This is not a drill

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FROM THE INSIDE

This is not a drill

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North Yemen, just a few hours by car from the front. It's 1 year after the beginning of the civil war that has so far claimed the lives of more than 8000 people.

I'm on my second mission with Médecins Sans Frontières (MSF; Doctors Without Borders). Here, we provide support to a local hospital where we run two operating theatres, an emergency department, 70 ward beds and an intensive care unit (ICU). There is no shortage of road accidents, but we mostly see traumatic injuries resulting from the conflict. No pre-hospital emergency service is available, so patients often reach us after hours of travel lying in the back of a pick-up truck.

Fortunately, we are not alone: an excellent team of local doctors is the backbone of the hospital. There are three general and two orthopedic surgeons, an anesthetist, three anesthetic technicians and seven general doctors who keep the emergency department, wards and ICU running. There is a great need for specialized intensive care training.

The city was last bombed more than a month ago and so now things appear calmer.

It is twilight outside, almost no one is around, and the "blue hour" is invading the brown clay buildings in the old city. With no noise and only a few lights on, you can see the first stars appearing from inside the hospital. I have just finished admitting a patient andg I think, I'll be able to get home for dinner time. "Home" is actually nothing more than a compound within the hospital perimeter. For safety reasonsg we are not allowed to go outside. Here the working day is always 12 h long, every day of the mission, you are rarely without work, and at night you are always on call for any emergencies. It is physically and psychologically tiring, but when you're here you can do no more than want to work, want to do everything you can.

I am outside the emergency department when I see a patient being brought in from the road. A man between 50 and 60 years old, he looks very unwell and is unconscious, but at the time he seems to be an isolated case. The doctor on duty in the emergency department decides to immediately intubate him. He is bleeding from his left ear and, upon examination, he is found to have a severely wounded leg. He is also bleeding from facial wounds and his mouth is full of blood. I run inside and prepare myself and the team for a potentially difficult intubation. Local experience in airway management is limited, and it is one of my training objectives during the mission, because in addition to the clinical work, we should provide staff training too. There is a need and an opportunity to improve local staff's skills.

The only monitoring available is a portable pulse oximeter and a monitor for non-invasive blood pressure measurement. There is no ventilator in the emergency department, so someone, perhaps a relative, offers to ventilate him by hand with a Bag-Mask-Valve and will continue to ventilate him until a place frees up in the intensive care. While we assess the case, a second patient is brought in: a young woman, between 15 and 20 years old perhaps. She is screaming. She has third degree burns to her body and face and her face is blackened. There is something wrong, I think.

In the Emergency Department, the chaos begins. I shout to a nurse to call immediately to Juan, the other doctor who is at the end of his mission and who I am replacing. Call him, tell him to run over here immediately as we need a hand. The girl has third degree burns over 50% of her body.

There are some means of communication between the locals that are totally obscure to me, but thanks to which in the meantime other doctors arrive, the one on ward duty and the one on night duty, in addition to others who today were not on call, many of whom live in the vicinity

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of the hospital. They were already expecting this, but I have not yet fully realized that what we are experiencing is the onset of a mass-casualty incident.

In the meantime, a young man and two girls of maybe 6 and 8 years of age arrive in the emergency department. They are pale, covered in dust, and are weeping; they have burns that look just superficial. They are alone and very frightened; they need someone to take care of them. The young man is left on the ground on a stretcher because all the beds in the department are already filled.

Chaos reigns, noise, dust, a smell of blood and burnt flesh. I move from one patient to another and try to ensure that each of the critically sick is assigned one of the local doctors.

Another two children arrive, young, perhaps 3 years old, wrapped in a blanket; ashen, they too are covered in dust, and surely already dead. May they rest in peace.

There is no time to take this in, there are still things to do for the living. The doctor who is treating the young woman with burns wants to perform a laryngoscopy to check the cords; he fears edema and swelling. In the meantime, I go and check on the two young girls with burns, one of whom has received morphine subcutaneously as prescribed by one of the local doctors; our midwife who is monitoring them asks me what to do for the other. I reply that she should do the same with her, too. They calm down and fall asleep. Better that way.

I go back to the young woman: in addition to the burns on her body, she is bleeding continuously from her nose and mouth. She is definitely inhaling blood. We decide that she needs immediate intubation as well, but our thoughts turn to the future: what resources do we have to manage her once she is intubated? Somebody will ventilate with a Bag-Mask-Valve and then we will see about a place in intensive care for her, too. The local doctor shouts "laryngoscope! laryngoscope!". But there is no sedation ready and the Bag-Mask-Valve system is somewhere else.

The chaos continues. I raise my voice slightly. I think things through: there are too many people and most definitely too many talking. Health care professionals, relatives, the curious, where is security?

A man is filming with a camera. Who is he? You cannot film here. Our nurses tell him he cannot film but he pretends not to hear. He gets good close-ups of unconscious patients. My nurses try to get in his way. We call our manager who speaks to the hospital director. It is a reporter from a local television channel; the director says to let him carry on. How will these images be used?

In the meantime, the young man who arrived with the girls is still on the ground and is assisted by one of the local doctors and one of the local surgeons. At last, the blood arrives. The surgeon thinks there is an abdominal injury. He will be the first patient for imaging. He needs to be taken to radiology because the hospital only has one ultrasound machine and it is not portable.

I have a briefing with all the doctors. It is time to reassess and prioritize.

The two little girls are sleeping, and one of our nurses takes them in her arms and carries them somewhere quieter. Things are a little calmer.

Now there are only the elderly man with the traumatic brain injury and the young woman with burns in the emergency room. Things do not look good for them. Parameters are stable for the male patient, but his pupils are fixed. The female patient has tachycardia and continues to bleed from the mouth. The doctor on duty in the intensive care that night arrives. We review the patients; they are still unstable, but at this stage we decide we will move them to ICU anyway and he will continue to stabilize them there. We need to keep creating surge capacity in the emergency department.

I talk to the surgeon. The young man has returned from radiology and he does not appear to have intra-abdominal free fluid. He has a fracture of the pelvis and a broken femur. He will be taken to theatre shortly. Even the young woman leaves the emergency room.

Another patient, yes, another patient arrives. Almost one and a half hours have gone by since the first patient arrived.

He is unloaded off the back of a pick-up truck. My colleague examines him but there is nothing we can do, as he is already dead. He is taken away and given to the relatives who had accompanied him.

The hearsay news is that an air strike has hit the house of the people who have come to us, in a village about 20 km south of here. The news is also reassuring: there are no more people involved expected here.

Only one patient from the airstrike remains in the emergency room: the elderly gentleman, the first to arrive. At 10 p.m. the last patient finally leaves the emergency room for the intensive care unit.

Three code red, two yellow, three black, a few green that I had not had the opportunity to see and a further two patients who went to another hospital in addition to two dead on scene. The balance is five deaths including two young children.

Calm has now been restored in the emergency department. The janitors are cleaning up. On the floor there is blood, torn clothes, and surgical materials. I take a deep breath.

This was not a drill. In Italy, I had never seen or lived a real mass casualty incident, only drills. I am surprised by the fact that the mass casualty did not surprise me nor did it rattle me, and that I unconsciously worked as if nothing out of the ordinary was happening around me.

I am impressed by the defense mechanisms that I have unconsciously built up during my years of clinical work in intensive care. Will I be dreaming of this for many nights to come?

It is now 11:30 p.m.

They advise us that other bombings have just taken place, 50 km to the north. I hope no one else will arrive overnight even if that seems unlikely.

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Compliance with ethical standards

Conflicts of interest

The author declares he has no conflict of interest.

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