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Serving in Haiti: Perspective of a Physician

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ABSTRACT

In the wake of the 2010 earthquake in Haiti, medical relief organizations and individual practitioners mobilized to provide assistance. Here, an emergency medicine physician who worked with a Louisiana-based team in the mountains in one of the hardest hit areas relates his experiences.

On January 12, 2010, an enormous earthquake struck the impoverished Caribbean republic of Haiti. The magnitude of the earthquake would have been disastrous for any country, but for Haiti this geologic phenomenon compounded the chronic problems the country has suffered for generations. Haiti has relied on foreign aid for its sustenance for years, and after several devastating hurricanes over the past years, its reliance on foreign aid and diaspora remittances has increased. The country had to cope with this newest tragedy with very little political, economic, or educational reserve.

After the earthquake, Haiti became a target for humanitarian and medical aid relief from around the globe. Money, supplies, and manpower were mobilized within hours of the event to assist the country in the Western Hemisphere that is the most poorly positioned and the least prepared to respond to such a catastrophe.

I am an emergency medicine physician with Ochsner Clinic Foundation and work at 6 of our partner facilities. I am fortunate to have trained at Louisiana State University (LSU)/Charity Hospital before, during, and after Hurricane Katrina and have a Master of Public Health degree in global health. Because of these qualifications, along with an extensive history of working and traveling in Africa, Central America, South America, the West Indies, and Asia, I received inquiries about my availability to serve in some capacity within the massive relief operation being mobilized to assist the Haitian people. The combination of my having worked in Haiti several years ago, my desire to help the less fortunate, and an interest in the politics and motivation of aid/relief made me very receptive to the requests of many groups for my services. I wanted to serve in Haiti.

A few hours after the news of the earthquake, the association Doctors Without Borders/Médecins Sans Frontières in New York contacted me to assess my availability. The organization was putting together a pool of doctors willing to go to Haiti once needs were assessed. As a member of Doctors Without Borders, I served with the organization as a tuberculosis/human immunodeficiency virus (TB/HIV) field physician in the Mathare slum of Nairobi, Kenya, East Africa. I served for a year after completing my residency at LSU and before my start as a physician with the Ochsner Clinic Foundation. It was a monumental year that hugely impacted the doctor I am today. It also made me more qualified to work in the postearthquake disaster zone in Haiti.

I discussed the request from Doctors Without Borders with the leadership in my department. Joe Guarisco, MD, and Erik Sundell, MD, could not have been more supportive and agreed that it was important for one of our group of emergency medicine physicians to be involved in the massive response being pieced together. Although I had plans to travel in the coming weeks to Colombia, South America, I canceled that trip, and within hours of the email requesting assistance, several of my emergency medicine colleagues volunteered to fill my work shifts, allowing me to commit 3 weeks of volunteer time to Doctors Without Borders.

Unfortunately, in the days following the earthquake, it was difficult to accurately assess the needs, coordinate the facilities, and mobilize transport for individuals who were willing to assist in Haiti. I voiced my concerns regarding these issues to Doctors Without Borders, an organization that I believe is the best at mobilization, and to which I am committed.

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Administrators at Doctors Without Borders were understandably unable to produce a timeline for my service or guarantee a position during the emergent phase of the disaster. They encouraged me to volunteer with another nongovernmental organization if given the opportunity. I recognized that the response had been massive, as many humanitarian and medical aid organizations had already ceased accepting volunteers, and I therefore decided to find another organization with which to serve.

Four days after the quake, I received an email from my mentor at LSU, Peter DeBlieux, MD, in which he mentioned a Haitian-American physician named Charles Rene, MD. Dr Rene is an obstetrician/gynecologist (OB/GYN) at LSU and Tulane and is the director of AHDH (an organization headquartered in Louisiana whose French acronym is Association Haïtienne de Développement Humain). AHDH serves residents in La Vallée de Jacmel, a town in the mountains between Port-au-Prince and Jacmel, two of the cities most affected by the earthquake. After I told Dr Rene about my background, training, language skills, and international experience, he was receptive to my joining his team that would be leaving in the coming days for Haiti. I reconfirmed my shift coverage and received permission from the administration of the Ochsner Clinic to travel to Haiti with Dr Rene's team to assist with medical needs of those affected by recent events.

After 2 days of false starts owing to logistics, early on Saturday, January 23, 2010, several nurses, physicians, and I flew through Miami to Santo Domingo, Dominican Republic, to attempt to enter Haiti. After a couple of uneventful flights, we found ourselves in a small interisland airport that was alive with disaster response activity. Several groups of people with obvious humanitarian backgrounds were milling about with duffel bags and containers loaded with supplies destined for Haiti. Some were speaking on cell phones and satellite phones, loudly discussing plans for their organizations. The media were there in several smaller groups, with cameramen and equipment in tow and also a considerable United Nations (UN) entourage, which is always present during a disaster response. The mood was one of urgency amid an air of chaos. Several sunburned physicians and clergy passing through on the way back to the United States or Canada shared a look of exhaustion and of having seen something that had obviously affected them.

We eventually found a plane that could take our team of 6 doctors, 3 nurses, and an engineer, as well as thousands of pounds of medical supplies and drugs, on to Port-au-Prince. We boarded an aged dual-prop plane just as a group of Israeli medical workers, all in matching orange shirts, boarded another. I imagine that this small airfield had never seen so much activity, as Santo Domingo became the primary jumping-off point for entering Haiti. The short 1-hour flight to Port-au-Prince is notable for the obvious change in foliage as you cross the border from the Dominican Republic to Haiti. This blatant difference in color and terrain owing to severe deforestation on the Haitian side of the border is very visible from the air.

We landed at Toussaint L'Ouverture airport in Port-au-Prince and parked our plane in a field because huge C-140 airplanes were using the regular gates for unloading. The airport had changed very little since I had last been in Haiti a few years earlier. Like airports in other developing countries, this airport was poorly updated and maintained. The old control tower was empty, and the glass was no longer intact. It looked as if a hand grenade had been lobbed inside. The controls were actually being manned from a card table on the ground, not far from where we parked, by a group of American military personnel. Yet the system appeared to function just fine, as multiple huge Apache and Chinook helicopters, C-140s, and aged Boeings all continued to arrive and depart smoothly while we parked. It reminded me of the Louis Armstrong airport in New Orleans a week after Hurricane Katrina, where I had spent a day after my evacuation from the city. It appeared organized, but also apocalyptic. Here, though, there were French flags, Union Jacks, Turkish flags, and UN banners. The fields were full of makeshift warehouses for supplies and tents, extending almost to the tarmac. Many aid workers and military groups had made the airport their base camp. Members of the Haitian fire brigade sat around in chairs, cooking over a small grill. I imagine that they had been relieved of many of their regular duties by the influx of so many workers.

As I waited for a second plane to arrive that would take us to southern Haiti and into the Canadian-occupied town of Jacmel, I noted the Haitian flag at half-mast, which I imagine was a symbol of mourning for the population as a whole rather than a single individual. Among the chaos, however, commerce was still alive. Two Haitians extracted my backpack from the rest of our cargo and asked for a small *cadeau* (gift/tip). They were smiling and joking as if no disaster had occurred. It was as if they had lost no friends or family and were simply thrilled to have the work. From the looks on their faces after they received my tip, I imagine many of the diplomats and other Western aid workers had been more generous than I. Later, a pilot approached me for a donation of a water filtration system for her clients, whom she was transporting to some desolate part of Haiti. I was

unable to help and soon realized that much of the manpower coming to Haiti's aid was disorganized and was potentially compounding the problems in this desperate country.

We finally boarded a plane for the short flight to Jacmel, 30 miles from the capital. A plane was necessary because the road between the 2 towns had been in disrepair for years and had worsened with the earthquake. We landed in Jacmel to a hive of activity. At the shell of an airport, 3 Canadian soldiers were sitting at a card table, which, as with the air coordination in the capital, was acting as the control tower. To the left of the runway was a small wrecked plane, ominously sitting in the field beside the runway. It had suffered a landing gear malfunction a few hours before our arrival. With thousands of flights coming into the country each day and a wide range of pilot skill levels, many more of these accidents would likely occur. At the airport, Canadian soldiers were everywhere, as they had assumed control of the city of Jacmel the day before, leaving Port-au-Prince to the US military. We unloaded our gear and medicines and waited for transport. Several doctors who had taken over the coordination for medical activities within the city and region approached us. We also met an orthopedic surgeon and his physician assistant who had been in the country for a few days. He shared grim stories of multiple amputations and the difficulties his team had encountered. After our brief meeting, the tiny airfield exploded with activity and noise as a huge C-140 landed on the field, bringing loads of necessities from Canada.

Our vehicles arrived with 2 men from La Vallée, who would become invaluable as translators for me while I was in Jacmel. As we drove through the city, which was full of vehicles branded by every aid organization imaginable, most of the residents looked weary and stared without emotion as we passed. Certain areas had been affected more than others, and obviously, the building standards occasionally applied to some buildings had spared them from the damage sustained by neighboring structures. The most remarkable damage I noticed was a gas station awning that had been twisted into an impossible shape. The chaos and dysfunction of the developing world, coupled with its sounds, sights, and smells, assaulted my senses, as it always does when I first arrive from home. This time, however, there was also a feeling of desperation and unpredictability that was both apparent and disturbing.

The drive up the mountain to La Vallée was probably no further than 15 miles, but because of the mountainous terrain and poorly maintained switchbacks, the trip took a couple of hours. The rural areas appeared to be largely intact, and the agricultural inhabitants of this area seemed to be going about their business very differently from the people in Jacmel. The structures in the rural areas were much more resilient during the earthquake because of single stories, wooden frames, and time-tested rural architecture. Conversely, structures built with bricks and blocks after the recent hurricanes were most affected because such wind-resistant buildings crumbled with the force of such a massive earthquake. As we climbed into the hills, the air became cooler and the roads became worse. Eventually we arrived at La Vallée de Jacmel.

La Vallée de Jacmel is an old parish seat that at one time had been a center of cacao and coffee cultivation. After years of mismanagement, the population now relies on subsistence farming and remittances from individuals making up the Haitian diaspora. The people are generous and extremely kind. Although the town has several schools, the place still exudes an air of extreme poverty and desperation. In the region, 4,500 families had lost their homes. The death toll, injuries, and missing persons had not yet been reliably assessed when we arrived and would not be known for months because much of the population had left the region to go to the capital for work or school. This factor of the unknown added to the distressed feel of the area and its people. Before the earthquake, the town had a few nursing assistants and a Cuban-trained physician who worked at the small hospital from time to time. Local resources were scarce. The large region relied mainly on the American medical missions that traveled to the town on a regular basis, as well as on traditional medicine, an ingrained and important form of medical care on this impoverished island.

The St Joseph's Dispensary, built by the community in the 1970s, was the pride of La Vallée de Jacmel. For a long time, many had hoped that the town would be able to support the clinic and fund the caregivers. However, the economics of Haiti and years of political chaos had negatively impacted the facility; over time, much of the support, upkeep, and expansion of the small facility was transferred to AHDH and others with ties to the organization. For years, individuals came from the United States to provide quality medical care and methodically build up the medical stores of the small 10-bed hospital. The yellow building also contained a pharmacy and laboratory, a surgical suite, a couple of wards, and a clinic and wing devoted to maternal and OB/GYN care primarily provided by midwives. The facility is located under a jacaranda tree overlooking a valley in southern Haiti. In the yard was an old, nonfunctioning ambulance donated from New Orleans. It added to the surreal scene during my first day in the clinic.

To me, a physician who had spent the previous year in a slum in East Africa, the supplies and physical plant were impressive. The facility appeared to have strong potential, and the staff who began to show up that first day to help seemed to truly care about the facility and the population it served. We spent the last part of that first afternoon assessing supplies and clearing space for the clinical day that we would begin the following morning. I sensed relief from many around the facility as they anticipated the next day's work, helping those who had received no medical care for several days after the earthquake. I, too, began to get excited about the prospects of making a difference in this struggling country where I had served almost 10 years earlier.

That afternoon and throughout the night, we experienced several aftershocks that were unsettling to the naïve doctors and nurses who had just arrived. These convulsions also brought about an uneasy panic in those who had experienced the massive disaster in prior days. Watching their faces, tears, and quick exits from any structure they were under gave me insight into how terrifying the earthquake itself must have been. I witnessed the faces of a people who had experienced something that I hope I will never experience myself. The daily aftershocks continued into February and caused reactions that recurrence never blunted.

My first patient, a 6-year-old boy, had a tropical foot ulcer that had developed during the first few days after the earthquake. His family's roof had caved in, and he had been trapped under the rubble. The ulcer was eating deeper into his lower leg and ankle, and without adequate care, he would eventually lose his limb. Aggressively, I debrided the infected tissue and scrubbed the wound, followed by irrigation. The boy stared at me stoically as the painful procedure continued. A male family member had carried him in because he was unable to walk because of the pain. He did not cry. He did not squirm. Instead, he sat there with tears welling in his eyes as he tried to focus on something else. A 30-year-old man in my New Orleans emergency room could not have displayed more endurance. It was impressive, and this stoicism would continue to define the patients I cared for in this rural part of Haiti. We gave the young boy antibiotics and instructions for further care and follow-up. He was going to do well, as he took it upon himself to come every day for wound care, a much more frequent schedule than what I had even instructed. I imagine he came because he had nothing else to do. It was an event. And he knew if he could endure the discomfort, he would improve.

The first day progressed smoothly until the first aftershock of the day hit. All patients and staff within the building exited hurriedly. It was eerie to observe the faces of the Haitians. Some laughed uncomfortably while tears quickly welled in their eyes. As clinic resumed, more and more folks lined up and braved the heat so they could be seen by our team. One young girl arrived who was unable to move her leg. She had been pinned under rubble for several days, and her femur had fractured. I believe her femoral nerve was damaged by the fracture and the length of time her leg had been in a hyperextended position. If this injury had been caused by a common mechanism and the patient had been cared for and positioned properly, this loss of function would never have occurred. Instead, this young girl had to be carried into the hospital and would most likely never walk again. She was 13 years old. She laughed uncomfortably as I explained to her brothers in French that there was little we could do. In the end, we applied a splint and sent her to an orthopedic field hospital in Jacmel, 2 hours away. There she would have a better chance for intervention that might improve her outcome. I hurt for her.

Figure 1. Morning rounds in a tent which housed admitted patients.

As my patient load began to increase that first day, I began admitting patients to the hospital if they required more advanced care. I could tell that the patients had some resistance to this idea, not because of their fear of being away from home or of costs incurred, but because of the building's potential to collapse and maim if another quake occurred. On the first day of clinic, the facility emptied within 30 seconds of the first early-morning aftershock. Immediately after we witnessed this response, we set up tarps and several small tents to shelter the infirm patients and the slowly growing population of admitted patients who were too ill and weak to quickly remove from the concrete structure (Figure 1). The

Figure 2. Setting up an intravenous line in the courtyard.

patients and their families decided that nobody would be allowed to sleep under the hospital roof. All would sleep and receive therapy outside, inside one of our many donated tents. Some were willing to forgo therapy, which at times might have been lifesaving, if we encouraged them to receive care that would keep them in the building for too long. Their fear haunted me.

Over the next few weeks, I treated many of my chronic patients in the tents and large tarps in the courtyard (Figure 2). Daily, I entered the small, hot, festering tents that smelled of medicine, sickness, sweat, mildew, and bodies. Sometimes the smell nauseated me. But the patients appreciated my efforts. I was entering their home. I was sitting on their bedding, touching them, being with and among them, helping them heal under the only roof they had in the world at this time. A donated tent was their house. This humbles you and reminds you how lucky you are—so lucky.

During the next few days, some patients needed serious care. A cab driver returning with a body from Port-au-Prince was shot in the neck and the decedent was pulled from the vehicle and burned in the streets to ensure a less-than-respectful transition into the afterworld. Another patient fell from a tree while collecting mangoes to feed his children. I had never seen a human being with such a complex facial laceration to survive such trauma. Also, I delivered several babies the first night and continued to do so throughout my stay in Haiti (Figure 3).

I treated a young girl with malaria for several days. She looked skeletal on our arrival and could barely lift her head off the pillow. With supportive care and medication that was fortunately available on the island, she did well and was able to go home per her request a week into my stay. She thanked me

Figure 3. A baby delivered on Dr Vinroot's second day in Haiti.

shyly. Her mother cried when she thanked my staff and me. After losing so much, she still had her daughter.

Typhoid was rampant, and the emaciated bodies of those stricken with the disease trickled into the hospital every day (Figure 4). Some did well. Some had no reserve and therefore had poor outcomes. We had limited resources and limited manpower. Those who did poorly had come to us too late. This situation distressed me and the others, but it is a common occurrence in the developing world and after a disaster hits. I had often seen this outcome during my prior year working in a Nairobi slum, but you never get used to it.

One patient, a young boy who came with his mother and several family members in tow, had a dazed and distant look. The mother looked distressed. The boy was confused and complained of a headache. He was talking to people who were not present in nonsensical ramblings. He had a fever and no focal neurologic findings. His headache was concerning. In the United States, I would have immediately given him antibiotics and performed a lumbar puncture, but this procedure was not possible in Haiti. I decided to begin treatment with as broad a

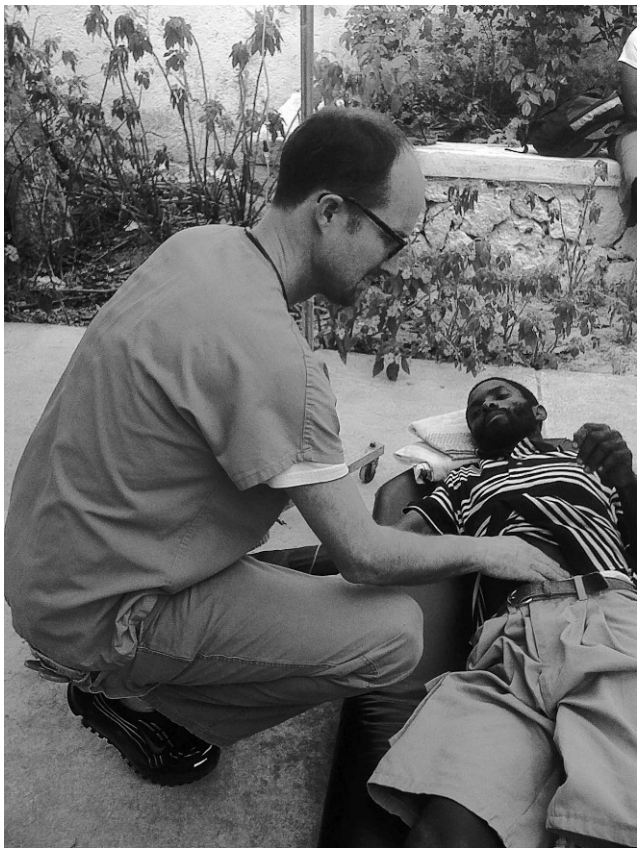

Figure 4. Assessing a patient with typhus in the courtyard.

spectrum of antibiotics as was available, watch him, and provide supportive care. The family refused to stay within the confines of the hospital for fear that it would cave in. I relocated the boy to a tent in the courtyard, and it became his home for the next few days. I cared for him to the best of my ability, and he improved physically. His confusion and affect did not improve, however. As I learned more about him, I discovered that he had been in Port-au-Prince with his sister in a house that had collapsed. She died instantly, and he remained trapped under the rubble for several days. He would intermittently hold his sister's hand when he became lonely. He was eventually found and rescued from the building. His immediate issues were no more than a few scratches; he was left to wander around the capital and then walked home, with the recent haunting events obviously filling his thoughts. This experience was most likely the reason for his random thoughts and confusion, not meningitis. When I awoke one morning to do rounds, he and his family were gone. A nurse felt that the family was concerned about others seeing the boy in this state. Another felt that the family would seek assistance from a traditional healer. Regardless, I believe the boy will have a long and difficult course ahead. I think about him often.

Figure 5. Dr Vinroot and fellow Ochsner physician Fred Wilson, MD, Orthopedics.

After several weeks in Haiti, I left in a truck late one afternoon for the long drive down the mountain from La Vallée to Jacmel for the long and disjointed trip back to New Orleans. When I arrived at the shell of an airport, the coordinators found a volunteer plane that could transport me to Santiago, Dominican Republic, late that night. There I found a hotel and secured a flight the next morning to Miami and eventually a flight to New Orleans. All along the way, I encountered doctors, priests, relief workers, refugees, and young people, all traveling as a result of the earthquake. Most had a haunted look in their eyes, one I hoped I had not developed.

My skills as an emergency physician were greatly needed in the postearthquake environment of Haiti. I initially learned these skills during my residency training that largely took place at LSU and Ochsner Clinic. The added experiences after Hurricane Katrina and the long recovery were also invaluable. Finally, my recent year as a TB/HIV physician in an East African slum, which the leadership at Ochsner Clinic endorsed, made me an invaluable physician in this, at times, apocalyptic environment. I was a surgeon, obstetrician, pediatrician, psychiatrist, and cardiologist and was confronted with many other responsibilities as well. I assure you that I am an even better doctor and person today after my experience in Haiti and will be more valuable to other individuals and communities who may require emergency relief aid in the future. This was part of my goal in life.

Ochsner doctors made a difference in Haiti (Figure 5). There are many similarities between my experiences during and after Hurricane Katrina and after the earthquake in Haiti. An aspect of shared disaster, coupled with a historic and cultural relationship that goes back more than 200 years, makes a New Orleans physician or nurse the natural medical

humanitarian in Haiti. We must continue to support and encourage our colleagues to assist in Haiti. It will be invaluable, not only to Haiti, but also to all of us as individuals. It will make us better caregivers, parents, friends, and global citizens.

Thanks are due to the Ochsner leadership and to my emergency medicine colleagues who made it possible for me to assist the Haitian people in this time of need. I will always be grateful for your selflessness and encouragement.

This article meets the Accreditation Council for Graduate Medical Education competencies for Professionalism and Systems-Based Practice.