High hopes
By Rosalie Hughes

Tomorrow, Mandari Buddha will leave her village in the Himalayan foothills for the first time in her life. She will leave behind four small children, an aging buffalo, and a two-room mud house that she helped build. She will walk 10 hours to a town where she will get on the first bus she has ever seen. Over the next two days, she will travel to an urban teaching hospital.

Mandari suffers from uterine prolapse, a condition in which a woman’s uterus loses its moorings inside the body and drops, hanging out of the vagina. She is traveling to the city so she can have an operation to remove her uterus. The International Rescue Committee (IRC), a global humanitarian organization, is enabling Mandari and 20 other women from rural villages in western Nepal to take this trip—one they otherwise could not have afforded, much less imagined.

According to some estimates, uterine prolapse afflicts nearly one in three women in rural Nepal.

The people of the Himalayas live amid the world’s highest peaks but suffer some of its lowest health indicators. Two young women with Dartmouth ties—a graduate of Dartmouth College and a student at Dartmouth Medical School—recently traveled with health-care teams to remote villages there.

Hughes, a Dartmouth College ’07, worked from June 2008 through May 2009 in Kathmandu, Nepal, for the International Rescue Committee (IRC). Her responsibilities included writing grant proposals and donor reports and supporting the IRC’s Nepali field staff—including those involved in the project about which she writes here; her stay in Nepal was partially funded by Dartmouth’s Dickey Center for International Understanding. She is now based in Kenya as a caseworker for the Joint Voluntary Agency, where she works with refugees who are eligible to resettle in the U.S. Either she or one of her IRC colleagues took all the photos here.

For a photo gallery with many more images of the Himalayas by both authors of this feature, see dartmed.dartmouth.edu/f09/we02.
We meet Mandari outside her village. She is wearing thin canvas shoes and a red wrap skirt. On her back is her youngest son, the size of a sack of potatoes.

The day before we depart I meet Mandari, a small woman with high cheekbones, two heavy copper nose-rings, and a bright red swath of cloth wrapped around her tiny legs. Mandari tells me her fears as Rajan, a public-health worker from the IRC, translates for us.

"Can," she says. She sticks out her tongue and makes a noisy "bliblish" noise, mimicking vomit- ing. A neighbor told her that motor vehicles make you vomit. She’s also worried about leaving her buffalo behind. "She’s feisty," Mandari says of the animal. "She doesn’t let anyone but me milk her." Mandari makes the "bliblish" sound again, this time clapping her bony hands to her neck. "She’s afraid she’ll die," translates Rajan.

Mandari thinks she is about 35 years old. Orphaned at four, she grew up with seven siblings in a one-room mud house. Ever since she learned to walk, she has fetched water, cooked chapatis, and carried grass to feed the animals. She married at 17 and then gave birth to six children—five of whom survived. Her oldest child, a daughter, is now 10.

Mandari’s day starts at 4:00 a.m. She lights a fire, milks the buffalo, then makes tea and chapatis for her family. She leaves by 8:00 for a four-hour hike to the jungle to collect firewood and grass for her animals. By 8:00 p.m. she has cooked dinner, cleaned up, and, exhausted, is ready for bed.

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In July of 2008, her routine changed. Something started coming out of her vagina. It became painful to walk, lift heavy loads, and milk her buffalo. She could no longer make love to her husband. And only he knew about her problem. She could not tell anyone else, since weakness in a person’s sexual organs is considered a bad omen.

Finally, in October, the pain became unbearable and she sought help. After attending an IRC-sponsored clinic in her village, she learned that the bulge coming from her vagina was her uterus. If left untreated, she was told, it would become ever more painful. In time, as sensitive tissues that belonged inside her body were exposed, ulcerations would form and fester. Eventually the condition could kill her. The only way to fix it was through surgery.

"You’re lucky," she was told. "The IRC will pay for your surgery." But Mandari did not feel very lucky; she was afraid to leave home, afraid the surgery would kill her.

But the pain was so bad. Her husband insisted she go. "Who will take care of our children if you die?" he asked. So she signed up. She pauses in the telling of her story. Tomorrow she will embark on the most frightening journey of her life, but right now she has to go home and make dinner over a wood fire.

The next morning, Rajan and I meet Mandari at the top of a small hill outside her village. She is wearing thin canvas shoes and the same red wrap skirt she wore yesterday. Strapped to her back is her youngest son, the size of a sack of potatoes.

The trail heads immediately up, and I, in my fancy American hiking boots am soon left sweating behind Mandari in her primitive footwear. Several hours, and thousands of uphill steps later, we come upon the only settlement we pass on the way to the hospital in the region’s largest city, Nepalgunj.

As we approach Mandari’s village, the IRC facility in it comes into sight. At left, Mandari walks along its dusty main street.

Above, the village where the trekkers will meet the bus comes into sight. At left, Mandari walks along its dusty main street.
None of the women who take this bus to the hospital have ever been so far from home. Mandari has never even seen a motor vehicle.

The bus trip takes two days. Outside the bus windows, buffaloes and rice paddies give way to metal road signs and fruit stands selling pyramids of oranges. As we near the hospital, rickshaws, motorbikes, and buses crowd the road. The women chatter, point outside, and exchange excited smiles and laughs. A younger woman points to a bike outside the window. “What is that?” she asks. “A cycle,” the old woman next to her says. She explains that it’s meant for one person, but two or three people can fit, too.

But the bike is forgotten as the young woman sees a more awesome sight ahead—a multistory brick complex bigger than any building she has ever seen before: the hospital.

Inside, the hospital is a maze of long, white hallways. It smells of curry and urine and Lysol. Men in white jackets bustle by, clipboards in hand.

We go to the preoperation ward. White beds line a room the size of a basketball court. Nurses in starched white robes assign a bed and a number to each woman. The women’s pink and red wrap skirts and flat canvas shoes. They wear brilliant wrap skirts and flat canvas shoes.

Most of the women have walked for days to get here. None of them have ever traveled this far from home in their lives.

I talk with an older couple sitting apart from the rest of the group. The woman’s earring holes are dime-sized, weighted down by thick, gold hoops. The man’s hair is storm-cloud gray. He talks. She bites her nails. “Nineteen years,” he says. “She had the problem for 19 years.” The woman looks at the ground. For the first 18 years, they had no idea what was wrong. “We thought she was a mutant,” he says. Then last fall they attended a reproductive health seminar in their village. “And what is it like to be surrounded by other women who have the same condition?” I ask. The husband begins, but the woman interrupts him, speaking for the first time.

Before this trip, I thought I was the only one in the world who had this problem,” she says. “Now I see I’m not alone.”

I ask her how she feels about the surgery. Her calloused fingers fiddle with the bead necklace hanging from her neck. Her eyes moisten. “I feel afraid I might die.”

Over the next few days, I hear this same fear repeated. Often the women clutch their necks as they tell me this, just as Mandari had a few days ago. I ask why they’ve come if they think they’ll die. The answer is always the same: “If I don’t have the surgery, I will die anyway.”

The bus trip takes two days, first along the narrow winding roads of Nepal’s hills then on the straight roads of the country’s flat southern plains. Outside the bus windows, buffaloes and rice paddies give way to metal road signs and fruit stands selling pyramids of oranges. As we near the hospital, tickling his tiny feet and comment on his chubby cheeks. They joke in the sun and braid each other’s long, black hair. Mostly they wait.

The second night, I hear a chorus of giggles as I approach the prep ward. I see an old woman dancing in the middle of the room. Her arms wave, her arthritic body spins in stiff jolts. The women in her corner are clapping and cheering. Then the old woman turns to Mandari, who is in the bed right next to hers. She holds a sack of air in her hands and points to Mandari’s crotch. Still dancing, she mimes the sac hanging and wobbling between Mandari’s legs. Mandari laughs—the first time she’s laughed since leaving home. The old woman makes a cutting action with her hands and grunts. The room erupts in laughter—years of suffering in silence released.

It is the afternoon before the operations. I talk with Mandari as we sit on a concrete bench outside the x-ray room. I ask if she’s afraid. She claps...
The benefits of this trip are clear: The lumps plaguing these women will be removed. They’ll be able to walk without pain, bend over to milk their buffaloes without feeling ill, and make love to their husbands again. But something bigger happened during the journey—the women are now talking, sharing stories, and laughing. They are coming out of what must have been a terrible, isolating situation. They know now that they are not alone.

The eve of the operations, I come to wish the women good luck. Most are asleep, but I see Mandari and her son Babu are now safely home, and she is milking her buffalo—without pain. Mandari and her son Babu are now safely home, and she is milking her buffalo—without pain.

Mandari had her surgery. From the corner of a sterile operating room, I watched the doctor and his team of six remove her uterus. A heart monitor beeped. The surgeon sat between Mandari’s spread legs—cutting, poking, sewing, pulling, sucking, tying, and squeezing. His thick fingers moved quickly. His eyes squinted behind thick glasses. A green vein on his forehead protruded.

Mandari’s face was covered with a clear plastic mask and her body with a thin blue sheet; her birdlike form was barely evident on the operating table. Her operation was successful, as were all the others. Mandari and her son Babu are now safely home, and she is milking her buffaloes—without pain.

Monumental challenges
By Katherine Kosman
A
s our plane drops below the clouds, the snowy peaks of the Himalayas come into view, rippling across the horizon. Soon we’re landing in the sunlight-splashed valley at their base. The plane’s altimeter still reads 10,000 feet, but we have arrived in Leh, India.

In Leh, cows, cows (with their horns blazing), motorcycles, pedestrians, and stray dogs all compete for the right of way on narrow streets with no defined lanes. Peddlers come out of nowhere selling drums. Barefoot young men beckon passersby into tiny shops to sit on a comfortable couch and sip a cup of ginger-honey tea. Hand-stitched cashmere carpets, so beautiful that even the backs are a feast for the eye, line the thangthoronglas. Colorful prayer flags flutter in shepherds’ doorways and from the eaves of buildings, against the deep blue sky and the temples built into the encircling hills.

But beneath the aura and visual chaos, I discover that Leh has a peacefulness all its own. Just a short hike away is Leh Palace, whose stone corridors exude calm and whose prayer room can only be entered barefoot. Nearby, Shanti Stupa Temple towers above the city in white, shining glory. From the steps leading up to it, I watch my first sunset on the top of the world.

It is the summer of 2008, and I have traveled here to work with the Himalayan Health Exchange. I had read about the spectacular entry into Leh. But nothing could have prepared me for the awe-inspiring panorama of the mountains or for the journey of discovery that still lies ahead.

I will return to Leh later, between trips into the mountains, but this initial stay isn’t long—just long enough to become acclimated to the altitude. Soon our group departs on a six-hour drive into the mountains to establish temporary, makeshift clinics, mostly housed in tents that we carry with us. The team includes a handful of M.D.’s and numerous medical students from the U.S., the United Kingdom, and Canada, plus a few dental students. We are assigned variously to rotations in the tents for internal medicine, women’s health, ophthalmology, minor surgery and sutures, orthopedics, or pediatrics, in addition to helping with patient triage and the pharmacy tent.

We arrive for clinic early each morning, but the patients are there even earlier—sitting along concrete walls, holding small children, clustering around the tents. Every day is chaotic, exhausting, and challenging, but rewarding beyond measure. I quickly come to value the independence I’m given. My fellow medical students and I are thrust into collecting medical histories, conducting physical exams, formulating assessments, and proposing medication plans before we present each case to our attending physicians. As I strive to gain patients’ trust, I watch them grow in confidence and competence. I witness their ability to exude calm and whose prayer room can only be entered barefoot.

Kosman, a Dartmouth Medical School ‘11, holds a B.S. in electrical engineering from Washington University in St. Louis and before coming to EDM worked for four years as a risk and opportunity manager at Raytheon. She writes here about her experience working with a health care team in India. Kosman also reports another international experience—in Vietnam—for the Student News Network, a service of Democrat-Missourian. Winter 2008 issue (see dartmed.dartmouth.edu/w08/e01). Either she or another member of her group took all the photographs here.
The wound looks bad, but the boy evinces no pain or fear. As I scrub it with antiseptic, I look up at exactly the right moment to see his face widen into a huge grin.

On her first day, author Katherine Kasman, left, helps tend to a boy who has badly injured his heel.

On our first day out, I’m assigned to a catch-all surgery/orthopaedics/pediatrics tent. Being brand new, I’m not sure what to expect—but I learn quickly that in this tent that’s the case even for old hands, as here one never knows what the next case will involve. I also learn quickly that I have the pediatric patients. They approach us shyly but warm up fast. I soon feel like I have my own little fan club.

trust, listen to their hearts, draw diagrams to explain pill schedules, I begin to feel like a doctor. On our first day out, I’m assigned to a catch-all surgery/orthopaedics/pediatrics tent. Being brand new, I’m not sure what to expect—but I learn quickly that in this tent that’s the case even for old hands, as here one never knows what the next case will involve. I also learn quickly that I have the pediatric patients. They approach us shyly but warm up fast. I soon feel like I have my own little fan club. Toward the end of that first day, a small boy enters the tent and shows us where a fall has badly ripped the bottom of his heel, exposing deep layers of skin. Our plan is to remove the epidermal wreckage, clean the wound, and bandage it. It looks bad, but our patient is quiet and stoic, evincing no pain or fear. Still, I worry that the antiseptic might sting badly, so I proceed with care as I clean the wound. Then my attending reaches over to demonstrate that I must scrub the area fiercely to be effective. Continuing as instructed, I look up at exactly the right moment to see the little boy’s face widen into a huge grin due to my inadvertent tackling of his foot. A moment later he’s giggling so hard that he almost squirms out of the little clinic chair. Then all the other nearby children—who’ve been observing his fate with concerned silence—erupt in shared laughter. It’s a priceless moment of bonding and friendship. As I send the little boy on his way, it occurs to me that the ability to turn stoicism to joy may be our most powerful medication.

As our travels continue, I encounter many such moments of light-hearted charm, but also many dismaying reminders of the limitations of international medicine.

For example, numerous elderly patients with aching knees come to see us. We can’t begin to help them without first finding a translator. Translators are a major limitation in our ability to treat the long lines of patients waiting for care. Conversations are often a three-way, circular affair—from English into Hindi, then Hindi into the local dialect, then back again the other way. And even with a translator, interviews prove frustrating. For patients with knee pain, I start by asking if they have pain anywhere other than their knees. A several-minute conversation proceeds around the circle in various languages. Finally, I get back a one-word answer: “No.” What words have been added and subtracted along the way, I will never know.

Then the patients commonly volunteer to peel away their heavy tunics and layers of wool socks to show me multiple scars on their knees. Pink and about the size of a thumbnail, these lesions are an aftereffect of a traditional therapy, in which herbs are pressed onto the skin with a heated rod. Many of our patients believe these treatments help them feel better. But they also get relief with the tiny white pills they obtained at last year’s tent clinic, so they have come back for more.

As the days pass, I begin to reflect deeply on my role here, on what it means to introduce Western medicine to a remote region. Two patient encounters crystallize for me this intersection of culture and technology.

One day, a Tibetan monk finally works his way to the head of the line outside the one-room building where my clinic is located that day. Silhouetted by the outdoor sunshine, he enters the room’s shadowy interior. His soft sandals whisper against the sandy floor, and his floor-length red tunic swishes softly. As he sits down, I hear a ringing sound and am amazed to see him reach his hand into the fold of his tunic and extract a cell phone. He politely excuses himself to take the call and steps outside. I will never forget the sight of this noble monk, leaning against a rough stone wall and laughing deeply as he speaks into his silver phone, gleaming in the bright sun.

That same day also brings an elderly gentleman to my clinic. He has a long history of tuberculosis (TB) and Fott’s disease—a form of TB that affects the spine and causes bone loss. He is frail, weak, and thin and because of his inadequate access to medical care. I know that if he lived in the U.S. he’d almost certainly have long ago received therapy to halt the progression of his devastating illness.

In fact, every day we see deep distress that our fragments of modern medicine can only begin to put right. Our group includes an attending ophthalmologist, and we are also armed with vision charts and eyeglasses. But when I work on the ophthalmology service, I often sit in my throat as elderly patients quietly recount the vision they’ve lost to glaucoma or cataracts.

How, I wonder to myself, can we keep from internalizing our patients’ worries about their declining health, their fear of the unknown? How can we keep from being paralyzed by the wish to always do more? On the pediatric service, I see child after child with severe iron deficiency. The parents are worried about their children’s tiny size, about their growth. I will never know what words have been added and subtracted along the way, I will never know.

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As I work my way through the endless lines of patients, I continue to ponder these dilemmas and contradictions. On the very last day of clinic, my very last patient tells me that she is 25 and that she has come to see us because she often has headaches. It’s a common complaint. Every day, people clamor at the pharmacy for sunglasses, because the sun is much harsher at high altitudes and often causes headaches. By the last day we are running short on supplies, most of them donated, and we’ve started debating how to parcel out the remaining glasses (and pills) to the countless pleading patients, all of whom clearly have a bona fide need for our now-meager offerings. It has been a rough day, with two older men demanding in an unusually forceful fashion that they be allowed to cut in line to get care for their painful joints. Each of us has seen breathtaking beauty unfold before us—its mountains, its farms, its dappled valley below me, I try to imprint these and so many other memories on my brain so I will never forget them. Several nights when we were up in the mountains, we had an unobstructed view of the stars. Even after a tiring day in clinic, I would fight to keep my eyes open because every few minutes a shooting star would blaze across the sky. Unlike those split-second flares, I knew this experience with the Himalayan Health Exchange will not be a brief spark in my education and career. I have been forever changed by the experience of having to visit the Himalayas in a few months, so our limited supplies, most of them donated, and we’ve started debating how to parcel out the remaining glasses (and pills) to the countless pleading patients, all of whom clearly have a bona fide need for our now-meager offerings. It has been a rough day, with two older men demanding in an unusually forceful fashion that they be allowed to cut in line to get care for their painful joints. Each of us has seen breathtaking beauty unfold before us—its mountains, its farms, its dappled valley below me, I try to imprint these and so many other memories on my brain so I will never forget them. Several nights when we were up in the mountains, we had an unobstructed view of the stars. Even after a tiring day in clinic, I would fight to keep my eyes open because every few minutes a shooting star would blaze across the sky. Unlike those split-second flares, I knew this experience with the Himalayan Health Exchange will not be a brief spark in my education and career. I have been forever changed by the experience of having to visit the Himalayas in a few months, so our limited supplies, most of them donated, and we’ve started debating how to parcel out the remaining glasses (and pills) to the countless pleading patients, all of whom clearly have a bona fide need for our now-meager offerings.

T he good news is that a team of surgeons will visit the Himalayas in a few months, so our patient may be able to get diagnostic imaging and surgical treatment. But the surgeons will be in Leh, a six-hour drive away, and care are rare on these isolated roads. What does it mean to suspect a challenging diagnosis in the middle of nowhere? We ask our young translator to explain all this to the patient, to tell her the date on which she can come for her neurological exam—testing her reflexes, her memory, her sensory and motor systems. I watch as our patient struggles with and fails one simple task after another. My heart breaks as my idealism collides with the reality that this 25-year-old woman may well have a brain tumor.

What does it mean to tend to an elderly man who has experienced extremely painful joints for 30 years, if our makeshift clinic can dispense only an arcane word like osteoarthritis and a two-week supply of ibuprofen? Is it useful to merely supply knowledge—such as why someone’s vision has grown cloudy, why someone feels chest pain after eating spicy foods, why a child eats sand, why an elderly person’s joints hurt? Do our fancy explanations really benefit these people in the middle of nowhere, with little or no access to follow-up care? If they did not know the word osteoarthritis, would they just continue to think that joints become stiff after decades of walking rocky mountain ridges and long days of working the fields? If they had not experienced two weeks of a magical white pill called ibuprofen, would they just continue with Tibetan traditional medicine? And once they experience the benefits of Western medicine, what happens when their pain returns but the doctors don’t? But how do we parcel out lifetime prescriptions from scanty supplies to an endless line of patients? And even if we could, how would we offset the side effects from the daily attack on their stomach linings from the harsh pills? Each day after clinic, as the dust settled literally and figuratively from the swarms of patients waiting in the hot sun, my thoughts turned inward to questions like these. As students, were we there to improve our clinical skills, to travel abroad, to meet new friends? Or were we there to really take a stab at saving one corner of the world, one person at a time? What level of responsibility do foreign medical groups bear? What responsibilities do their institutions, cities, and countries bear? One of the first rules of medicine is to do no harm. Are we achieving that goal?