

*The opinions expressed here are not necessarily the opinions of the National Medical Association.*

## The Psychology of a Disaster: Providing Realistic Care

In a disaster, the goal is to do the greatest good for the greatest number of individuals—not what is best for each individual.<sup>2</sup> We often have trouble ignoring the screaming patient in these situations, while we have been very successful at ignoring the psychiatric manifestations. Having mental health workers “on site” in a disaster and at the shelters would be very beneficial.

Mental health concerns are real. Physicians need to address these issues so mental health services are easily accessible and that those who need it can find a way to utilize those services. It is also important to plan for mental health aid to be available long term.<sup>3</sup> Many volunteers are eager to help in an acute disaster situation, but people often wait until later to request psychological help. Those that need chronic help or don't notice the problems they are having until after the acute disaster has passed may have difficulty finding help when volunteers are less numerous.

As people struggle to put their life back together, help with mental aid is not often something the victims focus on. People who are not coping well with the disaster and are having difficulty with acute stress symptoms such as sleep disorders, irritability, anger, and anxiety are more likely to have long-term psychological sequelae.<sup>1</sup>

We should also look at how their self-esteem has been affected. Effects on a person's self-esteem can play a big role in the recovery processes and should be

a consideration in evaluating those at risk so early intervention can be more appropriately focused.<sup>2</sup>

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## Rebuilding New Orleans and the Gulf Coast—Lessons Learned to Strengthen Nation's Healthcare

### Response to Ferdinand's “Public Health and Hurricane Katrina”

Dear Editor,

This letter is written in response to the editorial of Keith C. Ferdinand MD, FACC in the February 2006 edition of the *Journal of the National Medical Association*. Ferdinand has proposed several essential elements required to rebuild the New Orleans medical community.<sup>1</sup> His editorial has raised several policy issues for healthcare providers, consumers and planners as the framework for healthcare is rebuilt in New Orleans and the Gulf Coast region.

Specifically, hurricane Katri-



na exposed the world to the reality of the effect of poverty and healthcare that most black physicians faced in serving poor black and other economically disadvantaged patients. These patients with multiple medical problems have been displaced throughout the United States, but as they return, they will find that their traditional sources of healthcare do not exist. This may lead to worse health outcomes in a state that ranks near the bottom for most indicators of health and in health outcomes. Six months after hurricane Katrina, only three hospitals are opened—two serving adults and one children's hospital—and there are no acute psychiatric beds in New Orleans. Many of the community clinics as well as private offices remain closed or provide limited services. By far, the most significant impact on healthcare for the community has remained the continued closure of the Medical Center of Louisiana at New Orleans (MCLNO), also known as Charity Hospital. This facility provided care to 150,000 unique patients in fiscal years 2004 and 2005 and of which more than 85% were black. As pointed out by Ferdinand, this facility was the only level-one trauma facility in the

state. As the primary teaching facility for the schools of medicine for Tulane University and Louisiana State University, medical students and residents had many of their clinical experiences at MCLNO. With the closure, students and residents are displaced across the state and country in other clinical sites. This may impact the future physician workforce in Louisiana, since many residents ultimately practice in the communities where they trained.

Physicians have been displaced to many communities across the nation. This has been particularly true for black physicians in New Orleans. Many black physicians practiced in the areas of the city sustaining the most severe flooding. Many offices, including significant medical equipment, were destroyed. Since many displaced physicians have established practices in their new communities, the physician shortage in Louisiana will only get worse. Ferdinand has proposed the expansion of loan repayment programs to encourage health professionals to relocate to Louisiana. This effort should also include loan repayment programs for specialty care, dental care and behavioral healthcare, and public health nurses in addition to the traditional primary care loan repayment programs. Patients living in those communities suffered substantial damage to personal property and are now displaced as well. In the recovery effort, funds have been dedicated to housing and public safety infrastructure. No dedicated funds exist for medical infrastructure, including community health centers, physician office complexes, behavioral health units and the academic medical center.

As Ferdinand points out, electronic health records (EHRs) should be included in any rebuilding effort. This EHR should establish a standard plat-

form for interconnectivity among community health centers, private offices, hospitals, behavioral health centers, social service agencies, pharmacies and health plans. This shared platform will result in comprehensive healthcare, reduced duplication of tests and services as well as improved patient safety across the continuum of healthcare. This medical infrastructure rebuilding effort should serve as a platform for community-based healthcare through private practices as well as community health centers with the integration of the EHR. A key feature of the EHR will be the availability of information and records in multiple remote locations should a disaster strike again, if a web-based solution is developed. This format can be used for any community or state for integration of health services through an EHR.

I would summarize these hurricane Katrina healthcare recommendations as we move forward to rebuild healthcare adapted from the Institute of Medicine's report, "Insuring America: Principles and Recommendations."

1. Develop a safe, efficient, equitable and effective patient-centered system of primary care centers, multispecialty groups, private physicians and the academic health center that focuses on ambulatory care, chronic care management, health promotion and disease prevention.
2. Develop an academic health center to serve all professional health schools, including medical, dental, nursing, pharmacy, public health and podiatry.
3. Focus on the 10 essential public health services.<sup>3</sup>
4. Develop and integrated EHR utilized by all consumers, providers and payers of health services.
5. Prepare the healthcare infrastructure for future disasters.

Hurricane Katrina has exposed the weaknesses of the current fragmented system of healthcare that exists in all areas of the country, particularly those areas with large numbers of uninsured and medically disadvantaged patients. This is true for most urban communities, except those with a large coverage by health plans, such as the Kaiser-Permanente system. Any large-scale natural disaster, including flooding, earthquakes and hurricanes, may result in a major disruption of healthcare. As we rebuild New Orleans and the Gulf Coast region, our lessons learned can serve to strengthen healthcare throughout the nation.

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## Authors' response: Continuing Hurricane Katrina Public Health Crisis

It is always the hallmark of good medical and public health policy that clinicians and researchers continue to expand and refine our approaches to pressing health issues. The remarks of the letter above are well thought-out and add to this discussion of our response to the largest natural disaster ever to

impact the United States. Furthermore, two additional areas that need to be addressed are the continuing strain on the operations of the few full-service inpatient facilities in New Orleans post-Katrina because of the uncompensated care (and rightfully so) and the need to license volunteer physicians in an expedited manner by the Louisiana State Board of Medical Examiners (LSBME). Recently, the first problem has been addressed with \$383 million in federal funds for Louisiana hospitals, doctors and others to provide for the uninsured. As a member of the LSBME, I strongly urge all physicians sign up for the Federation Credentials Verification Service to create and maintain a permanent file of core credentials. This will expedite doctors who desire to come to the state to volunteer services (licensure still required) or for displaced clinicians who often desperately seek an income in other states with their practices and personal lives shattered. The Federation of State Medical Boards has further information at [www.fsmb.org](http://www.fsmb.org).

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## Master African-American Artists Should be Featured on JNMA Covers

Dear Ms. Taylor,

As a major collector of art by African Americans, I was truly disappointed in your selection of cover art by putting someone on the cover who is not a major artist. Then to have essentially an advertisement for the gallery is worse. In the Washington, D.C. area, you have major African-

American collections at Howard University. The Thurlow E. Tibbs collection at the Corcoran gallery, the David Driskell collection, and Hampton University—to name a few. I am responsible for the art by African Americans being featured on the front cover of the *Journal of American Medical Association*.

This journal presents an outstanding canvas by an outstanding artist, with an insightful write-up on the artist and painting. There are major authorities in your area who could help you improve your selection for your up-coming covers. If you are going to do this, please do it with class, that has been long overdue to the great African-American Masters. Looking forward to hearing from you.

*Respectfully,*  
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## Socioeconomic Inequities Often Translate into Health Inequalities

It is with great interest that we read Dr. Gadson's speech for the SCLC Annual Martin Luther King Day Celebration: "Health Equality: The New Civil Rights Frontier."<sup>1</sup> We wholeheartedly agree with her conclusions related to inequality in healthcare across the racial and socioeconomic divide. We find the same issues relating to levels of care for drug addiction. Opioid abuse and dependence are significant public health problems affecting people of all racial and socioeconomic backgrounds. Interestingly, physicians, especially anesthesiologists and surgeons, are overrepresented among opioid



abusers.<sup>2</sup> For over 30 years, methadone has been the treatment of choice for addiction to opioids and intravenous opiate abusers. Strict supervision in a specialized drug treatment program has been the standard for methadone maintenance treatment.<sup>3</sup> But what about physician addicts—do they receive the same advice and treatment? Can we discern what physicians think is the treatment of choice by looking at recommendations given to their colleagues?

We studied State of Florida physicians referred to the Board of Medicine and Professionals Resource Network for opioid abuse and dependence. Treatment referrals were made to various addiction treatment facilities throughout the United States, and outcomes were collected. A specific treatment contract was negotiated with each physician and filed. Outcomes were assessed by written counselor reports, physician/psychiatrist evaluations, AA/NA attendance, return to work and the quantitative result of regular, random urine testing.<sup>4</sup>

None of the physicians were referred for or treated with methadone maintenance therapy. All were referred for detoxification and long-term drug-free

treatment. Intravenous opiate abusers and addict physicians were uniformly sent to detoxification and long-term treatment normally associated with programs like the Betty Ford Center. A double “gold standard” exists in the recommendations given and the treatment of addicts. Why? Apparently, physicians recommend methadone for their patients, but the “not-in-my-backyard” phenomenon applies for their colleagues. “... Socioeconomic inequities often translate into health inequalities.”<sup>1</sup> This is further exemplified through Dr. Gadson’s mention of the IOM report: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Minorities are more likely to be given less-desirable treatments and procedures.<sup>5</sup> Whether there is a trend to refer African-

American or other underrepresented minority physicians to methadone and not abstinence-based long-term treatment is yet to be studied.

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