A Story from a Sealed Room

Contributed by

Jeffrey Borkan, MD, PhD

Some days you pack your black bag with antibiotics, other days you must fill it with antidotes to chemical warfare agents. Family medicine is renowned for its variation, but during the recent Middle East war, the challenges that I faced as a family physician in southern Israel stretched the usual boundaries. Since leaving a faculty position in family medicine at the University of Massachusetts in Worcester 2 years ago, I have been the sole family physician for 10 small kibbutzim (collective farming settlements) in an isolated region of the Negev desert on the Israeli-Jordanian border. My life during the war brought together the elements of medicine, community, and family that exemplify my role in this rural area.

During the night of January 16, 1991, we were informed of the start of military action against Iraq. We listened to the radio for hours. In the morning, the news analysts led us to believe that the war may have ended after a single night of Allied bombing. On January 17 all work was canceled throughout the country, and an air of celebration reigned. We dozed off that night with a sense of peace.

But at 2:00 AM the spell was broken. I received a call from the husband of a woman for whom I was providing prenatal care. He excitedly told me that his wife had been having contractions since midnight and wondered if they should join us at our house. Since I generally see patients in their homes rather than mine, I asked why. He quickly explained that according to the radio news reports, Israel was under missile attack. The population had been instructed to enter their sealed rooms and put on gas masks.

The last hint of grogginess left me as the air raid sirens began to sound. I yelled to my wife to wake up our two small daughters and bring them into the room immediately. I told the caller to quickly bring his wife to my house and to bring their masks. Provisions, medicine, and emergency equipment were already in place. Time began to take on an unreal quality of expanding and contracting as we raced to finish preparing our sealed "shelter," which in this case was our bedroom. The couple arrived, already wearing their masks. The wife was pale with fear. Her eyes tearfully relayed her pain and anxiety. The husband and I hurriedly placed the final strips of nylon tape that were used to seal plastic sheeting over the doors and windows.

I assisted my wife in placing our screaming 6-month-old daughter into her plastic "anti-gas" tent and secured a gas mask hood over our whimpering 4-year-old child's face. Our hearts ached as we did this. To what harm, both physical and psychological, were we exposing our children? Why were we, their parents, exposing them to these frightful protective measures, the terror of war, and the risk of death?

The initial tasks were completed within 10 minutes. The small room was filled with crying and fear. I struggled to assess the situation and reestablish calm, but on this, the first night of attack, it was difficult to estimate the risk since so little was known of the Iraqi threat. Were we one of the intended targets? Was this a conventional or nonconventional missile attack? Would the missiles be followed by Iraqi or Jordanian planes or troops?

Eventually, we were able to calm the children. The visiting couple took their positions at the top of our bed, timing contractions between radio announcements from civil defense. I huddled with my wife at the foot of the bed, surveying the scene. What were my priorities here, attending to my patient or my family? I struggled to do both, leaving the question for later.

After some delay, we were informed by the chief army spokesman that missiles had fallen in several areas and that there were multiple casualties. We were asked to stay in our sealed rooms, but gas masks could come off and the children could be removed from their plastic tents.

As the hours passed into morning and the sun rose behind the sealed windows, I periodically checked my patient's progress and monitored the fetal heart rate by Doppler. She progressed quickly, and I became concerned that she would soon give birth on our bed with our children in attendance. The emergency medical system was still paralyzed, and transport could not be arranged. Searching through our bedroom closets and through the emergency equipment I had stored, I assembled enough implements for a birth, including suction and local anesthetics.

As the woman reached transition, the radio announced that all missiles had been armed with conventional warheads and that everyone could leave their houses. We then received telephone permission to travel out of the settlement in an ambulance. I quickly prepared the

From the Department of Family Medicine, Ben Gurion University School of Medicine, Beer Sheva, Israel. Requests for reprints should be sent to Jeffrey Borkan, MD, Kibbutz Keturah, DN Hevel Eilot 88840, Israel.

 ISSN 0094-3509

patient for transport, and we began the 40-minute trip to the hospital. I felt an eerie "end of the world" sensation as we drove down deserted highways and into a shuttered city with no one on the streets. Soon after arrival at the hospital, my patient gave birth to a healthy baby girl. New life emerged out of a night of death and terror; hope remained.

I was told during my training that physicians are doomed to cynicism because, although trained for great things, few opportunities arise, and we are buried in the mundane. I have come to reject this because of both the major and minor wonders of life that we physicians are privileged to observe. I only hope that our adaptability is a match for the ever-changing world in which we are asked to practice.