Witness To Disaster

The stories of those who offered medical care in the wake of Hurricanes Katrina and Rita bear witness to devastation and strength in American life.

PREFACE: The Gulf Coast hurricanes in fall 2005 stand as unprecedented disasters in American life. Not only were the storms a body blow to the health of millions living in the affected areas, they effectively tore the roof off the health care systems of southern Louisiana and Mississippi, providing frequently unflattering views of local medical care. Horrible as they were, the storms brought out the best in many people—generosity, stoicism, heroism. In the health sector, many were called on to respond as patients, as providers, and as public officials. From elsewhere in the country, many health professionals volunteered their assistance, coming to the area to help in the wake of the storms. Most of these experiences made no headlines, but we thought that Narrative Matters might offer an opportunity for some of these people to tell their stories. Patients, local clinicians, state officials, and volunteers from around the country responded to our call for submissions. The following commentaries in this special edition of Narrative Matters represent the most compelling of these writings. In an effort to include as many voices as possible, we are publishing some essays in full and excerpting others. Taken as a whole, these thoughtful, sometimes troubling, always stirring commentaries fulfill an important human function. They serve as witness to the Gulf events—as witness to the disaster.

Lydia’s Story

New Orleans, Louisiana: During Hurricane Katrina

by Jan Brideau

Jan Brideau (jbridgeau@partners.org) is a pediatric nurse practitioner at Massachusetts General Hospital in Boston. She was in Louisiana 19–30 September 2005, as part of Operation Helping Hand, a group from Mass General that was based in Baton Rouge. It came to provide care, assess medical needs in shelters, and recommend plans for future medical visits.

Just before leaving Louisiana I met a small, slender black woman. She was in her sixties, with her short gray hair neatly tucked up inside a kerchief. Let’s call her Lydia. An internist and I had traveled to a rural town’s shelter housed in the VFW hall, the temporary home of seventy-some people. Entering the large VFW hall, we were struck by the chemical odor of a cleaning solution so strong that it seemed toxic. The hall had no windows; only fluorescent lighting illuminated the large space. Coming from the hot, humid weather outdoors, we found the inside uncomfortably cold from air conditioning. The cackle of a television set was the only sound. There were several rows of cots and mattresses with a few people lying on them. Most of the shelter residents had left for the day, to work or do errands, but they were expected to return later. A local official told us that two adult residents needed medical care. One of these was Lydia, who had an abscessed tooth. Lydia was soft-spoken but eager to have her tooth examined. It turned out that she had been unable to chew on the affected side for several months. She hadn’t been able to afford $25 for an x-ray, and she didn’t have medical insurance; the pain, she told us, waxed and waned. Her cheek was quite ten-
der, and it appeared that the tooth should be extracted. To address her immediate need, we started her on a course of antibiotics and made a note that a dentist should see her soon. The internist asked where she lived and if she knew how her family was doing.

Lydia told us that she lived alone in her home, located in the Eighth Ward in New Orleans, adjacent to that city’s devastated Ninth Ward. As the first storm raged, she knew to avoid windows. (Interestingly, she never used the names “Katrina” or “Rita” when speaking about the hurricanes. She, like many people I met, referred to them as the “first storm” and the “second storm.”)

Lydia took a sleeping bag into her windowless hallway. She slept on the floor for two nights. Then, one morning, she woke to find that her feet and the sleeping bag were soaking wet, and there was standing water throughout her house.

When she opened the front door, the whole street looked like a river, and water poured in. She described it as “rushing like the Colorado River.” She knew that if she went outside, she would be swept up in the current and drown. There was no one in sight.

She was unable to shut the door against the brown rushing water. Horrified, she tried not to panic. Seeking higher ground, she climbed on top of her dining room table. It, like most of her furniture, had been handed down from her grandparents. The table was bulky and heavy; normally, it took three men to move it. But as the water continued to rise, the table started moving, then rocking—and Lydia knew she was in trouble. She managed to climb up on her kitchen counter, but that soon became precarious as well. The water continued to rise quickly, and the water pressure was so strong that water spurted out of the kitchen sink like a fountain. Terrified of drowning, she kept reminding herself to think clearly.

The thing to do, she decided, was to find the highest spot in her one-story house. Lydia climbed off the kitchen counter and waded through the deep water, dragging a small kitchen stool behind her. She positioned the stool in front of her linen closet, propping one foot on the stool and the other on the door-knob; then she climbed to the top shelf of her linen closet. She described the shelf area as about three feet wide and about a foot and a half tall. Crouched there, she watched the water continue to rise. Her ceilings, she knew, were twelve feet tall. The water rose to above her height, then to above six feet, finally to about seven feet. (She could estimate numbers, she said, because she had gone to nursing school long ago. Eventually, she had to leave nursing because she cried over her patients’ conditions too much, and they ended up consoling her.)

Lydia waited, cramped on the top shelf of the linen closet, until the water finally began to recede. When we asked if she got hungry or thirsty, she said that she didn’t remember feeling that way. Her tongue became dry and her lips were cracked, but she only was aware of being terrified of the water. When the water receded to about five feet, it was five days later. She was finally able to come down from her perch. The water was up to her chin.

She tried to open the back door near the linen closet. But the wood had swollen from the water, and it wouldn’t budge. She knew that the windows were probably swollen shut, too. Then she remembered that she’d never closed the front door because of the strong current. She moved through the water, out the front door, and onto her front porch. She couldn’t recall how long she waited alone in the water, holding onto a porch post and screaming for help. Eventually, a far neighbor with a boat rescued her and took her to a larger rescue boat. Then that boat dropped her off at an overpass where, in the sun and the heat, she and a large group of other people waited without food or water.

At some point, a small van drove up and stopped directly in front of her. A female
driver, dressed in scrubs, jumped out. The van was loaded with medical supplies, and there was room for only one person; she ordered Lydia to get in. The woman told Lydia that she worked in the emergency room of a local hospital and was soon to become a physician. She drove Lydia to a shelter.

As Lydia was telling us her story, I heard strength and resolve in her voice. She was proud that she had “kept her head,” which had saved her life. She knew that she didn’t have a home to return to, that everything in it was probably destroyed. There was, however, a reason for her to return home one last time. She needed to get back to that linen closet. There, on the top shelf, was her family photo album. It was the only thing Lydia thought might have survived the water. It would be the only thing from her past that she could take with her on her new journey.

For me, the enormity of the double hurricanes became clear only after witnessing so many people left without homes. Everywhere we traveled in Louisiana, there were countless people in shelters that had once been a hotel, convention center, sports arena, school, church, YMCA, and, yes, the VFW hall where I met Lydia. It was my privilege to meet and serve them. But it’s Lydia’s story that stays with me most, probably because it represents the essence of hope and determination in the face of terrible adversity.

**On The Dock Of The Dome**

*New Orleans: Wednesday, August 31*

By Frederick P. Cerise

Frederick Cerise is secretary of the Louisiana Department of Health and Hospitals.

Avoiding low-lying roads and dodging power lines, driving a circuitous twenty-five miles to make what should have been a five-mile trip, it took our group until Monday evening to reach the Superdome. As night fell, the water kept rising. Monday night and Tuesday were spent relocating the elderly and infirm from the dark and wet intestines of the Superdome to the dry, sunlit concourses of the adjacent basketball arena. The Dome had become an island, as had a number of the city’s hospitals.

Wednesday before dusk, I sat on an upturned bucket, alone, on the loading dock of the Dome studying the water line, in some irrational hope that the water was receding. It looked to have risen a bit more. Into that rare calm, a twentysomething man wandered by and asked to use my cell phone—which happened to be working at the time. I heard him tell his grandmother that he was OK.

Alone once again, I called Jimmy Guidry, our state health officer, who was directing emergency operations from Baton Rouge. Jimmy relayed that the Wildlife and Fisheries agents were concentrating on emptying hospitals. The interstate highway was packed with civilian cars towing boats, coming into the area to rescue stranded people from the water. The assistance would allow the state agents to concentrate on hospital evacuations.

Guidry’s words struck me. A flood of help by regular citizens during our flood of stormwaters had begun. I hung up and thought about the day of work ahead. Then, overwhelmed by the demonstration of human goodness and caring in the midst of tragedy, I sat still as tears rolled from my eyes. I was moved not out of despair but out of hope.

Since the storm, we have heard much about what was not done. The volunteer deluge is a remarkable example of what was done. It is testimony to the continued presence of the conscience in our world. From the phone calls from colleagues in other parts of the country with offers to help; to the volunteer physicians and nurses who quickly staffed local shelters; to the group of health information technology experts that developed an interactive Web site to make available evacuees’ prescription drug histories; to the health policy experts who regularly weigh in to help plan for the needs of the region, I continue to be overwhelmed by the great volume of assistance our state has received from regular citizens across the land.

Crisis provides opportunities for humans to exercise character. This tragic flood brought destruction to us but also hope. It has
given life to the words of poet John Donne that “no man is an island, entire of itself; every man is a piece of the continent, a part of the main.”

A Sense Of Duty
Raymond, Mississippi: Wednesday, August 31

by W. Richard Boyte

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A news report on my battery-operated television told of a group of elderly patients evacuated from their Louisiana nursing home to a rural church-owned camp near where I live in central Mississippi. The camp, like most of the surrounding area, had been without electric power since Katrina released her fury two days earlier. The patients were stranded there and suffering from the relentlessly brutal heat. The television announcer reported there had been a death at the camp, then pleaded for medical volunteers.

In my mind I developed a list of excuses against volunteering. As a pediatrician, I would be unhelpful to geriatric patients; the one-hour round trip would drain some of the suddenly hard-to-locate gasoline from my car; I was already sharing duty at our hospital’s pediatric intensive care unit that week; certainly there would already be enough help. But something inside—what I think of as duty—dictated that I go.

After arriving, I parked and quickly approached a large metal structure where I could see workers and police. Ambulances were lined up alongside. My medical scrubs seemed to be the only credential I needed to gain access to the building.

Indoors, the temperature was well over 100 degrees. As my eyes adjusted to the dim interior, lit only by sunlight spilling in through a few open doors and windows, I struggled to make sense of the scene. Loud fans, powered by generators, were useless against the oppressive heat. The air was thick, wet, and difficult to inhale. About half of the floor in the cavernous room was set up with metal folding chairs; the remaining floor space was covered by mattresses. And the mattresses were occupied by human misery. On nearly every one lay a gray-haired, panting person. Some were writhing, others moaning. A few wandered about aimlessly. Workers dressed in scrubs, uniforms, or street clothes scurried back and forth among the mattresses. I began to search for anyone remotely in charge.

I was directed to a man organizing ambulance transport. Each patient was to be taken to an evacuation facility with air conditioning or, if critically ill, to a nearby hospital emergency room. As a physician, I was asked to do triage, designating which option was appropriate for each patient. Among the busy volunteers, I found several off-duty paramedics, emergency medical technicians, and nurses. I did not find another physician.

During the next few hours, I moved from one elderly patient to another. Each, thank goodness, had a thick medical chart from the nursing home at the foot of his or her mattress. I would scan the lengthy list of health problems and search for diagnoses and medications. Then I would try to do a brief physical exam. All were obviously dehydrated. Confusion and disorientation were common. Several were significantly hypertensive. Some were vomiting. Others were unresponsive. One sweet-natured woman had a urinary catheter in place with dark blood clearly visible in the reservoir bag. Another woman’s pursed-lipped slow breathing and distant stare made me fear that she was slipping into coma.

I marveled at the ability of emergency personnel to place intravenous catheters in fragile and barely visible veins. I admired compassionate nurses as they fanned out to distribute...
aid and comfort. I was distressed by the decisions I had to make and the potential consequences of rendering wrong judgments. All along, I waited for additional help from another physician that would never come. I felt a mixture of emotions: satisfaction that I had answered an internal call to duty; anger that others had not; fear for the futures of these traumatized men and women.

I would later learn that after power was lost, a camp official had vainly sought help. His requests reportedly were rebuffed because the camp was not an officially designated evacuation shelter. When an eighty-year-old woman died, he turned to law enforcement and the media, which finally brought help.

Eventually, I felt I could leave. That night, I slept the deep slumber of the exhausted. I know little of the fate of the men and women whom I triaged. For their sake, wherever they are, I pray that they continue to find the generosity of volunteers.

**Day Five**

**New Orleans: Friday, September 2**

**by Benjamin Springgate**

Ben Springgate (bspringgate@mednet.ucla.edu), an internist and pediatrician, is a Robert Wood Johnson Clinical Scholar at the University of California, Los Angeles. A native of New Orleans who attended Tulane University School of Medicine, he returned to Louisiana three days after Hurricane Katrina hit; he is still there, working on health projects in New Orleans.

Thousands of evacuees—tired, hungry, dehydrated, and anxious—are crowded inside the New Orleans International Airport when I arrive by ambulance at Concourse D. This generator-cooled portion of the terminal, with roughly four hundred patients, is the medical area created by the disaster medical assistance teams (DMATs). It is divided into four color zones on the basis of the patients’ condition: Green for those whose needs aren’t urgent (mild dehydration, rashes); yellow for those who are more seriously ill (often recent arrivals from hospitals); red for those in critical condition who need intensive care; black for those who died en route to the airport.

The sick are being flown in by helicopter from the rooftops and parking lots of hospitals (Charity, University, Methodist, and others). Since Katrina slammed the city, these patients have received twenty-four-hour care from health professionals who stayed through the storm, watching with them, day after day, from the darkened upper floors of the hospital buildings as their homes and communities were ravaged by the hurricane and destroyed by rising waters. Now those patients are being flown here; other patients are arriving in ambulances from nursing homes or walking in on their own.

In these initial hours at the airport, I am assigned to the yellow zone. Our patients have undergone major operations, are recovering from heart attacks, or have tuberculosis or AIDS. Their soft-tissue infections are untreated, their mental health symptoms are escalating, and their dehydration and hyperglycemia are still unchecked. In recent days at the hospitals, food and water had begun to be rationed, and there had been limited access to medications and needed treatments.

Two nurses, another physician, and I attempt to triage and comfort the yellow zone’s two hundred patients; a few are on gurneys, but most lie directly on the dirty, hard terminal floor. Everywhere we turn, desperate voices and beckoning hands call for attention. I attend to a woman with rapid, shallow breathing and end-stage renal disease who complains of worsening “shortness”; a woman with postoperative uterine hemorrhage; a demented, combative elderly man with no ID.

The highly skilled DMAT units are outfitted to attend to mass casualty incidents, but not to address the needs of entire hospitals and communities isolated by a flood of epic proportions. There is only one blood pressure cuff available, and soon no functional glucometers, no diapers, no catheters, and no materials to clean patients who can’t get to a bathroom. We have no blood to transfuse and no access to lab tests. Even if we had supplies, few of our patients know their diagnoses and medications.
Fevers still have their charts; only some are accompanied by family members who can identify them and provide medical histories. Our patients need to be evacuated immediately and directly to receiving hospitals. But even now, on day five, they continue to wait on the floor.

The Nine O’Clock Meeting
New Orleans: Sunday, September 4
by Karen DeSalvo, James Moises, and Joseph Uddo

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Location: tarmac of the New Orleans International Airport.
Action: The U.S. secretary of health and human services and the chief executive officers of the three hospitals still open in the New Orleans area agree to create a forum to rebuild the city’s acute care sector.

The next morning, the U.S. Public Health Service (USPHS) Team, New Orleans, began to coordinate a daily meeting with the leadership of open hospitals, emergency medical services (EMS), military operating in the area, and physicians in the city that came to be known as the “nine o’clock meeting.” Soon other health-sector leaders from academic health centers, government, and other entities in the area joined in.

In the next few weeks, health-sector leaders came together—in person or by conference call—at 9 a.m. each day at the USPHS command center, Ochsner Hospital in New Orleans. They worked together and with plenty of straight talk to rebuild the city’s health care sector. The conference call made it possible to include state leadership in Baton Rouge and representatives of isolated hospitals.

The early focus of the nine o’clock meeting was on restoring acute care, including the transport of critically ill or injured patients. This resulted in the resumption of EMS one week after the storm and, shortly afterward, resumption of the 911 call center. The group then was able to move on to developing and coordinating a complex network of emergency transport and treatment that coordinated the complexities and technology of multiple branches of the armed forces and physicians working out of tents.

These morning meetings had the feel of the traditional medical morning report and provided a daily forum for health care leaders to identify a chief complaint, develop a differential diagnosis, and devise a treatment plan. The broad representation allows for quick action—in this case, about a health system rather than an individual patient.

One shared result so far, the Greater New Orleans EMS Web site, http://www.gnoems.com, provides unprecedented openness about hospital capacity in the area and a way to widely share system-level information that allows for real-time decision making. Now held weekly, the meetings have become the equivalent of a weekly hospital report for the city of New Orleans.

Parking Lot Triage
New Orleans: Monday, September 5
by Buck Taylor

Buck Taylor (BTaylor@chphealth.org) is director of the Gallatin Community Clinic in Bozeman, Montana, and is a volunteer fire captain/emergency medical technician. He was in Louisiana 5–10 September 2005.

Making use of my five-year-old’s frequent flyer miles, by September 5 I was part of a Seattle-based non-governmental organization medical team standing outside the New Orleans Convention Center. The scene was eerie. Debris and
refuse went on and on, as far as the eye could see, often in small hills. Guarding the grand building was a New Orleans police car sitting on rims, stripped of its contents and dignity. The heat was sweltering, and a thick, ghastly smell permeated everything. It was as if someone had taken garbage, put it in a sauna for a week, then added in raw sewage and other organic remains.

The Convention Center was a place where people without transportation to leave the city had spent five days without food, water, power, or medical care. Now, working in one of its outdoor parking lots, we had the task of medically stabilizing any evacuees who needed attention before they went by helicopter or bus to the New Orleans airport for care and shelter. We cleaned, we bandaged, and we hydrated. We lowered blood pressures, we raised blood sugars, but mainly we held hands and listened.

In the four days we spent there, our hodgepodge volunteer team, working alongside the wonder-working Army’s 82nd Airborne Division, met incredible people. One man had waded through the water again and again to rescue twenty-three strangers, carrying them to safety on his back. Now he said he had nothing left in the world and barely spoke. Miss Mildred, a slight, mischievous woman, cackled when I told her to drink plenty of water. “Not unless it’s mixed with bourbon,” she told me.

The fetid floodwaters created tremendous public health risks. Leg wounds were readily infected, and skin rashes were common. In desperation, a mother of two-month-old twins had finally mixed their formula with dirty water; one twin now had sepsis.

On September 9, a pair of crisply uniformed officers from the Centers for Disease Control (CDC) showed up to introduce the two-page form they wanted filled out on every patient seen at the triage site. Good idea. But, we delicately pointed out to the well-meaning officers, since it was now eleven days after the storm, a number of patients had already moved through triage.

But most startling to me was that the limited care we provided in the steamy parking lot was perhaps the best access to health care some of these folks had had in a long time—or ever. They were poor, and because they were poor they did not get medical care. High blood pressure and diabetes ran rampant, yet we saw hundreds of patients who told us—or sometimes we could tell—that their conditions had never been treated. The poor of New Orleans deserved more. As an American, I was aghast that it took a disaster of this magnitude to provide them with basic health care.

Clinic Shift
San Antonio, Texas: Monday, September 5, and Tuesday, September 6

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The Katrina evacuees begin arriving here in Texas on Friday, September 2. There are plenty of medical volunteers over the three-day Labor Day weekend, but by Monday night more physicians are needed. Responding to a call from our hospital’s emergency response team, I volunteer for the evening shift. I head out to Kelly USA, the former U.S. Air Force base, that is serving as the San Antonio center of evacuee operations. It’s about 7 p.m., and the nurses running the clinic are glad to see someone who can write prescriptions.

A woman in her fifties has high blood pressure, heart disease, high cholesterol—and needs her medicines refilled. I notice that her birthday is August 29, the day of the hurricane. A young woman is crying. She’s afraid she has an infection and, if she has to go to the hos-
hospital, she’ll be separated from her husband. I explain that I think her only problem is swelling in her legs; just keep taking the diuretic that is starting to work. Grateful and relieved, she smiles through her tears.

A pleasant middle-aged woman sits down next. I tell her that I like her pink Gucci purse. She smiles proudly and tells me she got it at Payless. She has sores on her feet from wearing wet shoes for days, and is thankful to be given a topical cream. The smile fades as she tells me that the Superdome was a hellhole, and she is glad to be out of there. She says if it weren’t for the sandals she got here in San Antonio, she wouldn’t have anything on her feet now. Her own shoes, she guesses, are floating around her closet right now.

The next patient is a young, obese woman with slight swelling in her legs. She is taking a diuretic and getting better. But, she says, the outside of her left thigh hurts, then goes numb, and she is afraid she has a blood clot just the way her mother did. When I examine her thigh, there is no redness or swelling, just a resolving bruise. Her strength is intact; there’s no pain anywhere. I tell her she has a bruise and offer some Tylenol. Not satisfied, she stumps away.

In the course of the evening, I see two teenagers with gunshot wounds received months before Hurricane Katrina. One has a chronic hip wound and uses a walker to get around; the other has nerve damage, and her arm is permanently disabled. Both come to see me to get their chronic pain medicines refilled.

Next is a woman with diabetes and arthritis, as well as chronic pain from a vertebral fracture received from a fall. She was evacuated with all her meds—except the Valium and Vicodin that had just arrived from the pharmacy. She left them on her sofa.

Two volunteers flank an anxious young man in a wheelchair; they ask if I can see him right away. He had surgery here in San Antonio for a gunshot wound received in the confused aftermath of the hurricane in New Orleans. He needs pain medicine and something to help him sleep. He talks about wanting to see his wife and children and begins crying.

A friendly man with bad teeth and lots of creases in his face tells me his neck is hurting. He comes from Kenner, Louisiana, just outside New Orleans. After the storm hit, he ended up sleeping on the floor of an abandoned school, and he thinks that is why his neck hurts more than usual. When I give him some ibuprofen and topical pain relief cream, he gives me a (mostly) toothless grin.

A disheveled young woman whose chart shows she is on three or four psychiatric meds comes because she wants a penicillin shot. I ask why. She gets one, she tells me, whenever she has an infection. She shows me a painful-looking red ulcer on her foot, likely related to wearing wet and ill-fitting shoes, like so many other patients we’ve seen. She’s relieved when I tell her it can be treated by oral antibiotics, and she won’t need a shot. She thanks me and says we are saving lives, so many lives.

A feeble man without a right hand comes in to have the dressing changed on a left-elbow wound. The elbow is deformed, only partially mobile, and has a chronic open wound draining pus. He has an intravenous catheter in his right arm, placed there several weeks ago to treat the infection in his left elbow. He tells us he has a left-elbow joint replacement that became infected. “They’ve been in there three times,” he says. He got an antibiotic infusion at the hospital yesterday, but doesn’t know what the plan is now. There are no culture swabs to find out what is causing his infection; I can only guess. My best guess is methicillin-resistant Staphylococcus aureus, a pathogen resistant to multiple antibiotics. I prescribe a new but relatively expensive antibiotic, but one he can take by mouth instead of intravenously. I don’t know whether he’ll be able to get it or not. On the other hand, I don’t know if he would be able to get the intravenous antibiotic
from local pharmacies providing evacuees with medicines, either. I come back the next day with culture swabs, but I can’t find him among the sea of evacuees.

Some patients tell me they made it out by car before the hurricane hit. They are staying with family or at a hotel—not at the shelter. One of them tells me, “I am so impressed with the people in this town. People are so kind everywhere. I’m thinking of staying here.”

“Elvis” must be in his seventies, and he can’t see me through his cataracts. His grandson (or maybe it’s his great-grandson) brought him in because he is “acting funny.” He is agitated and fights his family as they try to prevent him from getting out of his wheelchair. He is diabetic. I sit him on the floor so he can’t fall and hurt himself. His finger-stick glucose reading is 53, only half of what it should be. But Elvis is in no mood for treatment. He spits out the juice, the sugar pill, and the glucose gel. It takes several paramedics, his grandson, and two nurses to hold him down; then I hold his head still in my lap while they start a dextrose IV. After the IV is finished, his finger-stick glucose is 179, and he can think normally again. He is calm and quiet, and he apologizes to us.

After eight hours at the clinic, on the way home, I listen to the car radio. Everyone wants to blame “the administration.” But it seems to me that it is not just one administration, or even two or three. There are many larger issues, including that we continue to accept abject poverty—and poor health care for poor people—as a part of everyday life. On a typical workday, I see the results of lack of health insurance and adequate preventive care, but I diagnose and treat them one by one. Katrina brings them in one huge wave that can’t be ignored. It’s as if the floodwaters knock us down with the detritus that is the daily reality of these poverty-stricken people. I choke as I think about the contrast: We have the most advanced medical technology in the world, yet we are the only industrialized country with millions of uninsured people who go without basic needs. It takes a crisis to remind me of the appalling facts we have come to accept.

My son comes home from school, ravenous after football practice. “What’s for dinner?” he says. Although cans of food are stacked high on the shelves in the pantry and we can hardly close the refrigerator, I can’t think what to say.

Shouldering The Task
Southwestern Louisiana: Friday, September 9
by Jason P. Block

Jason Block (jblock1@partners.org) is a primary care internal medicine resident at Brigham and Women’s Hospital in Boston, Massachusetts. He grew up in Thibodaux, Louisiana, and went to Tulane University School of Medicine in New Orleans. He was involved in relief efforts in Louisiana 9–21 September 2005.

Taking the first chance to help, I enlisted with a joint American Red Cross–U.S. Public Health Service team going to Louisiana. Our task was to assess the critical threat of disease outbreaks, access to medical care, and sanitation conditions in the hundreds of shelters in southwestern Louisiana. Unlike what we had expected, we found that scores of Red Cross volunteers and local community members had adeptly met the basic acute needs of hurricane victims: food, shelter, safety, and first aid.

The surprise was that the hurricane hadn’t created new health problems—it had worsened old ones. Our interviews with volunteers and shelter residents unearthed a glaring, unaddressed need for primary care. Through resident surveys, the scope of chronic disease among the New Orleans evacuees living in shelters—a predominantly low-income population—became clear. The displacement that came with the storm and flood now compounded the challenges of delivering adequate and stable primary care.

Local communities and volunteer health professionals did their best. Take, for example, Joe Freeman, a primary care and emergency physician from Jennings, Louisiana, whom I met at Red Cross headquarters in Baton Rouge. With emergency rooms in that city overflowing with evacuees and their growing health care needs, Freeman established two
primary care evacuee clinics. Working initially out of a mobile home, he and volunteer physicians from around the country tended to a steady stream of patients with chronic and urgent needs. His efforts there continue in increasingly difficult circumstances. There is no end of the displaced population in sight, and the volunteer pool is quickly shrinking.

Freeman and physicians like him cannot (and should not be asked to) shoulder this task alone. They need systematic help from relief organizations, various levels of government, and other citizens. Now back in Boston to finish my residency, I’m continuing to work with colleagues in New Orleans to establish a primary care infrastructure there. It’s not going to be easy. What is needed are commitment, resources, and planning. It’s not too late to help remedy the situation on the Gulf Coast and to incorporate primary care planning for future disasters.

‘We Are Here To Help’
Berthed in Pascagoula, Mississippi: Saturday, September 10

Comfort Story No. 1
by Dana Braner

Dana Braner (branerd@ohsu.edu) is a professor of pediatrics and anesthesiology, medical informatics medical director, and pediatric intensive care unit chief in the Division of Critical Care at Doernbecher Children’s Hospital in Portland, Oregon. He was in Mississippi 2–28 September 2005. He served as the chief medical officer of Project HOPE’s effort to aid hurricane victims aboard the United States Navy hospital ship (USNS) Comfort, coordinating the Navy team and the Project HOPE team of volunteer nurses and physicians.

Tides, politics, and the random nature of damage to port facilities, caused the USNS Comfort to divert to Pascagoula, Mississippi, a port on the Gulf Coast we hadn’t intended to go to. On September 10, we ended up in a berth ten miles from the town center, making helicopter operations difficult, if not impossible.

It became apparent that the best way to help hurricane victims would be to go to them on shore instead of having them come to us on the ship. Suddenly, all of our special training and the ship’s unbelievable capacity couldn’t help; we had to rely on our own talents and fan out. So we did. Physicians used to practicing highly technological medicine were asked to see primary care patients in small clinics; operating room nurses practiced first aid, held hands, and just listened to people’s stories; physician department chairs spent many night shifts in far-flung emergency rooms giving local doctors some time off.

Perhaps the finest collaboration between the Navy and Project HOPE teams came in the reconstruction of a clinic that cared for the Vietnamese shrimpers in Biloxi, Mississippi. In two days the space was designed and built, with physicians and nurses working alongside seamen and corpsmen; performing carpentry, electrical, and structural work; then stocking and staffing the clinic.

We all lived by the same credo: “We are here to help. If that help is practicing medicine, great; if it’s lifting boxes, that’s fine, too.”

Comfort Story No. 2
by Julie Conlin

Julie Conlin (jconlin@partners.org) is an oncology nurse at Massachusetts General Hospital in Boston. She was a Project HOPE volunteer in Mississippi 9–18 September 2005.

At one point, the little clinic in Moss Point, Mississippi, where I worked was waiting for patients. Why wasn’t it bursting at the seams? Nearby, people were waiting in line overnight in the sweltering heat for a Red Cross check.

I started to make my way along the Red Cross line, making quick eye contact, looking for the elderly or the very young, watching for telltale signs of dehydration or exhaustion. “How’s everyone?” I’d ask. “We’re doing OK, ma’am, thank you,” was the constant reply.

Nonetheless, I found people without their blood pressure medications, without their insulin, unable to check their blood sugars because they lacked the necessary equipment.
Others didn’t have antibiotics, antidiarrheals, or psychiatric medications that they needed. When I offered them help at the clinic, I got the same kind of response over and over: “But we’ll lose our place in line if we go there, and we’ve been here hours already.”

Many of the people were accustomed to needing the next paycheck before they could get medications, groceries, or basics. Living in poverty, health care wasn’t their priority. After the hurricane, health care wasn’t their priority, either. Their priority was money. It had to be.

**Comfort Story No. 3**

**by Scott Leckman**

Scott Leckman (scott@dscottleckman.com) is a general surgeon in Salt Lake City, Utah. He was a Project HOPE volunteer in Mississippi 10–18 September 2005.

I worked in an emergency room in Gulfport, Mississippi, where one patient I saw was a thirteen-year-old girl with abdominal pain, vomiting, and diarrhea. It turned out that she had gastroenteritis, probably from drinking the still unsafe local water. While we were waiting for her lab tests to come back, her mother, weeping, told me their story.

They came from Pearlington, Mississippi, a small town in the swamps next to the Pearl River on the Mississippi/Louisiana border. When the storm hit, they evacuated to higher ground nearby and lived with family for two days. Returning home, they found that their trailer was ruined, with mud coating the walls to the ceiling inside. The only things salvageable were a doll, a box of old pictures, and a colorful beta fish still alive in its fishbowl. She speculated that the fishbowl must have floated in the rising water and, as the water receded, landed back on the table. We laughed about it.

Her husband worked as a diesel mechanic and still had a job in Gulfport. But she had just learned that the company that insured their trailer went bankrupt two weeks before Katrina. The day before, she had waited in line for Red Cross vouchers worth $380 for each family member. She had started out, she said, about “a mile back” in line, and eventually 2,000 people behind her were turned away. The first thing she was going to do with the money, she said, was buy towels for her family. Everyone, she said, should have his own towel.

Her family was staying with relatives who lived sixty miles from Gulfport; three families were living in a three-bedroom trailer.

**Houston, We’ve Got A Problem**

**Houston, Texas: Wednesday, September 21**

**by George T. Chuang**

George Chuang (George.T.Chuang@kp.org) is an internist at Kaiser Permanente in Martinez, California. He was in Houston 9–21 September 2005, as part of a Kaiser Permanente/HHS team providing primary care to Hurricane Katrina evacuees.

We’ve been here in Houston for thirteen days, providing services at a variety of clinics and screening posts, when suddenly Hurricane Rita is Topic Number 1. Last night the Galveston, Sugarland, and Clear Lake areas got mandatory evacuation orders. This morning it seems that Houston is in the direct path of Rita, and we, too, are ordered to evacuate. We’ve been told to pack and wait in the hotel for flight information. I watch on TV as Rita grows from category 3 to 4, then to 5. The voice of the anchorman goes from calm to pressured, adding a panic factor to the bad news. As a medical relief worker for Katrina, I’m already stressed from the events. How are the quarter-million Katrina evacuees going to handle running away from one deadly event after another? It’s beyond my comprehension.

Our team members finally get the word about our flights, and we head out to the airport. But there’s no getting anywhere quickly. All of the highways leading out of Houston are parking lots, jammed with cars full of belongings. Evacuees. The usual twenty-minute trip to the airport takes us two and a half hours. We all miss our flights, but we get rebooked on later ones. Once airborne, I look out the window at night falling on the city of Hous-

I'm on my way home to California, but I feel little sense of relief. My life has been changed by this mission and forever tied to the Katrina evacuees. Through their suffering, I see the world they live in. I see their pain and struggles. Their stories humble me. At the same time, I've been inspired and rejuvenated by the character and compassion that I've witnessed. It's given me a sense of how we humans have survived for thousands of years. Mankind has suffered continuous calamities—natural and manmade: Ritas after Katrinas, persecutions after wars. Poverty and intolerance clearly remain with us in twenty-first-century America.

Fortunately, there always have been angels among us, and many of them were at work in Houston and elsewhere after the storms. They serve as lights and consciences for the rest of us. I know that there is hope to sustain the human race for generations. I have seen it, felt it, and been touched by it in Houston, Texas.

The Continuing Anguish Of A Lucky Evacuee

Baton Rouge, Louisiana: Mid-October 2005

by Janis van Meerveld

Janis van Meerveld (Janis.vanmeerveld@arlaw.com) is a management lawyer in New Orleans.

Since Katrina destroyed my home city of New Orleans, I have sent upbeat e-mail messages to friends and family about what it is like to have evacuated to nearby Baton Rouge. Other things, I have joked of having to live under “blue laws”—those constitutionally dubious statutes that preclude the sale of alcohol on Sundays—that are an anathema to any self-respecting New Orleanian. I have wryly advised everyone ever unfortunate enough to be displaced by a natural disaster to go far away from home, where you'll be something special, where we don't outnumber them, where tuitions are waived, and where housing is available, maybe even free.

Despite the mostly humorous tone of the e-mail messages I have sent, one astute friend wrote back, “How are you really doing?” I tear up. I've been crying a lot, something I don't usually do. I have my life in a healthy perspective. My priorities are straight. Having been diagnosed with cancer twice, the second time just five months pre-Katrina, I've faced much greater adversity than this—and handled it much better. With a positive attitude, I've endured numerous surgeries, chemotherapies, and now radiation.

What is it, then, about this situation that has me, and so many of my strong, smart friends, so off kilter? So close to tears that we cry at every kind gesture, at every additional adversity, even for no reason at all? We didn't face the living hell of the Superdome or New Orleans Convention Center, wave at helicopters from rooftops praying for rescue, get left on I-10 at Causeway waiting for help that failed to come, lose relatives to drowning, or end up in Texas in the Astrodome. Heck, some of us didn't even lose our houses; we just can't live in them for months.

No, we're the ones who left early and enjoyed the first few days of evacuation as we always do. We cook with the relatives or friends to whose homes we evacuated with three days' worth of clothes and important photos. We watch storm coverage until the power goes out while the kids gleefully play with cousins for twelve hours a day. This is what we do in New Orleans when a storm is coming. Then the storm misses us, and we load up our cars and go home to find maybe some downed trees, temporary power failures, and debris in the yard. If you're really unlucky, you have some water in your house and have to pull out the carpeting immediately. Life is always back to normal within days.

Not this time. This time the adrenalin is long gone, and we are now adrift, worn out by the constantly changing information about the status of our homes, schools, and workplaces. Rumors fly over the Internet: Our neighborhood is being looted; squatters were seen in so-and-so's house; our school had no dam-
age—no, it flooded and now is full of mold. Our family relationships are tested as too many people with too-short fuses share a too-small apartment. Tempers flare. Character defects are magnified tenfold. We are exhausted by the demands of meeting housing, schooling, financial, employment, and medical needs all at once in an unfamiliar town that is straining with the burden of us.

In my case, I needed to maintain my chemo schedule, so I had to scramble to reach my oncologists, thankful that I was receiving my treatment from the only facility in New Orleans that also had a clinic in Baton Rouge. Getting New Orleans prescriptions refilled was not as easy, but I think that my bald head helped expedite things.

And I’m lonely. I cried when my sister returned early to her house in Jefferson Parish. I miss my good friends and neighbors now scattered throughout the country. Some of the people I love won’t be returning. All of my social plans and activities are gone. We can’t even spend Christmas at Grandma and Grandpa’s in Pass Christian, Mississippi, where my sons have spent every Christmas of their lives. Katrina’s storm surge crashed through my parents’ ground floor there, washing many of their belongings—and their way of life—out into the Gulf.

Then came the second storm; we prepared to take in evacuees from Houston and got to watch it all over again as Rita looked as if she would complete any destruction Katrina had overlooked.

Yet we are the lucky ones. I know that. So don’t say that I should count my blessings. I do every day, and I grieve for those who died, who lost loved ones, who are living in shelters, who have no jobs, no savings accounts, no friends and family to take them in. Knowing the desperate plight of so many, I feel guilty and confused about being affected so strongly by this, especially when—twice—I was so stoic about life-threatening illness. But before Katrina, even while battling cancer, I had the sense, however illusory, that my life was in most respects “normal.” I drove my sons to and from school, went to work, met my friends, walked my three miles on the lakefront, ate at my favorite restaurants, attended the ballet. When I came home from surgery or chemo, it was to the comforts of my familiar house and family. Now I’m bald and nauseated in a new town, a new school, a new office, with new doctors, few friends, sleeping four to a room, wearing hand-me-down pants, hoping against hope I’ll be home by Christmas.

Next time I see people standing and weeping over the slab of a house gutted by fire, wiped out by a tornado, or destroyed by a flood, I’ll understand. Whether they lived in a trailer or a mansion, they’re not crying for their possessions. They’re crying for the life that went with them. Because of the enormity of the damage done by Katrina, in this regard at least, we are all the same.

EDITOR’S NOTE: Since this was written, Janis van Meerveld has returned to New Orleans. She and her family celebrated Christmas 2005 in their own home.

Additional New Orleans updates and photographs are available on the Health Affairs Web site: http://content.healthaffairs.org/cgi/content/full/25/2/478/DC1.