

Zalzala, Zalzala!

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Throughout my childhood, I had heard about the unequivocal beauty of Kashmir – the so-called “paradise on Earth” – marred only by its status as a long-standing disputed territory. Awed by the stories I heard and the pictures I saw, I often wondered if I would ever have the opportunity to visit this beautiful but precarious warzone.

That opportunity presented itself when tragically on October 8, 2005, during the holy month of Ramadan, an earthquake struck northern Pakistan – an earthquake that measured 7.6 on the Richter scale, killed more than 80,000 people, injured another 76,000, and left at least 3 million homeless.

In the immediate aftermath of the earthquake, I had briefly entertained the hope of traveling to Kashmir to help in the medical camps, but that transient notion was overpowered by the practicality of leaving in the middle of my internal medicine rotation. Amidst morning rounds, running a few codes and even pronouncing a patient dead for the first time; however, thoughts of the earthquake lingered in the back of my mind and the daily barrage of emails requesting volunteers, especially appeals for female doctors, haunted me. At the same time, I struggled to measure my own level of inexperience against their need for manpower and the effectiveness of my hands-on help versus the importance of making a monetary contribution. I recalled that last year as I sat in my room studying pathology and pharmacology, I had sensed helplessness and frustration at my inability to directly help the tsunami victims. The difference was that now, three rotations later, as a third year medical student, I was better equipped with newly acquired skills as well as the confidence and determination not to make the same mistake again by letting this opportunity pass me by. Two-months later, I was on my first helicopter ride to the small mountain town of Chikar in Azad (free) Kashmir to aid in relief efforts.

In any other circumstance, I would have been

thrilled at the thought of traveling in the mountains of Kashmir on a helicopter. For me, that chopper ride, similar to every aspect of my trip, evoked a gamut of emotions, ranging from excitement and apprehension to empathy and sorrow. The novelty of my first “heli” ride, when juxtaposed with the story of a young child screaming, “zalzala, zalzala” (earthquake!, earthquake!) inside the medical camp as he heard the helicopter landing outside on the helipad, quickly dissipated. The reality of the devastating effects of the earthquake became more apparent; a myriad of thoughts from those I had encountered flooded me and I could only imagine what the earthquake victims and survivors must have felt ...

To experience the unsteadiness of the ground below your feet and the panic of being trapped, to feel as though the world is ending and to begin reciting the Shahāda as your last words, to see the simultaneous collapse of all the buildings in the valley before your eyes, to focus your attention on the one building that matters most to you – your children’s school, to comprehend absolute silence after 60 seconds of utter chaos.

This was just one of several heartrending stories recalled by the people of this region – stories of parents who had lost their children, or worse, of children orphaned at a young age. Mothers described their inability to sleep or eat and complained of vague aches and pains – an effect of both the psychological stress they had endured and the physical trauma they had suffered from their collapsing homes. Fathers complained of restlessness and anxiety and shared stories of searching for loved ones amidst the rubble as well as helping injured family and friends. It suddenly made sense why in the midst of continuous aftershocks, even those families whose homes had not been destroyed feared living underneath a cement structure and chose instead to inhabit tents – despite their discomfort and the bitter cold.

These tents dotted a landscape of broken

parts. Where once had been the site of the community health center in Chikar, now lay a pile of debris, scattered with broken furniture, books and medical paraphernalia. Medical camps such as ours, set up throughout Kashmir by various organizations, made healthcare services accessible to locals from the village and outlying areas.

In medical school, we have always been taught that 90% of the diagnosis is derived from the patient's chief complaint and history of present illness, that the physical examination contributes 5% to the diagnosis and that the remaining 5% of the diagnosis is confirmed by ancillary tests. However, in the United States, very rarely do we see this lesson put to practice as it is routine to order lab tests and imaging studies on almost every patient. In contrast, in the medical camp where we worked, we were forced to rely exclusively on our clinical skills.

I was initially comforted by the fact that I would be able to converse with the patients in Urdu to elicit their medical histories. But I soon discovered that not only did I not know the appropriate medical terms in Urdu, I was also unfamiliar with the local dialect. However, as I began seeing my first patients in Kashmir and asking them about their ailments – the questions came naturally, logically – despite the language barrier. Incidentally, my inquiries took the form of traditional “medical interviews,” the most fundamental clinical skills taught during the first year of medical school.

We asked about symptoms classically associated with gastroenteritis, we listened with our stethoscope to rule out pneumonia, we palpated for flank pain and suprapubic tenderness to diagnose urinary tract infections. In addition to these disease outbreaks, more prevalent now because of the earthquake and the subsequent changes in weather, sanitation, diet and living arrangements, we also saw patients with more chronic problems – children with kwashiorkor, rickets, and developmental delays; young women with anemia, goiters, and OB/GYN problems; and older women with heart murmurs, hypertension, and kidney stones.

Frequently, women and children waited outside the medical tent upon our arrival at 9 a.m. And each time we called, “*Agla mariz*” (next patient), two to

three women entered the tent at once, all waiting anxiously to tell us about their ailments and hoping for a “magic bullet.” Clinics ran from 9 a.m. to 4 p.m. and both the male and female medical camps each saw approximately 100 patients daily. After hours, we were occasionally called for emergency cases. The patients, often appearing very ill, came because the pain had been unbearable or they had not stopped bleeding. It was only in such dire cases that these patients were brought to our camp by several family members by foot in the dark. With limited resources, we would stabilize the patient, provide pain relief and antibiotics if necessary, and exhort family members to take their ailing relative to Abbas Hospital - unsure whether or not the patients would ever make the 4-hour journey by road to Muzaffarabad. I can still visualize their hesitancy and the disappointment in their eyes as we handed them a referral and told them that nothing could be done in our camp.

Despite the pain and loss the Kashmiris had suffered and the difficulties they now faced, each and every person we encountered treated us with utmost respect and hospitality. Although I had heard about the need for female doctors given the cultural setting, I had not realized the importance of our role and the extent of their gratitude of our time and efforts. In my short stay, I had even been unduly bestowed the status of a doctor. I initially questioned my ability to help as a medical student, but as the locals entrusted me with the title of “doctor,” I felt equally obligated to take on the responsibility of diagnosing and treating patients – I was humbled by the trust they had placed in me.

My first trip to Pakistan truly opened my eyes to the realities of healthcare concerns in a developing country in the wake of a natural disaster and armed me with the realization that my work did not, and could not, end with my short stay in Kashmir. My experience in this region of the world, as an Indian from the other side of the LoC (Line of Control) and as a female with the knowledge of medicine, strengthened my resolve to be a compassionate physician unrestrained by the boundaries of a class or of a nation.