

Purfield: —from the log book for a patient who'd been here before we had case report forms, or to take a case report form that came in from the community or the hospital and enter it into the database.

Q: I see.

Purfield: And then to—

Q: Into the info database.

Purfield: Right, and then to take the lab data that we were getting from our lab and to update the lab whether or not they were a suspect or a confirmed case. Then, if we had outcome data, to go into that database and enter in whether or not the patient survived, or if they were discharged, what their date of discharge was. If we could get any information on what their symptoms were, we would try to put that in, but that was impossible.

Q: Gotcha, I see.

Purfield: Impossible. It was mainly the data entry. We had someone who did the data entry, who would type things in from the case report forms. But when we were getting thirty or forty a day, it was more than one person could do. We would all kind of buckle down. Then, every day, I uploaded all—or would go into each individual participant—it should be a lot easier than it is, but we get a spreadsheet from the lab of all the results, test results, and then I'd take that and I'd look up each individual patient. Usually, we had the G number. We didn't always have that hospital number. But then, try to [match] their name, because sometimes the numbers don't always match, and the names don't always match. It's like you're trying to match all this personal identifiable information, but yet age is just approximate. We had a woman there who was 115 years old. Really? So age was approximate. A lot of times, they had their formal name, their family name, their nickname, their casual name—there might be four or five different names that they give different people along the way, whether or not they're talking to someone they know, whether or not they're talking to the physician or a white person, or whether or not they're talking to one of their community members. So [I'm] trying to figure out whether or not these are four different people or if this is the same person, trying to read the handwriting. [laughs]

Q: Right.

Purfield: Sometimes all six of us would be sitting around going, "Now, is that Kamara, or is that Koroma?" [laughs] The villages they were coming from, if there was a common exposure, [we were] trying to figure out if it was coming from the same funeral, that

same person or same participant. Sometimes it was, and so then we tried to look in the database to see if that person who died at the funeral was in the database and if we knew whether or not they had Ebola or not.

Q: I know that you’re probably synthesizing from many sources, but what do you do if there’s data missing? I’m sure that happens all the time.

Purfield: Probably half of it’s missing now.

Q: Probably half of it?

Purfield: Yes, yes. This is why our case counts were so—I mean, there was just a large margin of error for everything, especially when we went back to the log book for June and July and early August, and trying to piece together that information. I would go up and I would talk to the nurses a lot. I would be like, “Do you remember this patient?”—

Q: Okay, I understand.

Purfield: —especially when we knew it was a healthcare worker, because sometimes we could figure out that it was a nurse. “Oh, yes, yes, yes, she was,” you know, “she was a young nurse from Freetown and oh, she died.” As a scientist and epidemiologist, I want good data. Especially someone who came from the FDA, I want good data. But in this situation, you just want some data, the best you can do. Sometimes we had conflicting

death or—one person said that she lived, one person said that she died. The log book said she died, but a person was swearing that she lived. Sometimes you just had to make a judgment call, depending on where that data was coming from.

Q: Wow.

Purfield: Yes, so a lot of it was personal. Sometimes, too, it was like, "Oh, yes, yes, and her daughter is still in the ward." That type of thing.

Q: Gotcha, okay. Thank you, I think I have a much better understanding now.

I had a couple questions. When you're in that initial meeting and you come out of that meeting, and you're thinking, oh my God, this is going to be unreal, was there something specifically that you saw in that meeting, that you heard in that meeting that made you think that? Or is it the general mood, or what?

Purfield: It was this lack of strong leadership.

Q: Okay.

Purfield: Yes, it was a lack of a good, clear leader who could both build morale and be realistic at the same time. I feel like if they'd had that, if they had someone they believed in and someone they really trusted, I felt like a lot of things—it may not have saved any

lives, but in terms of, like—the road would have been paved and not so bumpy. We would have gotten to the same endpoint. You couldn't have changed the outcome. I don't care what figurehead tells us we could have changed what happened in Kenema in that point in time. Unless we knew it was coming, we couldn't have changed it.

[break]

Q: You've also mentioned staff strikes a couple times. What was that about?

Purfield: They weren't getting paid. The staff that was there, most of the staff left the hospital. Some people stayed. Some people stayed out of a sense of duty, a sense of commitment to their community. Some people stayed because they were getting an extra bonus. They would get $200 a month. Yes. I mean, it'll last three nights. I probably spent more than that on dinner and whatever, you know? Uber rides—in [Washington] DC. I don't live that extravagant lifestyle, normally. [laughs]

They were supposed to get paid on Friday afternoon. On Saturday morning, I went up one day, and it was just weird. It was oddly silent. There was nobody at the post where Ishmael was. I didn't see Thomas Smart there with his little security stand. I was walking around, and it was really quiet. I was wondering what was going on. You never know [if] it's a holiday? Or I didn't know if someone from the hospital had passed. Sometimes they would gather at the morgue as the body was loaded, or they would gather together and—I

want to say wail. Wail sounds like a—grieving together, and it was kind of like a wailing. That was kind of the grieving.

I saw Solomon, who was the guy who sprays my boots. He was a young guy. I was like, “Where is everyone, Solomon?” He said, “They’re not working. We lack motivation.” [laughs] I’m nervous because we’ve got ambulances dropping people off, bodies. We have family members who are angry that nobody’s caring for their family member. We have patients who are in the Ebola ward who don’t want to be there, and they’re not getting care and they’re not getting food. It’s not a prison. They’re not locked in. So there’s a lot of things that could have gone wrong that morning, the first morning of the strike. I can’t stand up there and give a big speech to them, but I talked to Solomon. I’m like, “Solomon, I know I’m going to do everything I can.” You just put your hand over your heart, like it’s the only thing you can—like, just sincerity and just “—do everything I can to help you and help the situation. I will call my people in Freetown. I will try to get funding and get your paycheck as soon as I can. But things don’t move quickly, you know that. It won’t be today, but you can trust me that you will get paid. But you need to tell them that they have to work, because this is their community, and this could be their family member that’s in there. This could be them. If they get sick, they are going to want someone to care for them. You have to tell them they have to go back to work, and you have to motivate them.”

I went back to the office and I called—don’t know if I called or emailed. We didn’t get phone very well, but I may have emailed Steve Wiersma, who was the “cash and prizes”

guy I met on the boat. I was like, “There’s a strike. First of all, safety is fine.” Not that at that point in time—nobody really paid any attention to us out there. [laughs] But I was like, “This is a peaceful protest, but I want to do what we can to get them paid as quickly as possible because it’s a delicate situation that could go wrong quickly. We need movement on this. We need somebody to help shepherd this through.”

That Tuesday they got paid, but they went back to work that afternoon. But there again, “we lack motivation,” you know? They weren’t angry. They weren’t yelling, they weren’t rioting, they weren’t flipping beds, pulling patients out. They weren’t stealing anything. They were just very peaceful. I don’t blame them. You’re putting your life at risk. You’re putting your family’s life at risk. You can carry this home to your family. You can orphan your children. They’re not paying you much. Bag of Peanut M&Ms and a soda can’t go very far.

There were maybe three strikes when I was there. It became a very regular thing. They just didn’t get paid, and then they’d go on strike. Then, by the afternoon or the next day, they’d go back to work. That happened with the nurses. It happened with the whole hospital staff, it happened with the phlebotomists. But the problem is, every time there is that interruption, I couldn’t get a log book, we had ten more people who were in the ward who were dying, and I didn’t know who they were. More lost incomes. More people who were going in who weren’t getting a wristband and a number. You think your job is very easy, to figure out the names of ten to thirty people who die every day and the ten people who were discharged every couple of days. But it was just so incredibly challenging to,

yes, yes. You can run a mile on pavement, or you can run a mile up a hill and a mountain, and we were definitely going up the mountain. It was just every single thing.

There were nights at that meeting where you'd go around and you'd hear reports. I remember there was somebody who had worked in the lab at Kenema who was charging people to test them for Ebola. He was basically just doing malaria tests, rapid diagnostic tests. He's taking their money, drawing their blood, testing them, handling their blood, and then giving them a fake certificate saying they didn't have Ebola. Well, he was caught. He was put in jail. Then, when he was in jail, he was like, "I've got these symptoms." He knew what to do to get out. He started throwing up and said he had all these symptoms, that he'd been exposed to Ebola. They pull him back, and they bring him into the suspect ward at the hospital. Now he's in the suspect ward, and you go into the suspect ward—and this is something that evolved as I was there. It was supposed to be for three days while we're testing you. You needed to have symptoms for forty-eight hours before we'd be confident your test was accurate. A negative test was truly negative. By day three, if you were still in the suspect ward, you either had to be discharged or you had to go in because we had people who were in there for a long period of time. Day three, he was discharged. He went back to jail, and then he really got sick and got Ebola. Or no, he escaped. See, I can't remember the story now, but it's such a good story because it was, like, there was an escape from prison and there was this testing. He ended up back in prison, and then he did end up getting sick and started throwing up and was really sick. They'd isolated all the other prisoners, but we suddenly were paranoid that

sixty people in the jail were suddenly going to get exposed and we'd have everybody in jail.

Then there was another night where the mayor of the town—people have these family compounds, and you have security gates for the wealthier people. Somebody within the family compound of the mayor, or the governor, or somebody politically important, had gotten ill and they were hiding. We were afraid suddenly now like this entire compound is going to be exposed, and there were nine children there.

There is another situation where there is a village far, far away. It was like a nine-hour drive away, the farthest-most tip of Kenema [District]. There is a burial and someone got sick. They got him down to [the city of] Kenema in an ambulance, and then somebody else got sick, and then somebody else got sick. What they did was they took these nine villagers. They consider, well, they're going to get sick. This is going to save us from having to drive an ambulance back and forth to get them as they all get sick. So, they brought them all down to the hospital, didn't tell them why. They set them up in the men's ward, and literally, they were just living like homeless people. They had no food, they had no money. I mean, they're from a very rural village. They didn't have money. Money is not something you have when you live in these rural villages. They couldn't buy anything. Suddenly, they're in the big city of Kenema. Nobody was telling them what to do. Nobody was feeding them. The little girl, her name was [name withheld], and the little boy was [name withheld], and he spoke some English. The rest of the family didn't speak any English. He knew a few words, and he would kind of translate for us. I

would talk to them every day. They also had this baby who is five, six weeks old. Tiny, tiny baby, the type of baby that's so small, when you hear the baby cry—you know, like a kitten's meow and a baby's cry: when they're that little, you can tell how young the baby is. That was that type of baby cry. There was a woman trying to breastfeed the baby there. Then there were these two small children, and they were stuck there for like two weeks, nobody telling them what to do.

I gave them some food. I gave them some sodas. It wasn't much. I was really trying to be wary of giving cash. Then I bought a ball for the boy, and I bought this doll. I was embarrassed to buy it and give it to him, because this doll—first of all, it's this crappy, ugly white, made-in-China doll that's got this yellow hair. The hair's very sparse, and the doll is—like, it's nothing anybody would want to give to their kid to play with. But this was all they had. I went into town, and I—and this ball. And [name withheld] started, the little girl started following me around. I think she couldn't get the package open, and so she couldn't take her doll out to play with it, because it was in this plastic sleeve. I think I helped her tear open the package, but then she kept the doll in the plastic sleeve, because she wanted to keep it nice. But she started following me around the whole hospital. This girl is like three or four. She's tiny. She's probably really like eight, but just malnourished. A lot of the kids, it was hard to tell their age. And [name withheld], I think he was about six, but he loved his ball. Every time he saw me, he would go get his ball, and he kept it in the bag, too, to keep it nice. I'd try to get him to kick the ball with me, but he didn't want to ruin or dirty his ball.

Stories like that, they were there. Then there are these other stories, like we had nine kids in the peds ward, and there started to be some deaths in the peds ward. They weren't Ebola. We didn't know if they were unknown deaths. We didn't know if they were dying from Ebola or not. Everybody's freaking out. Do we move all these other kids over to the Ebola ward?

Then there was [name withheld], and she was the first orphan that came. I had been there maybe a week. She came from Freetown. Her whole family had died—or near Freetown. Basically, the community or the compound or the village, whatever area she was living in, they kicked her out. They said, "Nobody will care for this girl. You have to take her." We were in a meeting with the district medical officer, and I remember he was on two cell phones at once. They were telling him that they were bringing this baby, this orphan baby to Kenema, and that we had to take her. He's like, "We can't do anything! We can't keep her! We have no place to put her. We don't know what to do with her." And so basically, we had no choice.

Q: Yeah.

Purfield: Ambulance came and just dumped her. She was three, and there was a table like this. Just a table in the nurse's room, and it was a wooden table. It was probably about three feet long by two feet wide. They just put a piece of cardboard under the table, and that's where [name withheld] slept. She slept there for like two or three solid days. You know, three-year-old doesn't care. Everyone's gone. She has no idea. Some strangers

picked her up, put her in the back of this ambulance. She was in this car, probably in a car maybe for the first time in her life, for four hours. They bring her in here, and now there's strangers who won't talk to her, won't touch her, won't do anything. That spawned from their fear because this baby had come in with his mother, and the mother was sick. This was really early. This was like late July, August. Early August. The mother had Ebola, clearly. The baby tested negative. [The hospital staff] didn't know what else to do. The baby would have died. Nobody was there to feed the baby. The baby would have died. So they let the mother breastfeed the baby. I don't know if it was because of the breastfeeding or the exposure in the ward, or if the baby had had Ebola before he came. But the mother died, and they didn't know what to with the baby, so they put the baby in this area—box, kind of became the baby in the box—to kind of quarantine the baby. This was before I got there. He was that age where babies are just very—you know, the peekaboo age where they first start playing peekaboo, maybe like eighteen months, where he was very responsive to people. When people came, he would light up and get happy. Then you leave and he'd cry all the time, because his mom wasn't there and he was all alone. He was in the ward where the other Ebola patients were, but he was secluded so that they couldn't infect him. The nurses and the hospital staff would go in and take care of him. After a week, they tested him and he was negative. They're, like, great. It's been a week, he doesn't have Ebola. He doesn't have any symptoms. They brought him out, and everybody was so excited that he survived, and they're passing the baby around. People were holding the baby. Then he got very, very, very sick, very quickly, and tested positive. He died. Thirteen nurses—we were told when we got there, thirteen nurses got sick. They all think the single exposure was the baby. Will was one of the nurses, Will

Pooley, because apparently he was just—they were all enamored with this baby. One of the physicians that I didn't meet when I was there but I've met since then in Kenya—or in Uganda—he said that he wanted to adopt the baby. This was their little piece of life that they were all hanging onto. Then I think when that baby got sick and died, it was just this cloud that—you know, because it was between the time that Dr. Kahn died in late July, and this baby died in mid-August. It was a horrible time for the nurses, for the staff, for everyone, and something that was such a sense of joy and I want to say recreation, but—

Q: Yes.

Purfield: Again, in the war zone, it's the little things, like, that—when normally you cling to—

Q: Right.

Purfield: I think when [name withheld] came, the three-year-old orphan, the nurses were like, I am not touching that with a ten-foot pole. For three days, she was on a piece of cardboard under a table, and she would just go out and wander around in the yard by herself. A three-year-old, you know? Emily and I went—it was right before Emily left—we went and we got a bunch of clothes from town. Pretty much all the clothes at Goodwill [that don't] sell, or you get rid of your clothes and, you know, t-shirt has a hole in it or something. Nobody's going to pay for a "5K Turkey Trot" t-shirt from 1999. But

they all end up in Africa. We went to a clothing stall in town and bought tons of clothes for this little girl. It was one of those things where we did it for ourselves, because it made us feel good that we were trying to help care for her. We got her some diapers and a blanket, and some cookies and crackers and things like that. Then she went into the ward two days later, and she died. She was another one that captured hearts. Nahid Bhadelia, one of the other physicians who was there, she really wanted to adopt [name withheld]. I think all of us went through that with these children. The story was just—you can't imagine losing everything. Everything. Everyone. You don't have a home to go home to. Us, we were there. We saw their names and the paper story. We got the paper story. But then just being there and seeing them and watching them brush their teeth. Like, watching little boys with Ebola brushing their teeth when they don't have a parent. There's nobody there. That was one of those images that I'll always have. Two boys, [names withheld], out there brushing their teeth. Could have been dying of Ebola. Yes, so there's just all these—just, yes.

Q: Yes.

Purfield: The children, the babies, just—even the adults. You want to just adopt an adult who's lost everyone, because you lose everyone, and it's really hard to go in and be there for a month or a few weeks and know that you're leaving in a few weeks and this person is not. I remember my last day there, I just kept thinking, I've got to get back here. I've got to get back here as soon as I can. I remember this movie—Cybill Shepherd and Robert Downey, Jr. It was back in the eighties or nineties, and they were—it wasn't

Robert Downey, Jr., it was somebody else. But they were this couple in love, and then he gets killed in a car accident or something. He gets up to heaven, and you're supposed to stand in line. Then eventually, your spirit goes back and you—recreated as a new person. I remember thinking of that movie. I was like, as soon as I get back there, I need to get in line to come back here. I can't wait for that line. I've got to come back as soon as I can. There's so much unfinished business. I've just got to see that they're okay, and that this person that I'm leaving in the hospital—I need to know whether or not they live or die.

Q: Right.

Purfield: You just get so attached to people. Maybe it's me. Maybe not everybody gets attached. You know, I see a dog on the street and I get attached. [laughs]

Q: What's your dog's name, by the way?

Purfield: Toby.

Q: Toby?

Purfield: Yes, he's now fifteen and a half.

Q: Aw, buddy.

Purfield: Yes.

Q: I wanted to ask, as well, when you—I really liked the way you put it earlier, that you can't just come and ask for a log book and take it and go away. You have to be aware of people's humanity and care for that and recognize it. Was there something that brought that home to you early on? You said you recognized that kind of early on. Was there any specific thing that you remember?

Purfield: I remember very early learning the nurses' names, trying to figure out who had the power in there and who didn't. I remember there was this one nurse, [name withheld], who—she was actually kind of the nurse in charge. She knew our tricks. She wasn't buying it. She was just—it was business. [name withheld] was just—now I know maybe why [name withheld] acted that way. She was one of the ones who got sick and died when I was there. But she denied her symptoms and her colleagues were telling her, "Look, we think you're ill. I think you need to be tested." And she was denying it for five days—

Q: Oh my God.

Purfield: —potentially also exposing everybody else, but also knowing—the moment I got there, I think she knew she was exposed and that she was going to get sick—that she was going to get sick, and that she was at risk. She was at very high risk. They think her exposure was the baby, as well. She was watching the last few nurses, before she got

sick, die because they'd touched this baby, and they'd held this baby. I think she knew that she did it, too. I think that's why [name withheld] was kind of more distanced from me and us in the beginning. But Helena was another nurse who wasn't, and you could see in Helena's expression just this vacant stare and this tiredness. It was just tiredness. They all looked so tired. One of the things that's really big in the culture is to, you know: how are you today? How is your family? I was trying to learn more about them, and in my first or second day, I was asking Helena, "Do you have any children? You're here long hours." I was just trying to be very, like, "You're a hero, you're doing an amazing thing. Thank you for doing what you're doing. What can I do to help you? And if it's a cold soda or—" you know. None of them asked for money. A lot of times you go, and you meet people and you're like, "What can I do to help you?" and "Give me money, my father's sick," whatever. But not a single person in Kenema ever asked me for money. She told me she had children, but she hadn't touched her children in a month. She would go home every night, and she had to lie about where she was and where she was working. They couldn't tell anyone. Some of them couldn't even tell their family members. Some were getting kicked out of their houses and their communities, their little villages, because they were working at the hospital. They all lied. But Helena told me she hadn't touched her children in a month. I said, "Here's your M&Ms, give these M&Ms to your children." And yes, she was just so afraid to touch her children. I can't imagine that on top of caring for your family members and your friends in the ward.

So yes, it was—I mean, the humanity hits you in the face, and I think you really have to be one of those people who lacks—I have a friend that teases me that I'm really high on

Maslow's pyramid of self-actualization, self-awareness. I think you have to be really low on that pyramid of self-actualization and self-awareness to go into that type of situation and not see the humanity of it, and to not see that even though you meet someone like [name withheld]—and she seems gruff and distant and she seems like she doesn't want to help you—not to see that there is so much in her head right now, and her fear is so great that maybe that's what she's doing to be able to get by and survive. I think I helped Emily understand that. I think Emily didn't understand that. She went up and she wanted the log book, and she was just straight out. She's a veterinarian, too. I'm not a clinician, and I think clinicians, too, distance themselves from that. The reason I didn't go to medical school—because I did an internship at the emergency department, and I just had way too much empathy for people. I couldn't deal with seeing a man, a fifty-five-year-old man sliding into second base at a church softball game. He came in and his knee was all jacked up, and then he was in such excruciating pain, and the emergency room physician was just yanking it and pulling it and manipulating it to try to figure out what was wrong with it. I was just like, "He's in pain!"

Q: Yes.

Purfield: "Can we take his hand for a moment and say this is really going to hurt, but I have to do this?" That kind of was in my mind as I was there. You couldn't touch them, you couldn't hug them, but you could just hold your hand [over your heart] and say, "I am so sorry that you lost [name withheld], your colleague, last night. I am so sorry. I'm going to give you time. I'll come back in a couple of hours." And when you come back,

you bring M&Ms and you're like, "I understand that this is a really hard day. Can I look at the log book? I won't take it out of this room. I'm just going to come over here and give you your space." Every single day was like that. It's not like I just skipped up there whistling and handed out Peanut M&Ms and gave everybody a high-five, grabbed a book, and then went down and stole my information. We had this scanner. It became very difficult to get the book out of the room, because there was always something that was—there was always drama. It was really hard to go up there and not do a little bit of psychosocial services at the same time you're trying to get the data. I would go up with a scanner. They'd go back and you—it's not like you were just scanning that day's page. Sometimes, that day wasn't updated for three or four days.

Every day, I would go up and I'd try to scan five or ten of the most recent pages to see if there were any updates. Between that and talking to Ian and George and Kate and Nahid, the physicians—WHO clinicians—asking them, "What about this person? What about this person? Did this person die?" And sometimes, for them, it was—there were days where Kate, who was an ICU [intensive care unit] nurse—I didn't know if she'd make it. Same with Nahid. They were just spent. Just—you know? I think part of that is they're incredibly dehydrated. They couldn't do anything to get enough liquid. They talked about taking their boot off and you dump the sweat out, and it comes out in cups. Incredibly dehydrated. All of the training and rules for the people who come here and walk through and tell you, you need to do this, you need to do that, tell you shouldn't be in there for more than an hour. You can't. There's ninety-seven patients in there. They're hungry, they're scared, they're dying. "Doctor, doctor, doctor, doctor!" They're reaching out and

grabbing for you. Each one of those clinicians gave all of themselves to those patients. Then it was the psychosocial aspect of dealing with them, as well, giving them all of the food I brought. I barely ate any of it, except for quite a bit of candy. [laughs] But I tried to give—because it was just—and that's my thing, when I went back, I took a whole suitcase filled with nothing but treats, things to give away. You're not giving money, it's not changing anyone's life. But sometimes just if someone is thoughtful enough. When you're having a bad day and a colleague of yours goes and they go to the cafeteria and they get two candy bars and give you a candy bar, it's amazing how that can perk you up. Well, imagine you've just had the worst three months of your life. You've lost everyone you loved, and someone just sits down, just sits down and gives you a soda and says, "It's okay. It's a horrible situation. Drink this." Really, a lot of what I did was not science at all. [laughs] At all, yes.

Q: One thing you mentioned, you said nobody at headquarters seemed to pay attention to what's going on out there. What did you mean by that?

Purfield: I was there a week and a half when [Thomas R.] Frieden came. He came to Kenema, and I think he saw what the horrible situation was. Then we had these layers of phone calls. There'd be this call in Freetown. There were like fourteen or fifteen epis in country, and they were trying to get them all together in Freetown. They'd have these calls, and people would be talking about this ridiculous stuff. They'd be like, "In Kenema, tell me what's up with my patient that I sent over in an ambulance last week. What's their status?" It was just like they had no idea. They had no idea about the

infection control issues. They had no idea about the strikes and the fact that our staff was dying. We'd get dead bodies dropped off in the middle of the night. Ian, our lead physician, would have to negotiate with people at the gate to let ambulances in in the middle of the night. Here's a man who's giving his heart and soul during the day, and then he's staying up all night long trying to get patients in the hospital and dealing with the politics of dealing with the district medical officer [note: Dr. Mohamed Vandi] who is getting pressure from other people in the district not to use Kenema as the country's sole hospital. "Only treat Kenema patients." Where are they going to go?

At that point in time, we didn't really have leadership in the outbreak. We didn't have logs [logistics]. We didn't have maps. We didn't have phones. We were dropped out there for two weeks, and we didn't have gas money to pay our driver. It was not what it morphed into being. In part, I think our experience helped change that, but at headquarters it was this constant, "Please, we need more people. Please!" Begging, with almost tears, "Please, please, send more people. You've got to give us more people. We can't do anything with what we have," and then expecting to see magnificent data in the VHF [viral hemorrhagic fever] database when—yes, if there were five more epis there, we could have done a lot. We could have done contact tracing, we could have gotten much better data. But we didn't have that, and then when we would get some demands for things—you know, "we want to know the case count, you need to give a PowerPoint presentation." It was almost comical sometimes, what we were capable of doing.

We were there [at] the hospital, from seven thirty until usually nine or nine thirty. We got home at nine or nine thirty. We'd eat, usually our only meal of the day, really. Then I'd go and I'd take a shower and I would do my laundry. I would write an email home to family and friends, and that was all I had in me. There was nothing beyond that.

The first time anybody reached out to us from headquarters was five days after Ian got sick. Somebody emailed us to say whether or not we needed to talk to somebody in EAP [Employee Assistance Program]. We were just laughing, like, laughed out loud. What are you going to do for me? [laughs] We told them the only thing we wanted was very frequent updates on his condition, like what was happening. They wouldn't send us that. We had to go back channels to get it. But yes, it was just—I was, "Just send us some more epis. Just send us someone," you know? It was—yes.

It felt like there was a giant disconnect of what was happening. Then, we remember when—we still quote this as a joke, when Dr. Frieden gave his big announcement and said, "We have a hundred people working on this at CDC," or "150 people at CDC and twelve people on the ground." [laughs] It was like, there are ten people sitting on their asses at headquarters for every one of us that was being consumed in a wildfire of Ebola. It was insulting. I know he was saying this for different political reasons, and it was a different crowd, but it was just almost so incredibly insulting. Then to get comments about how he wished we would have done more—yes, he told us that in person: "I wish you would have done more." It was just incredible. No one had any idea what it was like. Within a couple of months, I think it almost became this well—I wouldn't call it well-

oiled, but it almost became this factory of sending people out, getting them back in, sending them out, getting them back in. It was just so different, so quickly. But during that time period, we couldn't—we wanted to do more. [laughs] We really wanted to do more, but there was nothing to do more with. We were dealing with nurses that weren't getting paid and physicians who—two of our physicians got medevacked—three, if you count Will Pooley, the clinician, the nurse. WHO couldn't backfill. There was nothing. You couldn't get into the community because we didn't have people to sit there and enter data and other people to go into the community.

Again, it's not anybody's fault. I know there's a lot of finger-pointing. But nobody understood what the monster was like then. Perhaps, when we came back, we should have screamed louder about what needed to be done. We should have taken it straight up to the top to say, look, this is really what you need. Replacing us one-for-one with one-day overlap is not going to do it. You need a team of twenty people to descend. You need to set it up in an incident command structure. There was sensitivity about trying to integrate with the government and everything. This was a time where I think that integrating should have come as an afterthought. People just needed to get in there and get things done. That's kind of what MSF does, but they didn't have the epi. We had the epi.

Q: Right, so, the concern was to make sure that Sierra Leone leads and that you follow their lead? What is—

Purfield: I don’t even know.

Q: What does integration mean?

Purfield: Yes, like—

Q: I’m confused.

Purfield: We were working in the district. After we left, they set up these district emergency response centers called DERCs.

Q: Right.

Purfield: When I was there, it was just us. [laughs] But having someone who was a Sierra Leonean leading all of these teams for case management—but the problem was they didn’t have all of the skills and knowledge. They wanted capacity-building, but at the same time, nobody wanted to take the lead on this. We wanted them to take the lead on this, as the capacity-building—“This is your outbreak. We’re here for technical assistance. We’re not here to run the show” because then you get too many cooks in the kitchen. Things go wrong. What they really needed was strong leadership and someone to help run the show. I think that’s what [unclear] was supposed to do, but—

Q: Right.

Purfield: —it didn't happen that way in Kenema at that point in time.

Q: Right, wow. When we talked before, you mentioned how Dr. Crozier getting sick was a really big event in your time there. Was that during your first deployment?

Purfield: Yes.

Q: Yes?

Purfield: Yes. The WHO physicians were all volunteers on basically a two-week, two to three-week rotation. Most of them were there for two weeks. Kate and George were those two physicians—they're two clinicians that I took the boat over with, and then they ended up in Kenema. Nahid was another clinician. Nahid left early, so that put us down one clinician. They had another clinician who probably was not best suited to be there in the ward. He had kind of other duties. So, George and Kate were left, and Ian. Then George and Kate left I think on a Thursday, Thursday night. We all had dinner together, and then Friday was their last day out. I think Friday, they may have flown out. Ian was the only clinician, the only physician—there were the Sierra Leonean nurses and then there's the WHO clinicians. He was the only physician who was there on Saturday. I went up there on my way to get the book and to see everybody, and see how he was doing. We were supposed to have dinner, we were all going to have dinner that night [at] one of the hotels in town, the Paloma [Guest House and Restaurant]. Maybe I was going

up there to talk about dinner or something, but—stopping by, whatever, casually. He looked so incredibly tired and just mentally exhausted. I was like, oh, he's in there all alone. It's got to be an amazing task just to be there, "Doctor, doctor, doctor!" And knowing Ian, he's not giving up until every single patient is cared for and taken—you know, even if his time is up, even if he's exhausted, even if he feels ill. I went back to the office, and one of the last few things I had was this giant Costco-size thing of salted peanuts. Because he was so dehydrated. So, I took out my little Sharpie and I wrote "Ian's Salty Nuts" on it, and I took it up there. Since there weren't other physicians, I was, like, it's just Ian, now. Ian was supposed to leave, too. He was supposed to have been gone by then.

Q: Wow.

Purfield: But because there were no other physicians and he knew that, he extended his stay. I took up the nuts, and I put them down on his desk and I said, "These are all yours. You don't have to share." Immediately, Dario [Gramuglia], who's a logs guy, this Italian logs guy, chain-smoking Italian logs guy, he comes over, he grabs a handful of nuts. Ian had grabbed a handful of nuts. I was like, "Dario! Don't put your hands in the same vat of food! You pour them out!" Ian was like, "I can't. I don't think I can do dinner tonight. I'm going to be in bed by six. I'm just so tired. Just so tired." And he looked horrible. He'd just come out of the Ebola ward, and I knew he'd been in there all day long. I knew that the mental toll of being the only one there was hard on him. So, that was Saturday. Sunday, we go into work, and I'm in the office. Michelle goes up to the clinicians—

WHO clinicians—and she just went up for a few minutes, but she was there for a long time and comes back. She came back with Ute, and Ute told us that Ian called her that morning and was feeling sick and asked her to bring something to draw his blood. She did, and she came back and tested it right away. She said, “Ian’s positive.” Of course, you’re like, he’s not really positive. Run it again. He’s not positive. He just has malaria. But just like this gravity of—it was just so—fuck. Fuck, fuck, fuck, fuck, fuck. [laughs] Here’s someone that you care about, you worked with, you admire, you love. Also, the gravity of the situation of knowing we have no—we have ninety-seven patients twenty yards from this office who are going to be in there without anyone caring to them. If there’s no physician, the nurses won’t go in. No one’s going to feed them, no one’s going to move the bodies. No one’s going to give them liquids, help them drink, because they’re dying of dehydration. It was one of those things where so many things are going through your head at once, so many emotions of, like, I’m concerned about my friend. I’m concerned about the patients. I’m concerned about myself, because Ian’s my friend. I’ve sat with him, I’ve eaten meals with him, I’ve talked to him in meetings. We use the same toilet. All those things go through your head. But I think the biggest thought is, how soon can he get out? He’s alone, he’s in the hospital—or he’s in his hotel room, sequestered. What’s going through his head? I just remember this little tirade I had with myself of, well, they’ve got to get him out! They’ve got to get him out. We’ve got to get him. Somebody’s got to call CDC. We need the Phoenix [Air Group]. We need to get him out. We need to get him out today. We can’t wait, especially when we saw his test results. His Ct [cycle threshold] values, his viral load, was really high.

This is what I'd done for three weeks, was look at patients' viral load and record their outcome. I knew he would die. His viral load was so high that he didn't have a chance in Kenema, but you just keep—I also knew because of my relationship with Mary Choi, what Kent Brantly and Nancy Writebol were going through. We knew what was happening. We knew that Brantly was very, very, very, very sick when he got on the Phoenix. Then he survived. Quickly, within like a week, he was out of the hospital. It was crazy, the recovery. I kept thinking if we could just get him to Emory, he'll be fine. He'll be like Brantly and Writebol. He'll be fine. So, that was Sunday. Then Sunday night, we had one of those just horrible meetings where everything goes wrong. But then this time, too, it's like, what do we do without a physician? WHO folks were paranoid, and they had two epis, and they were hightailing it out of there. They were leaving. They were like, we're not going to be here anymore. This is unsafe, we can't be here. This is unsafe. People were leaving. We had the absolute opposite feeling. We'd gone through that entire Sunday trying to figure out how we could get to Ian in his hotel room to take care of him, or just to sit with him. I mean, we knew the risk. We knew that if there's one patient and he's sick, we can protect ourselves. Or to go into the hospital and—you know, Michelle's a nurse—doesn't take that much skill to help keep someone hydrated. I don't have to give an IV [intravenous fluid], but I can help them drink oral rehydration salts. If nothing else, I can just be someone who shows up when they're afraid they're dying. They know they're dying, the person next to them has been dead for twelve hours, and they're lying next to the body. Maybe it's their child, maybe it's a family member.

That was a really, really hard day for us, just to feel so helpless. We called headquarters, and we called back and were told from the highest level that we can't go in, and we can't see Ian, and we can't do patient care or our job would be on the line. I don't know if I'll ever forgive myself for being so afraid and weak [tearful] and not going in, not going to Ian, knowing the course of illness he had later. You just don't do that to your fellow soldier. You don't abandon them. I mean, he treated all those patients. He knew what his future was. He knew exactly what his course of illness was going to be, and there's a period before you get too sick where you are—you're very lucid. I just can't imagine that fear and that loneliness. I can't imagine what was going through his head in terms of thinking about his family, about what did he do to get exposed. What did he do to expose other people? And just what effect this would have on Kenema: his leaving, his getting sick, what effect would that have on the people he was working so hard to care for? I haven't talked to him about any of this, but it's just—I can imagine. I can just imagine that maybe if someone was there with him, just sitting in the room with him, kind of keeping his thoughts from going there, that maybe he would have had a different day. It wouldn't have changed his outcome. If I would have been there to give him a bottle of water, help him out of bed, it would not have changed anything. But just maybe it would have changed his mental capacity, and maybe it would have changed mine. So that was a hard day.

Q: Yes.

Purfield: Again, I went through with this selfishness of, this is Ian! This is my one friend! There's a hundred people twenty yards from me who have lost everything, and they're in there and they're afraid and they're alone and they're hungry. Yes, so it was just this horrible, horrible, horrible day. The days that followed that were horrible, of the logistics of trying to talk about what we were doing to care for people, trying to understand what was happening to Ian, and trying to stay informed of how his condition was, what kind of care he was getting. He didn't get out, he didn't get to Emory until Tuesday. It was just, like, every minute counted. Then, after Ian got sick, Michelle cleaned out his office. I remember Ian's like six-foot-five. He's a giant man with giant feet. [laughs] You can't mistake these Ian shoes. We cleaned out the WHO office, and everything had to be thrown out. All of the little pieces of paper we had that had notes about what patients we need to follow up with, the salty nuts, [laughs] everything and Ian's shoes. His giant shoes. Everything had to go. It was all sprayed down with bleach, and then it was just a sterile—nobody wanted to go in there. We had three or four days, and then some new physicians came. They were more experienced with Ebola. They came and they had the exact same, like, we can change this, we're going to do this, we're going to do this, we have to work on this with infection control. This is horrible, we—first thing, you come in and you try to change something. They go to the nurses and tell them they're doing something wrong. It's just—you can't do that. Not here. Maybe at MSF, maybe for WHO. But in Kenema, you can't come in here and tell them they're doing something wrong, because this is what they've been doing for two months, and they're still alive.

Q: Right.

Purfield: They're doing something right, in spite of what everybody else has been doing wrong. They're surviving and they are hanging on by a thread. Any bit of criticism can push anyone over the edge. It was hard to watch that. Then, after they're there for a week or so, they settle in and they realize—it's that same thing I dealt with Emily, when I'd come—I was there for three days. "It's not that bad, we can fix it. There's a lot we can do." [laughs] —and the look she gave me. That's the point I was at, at that time. It was just, you guys have no idea what you're saying. You have no idea what it's like here. Just let it wash over you and think about it, and then try to make some changes. It did. After a while, they all came to grips. Lewis [Rubinson], one of them, was medevacked out with a needle stick. You soon realize that it's not [name withheld]'s fault. It's not Ian's fault. It's not the nurses' fault they got sick. It's just the situation. You can have all the Kevlar you want on you and more, but you can still die. That's just something they all realized eventually.

Q: Do you want to take a quick break?

Purfield: Sure, yeah, I've got coffee.

[break]

Q: Do you remember the dates of your first deployment?

Purfield: I think it was like August 19th through September 21st-ish.

Q: Around September 21st?

Purfield: Yes.

Q: And then you go back when?

Purfield: And then I went back August—maybe 15th through September 30th of 2015. It was exactly one year later.

Q: Wow.

Purfield: Yeah. That’s how long it took me to get back in line. [laughter]

[break]

Q: You have that human perspective—

Purfield: Yes.

Q: —of being there and—

Purfield: Yes, and it's just—

Q: —embedded.

Purfield: Some people have it with small groups of people—you worked with ambulance drivers for two weeks, you worked with—but this was an entire hospital community. Everyone from the patients, to the clinicians, to the porters. You were just ingrained with—but then going back, I was afraid they'd forget me, they wouldn't remember me. But they all remembered me, and it was so great to hug them and to—

Q: I'll bet.

Purfield: Like, we just, you know—

Q: Guess what we can do now?

Purfield: Yes.

Q: Touch. [laughs]

Purfield: Technically, it was still an Ebola outbreak. They had cases. [laughter] But it was just, I didn't care. I needed it. I hugged Helena, and she just still had this look on her face. It was hard. It was hard for all of us, like, fixed glance. I just—

Q: Wow.

Purfield: [gasps]

Q: Yes, yes.

Purfield: —sobbing about my one-month experience there. Again, it just made me feel like such an idiot. I'm like, why am I making this about me? Why am I the one who's—

Q: Everybody makes it about them.

Purfield: It's about Helena, and it's about Kenema. It's about their survival. It should be their pride for getting rid of Ebola.

Q: Yes.

Purfield: —for getting rid of Ebola.

Q: Yes.

Purfield: For not dying.

Q: Yes, for not—surviving.

Purfield: For surviving. They didn't get paid from October [2014] on. Anything. Nothing. Where's the sense of pride in the community for the community's own healthcare force that did this?

Q: Right.

Purfield: Instead, ostracizing them and not paying them. What happens when something like this happens again? They're not going to step up. I wouldn't. There's no emotional or psychological support for them at all. There's tons now for the survivors in Kenema.

Q: Oh, sure.

Purfield: Which is great. It doesn't happen anywhere else in the country, but it's well-organized in Kenema, but there's nothing for the healthcare staff.

[break]

Q: Did you have intense experiences in Haiti?

Purfield: Haiti was different. I got there, I think it was like ten days after the earthquake. They were just stopping the rescue and going to straight-up recovery.

Q: Ten days after the earthquake?

Purfield: Yes, yes.

Q: Wow, still in January of—

Purfield: Yes, yeah.

Q: —2010?

Purfield: Yes, they were still pulling bodies out. There are IDPs popping up everywhere—internally displaced persons camps—popping up on every median. That was amazing, and we were basically running a supply line, medical supplies, to the only hospital that was still functioning, GHESKIO. There was one surgical team there, so we ran fuel, food, water, and medical supplies, blood, oxygen. I had been to India and other places before, so I knew what poverty and—

Q: Sure.

Purfield: —any people who were on my team who'd never been out of the States, hadn't seen this type of poverty before, were shocked and amazed and had this moving experience. But it was more along the lines of just—there was a lot of crumble. But we

weren't really interacting with people. We were running lines, we were working with US organizations.

Q: Yes, yes, yes. It was—different type of experience.

Q: You mentioned that you had a first trip to Africa. What was that?

Purfield: Oh, my first trip was doing malaria and TB laboratory capacity building with the Nigerian defense department.

Q: Oh! Okay.

Purfield: By the time I went to Sierra Leone, I'd been to Malawi and South Africa, Namibia, Nigeria.

Q: That's right, South Africa—

Purfield: All completely different experiences, completely different.

[break]

Q: Okay. Well, I don't want to make you at all late to your next thing. Why don't we call it for today?

Purfield: Alright.

Q: But that was brilliant. Thank you, Anne.

Purfield: Not brilliant. Believe me, it’s not brilliant.

END