community respond to spurious claims about the risks of the vaccine by refusing to vaccinate their infants, further outbreaks will occur even in industrialized countries.

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1. Katz SL, Hinman AR. Summary and conclusions: measles elimination meeting, 16-17 March 2000. J Infect Dis 2004;189:Suppl 1:S43-S47.
2. Garenne M, Aaby P. Pattern of exposure and measles mortality in Senegal. J Infect Dis 1990;161:1088-94.
3. Whittle HC, Aaby P, Samb B, Jensen H, Bennett J, Simondon F. Effect of subclinical infection on maintaining immunity against measles in vaccinated children in West Africa. Lancet 1999;353:98-102.
4. Edmonson MB, Addiss DG, McPherson JT, Berg JL, Circo SR, Davis JP. Mild measles and secondary vaccine failure during a sustained outbreak in a highly vaccinated population. JAMA 1990;263:2467-71.
5. Update: multistate outbreak of mumps — United States, January 1–May 2, 2006. MMWR Morb Mortal Wkly Rep 2006;55:559-63.

No Refuge for the Ailing

Ranjana Srivastava, F.R.A.C.P.

The still, oppressive heat of the afternoon seems to magnify the queue of waiting patients. A young woman separates herself from the crowd.

"Excuse me, Doctor, how long will you be?"

I answer with a flicker of annoyance, "I am not sure, but I *will* see you."

An hour later, it is her turn. She looks far too well, I silently judge. The well worried. She springs from her seat at the sound of her name but moves away from me toward the stairs. There, she utters a rapid command in a foreign tongue before turning apologetically toward me. Before I can greet her, a scarf-clad head comes into view. It belongs to an elderly woman physically supported by aides on each side. The aides stop on the landing, then wordlessly and cautiously lift her up to carry her into the only chair in my office. Her features are wizened, her frame more shrunken than the six decades indicated on her chart would predict. Her eyes are dull, opaque, her face a repository of apprehension, anxiety, perhaps worse. She periodically glances at her daughter, but mostly she keeps her face averted as we settle into the consultation. The daughter speaks for her.

"I am sorry if I was rude, Doctor. My mother has breast cancer, and she was waiting downstairs for a long time. We can't afford to see anyone. We need your help."

I am caught unaware.

This is a refugee clinic, run out of a makeshift health care facility as bare as any in the Third World. Volunteer physicians bring their own equipment and, often, spare drug samples. Limited numbers of doctors and meager donations mean that we can barely treat hypertension, eczema, and headache; we are rarely able to provide refugees with anything remotely resembling the standard of care.

"We don't do cancer," I want to say, keen to end the conversation right there.

"Doctor, my mother has no one. We can't pay the specialists. The emergency room bills us if it doesn't turn us away. They said you would help." Her tone combines pleading with frustration and accusation. The mother winces with pain. The daughter solicitously measures out some morphine. As the patient swallows it with a wry face, the daughter murmurs, "This is the last morphine. We have to wait now until . . ."

"Until . . . ?"

"Until my husband's disability pension arrives."

She brusquely runs her hand across the involuntary tears that have started. Her mother's hand surreptitiously reaches out to comfort her. In that moment, the enormity and heartache of the situation descend on me, and Mrs. Habib becomes my patient.

Having lost all the male members of her family through war, Mrs. Habib arrived from Afghanistan to live with her only daughter, an Australian resident. Here, her application for refugee status was denied on grounds of insufficient evidence, thus denying her access to any form of government support, including food, shelter, employment, and health care. While the decision is appealed on humanitarian grounds, a process that can take years, the restrictions continue. Reliance on the family's small earnings worked until she developed cancer. A public hospital provided her with a free mastectomy but no follow-up. Now she is riddled with painful bony metastases. I read letters

from physicians noting her inability to pay and theirs to continue her care. The documents mark a trail of disappointment.

I feel burdened by the realization of what I am undertaking. How will I adequately stage or treat Mrs. Habib's cancer? Where will her drugs come from? What will happen when she becomes terminally ill? The near-empty drug cupboard stares at me insolently. Reminders of past battles to achieve a modicum of care for less sick refugees fill me with a sense of foreboding. Distracting myself from the panic, I state aloud, "First, we need to control your pain. Then we can think about other things."

The clinic nurse locates an unused pack of donated morphine tablets and calls a local pharmacy to dispense morphine liquid at the clinic's expense. She also mentions a pharmacist who is willing to supply tamoxifen at cost. Mrs. Habib still carries the prescription that she could never afford to fill. The nurse kindly reassures the daughter that the clinic will do everything it can to ensure Mrs. Habib's comfort. I tell myself we will succeed.

"How long does she have, Doctor?"

"Without knowing the true extent of her disease, I can't really say."

Fresh tears arise from the daughter's eyes. "Can you see what it's like not knowing?"

I nod mutely, troubled by her grief and my growing concern.

A fortnight later, Mrs. Habib is back, this time with severe headaches and vomiting.

"It must be the morphine," I reassure her. "She needs a full workup," I chide myself.

The nurse sets about finding a laboratory that will run some basic tests free of cost — most claim that it is against their policy or simply refuse. Then, with patient and daughter watching, I receive a telephone call from the pharmacist who gave us the tamoxifen. He comes straight to the point.

"My colleagues warn that I could be de-registered for providing tamoxifen to an illegal. I have to get it back. And Doctor, perhaps you ought to consider how far you want to help these people — you are only starting out." Appalled and incredulous, I fling the tamoxifen I was about to dispense into its box along with the near-expired bunch of donated inhalers.

"Thank God my mother doesn't understand English," whispers the daughter, a mortified witness to the exchange. Anger, shame, and remorse collide within me.

An hour of phone calls later, I have located a radiologist who agrees to sign off on a free CT scan of the patient's brain. He tells me he was once an immigrant himself. When Mrs. Habib returns with a normal report, I am both relieved and disappointed. I have needlessly squandered a precious favor. The thought makes me feel petty.

Mrs. Habib's vomiting persists. In the succeeding weeks, the clinic pays for a panoply of antiemetics, nutritional supplements, and morphine, and her family resigns itself to her symptoms as a reality of cancer. But as the disease advances relentlessly in the absence of any treatment, another challenge arises, with an urgent need for palliative radiotherapy for her cancerous hip. The nurse worries that the clinic's money will run out if the heavy use of morphine continues. With a waiting list for radiotherapy at the best of times, I see little chance of convincing anyone to provide free service, but a few days later, we strike luck. As we bundle up a frail but grateful Mrs. Habib, it seems inappropriate to remark on how fortunate she is.

The months pass, as she holds on precariously to life in the devoted care of her daughter. The refugee clinic becomes the family's sanctuary, a source of practical assistance and simple goodwill. Our supplies — of kind service providers and of donated funds — dwindle. By day, I bolster the daughter's hope that her mother will not suffer; by night, I fret with the nurse about how much longer we can sustain the promise we only half-manage to honor at the best of times. I watch the holiest of my aspirations, to comfort the sick, turn sour in the face of a woman who is a refugee first and a patient second.

On other days, my job as an oncologist seems far easier. I involve my other patients with breast cancer in treatment decisions that take advantage of an ever-expanding set of tools, and I am filled with a sense of gratification for both them and myself. I readily abandon medications in favor of others that may or may not be marginally better. "It's worth a try" is the mantra of many desperate patients and their hopeful physicians. Multidisciplinary teams ponder their care, their suffering made all the more real by the noisy confluence of multiple opinions. To me, all the women look like Mrs. Habibs. But the difference between Mrs. Habib and other

women with breast cancer is patently obvious. Those women are legal residents, their disease legitimate, and their care our duty.

But where, really, does our duty as physicians lie? Is it contained within the limits of what is convenient, or is every physician also an advocate? Is it conscionable to treat one patient with hundreds of thousands of dollars worth of drugs while another dies an inhuman death for lack of palliation? As borders worldwide become porous and more ordinary physicians in developed countries are exposed to sick refugees with neglected rights, the medical profession will increasingly be faced with the moral dilemma of addressing their health. As I cared for Mrs. Habib, the vociferous political debate about refugees and their entitlements faded into the background, replaced only by the uncomfortable realization that I was prevented from doing for one sick patient what I routinely did for others. I kept thinking what a hollow victory it seemed to laud the dizzying advancements in the profession while we turned a blind eye to the basic medical care of the disenfranchised.

Consumed by rampant disease and defeated by uncontrolled symptoms, Mrs. Habib died one year after I met her. On the first anniversary of her death, I receive an unexpected call from her daughter, whose gratitude to the clinic remains undiluted. We speak fondly and emotionally of her mother, recollecting her brave fight. I wonder if the daughter has ever had the opportunity to discuss her mother's death. About to hang up, she says with utmost sincerity, "Doctor, no one told me, but I know that my mother cost the clinic a thousand dollars each month. It must be good to have that money for other refugees."

A stray reflex platitude freezes on my lips. The truth stings, but she is right.

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