

Our Helping Hands in the Aftermath of the Great Tsunami of 2004

Interviews with Asok Kurup¹, Fatimah Lateef² and Vincent Yeow³

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INTRODUCTION

“It came, swiftly and mightily.

No one expected it.

It left us battered and bewildered.

Then the Earth cried...”

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In the aftermath of the great tsunami of Boxing Day 2004, Singapore General Hospital (SGH)/Singapore Health Services (SingHealth) sent out a number of disaster and/or medical relief teams to neighbouring countries. Among those who heeded this cry for help were (in alphabetical order): Drs Asok Kurup, Fatimah Lateef and Vincent Yeow. These helping hands from SGH/SingHealth experienced first-hand the devastation and destitution of peoples who had survived the great tsunami. Their stories are both humbling and teach us valuable lessons.

RED CROSS, TRINCOMALEE, SRI LANKA — DR ASOK KURUP

Trincomalee is both a fishing town and district in the Northeastern part of Sri Lanka. Before and even after the great tsunami, the Tamil Tiger rebels, whose actual home base is in the Jaffna Peninsula, north of Trincomalee, had fiercely contested political and military control over this part of Sri Lanka. Dr Kurup had never been to Sri Lanka and never knew what to expect when he was deployed to help under the Sri Lankan Red Cross (Fig. 1).

MERCY RELIEF, MEULABOH, SUMATRA, INDONESIA — DR FATIMAH LATEEF

Meulaboh is also a fishing town and was closest to the epicentre of the earthquake along the Western coastline of Sumatra. Nothing really happens in Meulaboh — it is an idyllic tropical paradise. What Dr Lateef met in Meulaboh after the great tsunami was not quite idyllic. Incidentally, Dr Lateef is a member of the Board of Directors of Mercy Relief and a Specialist Volunteer in the Singapore International Foundation (Fig. 2).

“OPERATION FLYING EAGLE”, SINGAPORE ARMED FORCES, BANDA ACHEH, SUMATRA, INDONESIA — DR VINCENT YEOW

Banda Aceh is the largest town in the Northwestern part of Sumatra. It bore the brunt of the great tsunami because it was the most populous region that was near the epicentre of the earthquake. Dr Yeow braved meeting local rebels to bring relief to the Acehese. He was the Medical Team Leader for the Singapore Armed Forces (SAF) special relief operations — “Operation Flying Eagle” (Fig. 3).

THE DEVASTATION

Gerrard: So let’s begin by hearing about your experiences when you first met with the devastation.



Fig. 1. Dr Asok Kurup was the Medical Team Leader of the SGH/ SingHealth-Sri Lanka Red Cross relief mission to post-tsunami victims in Trincomalee, Sri Lanka. In this photograph, Dr Kurup stands on terrain ruined by the devastating tsunami.



Fig. 2. Dr Fatimah Lateef (left) is seen here with team mate, Dr Joanne Ngeow (right). Dr Lateef was the Medical Team Leader of Mercy Relief (the first NGO relief mission) to post-tsunami victims in Meulaboh, Sumatra, Indonesia.



Fig. 3. Dr Vincent Yeow (left) was the Medical Team Leader of the Singapore Armed Forces relief operations to Banda Aceh, Sumatra, Indonesia – “Operation Flying Eagle”. He is seen here double-checking the Ops Schedule.



Fig. 4. Although Trincomalee is several hundred miles from the epicentre of the undersea earthquake, the killer waves that reached it were massive. As can be seen in this photograph, waves as high as the branches of this palm tree literally destroyed virtually everything in its path.

Asok: About 10,000 to 15,000 people in Northeastern Sri Lanka lost their lives that day. When I arrived at one of the coastal fishing villages in Trincomalee 10 days later, the scenes of destitution and devastation were stark and overwhelming. The waves were massive, reaching up to the uppermost fronds of this palm tree (Fig. 4). Mounds of earth testified to the quick burial of the dead, leaving areas of eerie silence in parts of the flattened village. I left the village profoundly affected emotionally.

Fatimah: The devastation was really extensive and widespread and beyond what I had ever seen before. The ground and earth was literally flat. The disruption to lives, coupled with

the damage seen physically, touched me even more. If I stood by the beachfront, there were no buildings left or right, and no one standing in the area as far as the eye could see. The waters came all the way into the city of Meulaboh, as far as 4 to 5km inland. We saw boats pushed by these waters right into the middle of the city. Surprisingly, there were still a few mosques left standing that suffered only minimal damage to the ground floor levels. The military hospital in Meulaboh was completely destroyed, and together with it went the lives of numerous staff and healthcare professionals. The only healthcare facility remaining was the Meulaboh General Hospital. Dramatically,



Fig. 5. Numerous patients in Meulaboh were suffering from tetanus. Trismus and opisthotonus, as seen in this patient, were readily observed physical signs characterising this condition. The profound lack of modern medical equipment, such as mechanical ventilators, often made it difficult for medical relief workers to provide proper care to the critically ill.



Fig. 6. Numerous high-tech equipment was brought along, including this portable pulse oximeter. Out in the field, these equipment frequently became cumbersome to use, as demonstrated by the precarious way that such equipment needed to be deployed. In most situations, it was more effective for our healthcare providers to go back to the basics, aside from the use of high tech equipment, and to deal with problems sequentially and logically.

the waters stopped just a few metres from its front door, and spared the building.

Vincent: On the day we arrived, I immediately settled the team and stores before heading out on a reconnaissance of the town to assess the security situation as well as determine an optimal site for deployment. Passing through the town I was struck by the extent of the destruction. The water reached as far as 7km inland and everything within 3.5km was literally wiped off the face of the earth. I was instantly reminded of pictures of Hiroshima.

CHIEF HEALTHCARE PROBLEMS

Gerrard: This is an obvious question. What were the principal healthcare problems in these post-tsunami regions?

Asok: Both upper and lower respiratory tract infections were the most common problems. Then it was the wounds; followed by anaemia and malnutrition, especially in the children. The tsunami only served to exacerbate malnutrition in people long impoverished by years of political strife and civil wars.

Fatimah: I would say that acute infectious diseases were the most common. Both types of malaria and tetanus were extremely frequent. For the first time in my life, I saw so many patients with trismus and opisthotonus (Fig. 5). It was a real-life, hands-on lesson on

learning how to treat these conditions. I also saw a lot of gastroenteritis with dehydration, upper and lower respiratory tract infections (including pneumonias), dengue fever and injuries. Fortunately, most injuries were minor. Then there were skin infections, such as cellulitis and abscesses, which arose mainly from poor hygiene. I also saw some chronic diseases, such as hepatitis, coronary artery disease (including angina pectoris), asthma, diabetes mellitus and hypertension. Moreover, post-traumatic stress reactions were present in almost every patient we saw. Patients required only gentle persuasion to begin hyperventilating and break into crying fits, and/or incessant talking, which was often about how they had lost their loved ones.

Vincent: Dirty and infected wounds were our main challenge. The silt from the tsunami as well as the dirty water used for cleaning meant that almost all wounds that were treated or left open became infected. We spent the majority of our time debriding wounds, and then dressing them regularly. In addition to that, we managed primary health care problems and infectious diseases. As for the psychological conditions of our patients, there were many with insomnia and other vague symptoms that could not be attributed to any definite cause. In these cases, a listening ear, some vitamins and rations often did the trick.

YOUR GREATEST CLINICAL CHALLENGE

Gerrard: Having seen so many things that you had not seen before, what would you say was your greatest clinical challenge?

Asok: Frankly, it was my helplessness. As a physician trained in institutional practice, I felt more than a little handicapped in a rural environment devoid of the most basic laboratory tools, let alone a simple microscope. I found that I had to stretch my knowledge in tropical medicine to cope with the medical problems arriving at my clinic. Empiric treatment of fevers and perplexing dermatological conditions were just some examples.

Fatimah: I met my greatest challenge when I was attending to an acutely ill and breathless patient one day. After making the crucial diagnosis of acute respiratory failure and determining that mechanical ventilation was urgently required, I was shocked to discover that there were no ventilators in the entire hospital, and nothing else could be done. As you could imagine, there was a substantial lack of supporting infrastructure and services, as compared to the relative availability of these back home in SGH. And the frankness of an emergency situation, such as the one I encountered, urgently called for clever improvisation and flexibility. These harsh realities of life were indeed the terms of the day for life and death in these disaster stricken areas.

Vincent: I suppose one can say that our greatest challenge was trying to cater to such a wide range of problems with only basic equipment and medicine. We found ourselves going back to basics and dealing with things one at a time. One realises that a lot can be done with simple and first line medication as opposed to the more high tech and expensive approaches that we so often employ back home (Fig. 6).

YOUR LOWEST MOMENT AS A DOCTOR

Gerrard: It is interesting to note that helplessness, as doctors primarily involved in institutional practice and not exposed to rural medicine, should become a unifying sentiment challenging all of you. So was there a low

point in your practice as a doctor during the time you were there?

Asok: The children were the most pitiable (Fig. 7). As I mentioned earlier, they were very anaemic and growth retarded. And we were all ready to dish out care and love to them. However, we were hampered by the initial delay of our paediatric supplies at the Colombo Customs. So, we did not even have basic multivitamins to give to these poor kids on the first day! Subsequently, things improved but these children needed more, like real meat and good food, not just plain white rice and water. These kids lacked basic necessities, let alone family love, as the waves had rent asunder many a family unit.

Fatimah: To see children die is the most heart wrenching experience. This is made even worse by our helplessness from the lack and absence of appropriate equipment and supplies. For this reason, we should do more to help with the recovery and reconstruction of tsunami-devastated cities like Meulaboh, especially the general hospitals. Another very emotional experience for me was the mass burial ceremony I attended. Truckloads of body bags were literally planted into the earth, soil-to-soil, and earth-to-earth...a uniquely passionate and heart rending experience. It makes you think how fragile and how short life is, when death comes knocking at the doorstep.

Vincent: We lost a child that we had resuscitated back from the brink of death. Once the child had been stabilised in our makeshift ward, we decided that in view of the possible congenital anomalies, the child should be transferred to a tertiary hospital for further care and oxygen therapy. The parents felt happier and safer with us but it was a decision we had to make. Three days later, the parents came back to thank us as well as inform us that their daughter had passed away. We knew back home we could have done much more.

YOUR GREATEST SATISFACTION AS A DOCTOR

Gerrard: Let's lighten the mood a little and dry up the tears. Were there moments when you felt really great being a doctor?



Fig. 7. Children were frequently malnourished and anaemic. This Sri Lankan girl demonstrated a frequent problem observed in numerous children, i.e. infected wounds that healed very slowly and poorly. Sanitary conditions in survivor camps were grossly inadequate, leading to extremely low levels of personal hygiene, especially amongst the multitude of unattended children.



Fig. 8. With limited resources at hand, the relief team in Banda Aceh was often called upon to improvise. An empty mineral water bottle (there were numerous around) became a personal spacer for a metered dose inhaler (MDI) for an asthmatic child. These and other “inventions” were cleverly devised by our helping hands.

Asok: Not really. I wished I could have done more. No doubt I thought I ran a fairly comprehensive clinic, and provided adequate primary care, but it always seemed that I could have done more. I would say that I achieved only 65 to 70% of what I had planned to do, but that was not good enough for these disaster-stricken people. However, the Village Headman in one particular camp did give us some sense of satisfaction for a job well done. He, despite his profound lack of resources, managed to prepare some drinks for us, on one occasion, in appreciation for our efforts. It was good to know that at least we brought some solace to these displaced people.

Fatimah: Perhaps the best occasion when I felt the greatest sense of appreciation as a doctor was when I found out that an earlier planned trip to India to establish an emergency department in a hospital was to be delayed. This of course meant that I could now volunteer to head the first non-governmental organisation (NGO) mission (under Mercy Relief) from Singapore to Meulaboh. Importantly, I also obtained approval and support from both the Chief Executive Officer and Chairman, Medical Board of SGH to do this. I guess, if you had previously volunteered to participate in such disaster relief programmes, it in a way continues to flow in your veins; and you feel that you just want to give more and more each time. I have

a simple philosophy which goes like this, “If you have it, give it. And if you want it, get it”.

Vincent: You realise there, that sometimes just being around and providing basic care and concern does so much more for the spirits and mental well-being of the people than all the high tech and modern approaches we in Singapore believe in.

UNANTICIPATED PROBLEMS (SUCH AS SECURITY)

Gerrard: Were there other problems that you did not anticipate? For example, were there security issues, since many of these places were embroiled in civil wars?

Asok: As you know, the Trincomalee region is a disputed area that the Tamil Tigers seek to wrest from the central government. This region is also serviced by one of the worst road systems that I have ever encountered. Most of the roads were actually more like mud tracks, and on at least one occasion, I witnessed an area by the side of one particular stretch of road that was just cleared of land mines. Then there were local demonstrations where refugees blocked all traffic. Although our Red Cross signages were clearly displayed on our vans, we too were initially not allowed through. The reason was that they wanted us to provide them with medical relief and not the next town. Finally, they relented and we went on



Fig. 9. This was a typical tranquil evening in post-tsunami Meulaboh. In a way, it represented a real chance for peace in these troubled lands. Survivors of the great tsunami may never understand why it happened, but mankind will draw greater strength from all of this and hopefully make the world a safer and more blessed place to live in.

our way. There were also instances of miscommunication between Sri Lankan Red Cross and local authorities; and it is my belief that the Sri Lankan Red Cross could have more frequently assumed a more proactive role in improving the situation.

Fatimah: I am actually somewhat biased here, as I had been to Iran after Bam earthquake and to Afghanistan after the September 11th tragedy. Moreover, I had visited remote villages in China (for example, the Yunnan mountains), and the mountains of Africa; and seen utmost poverty in Nepal and Tibet. Hence, many of these experiences in post-tsunami Meulaboh were, by comparison, not too shocking. Perhaps, the most unanticipated encounter was the lack of running water in many places. Basically, your next refreshing shower was never guaranteed.

Vincent: I'm a commando, so we made sure that everything was as safe and secure as possible. As for living conditions and rations, "Necessity" is truly the "Mother of Invention" (Fig. 8) and bartering.

THINGS TO RECOMMEND

Gerrard: Your vast experiences will certainly come in handy when dealing with future disasters such as this great tsunami. Are there some things you could recommend?

Asok: Well, most certainly adequate communication should be the primary focus. The group leader and members of the team must know their exact roles. It is important to have the area surveyed prior to the arrival of the relief team. Had this been done for our trip, we would not have needed to spend an entire day on a reconnaissance expedition. Adequate quantities of relevant medical supplies (not a whole lot of PPE gowns for instance) should also be ensured and checked thoroughly prior to travel. The problem of security has also been mentioned earlier. As for the team, I think it should consist of primary healthcare providers with experience in disaster medicine (perhaps we should have a dedicated team of such healthcare workers for future relief efforts); and nurses, especially those with a paediatrics background. Finally, a few pharmacists and perhaps a psychologist would be wonderful bonuses to complement the team.

Fatimah: I think that it is important to know the native language to be able to communicate with the locals. Communicating in their language will in fact help you develop better rapport and have the upper hand in negotiations. One should also do some research and read as much as possible about the area before going on a relief mission. It really helps to know what's happening on the ground.

Vincent: Understand the local setting, culture and language. Know your limitations and make sure you go with a well-oiled team. Finally, ensure your organisation can support you with food, accommodation, logistics, communications, transport and security.

ANYTHING ELSE (PERHAPS A SILVER LINING)?

Gerrard: So is there a silver lining?

Asok: Well, I learnt how to improvise a spacer device for bronchodilators using mineral water bottles; but seriously I learnt that life must go on. It is heartening to see support arriving for these people and people picking up the pieces despite the odds. Also, I made a whole new set of friends in my team, friends with whom I would love to have another chance to work.

Fatimah: I learnt how to treat tetanus in Meulaboh. Coincidentally, after coming back to Singapore, I actually encountered a patient with tetanus. An Indonesian man from one of the islands was brought here by boat. He sustained some form of trauma about 10 days prior to this, and was in full blown tetanus. He was foaming at the mouth, and in opisthotonus. Well, I was on duty and immediately knew what to do! To me, each mission and disaster is a unique learning experience. To be able to share these experiences of mine with others is a blessing indeed (Fig. 9).

Vincent: A chance for peace in Aceh, possibly; and an opportunity for us to show that mankind, despite our flaws, always rises to the occasion.

EPILOGUE

Gerrard: Thank you all for sharing these experiences right from your heart. I am sure our readers appreciate your bravery, resourcefulness and charity; and bid you a warm “Welcome Home”. GOOD JOB GUYS!