HURRICANE KATRINA

Unexpected Necessities — Inside Charity Hospital

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The skyscraper housing the oldest continuously operating hospital in the country, New Orleans' Charity Hospital, was erected in 1936, to replace a centuries-old complex that had grown rapidly to keep pace with the health needs of impoverished southern Louisiana. In August 2005, shattered windows notwithstanding, this 20th-century Charity endured Hurricane Katrina's winds and survived. On Sunday, August 28, I was assigned as teaching physician for the infectious diseases unit on the ninth floor of the hospital. There were 18 patients in the unit, of whom 4 had active tuberculosis and 13 had opportunistic infections related to HIV infection and AIDS. We also had a boarder from surgery with a complicated gunshot wound and vascular access problems.

After the hurricane hit, I discovered that medical care in such situations becomes a matter of first aid and survival. We had no laboratory tests, no radiology services, no ability to confer with specialists, and poor communication. The medical decisions I faced were fairly simple: if possible, patients who had been receiving intravenous medication were switched to oral medication, and central venous catheters were removed to prevent bloodstream infections. We monitored vital signs and the blood glucose levels of patients with diabetes. We continued to dispense medications and used clinical diagnostic skills to make therapeutic decisions. I did perform a lumbar puncture Tuesday morning after the power went out to manage increased intracranial pressure in my patient with cryptococcal meningitis.

What became most important in this crisis, however, had little to do with medical management and much to do with personal preparedness, professionalism, and ethics. Survival, functioning, and sanity, for both patients and care providers, depended critically on a number of unexpected necessities, ranging from simple commodities to principles and codes of behavior. My list of 10 of these necessities begins with the seemingly trivial and progresses to those that became the most critical as the crisis deepened from Sunday through Friday.

Shoes. Sunday morning, I drove home to collect my husband and our 12-year-old son. As our son climbed into the car with pillows and a cartoon book, it never occurred to me to look at his feet. Days later, I learned that he and several other preadolescent children of physicians had left their homes with nothing but socks on their feet. Perhaps the child development experts could enlighten us about this phenomenon.

For me, running shoes were perfect for the countless trips up and down nine flights of stairs after the power went down. People with bad shoes have a much more difficult time climbing in and out of rescue boats after a flood.

NSAIDs. For lack of brewed coffee or cold Cokes after Monday, we all had severe caffeine-withdrawal headaches. The large bottle of generic nonsteroidal antiinflammatory pills that I had brought made me popular throughout the hospital and allowed me to take care of my coworkers.

Underwear and a fanny pack. As the days passed without running water, each of us wanted more clean underwear. The extreme heat didn't help, and it made it impossible to wear the traditional white coat with pockets. Wearing shorts and sleeveless shirts, we found that fanny packs were ideal for keeping track of messages, prescription pads, pens, and flashlights.

Flashlights and "D" batteries. The flashlight I had brought with me burned out after four days, and I had to beg, borrow, or steal illumination thereafter. I needed a flashlight even during daylight hours to navigate the dark halls and stairwells. The emergency lanterns distributed from the emergency department on Wednesday night could have lit an entire nursing station, but for one problem: each required eight size-D batteries, and there were none to be found.

Toilets. The toilets filled up by Tuesday morning, and the "portapotty" placed at the end of a long hallway became equally unpleasant several days later. There was no water to wash our hands, and we worried about the bacteria we were spreading. *Clostridium difficile* had been rampant on the

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ward before the storm; by Wednesday, everyone had diarrhea, and I put most patients on metronidazole, suspecting an outbreak.

A night nurse wearied of our complaints and stayed up during the day shift to create two restrooms. In the room where a nonambulatory patient had been evacuated, the toilet was still pristine; she scoured it with bleach and designated it for urine only. In the adjacent room, she set up a bed pan on a chair protected by an absorbent disposable pad. She placed a roll of large biohazard bags nearby and taught us to insert the bed pan into a biohazard bag when we needed to relieve ourselves, to invert the bag over the bedpan afterwards, and to knot it and drop it into a covered biohazard waste bin. Such innovations kept us human.

Shift work and adequate sleep. The nurses, experts at the concept of shift work, adhered to a disciplined schedule. They started at 7 a.m., ended at 7 p.m., gave report, and went to sleep. The night nurses did the same from 7 p.m. to 7 a.m. They maintained their ability to communicate coherently and to dispense kindness and caring to those who were suffering. In contrast, the doctors were terrible about sleep. Except in the emergency department, there was no clear delineation of shift work. After 48 hours, a dedicated and respected colleague was already displaying word-finding difficulty, and the problem continued to worsen. We are biologic creatures, and there is just one way for us to recharge our cognitive functions. If we don't discipline ourselves to do this, we compound the danger with our incoherence.

Morale-boosting activities. The hospital organized daily prayer services with a chaplain and several gospel singers. I attended one service with the mother of my patient who desperately needed evacuation for dialysis. I

saw blacks and whites, young and old, patients and providers, rich and poor holding hands and praying for deliverance. I will never be able to sing "We Shall Overcome" quite the same way again.

At the suggestion of our nursing codirector, we made a banner from sheets — "9 West has a big heart, Katrina can't tear us apart" — and hung it out the fire escape. In 24 hours, 15 more banners followed on other units. One night, we hosted a flashlight-illuminated talent show, to which we invited everyone — including the patients with tuberculosis, who donned N95 masks.

The strength of initiative to make your rescue needs known. It was painful to watch helicopters ceaselessly evacuating insured patients from the roof of nearby Tulane Hospital while our 250 patients were evacuated by twos or threes in boats said to lead to buses that sometimes did not appear. These halting efforts were interrupted for hours by gunfire. No National Guard was in evidence, other than as intermittent rescue personnel. Even colleagues at the neighboring Veterans Affairs hospital were unaware of the desperate conditions at Charity. Because our unit had a functioning telephone line and I had friends with media connections, I was able to communicate our situation to television and radio reporters. I received calls offering helicopters and one from CNN medical correspondent Sanjay Gupta. When I sought clearance for him from hospital officials, they gruffly asserted: "He can film whatever he wants; the media *is* our rescue plan now." When television cameras were pointed at us, the help came faster and more effectively.

Self-possession in the face of desperate, armed men. We had a patient from Orleans Parish Prison on our ward, with newly diagnosed HIV infection, pancolitis, and bloody diarrhea. He was initially shackled to the bed and had armed guards, but soon the two guards dwindled to one and the shackles were removed without explanation. When the remaining guard began to disappear for hours at a time, I objected — and had words with him, though he was sweaty, disgruntled, and armed. The chief of security had to come mediate.

I was never afraid of wind,

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water, fire, hunger, or disease. My moments of fear came when I was confronted by agitated, fearful human beings bearing firearms. My husband was exposed to sniper fire twice while helping to evacuate the emergency-room dock. People with guns shut down an entire hospital evacuation for many hours. The real Katrina disaster was not created by the elements but by a society whose fabric had been torn asunder by inequality, lack of education, and the inexplicable conviction that we should all have access to weapons that kill.

A team. The most critical necessity is a team of professionals who care about their patients and one another. All 18 members of our team (black, white, rich, poor, gay, or straight) had chosen to care for the disenfranchised, the tuberculous, and the HIV-infected. We might not have been able to control what was happening to us, but we could control how we treated one another. I repeatedly declined the option of fleeing to the Tulane helipad across the street, where my son waited with another family. Our group received an offer of special rescue, which we did not accept until each and every one of our patients had been evacuated.

In the end, we were kicked off the ward by armed men and shouted at by people herding us with bullhorns as they shoved bound, violent psychiatric patients past us on gurneys in the dark, fetid hallway, nearly knocking us to the ground. We were foisted onto boats by rough game wardens oblivious to our requests to travel together. After leaping into the swamp boats, we were rushed by armed guards to an empty helicopter pad, where we missed our would-be rescuers by minutes. We were then herded onto buses and repeatedly confronted by police, who insisted that we were not allowed at the airport. After several frantic cellphone calls, our mostly intact group was directed to an unsecured hangar on the airfield to wait. Through the night, lying on the tarmac by the airstrip, I reflected on the reasons for our survival.

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