ANNALS OF FAMILY MEDICINE

## Online Supplementary Material

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## Supplemental Appendix. Haiti Journal

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**2/28/2010**

I leave Boston's Logan Airport today after a night on call at Lawrence General Hospital. I fly to Miami, via Chicago, and arrive just after midnight. The airport is deserted except for a few international travelers who are trying to find a comfortable position on the odd-shaped couches and benches scattered throughout the airport. I am lucky—I get the last room at the airport hotel and turn in quickly.

**3/1/2010**

My flight from Miami to Port-au-Prince is scheduled to take off at 1:15 PM, but does not leave until 7:15 PM; this 6-hour delay is not surprising since the airport in Haiti has only one working runway.

There is a diverse group from all over the United States here: a medical doctor from India who had recently been on a cruise ship using her medical skills injecting Botox into the eyebrows and facial wrinkles of the well-to-do; a podiatrist from Florida whose surgical debridement skills and ability to perform below-the-knee amputations will be needed; a pharmacist from Philadelphia; a Nigerian anesthesiologist from Houston who works half a year and then volunteers for medical missions the other half; a group of students from the University of Tennessee, playing an impromptu game of hackie-sack for a good part of the 6-hour wait and who will be volunteering in an orphanage; a group of retired men from a Baptist church in Tennessee traveling to Haiti to initiate a 3-year building project; and a diesel fuel delivery man from the Midwest who said, "I'm venturing down to Haiti to help in any way I can." All told, more than 100 caring individuals will be chartered down to Haiti along with several tons of IV fluids and medical supplies. Everyone has a great spirit and a sense of adventure, but there is also a palpable sense of nervousness. We will get a better sense of what we are up against when we arrive at the Port-au-Prince airport and meet last week's volunteers who will be waiting to board our plane for their return trip home.

We arrive at the Port-au-Prince airport. It is past 9 PM, and the city from the air, which normally would be ablaze with light, is dim. We exit the plane into a hot and muggy night. The volunteers waiting to return to Miami are on the tarmac and give us a hearty cheer and round of applause, the first of many goodwill gestures we will see and need this coming week.

We exit the building and board a line of SUV's and are whisked off to Medishare's medical camp situated just inside the southern barrier of the airport grounds. The sleeping quarters are in a large wedding-size tent housing 140 fold-up cots placed side-by-side and head-to-head. There is a buzz, both with people's energy and audible noise in the tent. Our planeload, with approximately 100 people, represents half the number of personnel in camp. The overlap of clinicians is reassuring, allowing us to gain important advice from these veterans. The least important issue is which cot to choose—one that will not have a river running under it

when it rains. The tent is air conditioned to the extent that it is necessary to wear a sweater for comfort and also for our health—mosquitoes with malaria carrying parasites are less active in cool air. The generators needed to cool such a large area, as well as our location only 100 meters from the runway, make for constant white noise. I surmise that I will be unable to hear the gentleman next to me even if he does snore.

After claiming our bunks, we head back outside and split up into our specialties. There are doctors, nurses, and physician assistants of almost every specialty here. However, there is now an emphasis on primary care doctors, physical therapists, and social workers; this has been a natural transition over the last 6 weeks with the patients' medical needs shifting from acute trauma care to long-term primary and mental health care. There are only 2 other family medicine doctors, both of whom will work in the outpatient setting and are assigned to the triage area from 7 AM to 3 PM each day. Because of my more recent experience with inpatient hospital work, I am assigned to work with the internal medicine doctors. We are split into teams that will cover the emergency room, ICU, triage, adult medical ward, wound care, and ICU at Haiti's earthquake-damaged General Hospital. The day shifts last from 7 AM to 7 AM; the night shifts are split from 7 PM to 1 AM and 1 AM to 7 AM. We will be on rotating shifts and will catch sleep when we can.

The thought of an exhausting week gives me a charge of energy in a bizarre way, taking me back to my grueling resident training days. I am eager to see if I am still up for this challenge, much like an old runner who still wonders if he can handle a marathon.

**3/2/2010**

I awake at 6 AM; the day is bright and already warm. Not far from our tent is a small table that a good number of people are crowded around. Taped to the tent's awning is a handwritten sign, Starbucks Coffee. The coffee is institutional, sent down from Miami, but the humor is appreciated.

Within the compound are 3 additional tents similar in size to our sleeping tent. Two house the patients and one is a supply tent. On the grounds around these massive tents, whose tent poles stretch 3 stories into the sky, are dozens of 4-man tents used for housing everything from the administrators' offices to isolation tents for patients with active TB, to the morgue.

There are 4 showers, each a small cubicle made of plywood sides and a wood packing crate to stand on. Showers are of short duration; suggested time is less than 5 minutes, which is easy to abide by since the water is cold. Written in an indelible black marker on the side of each shower is, "Do not piss in the shower." After visiting 1 of the 20 overused and odoriferous Port-O-Lets, I can understand why there is need for such a reminder.

Overall, there are more than 200 clinicians and dozens of support personnel. As well, the US Army is stationed at the airport and is a constant presence here. There is bottled water everywhere, and US Military MRE (Meals Ready to Eat) are in abundance, mostly because these meals are rather unappetizing. Twice a day a small delivery truck from the Dominican Republic—the border is just over the mountains from Port-au-Prince—delivers warm meals (mostly rice and beans with a piece of pork or chicken). This food is very much appreciated by the staff and by the patients and their families. At present, food is not abundant in Haiti, and the government has started to scale back its food handouts—making a tough living situation even harder.

Like me, most of the incoming clinicians pause and have a nervous laugh or comment when they see where and how we will be living for the next 7 days. All of us will be tested in many ways this coming week: physically, intellectually, and emotionally. We will all live close to or beyond our "envelope of comfort." I hope we all do it with grace, for the bigger picture, the life and conditions that the Haitians are living under, pales in comparison to what we have in this medical camp.

My shift today will be from 7 PM to 1 AM in the medicine ward. Along with a resident from the University of Miami, I will care for these 100-plus patients. I use the morning to look around the medical camp and

then rest up for my night shift, but not surprisingly, I am asked to see a patient who has come to the hospital in labor.

She is 21 years old, pregnant for the first time, and has been at the hospital since yesterday. When she was admitted, she was not in labor but stayed for pain management. When I see her this morning, she indeed is in labor. A labor nurse from Miami and I attend to her the rest of the day. We do not have the luxury of modern obstetric monitoring devices, and to monitor the fetus' heartbeat we borrow the handheld Doppler from the ER. Every 15 minutes during the next several hours the nurse records the rate. At around 1 PM her labor appeared to have stalled out, her cervix having dilated to only 6 cm. At this point, if I were back in the States, I would have started her on oxytocin and would have closely monitored her fetus' heart rate. Without a way to continuously monitor this patient's fetus' well-being, however, starting oxytocin is not a prudent choice. We can perform a cesarean section if we have to, but it is still too early to subject her to this major abdominal surgery. Furthermore, the administration is giving mixed signals whether patients should be delivered at this hospital. In fact, at one point it is suggested that we transfer the patient to Hospital Chancerelles, which is able to monitor a laboring patient to a higher degree than we are. Admittedly, there is a bit of my ego involved here as well. I feel that "our" hospital, one that is this well equipped, should be able to deliver any and all patients who come here. The idea of sending her across town to Hospital Chancerelles, with the possibility of getting stuck in traffic, does not seem like a prudent option. Upon determining a reassuring fetal heart rate, we decide to allow the patient to continue to labor, and to help manage her pain, we give her an epidural.

At this time, a remarkably supportive and friendly obstetrician arrives at our medical facility. We consult her on our dilemma with our young patient, and it is reassuring to have her confirm that we are managing the patient correctly. This doctor also is very instrumental in efficiently arranging to have part of the pediatric ward cordoned off as a labor ward, draping a large plastic ground cloth around 2 beds in the corner of the building.

At around 9:00 PM this evening, after having pushed for 2 hours, our patient delivers a very pink and loud baby boy. There is happiness all around and great relief.

One thing that I am quickly learning about relief work is that everyone works together, and there are few egos involved. There is a softness and courteousness characterizing every clinician I have met working in Haiti. Many times this week I have been unable to determine the hierarchy within the medical teams, with attendings on occasion doing the tasks that normally are assigned to nurses, and medical residents acting as attendings. Everyone here works side-by-side, and there is a collective spirit of "we can do this together." This is far different from the hierarchal medical model that all of us were a part of just 2 days before back in the States. It is refreshing.

I arrive at my evening shift on the medicine ward 2 hours late, but given the presence of an extra clinician this evening, I am not immediately missed.

The medicine ward holds more than 100 patients, all lying side-by-side in rows of 20. The family members, many displaced from the quake, lie next to and under the patients' cots. The rule is that only 1 family member per patient can stay, but many patients have entire families huddled around their beds. I can only imagine what the dire living situation in Port-au-Prince must be to appreciate why family members would elect to stay here in a room full of very sick people rather than anywhere else.

The patients have varied levels of illness. There are innumerable amputees here for wound care. There are also many with crush injuries who now have external fixation devices—stainless steel hardware that resembles erector sets—placed on the outside of the appendage, holding the bones in place with screws. The orthopedic surgeons are opting for this less invasive fixation method because of the risk of an operative infection with surgery. The patients sit stoically, faces drawn.

Near the end of my shift, I head to the OR for a repeat cesarean section on the patient in labor who has been brought to us from a large tent city on the outskirts of Port-au-Prince. I head to bed around 3 AM, a 20-hour day.

**3/3/2010**

I awake at 6 AM. My head is groggy and my thinking slow. Experience has shown me that sometimes in a situation like this it is better not to have slept. Three hours of sleep when one is exhausted is a tease to the body, and it physically hurts to wake up; every part of my being aches for sleep. Being assigned to the medical ward for the 1 AM to 7 AM shift, I am supposed to have most of the day off, but a pregnant woman has shown up in labor.

She is pregnant for the first time. She speaks only Creole and I only English, and there are no translators available on this busy ward. For the next several hours we communicate through an evolving language of hand signals, head nods and shakes, facial expressions, and my pantomiming labor positions (some of which the patient agrees to and others that she rejects by pushing me away). She does not want me to check her progress or have me place my hands on her for support. For long periods I wait in silence as she, in the squatting position, rocks back and forth in isolation next to her cot. As her breathing deepens and her moans grow, she stands up, walks to her cot, lies down, and nods, signaling for me to help her. This is the first time she allows me to check the position of her fetus. She somehow knows that she is complete and ready to bring her child into the world. She is her own best doctor. She bears down over the next several waves of contractions and delivers into my hands a healthy baby boy. I imagine her knowledge of labor and the birthing process has been handed down from her mother, sisters, and neighbors, many of whom she may have helped during their labors.

It is a surreal experience here in many ways. Our labor beds, 2 in the corner, separated only by an opaque plastic sheet, offer only visual privacy. The screams of this patient's labor pains, culminating in a heartwarming newborn's cry, were punctuated with the moans of the pediatric patients having their wounds cleaned and dressed and the heart-wrenching wail of a mother who lost her teenage child to typhoid fever.

Lack of sleep can heighten one's emotions during these experiences, and it is then that one turns to colleagues for emotional support. The hugs, backslaps, high fives, and goodwill dolled out by all of the volunteers to each other, and especially to the patients, are truly needed.

By early afternoon I have a chance to lie down, but I cannot sleep. There are too many stimuli here. My mind is racing and my heart rate is up, most likely a result of my body's adrenaline that has been keeping me going over the last 2 days. The nonstop work, the constant hum of the generators, the regular roar of jets landing and taking off a few-hundred yards away, the bright sky and hot sun—all have put me into a restless state.

I venture out into the city with a photographer who has been hired by Medishare to document the volunteers' work. We hire a reliable driver who doubles as our guide and bodyguard; parts of Haiti were not safe before the quake and now are even more dangerous. We drive into the heart of the city, near the Presidential Palace and along Miracles Avenue. The irony of the avenue's name is apparent; the destruction to most buildings along and around this avenue is complete and sobering. Many structures are leaning askew and rubble is everywhere. Sewage is running in the streets, and the distinct and disturbing smell of putrefying bodies, unreachable under the rubble, is apparent. There are no earth-moving vehicles here, even 6 weeks after the quake. The Haitian government and the world have forgotten this place.

There are many blocks cordoned off by crushed cars and rubble piled high; behind these makeshift barriers are young men with rifles. The guide tells me that they are hired by owners of homes and businesses to keep the looters away. Even though some of these buildings are completely flattened—four floors pancake on top of each other with no visible way to extract any items—these guards are vigilant, and wait for the time that the owners can dig out their possessions or even loved ones.

We finished our tour by visiting the famous Notre Dame Cathedral of Port-au-Prince. The church, once an iconic and beautiful building, now lies in ruin with the roof caved in and the walls crumbling. The country's highest Catholic priest, Monsignor Miot, and 100 of his fellow priests died in this earthquake. For a country whose population is predominantly Catholic, one begins to understand the blow that these people have taken. Not only did they lose family and friends, but also institutions that give them solace and shelter.

As we drive back to our medical compound we are quiet. The photographer, who has traveled the world and recorded numerous other geological and societal traumas, appears to be moved. I am numb. But in some small way, I am thankful for this opportunity to have traveled outside of our protected medical compound to see the gravity of the situation, and I now have a deeper understanding of just what each and every patient is up against.

**3/4/2010**

Today I am scheduled to work on the general medicine ward during the graveyard shift starting at 1 AM. I am too restless to sit around camp, so I join a colleague at an elementary school in Les Bours, on the outside of Port-au-Prince. The school, a series of 1-story, tin-roofed, wood buildings surrounding a dirt courtyard, has withstood the quake well; there is no visible damage to the walls. In the courtyard are approximately 40 elementary school children aged 4 to 6 years dressed neatly in their school uniforms. They are being displaced for a couple of hours as we use their classrooms for examining rooms. The teachers keep them content and under control by dolling out lollypops from an enormous bag of candy that one of the doctors has brought. Sadly, some of these children are in need of sponsors, and some are in need of parents.

In the span of 2 hours I see 35 women and children. It becomes clear after seeing the first half-dozen patients that many have the similar complaint of headache and stomachache. When I inquired as to when these symptoms commenced, they tell me they noticed them after the quake. It does not take an epidemiologist to realize that these are psychosomatic complaints from the stress of the earthquake. These patients are suffering from emotional and mental anguish whose outlet is these physical complaints. Reassurance is one of the medicines that we give out in abundance today.

**3/5/2010**

The fatigue on the clinicians is becoming noticeable—its outlet being an increasing number of complaints from the volunteers about aspects of the hospital that could be better planned and run. These comments are understandable; many of them are from nurses who have worked 6 nights without a day off. The fatigue factor, physical and emotional, is why most relief aid organizations do not schedule volunteers for more than 1 to 2 weeks before they urge them to take a break.

All in all, I would say that this hospital is remarkably well run. The devastation in Haiti is beyond words, and the hospital, one of many that has sprung up, is doing an admirable job. It is efficiently handling the difficult logistical tasks of providing health care in a destroyed country. Everyone is working to exhaustion, especially our 2 neonatologists who alternate 12-hour shifts. With a NICU and PICU that has more infants admitted each day, these 2 doctors do not get much time to rest, tending for hours on end to infants not much larger than their outstretched hands.

The hospital's wards are overflowing, especially the pediatric ward, NICU, and PICU—so the hospital is closed to new admissions today because of overcrowding. The chief medical officer said the closure is due to our resources' being stretched too thin and our having too many premature infants to care for. The decision raises the question, Where will any new premature infant go, or for that matter any other patient go?

Being on the nightshift, I take the cross-cover phone calls from other hospitals and clinics scattered throughout the city and country. The medical care and coordination among all of the aid groups,

numbering in the thousands now, is unorganized and disparate at best. At 4 AM we receive a call from Adventist Hospital outside of Port-au-Prince requesting that we accept in our NICU a 27-week premature infant who had just been delivered and was in need of ventilator support. I wake up our medical director with the hope that, regardless of the fact that we were not accepting new patients, he might acquiesce on this admission, but he refuses. We do offer Adventist one of our respirators and then do our best to find a phone number of another hospital that might take this neonate. The decisions not to accept patients in critical need of medical care are tough to make, and very frustrating to experience.

One of the glaring challenges Haiti faces is the lack of any governmental body overseeing and coordinating medical aid groups. This situation is amply evidenced by the many calls we get at all hours of the day and night from other hospitals and clinics wanting to find beds and resources for their patients. Some doctors, like me, carry scraps of pieces of paper around with names and phone numbers of hospitals that we randomly call with the hope of finding one that can take our patients. In the spirit of working together and trying to even out the patient loads, early this morning we accepted a very ill premature infant from Partners in Health, and the Partners took 2 of our less sick infants. This type of creative problem solving is a necessity for all the aid organizations. What Haiti really needs, however, is for one organization to take on the role of central coordinator for all the aid groups and organizations. The amount of time, energy, and, unfortunately, lives that are lost due to lack of coordination of health care here is unnerving.

My shift ends at 7 AM and I take a nap for 2 hours. I will be working from 7 PM to 1 AM this evening.

I use a part of my morning to walk around the hospital wards and take photographs. One remarkable sight is a line of US Army soldiers who file into the pediatric ward to spend time with the kids. Two burly soldiers in battle fatigues lay down their M-16s, and each picks up a premature infant, holding and feeding it for hours. The image of a tiny infant being gently swaddled in the strong arms of a warrior is moving to everyone in the building.

I start my call again on the medicine ward at 7 PM, and I again take incoming calls on the consult phone. One call is from a clinic in the mountains 2 hours west of Port-au-Prince. The clinician is a French doctor, who speaks broken English, and despite the language barrier I can tell he is quite worried. He just delivered a healthy infant; however, the mom has had a postpartum hemorrhage and urgently needs a blood transfusion, which they cannot give. The doctor wants to know if we will accept the patient. Our lab has the ability to type and cross her blood, but our blood bank is very low, and we do not have any O-negative. During this discussion, I hear a voice behind me say, "I have O-negative blood!" I turn around and one of the nurses is standing there with a smile. With the confirmation of a blood donor, I give the French doctor the option of sending his patient here. I also give him the phone number of Hospital Chancerelles which has a greater surgical capability and most likely a larger blood bank than ours.

At the end of my shift, and with no obstetrical patients in our hospital, I am able to get to sleep around 2 AM.

**3/6/2010**

I awake at 6 AM, not feeling particularly rested, but also not as fatigued as I had been. Half of the volunteers will be leaving this morning.

There is a 9-year-old boy here who has become quite attached to a paramedic from New York City. This boy has been orphaned from the quake and has been looked after by volunteers. It is tough for him to see these caregivers leave at the end of their volunteer week. The paramedic and young boy embrace before the volunteer leaves for the airport, and he gives the boy his photo identification badge to remember him. This child's life of continual loss of parental figures is disquieting.

After the volunteers leave for the airport, the transport vehicles arrive back with 80 new volunteers, all looking fresh and eager, and as we did our first day, a bit nervous. An intern in internal medicine and I are

readying ourselves to go to the General Hospital in Port-au-Prince to round on the ICU patients when a pregnant patient with a previous cesarean section comes to the hospital. She is visibly uncomfortable with her contractions and in active labor. I check her quickly and determine she is dilated 5 cm. I start to prepare the OR for her cesarean; meanwhile, the chief medical officer is able to get Hospital Chancerelles to accept her, and we expeditiously put her in a transport vehicle and send her on her way. I have mixed feelings about sending a patient with a previous cesarean in active labor to another hospital, but this patient needs an OR that is fully equipped and has backup personnel available.

The intern and I jump into a car and ride across town to the General Hospital. The traffic, bumper-to-bumper, is intolerable, and my mind centers on the pregnant patient—has she arrived at the hospital or is she stuck in traffic?

The General Hospital in downtown Port-au-Prince is a large gated compound with many 3-story buildings. The buildings are simple concrete constructions, and there seems to be a different building for each specialty: medicine, pediatrics, and ICU to mention a few. A large part of the hospital grounds is closed off, but beyond these barricades I get a glimpse of the buildings that collapsed during the quake, taking the lives of dozens of nurses and doctors. It is understandable why many of the surviving clinicians, after experiencing this quake and the numerous nerve-rattling after-shocks, are reluctant to return to work in the undamaged buildings, even though the US Corps of Engineers has declared them safe.

Haitian physicians and volunteers from Partners in Health and the International Medical Corps primarily staff the General Hospital. There are large pup tents scattered throughout this compound, some functioning as coffee stands for the volunteers and others as temporary laboratories. The ICU is housed in a small wedding-sized tent, 2 rows each with 15 beds, all filled with the sickest patients. This unit is not air-conditioned and at the same time is fly infested. There are 2 overworked Haitian nurses here, and they do not appear to welcome our help—perhaps because of the added work we will give them with the patient orders we will write, as well as their own realization that there is a limited amount that any of us can do.

The patients, many with IVs, are washed and fed by their family members. For those without family, little is being done. The diseases range from cerebral malaria to cerebral vascular accidents, to HIV with all of its opportunistic infections, to postsurgical wound care, to trauma injuries, to sepsis. Many of the patients and family members are eager to be seen by a doctor and closely watch our movements throughout the tent.

I take a look at the medicine requisition sheet, and it appears that many medicines have not been given to the patients all day. When I ask one of the Haitian nurses why, she ignores me. A volunteer nurse from Chicago who appears overwhelmed, points to the haphazardly arranged and sparse supply of medicine and says that this is all they have. She also tells me they do not have a working blood pressure cuff or a thermometer.

The patients' medical charts that hang from the end of each bed are in disarray. There are no progress notes from specialists, even though these consult services have been requested multiple times. It is impossible to decipher what orders have or have not been acted on. We do our best to make sense of the patients' medical conditions and charts. Each time we approach a bedside, the family members look up with an expression of hope, but with such disorder it is hard to offer meaningful care or a lasting change for many of these extremely sick patients. It is very defeating to feel this impotent and ineffective.

Near the end of this harried and stressful day of rounds, while we are being pressured by our driver to leave and return to our compound before nightfall, one of the patients has a large bloody stool and she becomes tachycardic and tachypneic. The intern quickly tries to find the gastroenterologist. He returns shortly with an emergency room doctor who is willing to help.

At the end of the day, the intern and I, both concerned at our inability to make much positive change, are taken back to the camp by our driver.

**3/7/2010**
Our final day. We leave tomorrow if the plane arrives. I am assigned to the ER for the 8 AM to 4 PM shift; it is Sunday and most Haitians are attending church, which leaves the ER unusually quiet in the morning.

The hospital has hired many very able translators and transporters, which has also helped the local economy in small ways. One of the translators in the ER is a Haitian woman who sells lunches to the clinicians—$10 gets you an overflowing plate of tasty Haitian food and a cold Coke. This translator is also very apt at getting her friends who need medical care into the ER without having them first go through triage—one of the perks of her job, it appears.

The first patient I see this morning had given birth yesterday at the General Hospital and was sent home without any pain medicines. As well, her milk has not yet come in, and she comes to us for help obtaining formula. Her husband also needs a tent to house his family. One of our nurses, who is also a lactation consultant, helps this new mom learn how to breast-feed. We are able to locate some formula; unfortunately, tents are scarce and we cannot help with this request.

At 8 PM I venture back to see if any help is needed. There is a 22-year-old woman who has come in with severe right lower abdominal pain. Our working diagnosis is either ovarian torsion or appendicitis. She did have 2 of the classic signs of appendicitis: a positive psoas sign, and a positive Mcburney's point, although her temperature and white blood cell count are normal. Our immediate concern is her future fertility. Knowing that she had lost her left ovary and fallopian tube with a previous ectopic pregnancy, a right ovarian torsion would need to be corrected quickly. Without a CT or ultrasound to help us determine her diagnosis, we offer her exploratory surgery. At first she refuses, but after consulting with her husband, she agrees to proceed with the surgery. Fortuitously, it is not her ovary, but her appendix, inflamed and quite adhered down to the surrounding tissue. With the skillful hands of the surgeon, the appendix is removed without any complications.

**3/8/2010**
The volunteers and I are up at 5:30 AM preparing to leave. We sort through our belongings, leaving behind mounds of clothes, both worn and clean. There is also a growing pile of donated food items (Gatorade being the most plentiful). We pack up what we will be taking on the plane and are ready to depart the camp by 7 AM. The Haitian X-ray technician comes up to me and asks me for my particulars; he is looking to get further training in the United States and wants as many contacts as he can make.

The transport to the airport is seamless, and we proceed through customs and security without a delay. While we sit on the tarmac, many of the volunteers with newly acquired friends exchange e-mail addresses, and others just bask in the sun. When the plane arrives and pulls its nose up to a spot not far from us, many in the group cheer. They cheer again when the plane takes off on time and then again when it lands in Miami. I feel awkward about the cheering, but I realize these expressions of relief are well deserved.