

On Becoming a Medical Road Warrior

By Dr. Sibyl Jade Pena

Good morning, honorable guests and most especially to the new medical graduates. Thank you for giving me the time and space to share some thoughts with you, and to sum up more than 15 years of wandering the world in the spoor of epidemics, disasters and catastrophes, both natural and man-made.

First I would like to give homage to a singular doctor who recently passed away. Since I was born and grew up in a family of teachers and writers, the expectation was that I would continue the tradition. While in high school, however, I came upon this singular book, “Doctor to the Barrios,” by Juan Flavier. It was an account of his life as a doctor in the then countryside of Cavite, in the 1950s, at the height of the Huk rebellion. Working with and among peasants, Dr. Flavier found himself hard put upon and compelled to be creative in teaching health concepts to the barrio folks, including family planning. Barrio folks then tended to leave matters of health and children to fate and faith, so Dr. Flavier would run up against peasant wisdom in these matters.

Reading Dr. Flavier’s book inspired me to aspire to be a doctor.

The stereotype of the urban-based doctor – practicing in sanitized clinics and hospitals, assisted by other medical professionals, dispensing medical wisdom to patients who can pay, earning a ton of money and living a quiet life -- Such a stereotype was the complete anti-thesis of the doctor in Dr. Flavier’s book. That was the great attraction: to live differently and to make a difference.

The irony was that my lola made me go to the University of the East for my undergrad because she did not want me to be an activist.

Perhaps the thought occasioned by Dr. Flavier’s book stirred the universe and made me “fall” into my current work, almost as a matter of fate. After graduating from PLM, I joined an NGO that was providing medical service to displaced population and torture survivors. I was delegated to accompany a Swedish medical group that was supporting a small project in Mindanao. One evening, the surgeon in the group started telling us about his sojourn in Afghanistan, riding donkeys while dodging Russian planes. My imagination was fired up; I said

to myself, “that’s what I want to do.” By a quirk of the same fate, I would meet this surgeon again briefly, in Cebu, in 2013, during the early phase of our Yolanda (Hai-yan) intervention.

My first mission under Doctors without Borders, known more for its French name Medecins Sans Frontieres or MSF, was to Burma, near the Chinese border, where I was to be the medical doctor for a TB/Malaria and STI/HIV prevention program. The area where I worked was the epicenter for the HIV epidemic in that country and the standard medicine for malaria was no longer working. We introduced artesunate combination therapy, while instructing people on HIV prevention. We were a small team: 3 female international staff and 30 local staff, mostly college-age students who were waiting for universities to resume.

Once a month, we visited health facilities and conducted both malaria clinics and TB/HIV education. This was where I learned that the health practice is not simply the administration of treatment but empowering people to care for themselves. Often, we stayed in simple lodgings where truck drivers also stayed. We would wake up to a duet of roosters crowing and truck drivers expectorating.

From Burma, I went to India – months after the cyclone in Orissa killed 10,000. It was quite a challenge setting up a program in Kashmir. After one visit, I realized we needed more contacts. I had to return and do just that. And in one year, we were able to start the psychosocial program. The difficulty came from the fact that Kashmir was – and is – the hotspot of conflict between India and Pakistan. I was told, while I was there, that nearly 20,000 had been killed in the slow-motion struggle over Kashmir, which, by then, was already ten years old and right now, continues.

When the Gujarat earthquake occurred in 2001, I was fortuitously still in India and thus began my involvement with disasters. It was the first time I witnessed an emergency intervention. We dispatched two colleagues immediately to do the assessment – and 20 people flew in with a full charter. Our teams lived in tents pitched at a school ground. I and a logistician joined them for a week’s immersion.

It was shortly after this that I thought it would be expedient to what was turning out to be my “career” to do a masters in public health in Holland. As soon as I received my diploma in 2003, I was deployed to Liberia, where then-President Charles Taylor was about to exit, somewhat in a not very peaceful manner.

Monrovia was a city in shambles, with bullet holes everywhere and a population exhausted by fighting. Those who talk about all-out war often have no idea what it means. Since the hospitals were operating or had to operate throughout the conflict, we re-started the clinics. We set up a therapeutic feeding center for 200 children.

This was one tough mission. I would learn that children dying impact any staff the hardest, myself included. The pattern that emerged from this intervention was something like this: the children would arrive very sick, indeed; mortality rates would be above the norm. Slowly, as the situation stabilized, one began to be able to treat and save more and more children, and the mortality rates would go down.

More missions followed after that – different contexts, different challenges. Always with the objective of trying to provide the best quality care possible even if it's in the middle of the bush. We question ourselves, our actions and the results of our actions – Could we have been done better? Improved further the quality of care we provided? Implemented a better strategy to reach patients who needed the most care?

I did take a break from MSF and went to work with United Nations High Commission for Refugees (UNHCR) for two years as a one-person team dealing with emergency preparedness and response for refugees in camps or urban centers in the Asia region. Refugees were fleeing more and more to urban areas – which were not immune to disasters, much like the rural regions. Perhaps in a sense, preparedness was even more necessary, because of the congestion.

When I returned to MSF, my first deployment was to Haiti, then experiencing its worst cholera outbreak yet. I was deployed as an “epidemiologist.” Still reeling from the aftermath of a huge earthquake, Port-au-Prince was terribly unable to deal with a new disaster. There were many, many meetings as so many people tried to keep in step with the progress of the outbreak. How many beds, how much supplies, what other organizations were doing what so we don't duplicate... the discussions were interminable and furious. In addition, there were security issues.

My last mission in the field was to assess the situation in Libya, right at the time when the bombing was going on and Ghaddafi forces were clashing with other tribal forces. By hindsight, there were moments of absurdity in the middle of this frightful situation, as when our team of five got totally seasick on our way to Misrata to assess the needs of a trapped population.

Now, I am based in Paris and my work is mainly to provide support to our medical teams on the ground, in the countries we follow. It is not exactly a cushy job. I have to make an effort to have a life outside work.

This walk down memory lane is in the hope that I can do for you what Dr. Flavier had done for me: inspire you to consider working in the public health area, to jog you out of the stereotypical idea of what a doctor's life should be, and to bring to you the immense possibility for fulfillment in seeing and feeling a red-hot emergency cool down, an epidemic abate, and men, women and children learning to smile again.

To conclude:

- Public Health is an evolving field. (New approaches, new products are being developed as we speak, new ways of delivering vaccines, new rapid diagnostic tests; improving case management of different diseases)

- Public Health is not separate from Private Health Care – (WHO has identified Asia and the Middle East as hotspots for antibiotic resistance – mainly due to irrational prescribing habits among health practitioners, unregulated market, patient expectations and pressure from drug companies; you as a prescriber can do something about this.)

- It is possible to do something even in low resource settings, if there is political will. (Public health facilities are underfunded, understaffed, undersupplied – you need to be creative – focus on what the community needs.)

YOLANDA

I cannot not say something about MSF's biggest emergency intervention in 2013. I was part of the French "start-up" team in the aftermath of the supertyphoon Yolanda. I was with veterans of various wars and disasters but even they were visibly blown away by the destruction. In the first weeks immediately after the catastrophe, we set up inflatable hospitals, organized mobile clinics based on needs assessment, brought in 300 tons of medical supplies and constantly refined our plans. By mid-Dec. 2013, 200 international staff and 600 local staff were on the ground – in the most affected areas of Samar, Leyte and Panay.

32.4 M euros were donated to MSF for the Philippines and we ended our support to the Leyte Provincial Hospital only last month.

While still in Cebu, I was informed that our team in Palo, Leyte had found good accommodations. Each person would have a room and a bathroom and there was space outside the rooms for office work, space for our medical supplies and logistics supply. When I arrived and saw what they had found, I couldn't stop laughing. I was laughing so much I had to explain to my teammates. It was a motel.

Our teams were immensely impressed by the volunteer spirit of Filipinos. I hate to use the word resilience; rather I would use two words – *gratitude*, which even the most distressed can and does express; and *empathy* for those who are worse off, even in the middle of stark overwhelming need. Seeing these made one feel hopeful for the survival of humanity.

Finally

Sixteen percent of our class went into community medicine, when we left college 25 years ago; some joined communities under the Community Medicine Foundation (COMED); one joined the program of PRRM, I joined the Medical Action Group (MAG) while another classmate worked as MHO in her province.

I hope the Class of 2015 will one-up us. The world is entering one of those perilous eras where natural and man-made disasters are becoming more the norm than the exception. There is great need for community medical practitioners, who will thereby gain an understanding of human collective health needs beyond what any school can teach. One can go into community medicine directly, and then into specialization later or vice-versa; or go into research and specialization and then community medicine.

I say this by way of a reminder to everyone that medicine is not about pills, potions, and ointments. It is about people, the health of people; it is about life and the quality of the health of life.

It is there that one can find perhaps the original roots of medical practice and become truly a healer of communities.

For my finish, I want to leave you 7 nuggets to chew on, not only for today but perhaps for the rest of however long you intend to practice.

7 key Nuggets

1. Do no harm.
 2. Do your work and do it with both professionalism and passion. Let your work speak for you.
 3. Be modest enough to seek others' opinion. We learn from one another.
 4. On the other hand, speak out. You are de facto leaders of the community. You are part of the community. Push boundaries.
 5. Keep your integrity.
 6. Be critical. Think outside the box.
 7. Be vigilant. Dark forces are constantly trying to reverse the gains of the Generic Act Law, the Breastfeeding Act and the Reproductive Health Care. Law
- NAMASTE. May your souls rejoice in the glory of healing and service.