Public Comment
National Commission on Children and Disasters
Public Meeting, February 2, 2010

Speaker:
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I would like to speak briefly on behalf of the Pediatric Orthopaedic Society of North America to relay POSNA's support for the goals of the National Commission on Children and Disasters.

In many disaster situations a high percentage of the injuries will be life threatening orthopaedic injuries to the arms, legs, and spine.

The number of active Pediatric Orthopaedic Surgeons in our country is relatively small, approximately six hundred. There are many areas in our country that currently lack pediatric orthopaedic services.

America's Pediatric Orthopaedic Surgeons take care of injured children in our country's emergency rooms on a daily basis. In addition, members of POSNA have responded to many disasters such as the bombing of the Federal Building in Oklahoma City and the recent earthquake in Haiti.

The Pediatric Orthopaedic Society of North America is ready to assist the Commission and federal disaster officials with their goal of improving disaster response for children.

If asked by the commission or Federal Disaster Officials to help with the design and list of resources needed to develop a rapid deployment **Pediatric** Field Hospital, POSNA and the AAOS will help.

If asked to help recruit or recommend pediatric orthopaedic surgeon leaders for a Pediatric Rapid Response Medical Team, POSNA and the AAOS will set up a formal process to recommend our most qualified surgeons.

If asked to make a formal report and recommendations to the Commission regarding our Orthopaedic Surgeons recent experiences in taking care of children in Haiti, POSNA and AAOS leaders will assist.

Thank you.

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AAOS Haiti Update—Jan. 28, 2010

Dear Colleagues:

We have been awed by the stories coming from AAOS members on the ground in Haiti. Since the earthquake on Jan. 12, the AAOS has confirmed that 182 orthopaedic surgeons have been deployed to Haiti. Another 500 volunteers are standing by.

These initial stories all reinforce the long-term need that the Haitian people will have for orthopaedic services and humanitarian missions. Again, I assure you that if you haven't been called upon yet, do not become discouraged. There will be time to serve and people who need your skills in the months to come.

Let me share with you some of the most striking comments from our members…

Timothy D. Browne, MD: Just returned from Haiti with Hope Force International. We were partnered with World Relief, Medical Teams International, and SIGN in Port au Prince at King's Hospital. It is a fully functioning hospital with approximately 60-bed capacity and two fully (now) functional operating rooms. Our teams were doing approximately 10 cases a day—wash outs of open fractures and stabilization, amputations, IM nailing of femur fractures using the SIGN nail. The amount of orthopaedic trauma is unprecedented.

Many hospitals have not had electricity or sterilization. Most patients are without X-rays, and we know of no facility that has a c-arm. Hope Force International was able to secure and transport a new anesthesia machine to the hospital. USAID helped in getting the machine to Port au Prince and the Canadian military delivered it to the roof of the hospital by chopper.

No time in history has there been such an event that created a total collapse of the country's main infrastructure. Many volunteers have been frustrated about not being able to get in country and help, but people need to understand that this is very much like a war zone. Just the logistics to house and feed the current volunteers is a tremendous challenge.

This tragedy has created a huge opportunity for the orthopaedic surgery community to respond, and it will be a long-term project. All these fractures that have been provisionally stabilized will need definitive treatment. Untreated fractures will need addressing. The unfortunate complications, nonunions and malunions will require care.

Robert D Loeffler, MD: Just returned from a week in Haiti (with University of Miami Medishare project). I would urge you to let Academy members know that there appear to be enough orthopaedic surgeons with respect to available facilities and equipment. The greater need will be in a few weeks or months when the media attention begins to wane but the orthopaedic needs will increase as the non–life-threatening injuries decrease but the vast number of fractures and other injuries need attention.

Brian S. Parsley, MD: It is a bit overwhelming to see all the destruction that has occurred as the result of a natural disaster…It looks like an A-bomb hit this city—entire areas without a house standing and people all living in the streets …

Please don't believe the negative news reports that question where are the Americans and why aren't they doing more. I am proud to be an American and proud to be here representing my country caring for those in need. We all are doing the best that we can with what we have … It is impossible for anyone to step into a country that has little healthcare infrastructure in place in the first place and is light-years behind where we are in the USA, and add to that the destruction of what little they had left and then have this type of disaster that requires tremendous resources to address. This is an impossible task at any time, at any place, and anywhere …

I feel like the M*A*S*H series when you hear the helicopter coming and Radar O'Reilly announces their arrival. It is either feast or famine. The patients are now a week and a half out from their initial injuries and in need of secondary wound care and external fixation …

The situation appears to be improving on a daily basis based on reports here from all those we meet but it will take months to years. Once the acute situations and needs are addressed, the multitude of secondary procedures that will be needed. The challenges of rehab and the need for prosthetics will be incredible due to the number of amputations.

Seth Sherman, MD; Gary M. Sherman, MD; Mark F. Sherman, MD, Michael R. McLean, MD: Along with Travis R. Von Tobel, MD; Dapeng Fan, MD; Patrick Yost, MD; and an industry surgical instrument representative, we have just returned from 4 days at a Haitian border town hospital in the Dominican Republic. Approximately 65 surgical orthopaedic procedures were performed in a 48-hour period. … As we were leaving, several truck loads of massively injured people arrived, adding to the hundreds already at the hospital. This was so terribly frustrating. What was salvaged was miniscule in comparison to what needs to be done.

John F. Lovejoy Jr., MD: We now have about 50 volunteers, have received about 300 patient and done over 160 surgeries. It is a bit staggering considering that we have been here about a week. Every new group is so enthusiastic they want to change forward. We have to remember we are guest at their hospital and they have been working 16 or more hours a day since the earthquake and are physically and emotionally stressed.

We are all okay; our bodies are fatigued but our spirits are high with the knowledge that we have given our best effort to make a difference in others' lives and that helps to ease the anguish of this experience.

Timothy C. Gueramy, MD, and Joel H. Hurt, MD: A driver for one of the teams is a survivor from the earthquake. He was on the ground floor of a building with 50 or 60 other people when the quake hit. He was crushed under rubble, pinned down. He heard

people screaming and dying slowly. He reached his friend's hand and held it until she died. Another friend dug him out. Twelve other survivors had gashes, wounds, amputations. He was the only one walking with barely a scratch. He said, "Why me?"

As orthopaedic surgeons confronting the results of traumatic situations—whether motor vehicle accidents or earthquakes—we have all heard that question. We know there is a reason—because our work is not yet done.

The AAOS is continuing its efforts to find ways to facilitate the movement of orthopaedic surgeons and medical equipment to Haiti, and to develop plans for bringing Haitian patients to hospitals in the United States for definitive care. As these plans are finalized, we will keep you informed. We encourage you to visit our dedicated Web site, www.aaos.org/haiti, on a regular basis for the most up-to-date information, and to remember your comrades in Haiti and their patients on a daily basis.

Joseph D. Zuckerman, MD	John J. Callaghan, MD	Daniel J. Berry, MD
AAOS President	First Vice President	Second Vice President

Update Haiti

Following is an excerpt from an e-mail communication written by orthopedic Surgeon, Dean G. Lorich, MD, FACS

I believe we went to Haiti with a reasonably comprehensive service because we wanted to utilize our abilities as trauma surgeons and provide acute trauma care in an orthopedic disaster. We expected that we would have to perform many amputations, but we deployed with a philosophy that we would start reasonable limb salvage for what we thought were salvageable limbs.

Our team included: two orthopedic trauma surgeons, three orthopedic trauma fellows, two highly skilled anesthesiologists, one general surgery trauma surgeon, two Synthes reps who were also scrub techs, one trauma nurse practitioner to do triage, and two OR nurses. Our equipment included a huge amount of anesthesia medications and equipment and OR equipment including scalpels, soft goods, splint material, and prep material, which would give us the ability to construct 150 ex fix both small and large. We also had a dynamic plan for replacing physicians and equipment through which we could bring in what was necessary on the Synthes private jet within 24 hours.

We thought the plan was a good one. We were incredibly naïve.

Disaster management on the ground was nonexistent. The difficulties we experienced in getting into Haiti despite the intelligence we had from people on the ground and high political connections only portended the difficulties we would have once we arrived.

We started out on Friday morning because we got a slot to get in on Friday that was eventually cancelled when we were on the runway; our arrival was rescheduled for the next day. We diverted to the Dominican Republic and planned on arriving in Port au Prince on Saturday.

Once on the ground we discovered that General Hospital, which we thought was up and running with two functional ORs, was severely damaged in the earthquake and not operational because there was no running water and only a limited electrical supply via a generator.

We quickly took our second option and went to Community Hospital of Haiti. There we found approximately 750 patients in the hospital and discovered that the hospital had running water, electricity and two functional ORs, In our naiveté, we did not expect that the two anesthesia machines would not work, that there would be one cautery device for the hospital, that there would be an autoclave that fit instruments the size of a cigar box, and that there would be no sterile saline, no functioning fluoroscope, and no local staff, only a ragtag group of voluntary health care providers who, like us, had made it to Haiti on their own.

To summarize, we had no clue that the medical infrastructure of the country was so poor.

As we got up and running in the OR and organized the patients for surgery, we communicated our new needs back to Synthes, and more supplies were loaded for a second trip. Included in the shipment were a battery-operated pulse lavage, a huge supply of saline, and soft goods for the OR. This plane landed as planned on Sunday afternoon, equipment was loaded on a truck, and it subsequently was hijacked between the airport and the hospital. At the hospital we had zero security despite promises from the NYPD and NYFD to protect us.

Our philosophy was to run the ORs around the clock with the idea that we would have a defined extraction time of 11pm on Tuesday. We expected that the plane that would take us out of Haiti would arrive with a new medical staff compliment to replace us. Equipment that would be included on that flight were things urgently needed to enable us to provide better and more efficient care: two portable anesthesia machines, two electrocautery devices, two portable monitors for the PACU, two autoclaves, replacement ex-fix—all things that didn't arrive on our original flight.

That plane's arrival slot was cancelled by the military at 6 am on Tuesday. Although we had seen some relief regarding the number of remaining patients on Monday night, having completed approximately 100 operations, we found a huge number of new patients had arrived at the hospital on Tuesday morning. The hospital was forced to undergo lockdown and closed its gates; outside the crowd was becoming angry.

We also noted on Tuesday morning that many of the patients we were operating on were becoming septic. We finished operating at noon on Tuesday; the last procedure our group assisted with was a caesarian section performed by an obstetrician, and we helped resuscitate a baby who was not breathing.

We decided as a group that the situation for us at the hospital had become untenable: supplies were running out, our team was exhausted, safety was a huge concern, and there was no workable extraction plan in place with the ability to bring in new supplies. We decided to make our way to airport with the help of a hospital benefactor. We had to have Jamaican soldiers with M-16s escort us out with our luggage as the crowd outside saw us abandoning the hospital.

We made it to the airport on the back of a pickup track, got onto the tarmac, and hailed a commercial plane that carried cargo to Montreal, where we arranged for a private jet to pick us up.

We witnessed and were unprepared for:
1. The amount of human devastation.
2. The complete lack of a medical infrastructure in the country.
3. The lack of support from the Haitian medical community.
4. The complete lack of any organization on the ground. No one was in charge. We were at the first functional up-and-running hospital in the Port au Prince area, yet no one--and I mean NO ONE--came to the hospital to assess what we were doing, what we were capable of doing, and what we would need to be more efficient. The fact that the military

could not, or would not, protect the re-supply equipment when it arrived on Sunday or allow the Tuesday flight to land says it all.
5. Lack of any security at all at the hospital.

What I take away from this experience is that disasters like this one need organization on a much higher level than we had with the clear involvement and approval of the military from the beginning. Currently there is no one obviously running the show, and the ability to provide care is chaotic at best. Physicians are coming into the country with no plan for what they are going to do. Surgeons who expect to just show up and operate are delusional about what their role will be, because without a complement of support staff and supplies they would be of limited or no value.

When we left Haiti, we all felt as though we were abandoning patients and the country, and we felt terrible. Now that we are back in New York, we see our role as working to expose the inadequacies of the system to the media in the hopes of immediately effecting a change in this system. At this point, we feel that the only way to really help is to spur an urgent programmatic change and provide organization for the support of the medical staff on the ground and for a system to expeditiously bring into the country the equipment and supplies that are critically needed.

Cheerios on the tarmac are not getting it done for these patients, who clearly could be saved if good care could be provided on an urgent basis.

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