The Art of the Possible: Looking Back and Ahead 5 Years After Landfall

Geographic circumstances: Hurricane Katrina destroyed my private practice on the Mississippi Gulf Coast. After strong attempts to reestablish practice, I moved to Florida.

About the author: In 2004 I opened a solo pediatric private practice in the town of Bay St Louis, Mississippi. In 2005 Hurricane Katrina produced a storm surge up to 30 ft that damaged or destroyed 90% of the buildings. I returned to practice 1 month after the storm and continued there until June 2007, when I relocated to Naples, Florida, to work for a community health center. My experiences, thoughts, and advice were incorporated into the American Academy of Pediatrics “Disaster Preparedness for Pediatric Practices: An Online Tool” (available at http://practice.aap.org/disasterpreptool.aspx). In July 2007 I was asked to testify before Congress regarding elevated formaldehyde levels in Federal Emergency Management Agency trailers. Since 2007, I have been a member of the academy’s Disaster Preparedness Advisory Council.

Hurricane Katrina was the costliest disaster in US history.¹ The storm mobilized an unprecedented relief effort, both official and organized (state and federal authorities including the Federal Emergency Management Agency [FEMA] and National Guard troops) and impromptu volunteer (countless churches, nonprofit organizations, and kind-hearted people). Local capacity to cope was overwhelmed even before the storm came through. However, all responses must start locally, because all disasters start locally, and to understand a disaster’s true impact, you must also start locally, hearing how individual communities and neighborhoods experienced it.

My family and I evacuated our home in coastal Waveland, Mississippi, ahead of the approaching storm. When I returned 10 days later, I saw a cross between a Third World country and the post–atomic bomb landscapes of Hiroshima and Nagasaki. Soldiers armed with M-16 rifles patrolled the streets and manned checkpoints. The community hospital was cordoned behind a military encampment. Dark helicopters skimmed the treetops throughout the day. The stench of mold permeated every dank and humid building. After sunset, nightfall was complete for miles around; the only light came from the stars above.

As I returned to practice, constantly adapting to changing conditions, I was encouraged by the “can-do” spirit of my community and the struggle to make things a little more normal each day. As I would learn later, this is the “honeymoon” phase of response to disaster, which is usually followed by “disillusionment.”² Nevertheless, there were limits to what we could accomplish on our own. Such an extraordinary calamity mandated an equally extraordinary rebuilding and the greatest minds and resources of the entire country mobilized to help the devastated region. President Bush promised as much when he spoke from New...
Orleans’ Washington Square 2 weeks after Katrina and declared “we will do what it takes. We will stay as long as it takes to help citizens rebuild their communities and their lives.”

Optimism faded as state and federal authorities squabbled over jurisdiction and blame, agencies trumpeted small successes rather than acknowledging the magnitude of problems, and bureaucrats found new and ever-inventive ways to say “that’s not my responsibility.” Housing stalled from a shortage of skilled labor but also uncertainty regarding flood maps, changes to building codes, and costs of new insurance. The FEMA trailers, which cost tens of thousands of dollars apiece, were contaminated by formaldehyde. The health care system relied on out-of-area volunteers staffing free clinics and crippled hospitals and federally qualified health centers; most preexisting medical homes, such as my private practice, were left to wither and sometimes die.

Nearly 2 years after the storm I added up the slow pace of recovery, the compromising living conditions, the relentless economic and psychological toll, and the financial asphyxiation of my practice. I could not sacrifice the childhood of my 3 young boys waiting for the return of what was and would someday again be a beautiful place. Unlike many of my neighbors, I had the opportunity and resources to move, so I started anew in southwest Florida.

Three years from that point, 5 years after Katrina’s landfall, much has changed, and many lessons have been heeded. New Orleans and the Mississippi coast slowly and steadily continue rebuilding; housing is going up and FEMA trailers are leaving, schools are open, utilities are restored, and roads are repaved. Communities, states, and federal authorities have rediscovered the importance of local organization, preparedness, and direction around disaster and recovery, and the idea of community resilience has emerged as a focal point of planning. Meanwhile, the FEMA has recognized the necessity for and initiated coordinated federal assistance in the recovery process.

The American Academy of Pediatrics (AAP) created its Disaster Preparedness Advisory Council to coordinate both internal and external, anticipatory and responsive efforts to address the needs of children and pediatricians in disaster preparedness and response. The academy’s “Vision of Pediatrics 2020” document identified continuing disasters as 1 of its 8 megatrends and emphasized the continued impact on children’s health globally. When pandemic H1N1 influenza arrived in 2009, the AAP cooperated extensively with the Centers for Disease Control and Prevention (CDC) on recommendations and guidelines. In addition, the CDC created a special Children’s Health Desk for the pandemic and displayed a new transparency, disseminating constant updates and even modifying recommendations based on feedback from practicing pediatricians.

Yet, problems persist, for both the Gulf Coast communities and the competency of our nation’s disaster response. Children on the Gulf Coast are not able to receive needed medical and psychological services and do not have access to a medical home. Meanwhile, Charity Hospital, a New Orleans cornerstone institution for health care for the underserved, continues to be shuttered. At a time when children and families need even more services and attention than usual, they have fewer resources than they did before the hurricane.

Adding insult to injury, in 2010 the Deepwater Horizon oil spill further set back the psychological, environmental, and economic recovery of families and communities along the Gulf Coast. Although the precise extent of the impact may not be known for years, experience from the Exxon Valdez disaster in Alaska indicates that the spill continued to affect communities at least 6 years later.

When an earthquake devastated Haiti at the start of 2010, international volunteers assisted that country in an unprecedented effort. Mistakes that should have been avoided after Katrina continued to be repeated. The overall relief effort was poorly coordinated; preestablished aid groups took the initiative and started helping as they were able, but some overeager volunteers predictably arrived without adequate purpose, planning, or supplies. The demographics of Haiti’s population created a unique pediatric surge that still caught many responders by surprise. Months later, long-term planning (particularly for health care) seems little more than an idea.

Haiti is not the United States, and the United States was not in charge of the disaster response. However, the extent of American involvement in the earthquake relief raises valid questions toward what will happen when (not if) another large-scale catastrophe affects the United States. Will efforts on our own soil be any more coordinated? Will donations and volunteers be matched to what is actually needed on the ground? When local concerns meet state and federal assistance, who will assume authority, and how will questions be answered? Who will address long-term planning, and when, and how? And, of particular concern to pediatricians, will the needs of children receive adequate attention throughout the response and recovery?

After the experiences of the past 5 years, why do doubts persist as to our ability to respond effectively and meet the needs of those affected by disaster? Studies have repeatedly shown
that individuals and families consistently avoid their own preparedness.13,14 Reasons vary but include lack of time, lack of financial resources, and a denial of the personal risk. Repeated media exposure to disasters in general and to each particular event can lead to numbing or avoidance (“disaster fatigue”), a fatalistic pessimism that a large-scale disaster will be too overwhelming for preparedness to matter or even a blame-the-victim mentality (eg, “New Orleans residents were too stupid to build above sea level and too lazy to move out of free government trailers”).

In turn, authorities retreat into their own silos, constraining their activities to what has been strictly proscribed by precedent, jurisdictional disputes, or fear of litigation. The silo mentality also hampers communication and cooperation and limits each agency’s ability to see the big picture. Turf wars and self-preservation often take precedence over serving the public. The normal political process of officials awaiting approach by interested constituents prevents more active solicitation of the full range of stakeholder input and appropriate expert guidance.

Most of these limitations are self-imposed and perceptual. In the words of Otto von Bismarck more than 140 years ago, “politics is the art of the possible.” We must move away from the cynical interpretation of the “possible” as the limiting constraints on our efforts and look to the optimistic meaning of “possible”—the new frontiers and untapped possibilities. The failures in governmental response in the days and months after Katrina opened a new focus on personal preparedness and community resiliency, which can yield everyday benefits, not just in catastrophic situations. Community efforts, in turn, relieve some of the pressure on state and federal authorities and allow them to properly focus on guidance, coordination, and preparing for the larger-scale events when local capacities are overwhelmed. The distribution of pandemic H1N1 vaccine, although hampered by delays and initial shortages, nevertheless proved the effectiveness of such a coordination of responsibility: the Department of Health and Human Services and the Centers for Disease Control and Prevention developed guidelines and procured vaccine that was sent to the states for distribution, which in turn usually relied on local health departments for final allocation.

Success in H1N1 vaccine distribution came in large part from all parties having a common goal of getting vaccine to the most people in the highest-risk populations as quickly as possible. We need to continue this approach with disaster preparedness, response, and recovery by shifting the focus from what we accept as possible to what we wish to be possible: what will be our goals? What will a successful recovery look like?

Many of these issues are already known and evident and need to be better incorporated into anticipatory planning. For instance, the unique physical, nutritional, mental, and safety needs of children need to be given higher priority in formalized standards for temporary shelters. Similarly, tracking and reunification systems should ensure that no children are separated from their caregivers for long. Reconstruction of schools, child care centers, and safe playgrounds should be a topmost priority of disaster recovery to establish normalcy and healing for children while enabling parents to better attend to their own needs.

Other larger, more overreaching problems will require an honest and complete assessment of the postdisaster environment. Housing and health care are 2 of the most complicated yet important concerns of recovery after large-scale disaster and were 2 of the greatest failures after Katrina. The goals should be apparent and common: safe, functional housing that allows effective transition to a permanent, robust, and resilient community; and accessible, continuous, patient-centered health care (ie, a medical home) that provides quality acute and chronic, sick and well, physical and mental care. The solutions to these problems will be complicated and challenging, but they are not out of reach; they are possible. They do, however, require a break from business as usual and from politics as usual. Instead, when the opportunity arises, we must be prepared to engage long-term planning from the start, as soon as possible, and actively solicit the input of all relevant stakeholders as well as national and international experts and innovators. Federal authorities should be prepared to offer guidance and facilitation as well as resources and funding (because they will be involved only when local and state capacities are already overwhelmed).

Despite our best efforts from here on out, many of the children affected by Hurricane Katrina will likely now face permanent hardship as mediated by epigenetic rewriting of their fundamental physiology; lifelong challenges and risks to health; and decreased long-term productivity as contributing members of society. This is not a value judgment or a gut feeling but, rather, a factual assessment from the research literature.15,16 We have the responsibility and the ability to avoid repeating these serious, tragic mistakes when the next large-scale disaster strikes. When the moment arrives, let us use the art of the possible to create a better tomorrow and do right by our children and our communities.
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