Everest North Face — A Doctor's View

Richard Villar

The North Face of Everest towers over Base Camp in such a sombre and menacing way, I am astounded that anyone has dared climb it.

We left England in February 1984, a 14-man team led by two previous Everest summiteers. Our route was to be the N face, climbed for the first time in 1960 by the Chinese but as yet unclimbed by the British. Britain has not done well on the northern aspects of the mountain. Any expedition visits the area in the certain knowledge that it has a paltry 25% chance of success in putting a man on the top and a 5% likelihood that one of its members will die. Somehow, as climbers, such horrifying statistics are thrust to the back of one's mind and all teams, quite naturally, approach the mountain with a degree of guarded optimism.

To an expedition doctor, an attempt on a northern Everest route presents a number of problems that do not occur with the southerly approach through Nepal. The most significant worry is that of acclimatization, a subject surrounded by more myth and fiction than the mountain itself. The only certain fact is that rapidity of ascent is directly related to the frequency of altitude symptoms, that is, the slower one goes upwards the less one is likely to suffer. The advantage of a southerly approach is that the gradual walk-in required to reach Base Camp (5300m), allows all but the most unfortunate to acclimatize fully. This is not the case from the north. Climbing regulations ensure that all teams are deposited in Lhasa, the capital of Tibet, at 3600m within 24 hours of leaving sea level. I arrived feeling awful, staggering about for the first two days as if I had consumed an entire bottle of gin. The high cost of accommodation in the city does not permit 14 men to stay long without totally exhausting expedition funds and so, three days later, we were to be found jolting along the Friendship Highway towards Everest itself.

From a medical point of view, evacuation distances are enormous with no back-up helicopter support of any nature. Lhasa Hospital is adequate but lies 640km from the mountain with treatment facilities *en route* being limited, to say the least. One tends to rely on mountaineering accidents being either fatal or very minor, so that the problem of moving an unconscious and immobile casualty never arises.

We arrived at Base Camp, a three-day drive from Lhasa, late one evening in early March. From our vantage point at the now destroyed Rongbuk Monastery, the N face route was there for all to see and over the following weeks, even as a humble doctor, I became expert at the various terms with which I now hold cocktail parties spellbound for hours. Above, the Hornbein couloir, the yellow band, the diagonal line and the point at which Mallory's ice axe was found reminded us of the history that surrounds this mountain, Chomolungma, the Goddess Mother of the Earth.

The end of March came and went and the climbers were doing brilliantly. Now thoroughly acclimatised, there was no stopping them. The route was fully established on to the N face itself, fresh fixed line extending to almost 7000m with the men returning to Camp 2 at 6550m to sleep. Camp 3 was almost open with our expedition leader asserting his full authority to prevent the climbers from progressing too fast. I remember visiting Camp 1 on April Fool's Day expecting, at 5640m, to find individuals in some disrepair, as even at this altitude one can expect health to deteriorate slowly. I was astonished at how well they looked, became totally convinced that we were going to succeed, and strolled back to Base Camp feeling happy and confident.

Then the unspeakable happened.

At 5am the climbers were beginning to stir in their sleeping bags when a vast avalanche broke free from the North Col, sweeping over a mile downhill before picking up Camp 2 and throwing it 500m down the glacier. The scene was utter chaos. One man dead, one seriously injured, three more minor casualties and all our equipment, medicine and supplies buried under a vast weight of snow. Suddenly, our highly successful expedition had been transformed into a major mountain rescue operation. In the days that followed, despite a rigorous military training, I was to learn more about casualty management than I would ever have thought possible.

A death is a tragedy but, in terms of evacuation, poses no problems. My worry was what to do with a semi-conscious and immobile patient at over 6400m and 640km from the nearest hospital. All the emergency equipment had been destroyed and our stretcher damaged beyond repair. The three more minor casualties included a possible broken neck, frostbite of all fingers and toes and a somewhat shaken individual who was recovering rapidly. These three fellows, despite their injuries, were well able to walk and stumbled downhill from Camp 2 to Camp 1. A rescue party, including members of nearby Cumbrian and American teams, busied themselves with extracting our seriously injured man from the avalanche site. It took them the best part of a day to half push, half carry, half drag him to Camp 1 where he was handed over to my care. Then my problems began.

He should have been dead; his level of consciousness fluctuated wildly and he required artificial ventilation for a short period of time, his broken ribs and collar bone making unassisted breathing both painful and inefficient. In hospital he would have been placed in an intensive care unit; at this altitude we did not have that choice. Base Camp, and the road, were 10km from Camp 1 across heavily bouldered terrain. Sub-zero temperatures froze the intravenous drip and my one attempt to walk him downhill the following day ended in failure only 500m from Camp 1. We eventually delivered him to Base Camp, four days after injury, by manhandling him across country on an undamaged crevasse ladder — and never a more welcome sight did I see. As we descended, his level of consciousness improved steadily, though it took six days more (during which he survived a road accident *en route* to Lhasa) to reach Hong Kong.

I never want to have that experience again and so, if you are a doctor, read on. Do not think that the same will not happen to you for your quiet, pill-pushing existence can rapidly turn into major medical chaos.

In an attempt to avoid the back-breaking task of carrying a casualty 10km overland without the benefit of a stretcher, I chose to walk our man. Never again. In future, a casualty will be carried, by whatever means available, unless he can prove himself capable of walking. In future, when evacuation distances are so large, I shall insist on two doctors being present to avoid the utter fatigue of staying awake for days on end to listen for irregularities in breathing. In future, I shall ensure that there is sufficient emergency medical equipment in varying locations such that if one site is destroyed, enough will remain for treatment to continue. But finally, and most definitely, in future I will make certain that I climb with the same team again, as never have I seen such an assured chance of success until Nature, perhaps unfairly, intervened.