YALE JOURNAL OF BIOLOGY AND MEDICINE 80 (2007), pp.73-76.

ARTS & HUMANITIES

Stranger in a Strange Land: Reflections on My First Medical Relief Mission

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The camp had been christened Balakot Hospital, a glorious name for an altogether inglorious collection of canvas tents and steel operating containers that was the center of a spreading field of refugee tents marked "UNHCR" or "Iran Red Crescent." Before the earthquake, our camp had been the science high school for this small Northern Pakistani town nestled on the border of Punjab and Kashmir. A small secluded courtyard in the middle of the college was still beautiful, despite the surrounding destruction. In the silence of the early morning, I would walk alone through the courtyard as if it were a museum, looking into rooms exposed by ruined walls and a collapsed roof. With stunning similarity to the ruins of Pompeii, the little wooden desks and twisted metal bedframes that survived made it easy to imagine the lives the students had led. I recognized formulas scrawled on the chalkboard and read the elementary English penciled into a small black composition book. Although a new life pulsed outside the walls of the college, the immediacy of the past was a chilling reminder that this museum was merely three weeks old.

The foggy dawn at Balakot Hospital is one of many vivid scenes seared in my memory from a medical relief mission to Pakistan after the earthquake of 2005, a journey I never expected but had yearned to make.

Disaster relief is not a spectator sport, but my progression through medical school toward emergency medicine residency contributed to increasing restlessness as I watched the Indonesian tsunami and Hurricane Katrina relief efforts from the televised sideline. There was always some excuse to stay home, but desire and opportunity collided in October 2005. A magnitude 7.6 earthquake struck the border of Pakistani Kashmir and Punjab, a mere 300 miles from where I spent a summer baking in the heat at an Indian hospital for a summer research project. One week later, an e-mail was sent to all Yale medical students seeking volunteers for a medical relief team led by a Pakistani Yale professor. Twenty students replied, but only three fourth-year students, future Emergency Medicine residents, were chosen. The excitement was overwhelming; whether preparing a personal medical kit that I would eventually conclude was full of flashy but relatively useless items or breaking the news to Mom, I spent every waking minute immersed in the journey. However, when I finally

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stepped onto the tarmac at Islamabad International, I realized I had neglected an important question: Now that I was there, what was I actually going to do?

Being a medical student is often synonymous with being underestimated, and being both a stranger and a student on the mission seemed to prognosticate difficulty. I had dreams of needle thoracostomy by moonlight and fears of following yet another doctor around like a puppy, and I wondered just where reality would lie. Realizing this may be a common concern among strangers to medical relief, I would like to share some suggestions in finding a fulfilling role on one's first medical relief mission.

1. OTHERS HAVE THEIR OWN AGENDAS, AND NONE OF THEM IS YOURS.

The venerable commanding physician's initial (and thankfully rejected) suggestion for the American medical students was babysitting children in Islamabad. Our group subsequently was swayed into aiding the desperate patients at a hospital in Abbottabad, a large town modestly affected by the quake, by two female doctors' tear-jerking account of their plight. In Abbottabad, we were met by the hospital's owner, who escorted us past his Mercedes S500 into his plush house for a rich Pakistani dinner. We toured the hospital and found 40 patients, a number clearly incongruous with the three large Cuban surgical teams and one Australian team already present. Something wasn't right, and whisperings of discontent surfaced as we explored on our own. The Cubans had little work to do; all the patients had received necessary surgeries and no new patients were arriving. The Australians said the hospital was resisting discharges in the hopes of attracting relief funds. Donated medicines and respirators were being hoarded in the basement. We were so uneasy that we slept under lock and key that night.

We had placed ourselves in the hands of the "system" with the hope that our goals and their needs could be simultaneously met, but we found ourselves far from the epicenter and even farther from usefulness. In retrospect, nobody at the "command center" had any idea what was actually going on in the field. We all wanted to be in Balakot, so we did what we should have initially done: We went to Balakot.

2. IF THE SCENE IS WORSE THAN YOU COULD HAVE IMAGINED, YOU ARE IN THE RIGHT PLACE.

My experiences in Islamabad and Abbottabad left me underwhelmed and skeptical. However, as the van moved further into the mountains, the occasional damaged roof became a leveled block of homes. The small crack in the road became the remnants of a cleared landslide. The peaceful quiet was replaced by an uneasy brooding as families sat on the aluminum roofs of their toppled homes, unable to comprehend the impossible task of rebuilding.

Silence filled the van as we crested the valley's edge and descended into Balakot. Balakot straddled a swift river in the heart of a picturesque valley, and it's likely that if I'd seen it whole I would consider it just another town on the road to Kashmir. But the destruction was unimaginable. At that moment, it seemed as if the most beautiful city in the world had fallen. My clearest memory of the slow procession into town is of the prolific number of piles of clothing. Maybe recovered, possibly donated, they were now being used to stoke the open fires.

We arrived at the nascent tent hospital to find loosely controlled chaos. Tents were being erected, boxes of unorganized supplies were strewn over the grounds, and a small crane was moving huge metal containers that would later become operating rooms. Patients were being seen in the open air at desks pilfered from the ruins of the college, and a buzz of activity was contained only by the loosely defined Pakistani Army security detail. Our arrival was fortuitous; many of the doctors would be leaving the next day, and we immediately took over the medical operations of the camp. There was no good reason for us to have been sent elsewhere.

3. RELIEF MEDICINE IS NOT ROCKET SCIENCE.

I finally found my tent hospital, my translator, and my little desk in the outpatient tent, and I was incredibly nervous. Help was available if needed, but for the first time I didn't have to present to a resident or await an attending's blessing. I should have expected it, but I was amazed to find how simple most problems were: dehydration, URIs, wound care, and pain. Limited resources led to limited therapeutic options, and I grew adept at prescribing amoxicillin and handing out ORS. The most difficult issues were not medical in nature. Translation was a major problem, as five-minute descriptions of chest pain would somehow become "Oh, he's okay," or "His chest hurts." And patients, whether in Pakistan or in the United States, do not do as expected, a problem compounded by my limited understanding of patients' comprehension of my instructions. I discovered no explanation was too obvious (such as to drink the ORS solution after mixing it and not mix it with dirty water). I certainly made mistakes; I was incredibly embarrassed when I realized I had been oblivious to a developing scabies epidemic and had dispensed several useless tubes of hydrocortisone cream. But my confidence quickly grew as I learned to communicate with my patients and use what we had available.

One night, I wandered through the temporarily deserted camp, a lone Christian granted a moment's solitude during Islamic evening prayer, when a guard called me to the clinic tent. A young man had come in with a large gash on his forehead, and I was the only "doctor" available. I balked at first, being accustomed to requisite supervision. But as I looked at the wound, I realized it was far simpler than most of the repairs I had done in the ED. Five minutes later, I was suturing the man's head in the dark as his brother held a flashlight and his entire extended family intently observed. He came back every day to cheerfully show me the progress of his healing wound (that I prayed wouldn't get infected), and I couldn't have been prouder.

4. BE WILLING TO TRY SOMETHING NEW, EVEN IF IT MEANS IRRADIATING YOURSELF.

I was informed on our third day that I was to be the new radiologist. The then-current radiologist would be returning home and his replacement would not arrive for two more days. Consequently, I received a 10-minute lesson on operating the X-ray machine and developing the film in the sweltering canvas darkroom. My first attempt at radiology ended in a cloud of white. Convinced that I needed to increase the exposure, my next film was a deep shade of black. Neither demonstrated a fracture. In fact, neither really demonstrated an arm at all. My films improved with time, but the orthopedist concluded that clinical diagnoses would be in order until a more accomplished radiologist arrived.

While seeing patients was personally fulfilling, there were always a multitude of other enterprises of equal importance. Because of the predominantly transient corps of relief workers, the field hospital's greatest need was for sustainable organization, and any improvements made us far more efficient and effective. The American students, armed with a battered pocket pharmacopoeia, put a substantial portion of our energies into organizing the hundreds of boxes of donated medicines, establishing a pharmacy, and creating a formulary of available medications. Though not as exciting as wound repair and patient care, the effort expended with the pharmacy was likely far more beneficial.

5. BRING A GLUCOMETER.

Everyone on a relief mission remembers wound care supplies and antibiotics because they are the glamorous supplies. But for every one patient I sutured, 30 needed a glucose fingerstick that could not be done because our one glucometer had run out of testing strips. Similarly, the one nebulizer we had was running almost nonstop. And no one remembered to bring pregnancy tests or gynecologic supplies, although females with abdominal pain were extremely common.

Every member of a relief team should pitch in for a simple glucometer and testing strips (don't worry about the lancets — people love to bring needles), and it will be money well spent.

6. DISASTERS ARE THE ULTIMATE BATTLE FOR SURVIVAL.

Those mountaineers fortunate enough to successfully climb Everest say their bodies are so committed to survival that their time at the summit is devoid of understanding or enjoyment. Although the physical demands were clearly not comparable at Balakot Hospital, the battle for survival that raged in the Karakoram foothills truly demanded an emotional commitment to survival. I was constantly tired and almost always hungry in a place where I didn't speak the language and had a constant army guard separating me from a camp of potentially desperate people. Nightly aftershocks prohibited uninterrupted sleep, and virtually every waking moment was spent working. The constant stream of sorrow at the hospital became like a macroscopic Monet: seemingly disjointed streaks of color that could not be understood while immersed within it.

As time passed, this immersion in the routine of camp led to some level of comfort. The aftershocks became a mere annoyance, and I didn't worry that each meal would lead to a steady diet of cipro and ORS. The fascinating nightly congregation of our little international community quickly filled with camaraderie, although I found all topics inevitably led to Islam. But one thing never changed until my bags were packed, my goodbyes said, and I walked through the camp to the van waiting to take us away: Unprepared for the swelling undercurrent of suffering, I had adopted the same trance-like smile of denial that I came to recognize in so many of my patients. I had become a part of the living camp, immersed in its existence and subject to its emotional demands. I relied on the camp for food, for security, and, more subtly, the constant level of activity that made enforced empathetic monotony possible.

I'm not quite sure when this umbilical cord was severed. In the initial denial of grief, our return journey was dominated by plans for continued involvement. I vowed to write articles to raise awareness and attempt to raise money. But I returned to residency interviews, then holidays, then match, then graduation. My first attempt at writing this article was impersonal and devoid of the heartbreaking response that others expected but I had not yet permitted myself. Somewhere between then and now I've hopefully come up with something more translucent. I know I will never be satisfied with my portrait of a moment half a world away that continues to grow more distant. It's likely the process is the most revealing part, thus suggesting that my advice is far less useful than the simple encouragement to just go somewhere. Now.