Personal, Professional, and Community Re-creation After Hurricane Katrina

Geographic circumstances: I was on duty in the nursery during the hurricane and flooding of the hospital; the nursery did not reopen. I continue to work in 3 other local hospitals.

About the author: I am a neonatologist and have resided in New Orleans, a city that I love, for the past 32 years. After Hurricane Katrina, I am now very involved in the community, but my medical work is more administrative in nature.

A few weeks ago I was reflecting on the impact of the oil spill in the Gulf of Mexico when I received an e-mail asking me “to think and type some comments of my experiences post Katrina” as we were approaching the fifth anniversary of the worst natural or man-made disaster in the history of this country. It seems almost unreal to remember that event while evaluating another disaster, the worst oil spill in the Gulf of Mexico. Still, there is no comparison to the devastating human and economic effects of Katrina.

Five years have passed, and significant progress has been made. The educational system has been revamped, and steady increases in students’ academic scores are taking place. Community clinics established throughout the city are being praised as a national model for access to excellent primary health care. We have a new mayor and a new chief of police who are restoring the faith and hope of people in their government.

Emergency preparedness is also much better. We have substantially improved hurricane preparations with coordination and cooperation from the local, state, and federal governments. The state is now divided into 9 regions with a coordinator designated for each. A network has developed between the Louisiana Department of Health and the Louisiana Hospital Association. State plans of action are tailored to the characteristics of the disaster with a multitiered system that involves health care institutions in the region that could screen, triage, and manage patients as needed. Drills take place close to the start of a hurricane season to acquaint providers and facilities with electronically acquired data on the number of patients, acuity, equipment being used, and other information. Designated administrators at each health care facility are responsible for updating, communicating, and executing plans for emergency measures in the case of a potential or actual disaster.

In addition, upgrades to the hospitals have taken place to sustain the continuity of operations under severe conditions. Attention has been placed in locating generators, chiller, switchgear, satellite telephone rooms, and extra critical care beds for NICUs and PICUs on higher floors, so that flooding will not affect them as it did previously. Other precautions include increasing diesel fuel capacity, some with more than 3 weeks’ fuel reserve; improving hurricane...
window protection; building wells to provide water to serve the entire health care facility (with pumps capable of supporting the air conditioning system); taking care of sewage, flushing, and showers; and having purified water for laboratory work and drinking. Past experience proved the convenience of portable potties, additional food (MRE [meals ready to eat]), boats on site, gasoline supply, and chain saws. There are now better written shut-down operational procedures.

Communications systems have also been upgraded. Satellite phones and 800-MHz and ham radios were purchased.

The storm taught us the importance of security in the buildings. Emergency plans include having on-site local or state police, firefighters, and private security as needed. Special identification for patients and employees who remain in the hospital will be required. We learned that hospitals should hold as few people as possible and avoid sheltering too many family members and pets.

Health care institutions subscribed to Web-based emergency-preparedness programs that provide answers to many of the questions related to the crisis, keep up with information about patients, provide available resources, and track progress during and after the disaster. Some facilities have engaged in more sophisticated preparations including building a heliport, buying a helicopter, and providing for its operations and maintenance.

Louisiana and other states have enacted legislation to provide disaster liability protection to provide immunity to health professionals from civil liability unless gross negligence or willful misconduct is proven.

We now have a better understanding of the needs of the pediatric population, especially for the very young. Most evacuation plans consistently prioritize neonates and children with special health care needs. However, many of the financial aspects of health care access during a disaster, such as reimbursement, are still a work in progress as the state attempts to manage shortfalls in the Medicaid system.

Hurricane Katrina revealed the need to provide special help to people with limited English language proficiency. Lines of communication between authorities and representatives of such communities have developed. These representatives worked closely with city, state, and federal officials as well as law enforcement agencies to ensure the efficient evacuation and safe return of residents. Bilingual volunteers and staff may be assigned to command centers, bus terminals, and pick-up points. Easy access to Spanish-language radio stations helps communications to the Latino population, as demonstrated during Hurricane Gustav in 2008.

People’s recoveries from the multifaceted ill effects of disaster are complex and individual in nature, and practicing physicians are no exception. To mitigate the impact of such events, every practice should have a “disaster practice continuity plan,” a certain course of action that will help the practice survive and later to rebuild. Use of billing backup systems that could be accessed from different locations, practice-interruption insurance, and the formulation of options when revenue streams stop should be strongly considered. However, the ability of a private practitioner to respond to a disaster remains fragile. Hurricane Katrina revealed how significant the emotional toll could be; some colleagues committed suicide, and many others were emotionally scarred by the experience.

Because this is being written during hurricane season, I am working with my hospital team on the latest emergency preparations. I am being updated about building improvements, communication options, current contact information, our likely receiving NICU, and forms for recording information about patients and their extended families, including those who are out of state. This thinking ahead of a possible emergency relieves some of the pressure of collecting information when a crisis is imminent.

One important aspect we learned from Katrina is the ability to continue to practice if your patients have been evacuated. Having privileges in facilities that receive your patients will benefit your patients with continuity of care; the patient’s parents will appreciate the continuity as well. In addition, there should be financial and emotional benefits for the pediatrician and the practice.

Working opportunities for the neonatal multidisciplinary workforce (nurses, respiratory therapists, social workers, etc) are worth investigating. Extending working options to the evacuated NICU staff is important. More of the effects in the nursing and other ancillary personal during disasters need to be explored. Information from our experience at Memorial Medical Center showed that from 49 NICU nurses who were located 5 years after Katrina, 8 are no longer in practice, 3 graduated from the Master of Nursing, Nurse Anesthesia Program, 1 is a legal nurse consultant, 8 have primary employment other than in NICUs, and 1 is teaching in a nursing school. An interesting anecdotal statistic is that more than 40% of the nurses are no longer working in the NICU environment.

Finally, I was requested to speak about my personal situation.

I remain a neonatologist in private practice and continue to live in New Orleans. I am working in a community hospital as the medical director of a level III NICU and the vice chair of the...
department of pediatrics. Our neonatal medical group admits and treats patients in several neonatal units in the area. Since Katrina, our referral base changed substantially; there was a significant decrease in both the total number of patients and infants with private insurance. Medicaid constitutes more than 90% of our charges, which is quite a reversal from our pre-Katrina practice. Some of our referring obstetric colleagues left town, and others were hired by an institution with NICU-closed staff.

The financial impact of Katrina and the more recent economic downturn has been felt by many local medical practices. Ours was no exception, and on several occasions I had to provide personal loans to meet payroll obligations. However, lately, the situation is improving, although the Louisiana Medicaid program is projecting further cuts in reimbursement. Unfortunately, several of our patients are eligible for private insurance, but the parents choose to obtain Medicaid and use it exclusively.

With fewer patients, I have shifted my time and responsibilities toward administrative duties, but I still take clinical assignments as needed.

Regarding the emotional impact of Katrina, a question was posed to me on more than 1 occasion: “Are you staying in New Orleans?” Interestingly enough, leaving New Orleans was not an option that my family and I ever considered. Having lived in this town for more than 25 years when Katrina hit, our family never considered going anywhere. Furthermore, we have taken every occasion available to us to help the rebuilding of the city while admiring the incredible resilience of so many of our citizens. We are awed by the incomparable commitment of so many great people from around the country and overseas who so unselfishly came to the rescue of our beloved city. However, it is hard to explain to others the incredible pride of being called a “New Orleanian.” Of course, I cannot fail to mention the role that our Super Bowl champions, the New Orleans Saints, played in reinvigorating us.

As my professional duties have decreased, my community participation has grown significantly, and I am now involved with local and international community projects (some related to health issues). I co-host a program on one of the local Spanish-language radio stations about health issues, and I teach high school students at both public and private schools about drugs, alcohol, self-esteem, violence, and conflict resolution, among others issues.

Emotionally, a compliment by a teacher, a parent, or a staff member or especially a high-five or hug by a student, all expressing their feelings about my help, compares well with the thrill of an extremely low birth weight infant going home to be with his or her family. Recognition by the parent of one of your patients who runs across the room at a social function to show you the latest picture of his or her loved one whom you had the privilege of taking care of is an honor that we fail to recognize. Sometimes the NICU graduate is already married or a professional, maybe a nurse, a lawyer, or a doctor, or already a parent himself or herself, which provides a warm, rewarding feeling after practicing for over 30 years! Occasionally, the outcome was not optimal, such as the presence of blindness in a premature infant born at 24 weeks, but parents still smile broadly and talk about the positive aspects that the child has brought to their lives.

I have one final comment. We lost the follow-up of most of the infants (16) transferred during Katrina. However, I was fortunate that the infant (Christian S.) whom I transported by helicopter in my lap,1 ventilating him by hand using eyes as my only monitoring equipment, survived. I have kept in touch with him and his family, who relocated to Houston, Texas, but they come to New Orleans every year so that we can celebrate his birthday together. He grew from his birth weigh of 1 lb 6 oz (623 g) and height of 11 in (30 cm) to a healthy and handsome-looking boy at 33 lb and 3 ft in height. He is developing fairly well but is going to need some speech therapy as he enters kindergarten this year. He is surely a bundle of joy and healthy looking with good eyesight. Just as I continue to admire the resilience of my fellow New Orleanians, I celebrate the resilience of my dear tiny patient in his quest for quality survival. He truly represents the spirit of my beloved town.

“We are no longer rebuilding. We are now creating. Let’s stop thinking about rebuilding the city we were and start dreaming about the city we want to become. The world deserves a better New Orleans... today is a new day, today is a new time.” Mayor Mitch Landrieu, May 3, 2010

REFERENCE

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