2025, Volume 57, Issue 2, 134-135, e-ISSN 1938-3800

Family Medicine

NARRATIVE ESSAY

Reflection on Family Medicine Response to a Disaster

Diana Rahme, MD

AUTHOR AFFILIATION:

Family Medicine, American University of Beirut Medical Center, Beirut, Lebanon

CORRESPONDING AUTHOR:

Diana Rahme, Family Medicine, American University of Beirut Medical Center, Beirut, Lebanon, ds07@aub.edu.lb

HOW TO CITE: Rahme D. Reflection on Family Medicine Response to a Disaster. *Fam Med.* 2025;57(2):134-135.
doi: 10.22454/FamMed.2025.321378

PUBLISHED: 6 February 2025

On Tuesday, September 17, I was calmly preparing for an evening meeting after finishing my clinic when, at 4:00 pm, I received an SMS and WhatsApp code alert. Not following the news, I dismissed it as a routine drill. But minutes later, the notifications intensified: Code D Partial. Soon, I was informed of a new and terrifying reality—unidentified explosives had detonated across Beirut and other parts of Lebanon. Residents and staff flooded my office, seeking guidance as the sounds of ambulance sirens echoed outside. The alert escalated to Code D Full, and I, along with my residents, rushed to the emergency department.

In Lebanon, such crises, unfortunately, have become familiar. We are a nation accustomed to tragedy. From repeated wars to the catastrophic August 4 explosion—the third largest nonnuclear explosion in history—we have learned to respond with resilience, even in the face of unprecedented events. That day, however, presented a new challenge: the simultaneous detonation of 3,000 pagers, a form of attack that may be the first of its kind in the world.

Upon entering the emergency department, my residents and I noticed the chaos reigning. Crowds surged at the entrance, injured individuals arrived by ambulance and car, and inside, medical personnel were in constant motion, trying to restore order. I was struck by how instinctively our team mobilized, especially considering that we had never rehearsed a disaster of this scale. Residents and attendings worked as a seamless unit, responding to the crisis precisely and efficiently.

Family physicians in our country do not typically staff emergency departments; instead, we are called on in situations of extreme need, such as mass casualty events. Recognizing the scale of the disaster, we quickly organized ourselves. Faculty supervised residents, ensuring apparent oversight, while residents led interns and medical students in providing care. This hierarchical structure, though informal, allowed us to respond effectively under immense pressure.

Among the injured was a young man, pale and alone, covered in blood. Within minutes, we had stabilized him: cleaning his wounds, stopping the bleeding, and administering tetanus and morphine. His hand, damaged beyond immediate repair, would require reconstructive surgery, and though amputation of two fingers was inevitable, it could wait. We triaged, treated, and transferred him swiftly, continuing our rounds as we navigated the overwhelming influx of casualties.

That night, as I lay sleepless in bed, the scenes of the day replayed in my mind. The composure and calmness of the patients and their families unsettled me deeply. One patient in particular, a young woman with severe eye injuries, moved me to the point of tears. Despite the loss of one eye and a grim prognosis for the other, she never cried out in pain. Her mother, standing silently by, showed no visible emotion. It was a level of strength and acceptance that I found difficult to comprehend.

This theme of strength emerged repeatedly throughout the night. One man, after his scan results cleared him for transfer to a ward, declined further pain relief, saying, "I'm strong." His words echoed in my thoughts for hours afterward. What does this strength represent? Faith? Resilience? Indoctrination? I found myself questioning my own reactions. Would I have been able to remain so composed in their place? I remembered how I once panicked over a minor injury to my child during a school race. In contrast, these people faced life-altering injuries with extraordinary calm. Comparing my emotional response to theirs left me feeling both awed and inadequate.

By the early hours of the morning, my sleeplessness led me to deeper introspection. I began to question my own faith and strength. Could I ever tell someone to endure such suffering, as some religious narratives suggest? I couldn't. I realized I was not as strong as these patients and their families, and it shook me.

The next day, I found solace in speaking with my colleagues, who had shared similar feelings. Together, we realized that this disaster had not only tested our clinical skills but also forced us to confront our emotional and spiritual responses to trauma. We gathered our family medicine faculty and residents in the afternoon. Away from the chaos, we shared our thoughts and emotions. Everyone spoke openly about the challenges of the day before, from triaging severe injuries to managing the emotional toll of witnessing suffering. A psychologist facilitated the session, guiding us through our reflections and helping us process our experiences. It was a cathartic moment for many of us—a space to share, grieve, and find strength in our shared humanity.

We also debriefed with our family medicine residents, discussing the unique role of family physicians in crises. Despite not being in a frontline emergency specialty, our experience demonstrated that we can play a crucial role in managing the physical and emotional toll of mass casualty events.

Considering this, we are now reevaluating our family medicine training program to ensure that our residents are better equipped for disaster response, following Accreditation Council for Graduate Medical Education guidelines. We also plan to hold a series of debriefing sessions with our medical staff, including psychologists and psychiatrists, to process the emotional and psychological impact of this event.

This experience has raised important questions about our preparedness as family physicians, not just in managing the immediate medical needs during a disaster, but also in understanding and addressing the emotional resilience of our patients—and ourselves. I hope that our reflections will contribute to a broader conversation about the evolving role of family medicine in crisis situations.