MEDICAL PRACTICE

*Letter from . . . the Sudan***Perspective from a Sudanese refugee camp**

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I have worked before as a volunteer in an emergency refugee relief programme, in Thailand in 1980,¹ and now I find myself here in the desert of the Sudan in a setting which is so similar, and yet so different, that these two experiences beg to be compared. Indeed, it has surprised me how many of the old players have returned to work in this crisis and how many of the relief workers are familiar and respected colleagues. I had not realised how many people make a career out of relief work around the world. It is certainly exciting and challenging, and there are hardships and rewards of a nature that few, apart from this fraternity, seem to comprehend. Aside from the compassion and sense of adventure that we all have I think that many of us satisfy a basic need in ourselves as part of the price for helping others.

In this communique (for it is indeed written by candlelight from my camp) I shall try to compare my experiences in Africa and in Asia, try to describe what life is like at present in this camp, and try to encourage others to become relief workers themselves.

Familiar problems

Regrettably, the most striking similarity between the two camps is that there are many of the same old problems, which spawn the same old discussions, which lead to the same old mistakes—problems of logistics, of staffing, of morale, of personnel management, of sanitation, and of camp politics. Sometimes it is as though I had never been away and as though no one had ever learnt. With disasters occurring on the scale of this one all over the globe, surely someone must have come up with the best available solution to the problems of camp latrines, of water supply, of nutritional, medical,

and personnel needs, etc for most given situations? We all read of immediate disaster relief systems which are ready to leap into action with prepared systems right up to and including equipped hospitals—but after the first flush of excitement is over, when a longer term problem is emerging, where are those prepackaged plans? Why should there be a mad scramble for such basic needs as water pumps, chlorine, oral rehydration salts, and even basic medical supplies? “Plus ça change, plus ça reste immuable.”

My camp has now been established for three months, the same length of time that Khao-I-Dang had been open when I arrived in Thailand. By that time Khao-I-Dang was a camp for 110 000–120 000 and there were two hospitals with over 1000 beds. Each ward was staffed by a different voluntary agency, and there must have been 10 to 15 different agencies carrying out such diverse activities as supplementary feeding, tuberculosis clinics, holistic and folk medicine, cultural development, schools, and craft industries. Thailand is a rich, lush country with a long cultural heritage and a truly international capital. We lived about 19 miles (30 km) from camp in neat Thai houses, and our domestic life included such luxuries as electricity and refrigerators.

But Khartoum is not Bangkok, and the African desert does not compare with the rice paddies of South East Asia. Sudan is a proud country struggling against immense odds to overcome an impossible geopolitical catastrophe; they have so little, how much can they spare for the plight of others? Plainly, here is a crisis that calls for outside help on a massive scale. We hear of all sorts of offers of aid but only a few voluntary agencies are here (is it because they are not welcomed?), and these are being stretched further and further as the crisis expands. The International Rescue Committee, with whom I work, is now responsible for all aspects of care for about 100 000 people, scattered in different camps hundreds of miles apart.

Relief worker's role

This camp, Fao 1, was opened almost three months ago. Until we arrived it was staffed by one young doctor (Simon Mardel) and one

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nurse (Deborah Young), who were here at the outset. They literally had to help build their own accommodation at the same time as working with the rising flood of very sick and terminal patients. Simon has now left, and I am in his shoes. Our team has expanded steadily, to three and then four nurses, other physicians, nutritionists, and others. The vast majority of the workers, however, are local staff, often unversed in any medical practice, but all anxious to learn to help their people. It always astonishes me how quickly we can train replacements for ourselves, neophytes capable of all sorts of techniques including lumbar puncture or a bladder tap for acute urinary retention. Even my interpreters can recognise and treat most of the pneumonias and much of the daily workload that comes through outpatients. There, then, is the essential nub of our *raison d'être*—to teach. Those of us who come and get swallowed into the endless maw of primary patient care are performing no real service except to our own egos. Those of us who can stand back and allow some to die so that all can live better will leave more of a mark, although this lesson is hard to learn and impossible to teach one's colleagues.

What, then, is my camp like? We have 8700 refugees, all illiterate farmers from Tigré. They live in straight rows of tents, eight to 12 to a tent. There are usually two beds and a few blankets. Each tent has its own cooking area outside, and already some of the more enterprising have small gardens sprouting in the otherwise unrelenting ochre soil, which runs flat and featureless to the horizon.

As I first walked into the lines of tents in the camp the sense of never having been away, the sense of *déjà vu*, was astounding. There were the same faces and the same grins, the same outstretched hands grasping to touch the foreigner and run giggling away, the same rags, the same bleak and blank stares of those still immobile at their tents, the same cries, but mostly the same laughter, and, joy of joys, the same homemade toys—tin lids on string—that heralded the second stabilising phase in 1980. I had arrived at the same point in the evolution of this camp as I did in Khao-I-Dang. May I leave here with the same kind of improvement.

Food supplies are mandated and arranged by the United Nations High Commission for Refugees and orchestrated by the Sudanese. Supplies of basic ingredients are now coming in adequate but dreary quantities, and food beggars are now rare. Indeed, the state of nutrition in this whole camp is far removed from that depicted in most of the media. Gross marasmus now implies that the victim has another major serious underlying condition, but there are some exceptions.

Vitamin deficiencies are prevalent and are not usually recognised by any of the medical staff. Everyone in the camp has received therapeutic quantities of vitamin A and there is no xerophthalmia, although the ravages of past deficiency are obvious. Beriberi is common and there are many people with gross, even lethal pellagra. Why is niacin not available in therapeutic quantities? Scurvy presents with sore joints and there is vitamin C available for that. By contrast, in Khao-I-Dang vitamin A deficiency was rampant but vitamin B deficiencies were rare. The reasons for these differences lie not in the severity of the malnutrition but in the constituents of the basal and restitutive diets. Why does the diagnosis of these allegedly exotic diseases evoke such surprise, especially when we all expect equally exotic parasitic diseases? There is also a supplementary feeding programme, the food being provided by the United Nations High Commission for Refugees. We feed there about 1000 people—children who are less than 85% of expected weight for height, and pregnant and lactating mothers, of whom there is an increasing number.

The hospital

My hospital is built of reeds and houses 35 adults. In addition, we have a tubular plastic tent, in which 25 children and their parents and families are nursed on the floor: now that is hard work—especially as we work on the floor and the history passes from English through Amharic to Tigrinya and back again. Next week we shall move to a new hospital designed and built within a week—the newest teaching hospital in the Sudan.

As our camp matures, I find the lack of a laboratory increasingly frustrating. On the other hand, I am not bound by laboratory findings to make a diagnosis of some new, mysterious tropical condition: who can gainsay me?—especially since I have not yet met a tropical disease expert in the field.

My comment on the availability of chlorine reminds me that for the past two weeks our camp has had none, so that all our refugees have come down with bloody diarrhoea. How needless, especially when it exhausts the pharmacy of all therapeutic agents.

In Thailand I was struck by how many patients with congenital malformations and specific genetic defects were in the camp. By contrast, I have seen none of any significance in this camp at all. Another surprise is that we have not seen a single patient with ascariasis, nor are there any in the surrounding villages; perhaps there is something inimical to this universal parasite in the soil.

Job nearly over

Now that the death rate has fallen to nil to three a day we are ready to benefit from our experience in Thailand and help to heal people's minds as well. Our occupational therapy and cultural centre will soon be ready, when we shall be well on the way to being done with this job.

For some of us it will not come too soon. Our living conditions are still fairly basic. We do now live in standard African grass huts, attractive on the outside and remarkably efficiently plastered with mud and cow dung on the inside. There is not enough fuel for reading lights at night and it is so warm until the small hours that one is often listless in the evening anyway; we have no refrigerator, of course, but perhaps the worst feeling is that of isolation. We have no contact with our base camps for days on end (radios are not permitted by the Sudanese), and always those in the field are rather intolerant of our overworked administrators and the erratic supply lines. But if you fancy a chance to see the world and to practise thoughtful, thought provoking medicine as a teacher under circumstances which will strain both your mind and your physique, surely three or six months is not too long an investment in such a gamble.

Reference

- 1 Buist NRM. Perspective from Khao-I-Dang refugee camp. *Br Med J* 1980;281:36-7.

(Accepted 11 April 1985)

WORDS PAROTID, CAROTID. A good rhyme, but otherwise unrelated. Parotid derives from Gk *para*, beside; *ous, ōtos* (genitive), ear, which aptly describes the gland's anatomical position. The usual adjectival suffix for "ear" is -otic, as in periotic (capsule), which it shares with words ending in -osis, as in cyanosis, cyanotic. I can think of no other ear related words ending in -otid. The carotid arteries lie, at their cephalad ends, near the ears, but this is terminologically coincidental. The *Oxford English Dictionary* tells us that "carotid" stems from Gk *karotides*, from *karoun*, "to plunge into a deep sleep, to stupefy, because compression of these arteries is said to produce *carus* or stupor" (quoting Galen but not citing a specific reference). *L carus* is a term applied to various forms of profound sleep or insensibility, especially "the fourth or extreme degree of insensibility, the others being sopor, coma and lethargy."¹ With the obsolescence and disappearance of "carus" from current usage "coma" has now shifted its relative position to that of "carus," whereas "lethargy" is now the mildest form, about which I would submit for publication in this journal a Personal View, if only I could find the energy to do so. Of especial interest is the current use of the term "sleeper" for the manoeuvre of compression of a contestant's neck to cause loss of consciousness in wrestling. Once again the Greeks had a word for it.—B J FREEDMAN.

- 1 Power H, Sedgwick LW. *New Sydenham Society lexicon of medicine and applied science*. London: New Sydenham Society, 1879-99.