Journal of a Surgeon Volunteer in Haiti

By Sacheen H. Mehta, MD

Thursday, February 4

My phone rings at around 1:10 pm on my way back into the office from lunch. It is Loretta at the University of Miami. She says that they have a last minute cancellation and need a orthopaedic surgeon to travel to Haiti on Saturday. They got my name from the American Academy of Orthopaedic Surgeons volunteer list, which I had signed twice in the last two weeks. We will have to get to Miami on our own by tomorrow. There is a lot to consider. I will have to cancel my office, my surgeries, the first practice as coach of my kids soccer team, miss a superbowl party, and arrange for someone to cover the calls for my office.

The short notice doesn't give much time to think about things. There is much to do. We will need to purchase last minute flights to Miami, and arrange for a hotel room tomorrow night (superbowl weekend) and Thursday night on the way back. I will need appropriate vaccinations. I will need to gather personal equipment and supplies and pack up by tomorrow.

Friday, February 5

Doug, my physician's assistant, has never been out of the country. He drives all the way to west Texas and back beginning at 5 am to get a certified copy of his birth certificate, which he needs for a passport. It's a six-hour roundtrip. He is at the passport office in Dallas at 2 pm and at the vaccination clinic by 4 pm. He is ready to depart for the airport at 4:30 from our office. Doug proves his desire to help in Haiti is both visceral and unambiguous. Sangini, my wife, gets stuck in traffic on the way home from the airport for 1 hour and 45 minutes.

Friday I am hung-over from the send off party the night before, have sore legs from breaking my hiatus from running the day before, feel feverish (hopefully from the 4 vaccinations and not from illness) and have sore arms (definitely from the vaccinations). I am nervous and excited about the adventure. I find myself wondering whether I'd have the skills necessary to treat the specific types of injuries that I would encounter.

The flight to Miami is uneventful. We wait almost a full hour to get our bags, however, and by then the hotel shuttle is no longer running. We take a cab to the Hampton Inn near Miami airport, but it turns out our reservation is for a different Hampton Inn 20 minutes away. We take another cab to the further Hampton Inn, while I call expedia.com to complain about the error on the website. After spending 30 minutes on the phone they agree to compensate me with a $50 credit to my account. It seems important to me at the time to be compensated for the inconvenience.

Restless sleep Friday night, but it is our last night in a real bed.

Saturday, February 6

We have a big Hampton Inn breakfast, take one last, long, hot shower, and catch the free shuttle to the airport-terminal G for Vision Air, a charter flight to Haiti.

The Vision Air check-in counter is chaotic; a preview, perhaps, of things to come in the next week.

At the gate we watch the airport baggage handlers struggle to load a C-arm X-ray unit on our plane with a forklift for 30 minutes. They bang it around and nearly drop it. In the end they are unsuccessful. It doesn't make it on the plane. Sure hope they already have one there.

We arrive at the Port-au-Prince airport. We get off the plane and unload the plane ourselves. Lots of international soldiers are here; Canadian, Venezuelan, Indian, Italian etc. Immigration services is functioning in Haiti though it seems to be just a formality. No one is being turned away.

We catch a ride to the University of Miami/MediShare hospital. It consists of 4 giant white tents. The doctors and medical staff here seem exhausted. Most have been here only 5 days. They do have plenty of antibiotics and pain medicines at the moment. There is a supply and equipment wish list. But it is a dynamic list that keeps changing as supplies run out. The charting and record keeping is a joke. Plan of care instructions are written on the bandages and casts. There is an ER that sees 100-150 patients per day. There are 4 anesthesia machines but oxygen tanks are running low. Everything is rationed because supplies are limited and restocking is unpredictable.

I have cold soup right out of the can for dinner with some wheat thin crackers.

The UN has a permanent compound here. There is a bar and grill where relief workers and UN military troops can hang out and have a beer. We went there tonight despite being exhausted to see if we could learn anything from the other surgeons who have been working here.

Sunday, February 7th

Up at sunrise. No shower yet. Water is scarce and runs out. The lucky few who do get a shower take a cold one. I was happy to sacrifice mine for now.

I eat a dry bagel and coffee for breakfast. Medical staff meeting is at 7:30, which is basically the chief medical officer standing on some boxes and shouting advice to everyone using a bullhorn.

Surgery staff meeting is immediately afterwards. We decide to divide and conquer rounds. On the ward, everyone takes a row of patients and makes a list of the patient, their problem, and the treatment plan. We are warned that charts, which are a clipboard with scribbles on it, are unreliable. The chaos and understaffing of the immediate aftermath of the earthquake left the paperwork in utter disarray. Many charts have the wrong name, wrong diagnosis, or no information at all. Our first job is to verify which patients are on which cots and then find out what is wrong with them. None of the patients speak English, their native language is Creole. So the job requires everything to be translated. Several Haitian men are on hand to help translate, but it is difficult and time consuming nonetheless.

I identify one patient listed as an "above-knee amputation" on her chart, that actually has had a below-knee amputation and another with a "below-knee amputation" that is actually a Syme amputation. Yet another is listed as a pelvic fracture that actually has a fracture of the femur. The ward smells of infection and indeed it is rampant among the patients. Many of the patients have been there for weeks without bathing. Most of the patients are chronically malnourished. Many are getting wound care with some regularity, and fortunately antibiotics and pain medications are plentiful. There are no bacterial cultures so all treatment of infection is presumptive.

Rounds finish. The orthopedic surgeons meet to discuss all the patients. We make it only halfway through the first row, when the first patient scheduled for surgery arrives. It is my middle aged lady with an "above-knee amputation" that is actually a below-knee amputation. She also has a fractured arm and open infected wounds on her thigh and buttock. I operate on her to clean the infections and remove dead tissue. This leaves her with wounds that are even larger and they must be left open until the infection has completely resolved. Wound vacuums are available but EVERYTHING including saline for washing the wounds is conserved.

Everyone here is on a first name basis with each other. There are no titles. Leadership comes from those who chose to give it and those who have been here the longest. An othopaedic PA named Heather runs the show in the operating room.

There is a rapid turnover rate of staff here. Plane loads of medical personnel come and go approximately every day or two. The repeated influx of planeloads of "first day on the job" people and the loss of planeloads of experienced people adds to the confusion and chaos. Knowing the established procedures, logistics, location of supplies, and capabilities of this rudimentary facility is key to its function.

My next case is a 20 year old girl with a swollen knee:
"Hey Dr. Mehta, do you want to do a septic knee?"
"Sure," I said guardedly.
"Ok, the army medic withdrew fluid from it in the field and got frank pus"
"Oh, I know Frank," I joked, "never liked him very much."

The patient arrives writhing in pain. Her knee is 3 times the size of her other knee. It was injured in the earthquake 3 weeks ago, but didn't start to swell until 3 days later. The c-arm X-ray images are normal. Having just recently acquired the capability to check for bacteria and tuberculosis by gram stain and AFB smear, I decide to withdraw fluid. Only clear fluid is extracted, but the patient is in severe pain and can't walk. I open her knee and she bleeds profusely. We use an elastic bandage as a tourniquet since inflatable tourniquets are not available, but she continues to bleed. Electrocauteries (used to stop bleeding) are not available since the donated supply ran out recently. A nonsterile electrocautery is available, however. We have no choice but to use it, and risk infection.

The swelling turns out to be a solid mass in the knee slightly eroding the bone. The patient has a rapid heart rate probably because she has lost so much blood. Her hemoglobin level comes back 6, which is extremely low. I consult with anesthesia and another orthopaedic surgeon. Blood is scarce, but 2 units of type O+ are found, which is all the blood available for the entire hospital. The patient's blood type is unknown, but the test is available and it turns out she is type AB+. The type O+ is compatible though not ideal, so we give her a unit. Removal of the mass, however, has to be abandoned due to the ongoing life-threatening blood loss. The chief orthopaedic surgeon suggests an above-knee amputation. I refuse. I will not amputate her leg until I know for sure what I am treating.

We pack her wound, wrap the dressing tight, let the tourniquet down and pray. She does not bleed to death. We may never know what the mass is. Could be tuberculosis, cancer, inflamed joint lining, etc. In the end she may require amputation, but not until we know for sure. I am emotionally spent.

Four pm - hunger pains, time to eat lunch.

Last case of the day: An infected femur rod put in by a Czechoslovakian doctor who insisted on trying to stabilize fractures “properly" through open methods. The rod became infected and it spread into the knee. The patient arrives on my wooden operating room table with several catheters and drains that are all unlabelled. It appears to be an ingress-egress irrigation system setup by the Czech doctor. The chart note is incomprehensible except for the words DO NOT REMOVE FOR 7-10 days in capital letters. It has been only 4 days. The "ingress" fluid bag is completely full of dirty yellowish serous fluid. The "egress" is connected to a Foley bag containing dirty yellowish serous fluid. I am immediately reminded of Joseph Heller's soldier in white.

We remove the catheters. And wash out the septic knee and lateral thigh wounds.

We stay covered in DEET. Daytime mosquitoes, we are told, carry Dengue fever, nighttime mosquitoes carry malaria. Prophylaxis and treatment is available for malaria, but not so for Dengue. We take our daily Doxycycline capsule for malaria prevention religiously.

We hear rumors that the 82nd airborne division has a large screen TV setup to watch the superbowl and Wal-Mart will be donating an array of food and beverages. A group of 20 surgery staff ride to the military base in the back of a Humvee ambulance. We get there at about halftime and the troops are all using their cots as bleachers watching the game on a giant outdoor movie screen. We join them, but the food and drink never materialize. I enjoy watching the game with the vocal troops, always enthusiastic anytime a beautiful woman is shown.

Time to go back to the hospital camp. This time there is no ride. We walk through the airport grounds about 1/2 mile. It's an easy walk, though we are told it may be dangerous at night.

Monday, February 8

After a disillusioning surgical day yesterday due to lack of equipment, today I have reassessed the resources that are available and the needs of this functioning, but primitive hospital and determined that what we need most is to begin to organize our way out of chaos.

My contribution to that end is to gather a team (me, Doug, the pediatricians, the pediatric nurses, and a translator). Our goal is to evaluate the status of every child in the pediatric ward, assess and document their injuries, their treatments to date, and the future care plans. Ordinarily this would be a simple task, often done with one mouse click at home. Here it is a monumental undertaking that requires almost all day.

It is badly needed. There is little or no prior communication between surgical services and medical teams. The charts (a clipboard with a few scribbled-on pages) are virtually useless. In the chaos of the aftermath of the earthquake here, much of the treatment rendered and surgeries performed are understandably unrecorded. Often it is difficult to tell if a bandaged patient has had surgery or not yet.

The one functioning x-ray machine is digital but has limited memory so any x-rays older than a few weeks have been deleted. Medical staff now takes pictures of their digital x-rays with their own personal cameras to prevent permanent image loss.

There is a new patient on the ward that came is last night. It's a very cute 7 year old boy. He is with his mother. He has a few open wounds which have been dressed. The translator tells me his mother says that he does not move his right arm. I observe for a minute and then begin my exam. We don't really have to ask what happened because everyone’s story is exactly the same, but I ask anyway. He was trapped under concrete when his house collapsed in the earthquake. My exam confirms that there is no ability to move any muscle in the upper extremity at all and sensation is completely gone up to the scapula. The pediatrician asks me, "What should we do?" We should get an MRI, and a nerve study (EMG/NCS) to determine the level of injury and refer him to a peripheral

nerve subspecialist to see if it can be repaired, I think to myself. "There is nothing to do," I reply.

We do accomplish our goal and we have helped get those who need surgery on the OR schedule without further delays, those who need PT to begin their rehab, and those who need wound care to the wound care docs, etc. The pediatricians are extremely appreciative of our efforts since they often are given no direction as to what to do with the kids on their ward who have orthopaedic problems (which is the large majority of them)

Doug and I are proud of what we accomplish and feel that we really make a difference in this very difficult environment.

When we are done, it's time to get back to surgery. I notice there are fly traps today to reduce the fly contamination of the sterile fields. A nurse points out that there is some material in the trap that attracts the flies. Doug remarks that the success of the trap assumes that the flies will be more attracted to the trap than they are to the infected wounds. It is an hilarious but tragic observation.

There are many surgeries to be done today. The ER is very busy and every time I go in or out of the surgery tent, the ER doctor curbsides me. I am happy to help though. It is the reason I came down here.

My first case of the day is a severe open tibia fracture that has been externally fixated. I am told it is infected and needs debridement. To my surprise the wound is actually clean and granulating though there is some exposed bone. The plastic surgeon suggests using Collagraft, a synthetic collagen substitute to cover the bone. He brought some with him. There is no other alternative, so we use it. I cut the material to size and sew it in. The patient should be ready for a split-thickness skin graft in a week or two. I'll be gone by then so I won't know how she does.

On my way out of the operating room the soft spoken ER doc curbsides me. He shows me a 5 or 6 year old boy with externally-fixated femur fractures in both legs. The boy has been brought in by his mother to have the pin sites checked. They are clean. As I begin to lift his left leg to redress the pins, he shakes his head. He removes my hands from his leg and then lifts it himself with his hands. He is as proud of his ability, as I am amazed by it. The staff all gathers round to take pictures of the amazing boy. It is a cherished moment.

My second case of the day is a severe open tibia fracture that has been externally fixated. I am told it is infected and needs debridement. It's no coincidence. It's horrible injuries, one after another and many are almost exactly the same. This one has bone loss, but there is no bone graft available to use, even if the wound were clean. But the wound is not clean, it is grossly infected. After a thorough debridement, nurse starts to irrigate the wound with a 1 liter bag of sterile saline. “Are you going to use it all,” she asks. Back home I would have used 6-9 L of saline to wash the wound. “The solution to pollution is dilution,” I remark, but everything is in short supply including saline. It is part of the

reason infections are so difficult to treat here. The malnourished patient population is also part of the challenge. We finish the liter and apply a wound vacuum, the wound care device of choice here (there is a good supply of these).

The big event of the day occurs when they bring in a man who has been trapped in the rubble for 26 days. He was being given water through a small hole until he was finally extracted from the rubble by his brother. He is severely disoriented, dehydrated and emaciated, but alive and conscious. His skin is wrinkled and shriveled making him look like an 85 year old man. He is 28. His feet have small areas of dry gangrene. Unlike so many others trapped in the earthquake rubble, it appears that he might NOT lose them. The media arrives in force to interview the miracle man. We found Haitians in general to be very friendly, very happy despite tragic circumstances, and they love to have their picture taken. Ironically the one man that is of most interest to the spotlights and cameras steadfastly refuses to allow his picture to be taken.

Outside, Doug and I are discussing the case and I notice a familiar face walk past. Dr. Sanjay Gupta is on hand to report the story. I am certain it his him since there are cameras following him. People begin to recognize him and are snapping pictures. I must admit I am somewhat star struck as well, so I introduce myself. He is surprisingly friendly and agrees immediately to have his picture taken with me.

The CNN team proceeds to the surgery tent. They are trying to get an interview with our newest patient. The ICU is in the surgery tent, so I hand a surgical hat, mask, and shoe covers to Dr. Gupta. Word comes out from the ICU that the patient does not wish to have any visitors or media. The interview is cancelled.

Another ER curbside consult: a man has a pelvic fracture. He was seen here at this hospital shortly after the quake. He has an open-book unstable fracture with severe weakness in his legs. He needs surgery desperately. A transfer to the USNS Comfort naval hospital ship anchored offshore is recommended for definitive fixation of the fracture. However, they are full, so the transfer request is rejected. Because of the lack of equipment, sterile conditions, and expertise he cannot be treated here. His wife is an American citizen. She decides to take him to their Haitian home so he is comfortable since nothing is being done for him while he waits for an opening.

Three weeks later she brings him back. She tells me he has not had a bowel movement in 20 days. His old x-rays are not available and he still cannot walk, still in pain and still has weakness of his legs. I try desperately to get him transferred. Maybe because his wife is an American citizen, maybe because she speaks fluent English with no accent, or maybe for some other reason which is unclear to me, I made it my mission to help this particular couple get the care they need. But day after day we are promised that the USNS Comfort officers are coming to evaluate potential transfers. Maybe they will show up tomorrow. Eventually, the rumors prove to be true. His transfer request is accepted. I do not get a chance to celebrate the news with the couple before they left. I hope he regains some use of his legs though I am not hopeful. I will likely never find out.

On our way to the UN compound outside the hospital grounds, we run into Dr. Gupta again. I chat with him for 10 minutes mostly telling medical stories. He was here in Haiti for three weeks the last time mostly taking care of patients contrary to popular belief. He came back to report the story. I share the difficulties of operating in this environment.

Still no shower yet. Doug and I go to the UN compound to get a good shower today. It is a cold shower but it feels fantastic, nonetheless.

Tuesday, February 9th

At the morning staff meeting they announce that we are now out of MREs (military vacuum packed dry meals ready to eat), which have been the main source of food for the medical staff breakfast, lunch, and dinner. A local restaurant is bringing 600 meals for patients and staff today. Hopefully more MREs will be arriving tomorrow. Being a vegetarian, I brought all my own food and Doug and I and a few others share it.

On the way to surgery, I encounter a child (the nurse tells me he is an orphan) with an extremely enlarged head in the pediatric ward. He is a new patient who arrived last night. He has severe hydrocephalus and will need a pediatric neurosurgeon ASAP. We have no neurosurgeon at the moment. No one here seems to know if or when one is coming. He waits.

Our 26 day survivor is now doing well. He is conscious and oriented and thinking clearly. His kidneys are working well, surprisingly. He is starting to look his age (28) now.

Today the craniofacial surgeon is fixing a zygomatic arch fracture and suddenly the anesthesia machine turns off. The surgeon calmly but loudly reports this to everyone in the room. A nurse had already realized that the plug hanging from the ceiling of the tent fell out. "It does that," she says. Pin-drop silence. "Tape the F*@$ing thing, Holy s*&%," I said. And everyone resumes working again.

Curbside consult in the ER: A lady with an unstable hip dislocation. It had been relocated at another facility, but when they let her get up and walk on it, it popped out again. I check the film x-rays she brought with her. (Film x-rays are a huge treat for the doctors here-they are much easier than having to wait in line at the digital x-ray machine, and then search for the patient's X-rays by first name, last name, variations of name spellings, and medical record number (all of which are often inaccurate in the computer.) The French names are easy to misspell since they are often not phonetic.

She has a dislocated hip with a fractured femoral head and it has now been out of socket for two weeks. She will require closed reduction of the hip dislocation and ultimately fixation of the femoral head. Loss of blood supply and death of the hip bone is a huge risk, but hip replacement is unlikely to be an option for her in Haiti. She is 3 months pregnant. We relocate her hip under spinal anesthesia, but it is grossly unstable and when her leg is allowed to internally rotate to neutral it pops out again. Therefore we decide to

put her in bilateral short leg casts connected by a bar to hold her feet in external rotation, similar to a Dennis-Browne bar. It's a very creative solution. Ultimately she will require fixation of the femoral head fracture to stabilize and preserve her hip. We attempt to arrange transfer to the USNS Comfort floating naval hospital where she can be adequately treated. The waiting list there is long, so the patient waits.

The pathologist stops me on my way back to the staff tent. He was able to get the tissue sample from the girl's large swollen knee mass sent to the US, which is a miracle in itself. I am extremely grateful. He plans to have pictures of the sample sent to various experts around the country for opinions He takes my email address to add me to the list of those doctors working on this case.

Wednesday, February 10

Our Haitian transport/translator team has walked out this afternoon because they are not being paid. Apparently their services are provided by a contractor who has hired them to work here. The money never trickled down the way it is supposed to. Earlier in the week the head PA running the OR schedule suggested that we take up a collection for the hardworking Haitians translators. The chief of Orthopaedics shot the idea down declaring that it would only help them temporarily and it would make our lives miserable since they would come to expect it. This doesn't make much sense to me, but the Chief administrator here is able to keep them on the job after speaking to the head contractor. Crisis averted.

There is a code blue in surgery today on the patient who is having an Illizarov fixator put on by a Bangladeshi orthopaedic surgeon trained in the Soviet Union under Illizarov himself. The patient is under spinal anesthesia. The medical team calmly and swiftly springs into action in a coordinated way that makes me proud to be a part of the team. Remarkably, the patient's pulse is regained.

Two more code blues occur simultaneously in the ICU shortly thereafter, though neither patient makes it. A short while later, an administrator asks the ER and ICU docs not to code anyone due to limited resources which could be "better used" elsewhere. The docs protest the new policy for a while, but the conversation ends with tears streaming down the face of one of the pediatricians.

We heard that there was some singing in the adult tent tonight. "A sight to see," we are told. We rush over to catch a glimpse, but it is already over. Lets try the peds tent suggests Doug. We enter the peds tent to the rhythmic clapping of a popular Haitian song. A man is leading, but the entire ward-kids, their parents, transporters/translators, nurses, therapists, and doctors have joined in the loud singing and dancing. The lyrics are a repetitive chant so it is easy for the Americans to catch on. We have been going in and out of the Peds ward repeatedly for three days now. We have seen hopeless and heartbreaking injuries in these children.

Tonight we witness a moving emotional display of celebration and joy that seems to snub the misery entirely, albeit temporarily. Nurses are crying; I overhear one say that this just makes the whole trip worthwhile. I agree. A warmth rises within all of us and the emotion overflows. I am moved.

We hire a driver to show us around Port-au-Prince. We have been anxious to get off the hospital and airport grounds to survey the city. Remarkably the city is functioning. This is a country of over 9 million people. Latest reports say that approximately 230,000 people have died in the earthquake. That leaves over 8 million people that must continue living life. And they are doing just that. Lives are changed forever, but life does go on. We see many buildings that have collapsed and turned to rubble, banks, hotels, grocery stores, hospitals, even the Presidential Palace. There is one building with a clearly visible leg hanging in the rubble. Our driver shows it to us as though it were a tourist attraction. He stops and asks if anyone would like to take a picture. No one does. He also takes us to the food lines. There are thousands of people in line for food. There is one patient in our hospital who was hit by a car after being pushed while in the food line.

We continue on our tour to the Hotel Montana where several college-aged American missionary kids were killed when the popular Hotel hangout collapsed. The building is reduced to a large unrecognizable pile of broken concrete. A large piece sticks up from the top like a headstone.

I check my email on my iPhone, as I do regularly while in Haiti. Fortunately, AT&T wireless phone service is working here and the charges are all being waived by AT&T until February 28th. Access to international phone and data is a huge help, both personally for staff to communicate with their families and professionally for phone consultations with experts in the U.S. as well as for internet reference. I receive an email from a pathologist in the U.S. I am excited to open it because it will likely hold the answer to the swollen knee puzzle. It does, but it is not the answer I had hoped for. The tissue sample looks like an intermediate-grade sarcoma (a rare type of cancer). I immediately begin to think about the options for this girl.

The tumor is fairly aggressive and rapid growing, this portends a poor prognosis. She may very well die, no matter what we do. Is it really necessary to amputate her leg if she will die either way? Will she have access to radiation treatment or chemotherapy?

I could not stop thinking about how this poor girl's immediate fate rest in my hands. And this is not an area that I consider myself an expert. It is intolerably stressful.

After some thought, I decide to call a bone and joint tumor specialist in the U.S. for advice. His opinion, "You should proceed with the amputation because it MAY help prolong her life and it will help reduce the pain in her knee for the duration of her life." A Haitian doctor advises me that there may be a place where she could get chemotherapy or radiation treatment. She may have a chance.

Now I must face the horrific job of explaining it all to the patient herself. All of the intricacies and options must be explained through a translator. I begin my explanation. I am careful to go very slow to let the translator relay my words sentence by sentence. I watch the expression on the girls face change from the excitement of finally getting some medical attention to horror. She breaks down. The translator reports her words relentlessly. “I am one of five children in my family. My mother cannot take care of us even now. She cannot take care of me with two legs. She will never be able to take care of me with only one leg. I will be a useless burden. I would rather die.” We do the best we can to comfort her, but it is little help. She will need time.
I

Thursday, February 11

The rains start today in the middle of the night. It is a tropical rain shower that stops as suddenly as it starts but now the ground is wet and we will be tracking mud everywhere.

There is a 3 year old little girl on the ward with an open wound from her below knee amputation. It has become infected. I operated on her 2 days ago to try to wash it out and remove dead tissue. The plan was to bring her back to surgery in 2 days and try to close it if it looked clean. I unwrap the dressing with the hopeful anticipation of a child unwrapping his Christmas present. Disappointment. It is still purulent. I wash it out again and close it very loosely. Hopefully the infection will eventually resolve and the wound will heal.

I am anxious to speak to Tom, the head administrator of the hospital. I have several simple and not so simple ideas about how things could run better. He is open to my ideas.

First of all I tell him we need to keep running medical wish lists of all the equipment that is needed. That list should be sent to all incoming and outgoing personnel. That way supplies and equipment could be brought in as people arrive or sent back by people after they leave. Tom informs me that a system is being set up whereby incoming physicians will be given patient lists before they arrive so they know in advance what they will be dealing with and may then be able to bring appropriate equipment.

Secondly, we the medical staff should be voluntarily donating blood for our blood bank. Amazingly this idea is novel; no one had suggested this to date. He says that there is some blood being donated to us by the Airforce medical unit, so we may not need staff blood for now, but it is an option in the future when supplies run low. Why haven't we been doing that all along, I wonder.

Thirdly, this place desperately needs a real charting system. It's as simple as having color coded forms such as progress notes, order sheets, a cover page with demographics, etc. This would be a major advancement in efficiency. And the more efficient we are, the more people we can treat. He agrees and they are working on this one already. Why it should take so long, I wonder.

Fourth, why don't we create a master cell phone list of everyone who has a functioning cell phone here in Haiti? That would greatly facilitate communications and therefore efficiency as well.

Lastly I explain that the biggest problem for those of us who work in surgery is the lack of sterility. I was told by some military personnel that there are portable sterile operating room units that can be utilized for our purpose in Haiti. Access to those portable sterile operating rooms would revolutionize the way we are able to care for people and properly fix their broken bodies without making every decision based on the high infection risk. I'm sure they are expensive, but they are sorely needed and will be well worth the money.

A Haitian translator stops me. He tells me that the girl with the swollen knee has agreed to the amputation. Her surgery is scheduled for the next day. Our successors will be taking care of it, since we are leaving today. I am secretly glad in some ways that I don’t have to deal with it, but there is also a crushing guilt in leaving the situation open-ended.

We say our goodbyes; it is strangely difficult to leave. Some are tearful. We pile into three open flatbed trucks and they drive us to the airport. A quick check through immigration and then we wait on the tarmac. Military planes and helicopters from countries around the world come and go every couple of minutes. We are close enough to be wind blown by all the propellers and stick our fingers in our ears to shield from the obtrusive noise. After a few hours our plane finally arrives. The longing to be home is palpable now. It takes an extraordinarily long time to unload bags and for our replacements to load into trucks and ride to the hospital. Finally the gate opens and we rush with our bags toward the plane. At the plane we are told, unbelievably, that there will be a 2-3 hour delay because the VIPs who donated the money to pay for this flight would like to take a tour of the city prior to departure. We go back to the terminal area. The terminal building itself appears severely damaged and is likely unstable, though it is still standing. The delay is a particular problem for me because I have donated all my remaining food to the Haitian food collection. It could be a very long day.

The flight to Miami is again uneventful. We have heard, however, that much of the country including Dallas has had record snow falls causing a chain-reaction of travel delays. Our desire to get home motivates us to attempt to catch a stand-by flight to Dallas tonight (against the odds). We rush off the plane, through immigration and customs to baggage claim, and then to the American Airlines ticket counter. We arrive in time and there is a late flight, but it is cancelled due to the weather in Dallas. Severe disappointment understates our feelings. We will need to stay overnight in Miami and catch an early flight in the morning.

Friday, February 12th

The alarm rings early. I call American Airlines right away. The automated system reports that our flight is cancelled. I call again to talk to an agent. This time I am put on hold. I set the phone on speaker and put it down. The hold lasts one and a half hours and

counting. The phone vibrates. It's an email reporting that we have been rescheduled onto another flight leaving in just 1 hour. I hang up the phone. Doug and I jump up, and we are out the door in less than 5 minutes and at the terminal in under 15. But we are too late.

Annoyed at the late notice, we proceed to the ticket counter to complain. There is no sympathy for us there. We have been rescheduled to fly stand-by on the 10:40 am flight. We proceed to the gate where we learn that there are about 120 other stand-by passengers. Some have been attempting to get to Dallas since yesterday. One guy says he's on his 6th stand-by attempt. Discouraging news. We consider playing the "Haiti card" to see if that would help our case. Neither of us knows exactly how exactly to do it. We miss stand-by flight after stand-by flight, and our stand-by number moves down instead of up.

Frustrated and exhausted, we finally go to AA customer service. I walk up to the counter. The agent's name tag says, "Nadine".
"Nadine," I started, "We desperately need your help. Doug and I have been living in a tent in Haiti for a week. We're tired and we stink. We went as volunteers to help there. I am an orthopaedic surgeon and Doug is a physician's assistant. We have been trying to get home to Dallas since 7:15 this morning. It's now 6 pm and we are 39th on the stand-by list. We paid over a $1000 dollars for last minute tickets to Miami since they called us on short notice to go to Haiti. Our flight this morning was cancelled because of weather. Isn't there anything you can do to help us?"
After a lot of typing, Nadine booked reserved seats for us on the 8:45 pm flight. The day just got longer, but at least there is an end in sight.

The trip home is difficult. My friends had painted an idealistic picture of my decision to go Haiti while I was gone.
"You will touch so many lives."
"Put on a cape, my friend, you are a hero."
"God is working through you."
The guilt is overwhelming. I did what I could with what I had. I worked as hard as I could. Were my efforts "successful" in any meaningful way?

I dread the inevitable questions that have no satisfying answer. How was your trip? How did it go? Did you see any cool cases? Do any cool surgeries?

Saturday, February 13th

In the end it is more difficult to get home than I had imagined.

"Honey, you lost weight over there. Where would you like to go eat?"
"Wherever."
So many questions in my mind. Where did the all the money donated by the U.S. go? One hundred million dollars from the U.S. government alone. Why didn't we have even

the basic supplies that we needed? How can the money be directed so it actually helps our patients.

"Sacheen, can you tell the kids to stop fighting and come down here so we can go."
"Uh-huh."
Could I have done more? Should I have stayed longer? When will I go back? What will happen to the girl with cancer in her knee? What will happen to the boy who lost use of his arm? What about the two patients with open tibia fractures? How will all those people with amputations, get prosthetics? How will they get rid of all those infections? What if I send some nutritional supplement drinks, like Ensure or Sustacal? Could that help improve the malnourishment which is making it harder to heal wounds?

"Daddy, do I have to drink my milk?"
"Um…yes."
What could I do to help now? How much would a mobile operating room cost? Could I afford one, myself? Could I raise enough money for one? How would I get it there? Would the people there know how to run it?

I avoid phone calls, though I know everyone wants to hear from me. I know I will have to answer eventually.

“Hello?”
“Hi, Sacheen. Glad you made it back safely. How was your trip?”

Facts:

On January 12th, 2010 at 4:53 pm a magnitude 7.0 earthquake struck with the epicenter 10 miles west of Port-au-Prince, Haiti. Approximately 230000 people died. Haiti is the poorest country in the Western hemisphere. Eighty percent of Haitians live below poverty level. Haiti's capital is Port-au-Prince and is home to about 2 million people. Total population of Haiti is over 9 million. Haiti has no military force of its own.

General impressions:

Haiti: It is a dusty, relatively dirty country with evidence of recent structural trauma around every corner. But much of the country is still functioning normally. Of the over 9 million people in Haiti, 230000 were killed and many more were injured, but for the other 8 million or so people life must and does go on. The city was bustling with traffic, laughing and waving kids, and busy open markets--signs of normalcy. Yet there is also a least one huge pile of rubble on every block (including the presidential palace), heavy diggers working to clear it, and thousands of people waiting in line at a food distribution center daily--signs of the disaster.

Parts of Port-au-Prince are subject to flooding. During heavy rain, these areas flood routinely sending raw sewage from drainage ditches into the streets and homes. It is unspeakable poverty, though it reminds me of India in many ways. The streets are narrow and crowded. The smells of dust, burning trash, and sewage alternate randomly with the direction of the wind. Car horns beep incessantly. Traffic rules are nonexistent.

Teamwork of Volunteers :

I am amazed by the level of teamwork and cooperation between volunteers from all walks of life. Everyone here goes by their first name, including doctors and it seems very appropriately casual to me given our surroundings. There are no temper flares, no barked orders, no passive-aggressives despite stressful and emotional situations. Just a bunch of friendly people working hard toward a common purpose and everyone does anything that needs doing. No one EVER says, "that's not my job." No one complains about the quality of someone else's work. No one complains about the amount of work. It is an ideal collegial environment that is often only a dream back home.

Haitian People:

They are friendly and remain upbeat despite personal tragedies that have affected all. Their reaction to the tragedy is almost inappropriately muted, while their tolerance to physical pain seems unusually low. Many require sedation even for simple wound dressing changes. It is perhaps a manifestation of post-traumatic stress. Their reaction to

the death of a loved one is by our standards exaggerated, though certainly understandable. They smile through all adversity.

Sacheen H. Mehta, MD