Lessons Learned From Katrina: One Department’s Perspective

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Friday, August 26, 2005, was a Friday like many other Fridays during hurricane season in New Orleans. There was a strong hurricane, Katrina, the eleventh in a very active season, approaching the Florida Keys. The expert meteorologists were predicting a track that would bring her into the Gulf of Mexico and swing northwest straight up the mouth of the Mississippi River and into New Orleans. This was not an uncommonly predicted track for a hurricane in the Gulf. A relatively large number of storms start their paths there with their sights set on New Orleans but begin to veer eastward or westward as they encounter various prevailing obstacles, such as an atmospheric high pressure system, warmer pockets of water, or protective barrier islands. Consequently, New Orleanians had their eyes and ears open for the latest weather reports, debated the possibility of this being the “Big One,” but were not necessarily ready to evacuate because yet another hurricane was predicted to make landfall.

Things began to heat up on Saturday, August 27, as the storm continued to follow the predicted track. People began to batten down the hatches, put up storm shutters, board up windows, and fill bathtubs with water. Many heeded the pleas from Mayor Ray Nagin to begin evacuation on Saturday. The major thoroughfares out of the city began to experience heavy traffic flows. Some of the luckier people were able to get flights out of the city before the airport was shut down. By Sunday morning, the storm was imminent, traffic out of the city was at a standstill, and everyone was pretty certain that this was, indeed, the Big One. Contraflow traffic routes were initiated, a mandatory evacuation was called, and thousands of panicked people were stranded for hours on interstates so heavy with traffic that many feared that they would be stuck in their vehicles on the interstate over Lake Pontchartrain, unable to make it to safety before the storm hit.

Most of our faculty, residents, and staff at Tulane were able to evacuate to “higher ground,” staying in hotels when they could find a vacancy, being taken in by family and friends, or, in the case of some, evacuating to a “shelter from the storm” in a distant town and being taken in by complete strangers who reached out to their fellow Americans in a time of extraordinary need. Everyone assumed that they would return to New Orleans within 2 or 3 days, clean up their yards, patch a few roofs, and get on with their lives. Then, on Monday, August 29, all hell broke loose. People sat glued to their televisions as reports came in that there were several breaks in the levee system.

The situation went from bad to worse as New Orleans spun out of control. Some of our people were able to return to the city to help as First Responders, doing whatever they could to try to help the panicked population who were stranded in a flooded city with nowhere to go, with very little to eat or drink, and with very little hope of rescue and survival. The rest of us who were stuck in temporary quarters soon realized that we would not be returning to New Orleans for some time and would have to find more permanent living arrangements where we could regroup and resume the responsibilities of everyday existence.

Once faculty, residents, and staff had evacuated to their secondary evacuation spots, it became abundantly clear that our department should have had its own disaster plan and communications officer. As it turned out, our residents quickly organized themselves around a Yahoo group and began to collect information about each other’s whereabouts, phone numbers, and other contact information. Since it sounded like a good idea, our departmental administrator set up a Yahoo group for our faculty and staff and we began communicating through this link, since the Tulane server was still down (as it turned out, it would be down for several months).
When it became apparent that most people would not be allowed back into the Greater New Orleans area and that we would not be able to occupy our departmental offices for several weeks, the decision was made to set up temporary headquarters at the state hospital in Jackson, La. The leadership there graciously provided us with access to one or two rooms where we immediately installed a router so that laptop computers could be operated off of a Wi-Fi system. Since mail was not going to be delivered or accessible in New Orleans, we also rented a post office box for the department in downtown Jackson. This made it possible for us to continue to correspond with the outside world and to continue to bill and collect for services rendered by our faculty who were on various contracts with the State of Louisiana. At this point we began to feel the distinct disadvantage of not having a remote backup server on which we could have relied for much needed data for historic reference and ongoing projects.

The establishment of the Yahoo group allowed us to check on the safety and welfare of our faculty, staff, and trainees, and we actively encouraged people to tell their evacuation stories, feeling that it would be therapeutic to share experiences with one another. Many heart-wrenching stories were posted and support poured out from many individuals.

Faculty and residents who were normally assigned to hospitals or community mental health clinics in the Greater New Orleans area were reassigned to mental health clinics, health clinics, or shelters in the Baton Rouge area to assist in caring for the evacuees. It immediately became apparent that patients needed electronic medical records and detailed education regarding their condition, medications, and treatments. A number of chronic patients had no idea what medications they were taking nor the correct dosage of those medications. Patients who had previously been enrolled in methadone maintenance programs had to be reassessed and reassigned to treatment programs that could handle their need for methadone. Here again, the dosage of the medications was often unknown or inaccurately reported. When the need to evacuate arises, it would be best if patients have their pertinent medical records with them in writing or in a flash drive format that they can carry with them.

After about 3 weeks, we were notified that the Tulane University School of Medicine was going to “move in” with the Baylor College of Medicine in Houston, Texas, and had been offered the use of their facilities for the remainder of the academic year (1). Furthermore, we were also notified that opportunities would be made available for our house staff not just at the Baylor College of Medicine but at the other Texas-affiliated medical schools as well (2). Thus, it was going to be imperative that we move a core group of faculty to the Houston area. Fortunately, we were able to work with the Veterans Integrated Service Network, which allowed us to move three psychiatrists and two neurologists from the New Orleans Veterans Affairs (VA) Medical Center to the Houston VA. This included our director of medical education in psychiatry. Our vice chair and director of medical student education in neurology also volunteered to move to Houston, as did our residency training director in psychiatry. This gave us a critical mass in psychiatry and neurology, enabling the teaching of our medical students in psychiatry and neurology and our residents in psychiatry. As it turned out, many of the neurology residents were able to stay in the Greater New Orleans area for their rotations, although two were granted permission to do rotations out of state for several months until they could move back into the New Orleans area.

By early October, we had faculty at work in Houston, throughout central Louisiana, and in Little Rock, Ark. In addition, we had faculty and staff dispersed throughout 20 or more states from Maine to Florida and from southern California to Oregon and many states in between waiting for the chance to return to New Orleans.

We realized that it would be important to try to help people remain connected and, thus, scheduled a series of weekly and biweekly meetings, each of which was connected as a conference call so that faculty, trainees, and staff could phone in and be updated on departmental developments. Furthermore, the Chairman started sending out a weekly e-mail message to try to connect with those who might not have been able to participate in the conference calls. Once communication was set up within the department, we began to network with other departments, the State Office of Mental Health and Department of Health and Hospitals, the VA, other federal facilities, and national professional organizations. Appendix 1 provides a list of various tools and strategies to help sustain a working environment postdisaster.

As events unfolded, it became apparent that most of us were suffering from some degree of acute stress response that might include anxiety or irritability, depression, cognitive slowing, indecisiveness, or other such symptoms. Support groups were organized for faculty, staff, and trainees both in Houston and in New Orleans (3). Individual counseling was also provided by our psychology faculty.

Leadership of both the school and the department felt that hope for the future needed to be extended and that
this needed to be associated with reasonable timelines. We soon learned that there would be extraordinary delays in our return to New Orleans because of the massive need for debris removal and restoration of utilities and communication systems, that insurance adjusters needed to do their work before repairs could begin, that there would be a shortage of workers, that “loss of business” insurance would preclude institutions from quickly returning to a high level of functioning, and that there was a lack of support services in general to include security, housekeeping, and food services. Most of us began to clamor for a return to our previous offices. We were finally allowed back on December 5, 2005. However, once there we realized that returning to one’s previous space did not necessarily mean a return to “normal,” as much had changed with the university and the city.

We were initially led to believe that faculty positions and salaries would be guaranteed for the remainder of the academic year, although staff cuts were anticipated. In early December, we were notified that faculty cuts would indeed be necessary. The departmental chairs were asked to identify those faculty who were “critical to the mission of the School of Medicine.” Thus, we were to identify those key individuals who were most important for medical student education, residency training, and funded research activities. Since various clinical facilities were closed and had discontinued their funding for both faculty and resident positions, the university had quickly discovered that it was heading for financial trouble unless such cuts were made. About 35% to 40% of faculty and staff at the Tulane School of Medicine were cut, and our department was no exception. Pre-Katrina, we had approximately 85 full-time faculty members. That had dropped to 75 by attrition, prior to the need for faculty separations. When the dust settled, 25 additional faculty members and 24 staff (12 full-time and 12 part-time) were separated from the department. Naturally, this was the most painful part of the entire post-Katrina process. Fortunately, separation packages were made available for faculty members, and good faith efforts were made to relocate terminated staff to other positions within the School of Medicine or the university at large. While this was helpful in a number of situations, there was still a great deal of pain and hardship experienced by both those who were terminated and those who remained on faculty. Survivor guilt was as common as termination anger and disappointment.

By March 2006, most of the faculty had returned from Houston, although several still traveled back to ensure that our medical students were getting appropriate instruction. Furthermore, all but two of our residents had returned to the Greater New Orleans area and were placed in appropriate clinical settings for the continuation of their residency training. Although we lost several residents to other programs at the end of the academic year, fortunately the vast majority of our trainees decided to remain with us here at Tulane. We drastically reduced the numbers that we were willing to accept in the Match and thus have a much smaller resident class for academic year 2006–2007. This will hopefully allow us the time necessary to regroup so that we might return to our usual class size by the next academic year (2007–2008).

Researchers were grossly affected by Katrina. Our clinical research section (drug trials) had to be totally closed down because of the permanent loss of dementia patients and specimens, as well as the break in every treatment protocol. This resulted in the loss of jobs for three of our staff and resulted in one of our top researchers relocating to the Northeast. One of our young child psychiatry researchers lost a good number of his subjects and was forced to ask for a supplement to his project to cover his expenses during the downtime of his National Institute of Mental Health grant. In addition, two of our researchers suffered equipment losses that still have not been resolved or replaced, while paperwork and more paperwork is submitted to federal agencies and insurance companies to determine whether the loss is considered a direct result of Hurricane Katrina or mere common theft.

The trickle-down effect from this natural disaster has yet to reach its limits. Every aspect of one’s life was affected. It has been a lesson in humility and a true test of one’s fortitude and faith. Appendix 2 outlines three stages of post-Katrina New Orleans.

The president of Tulane University, being a man of action, did not wait for the state and federal governments to step in to help rebuild the university. He contracted with a private agency to start the reconstruction of Tulane. As of March 15, 2007, reconstruction/losses directly related to Katrina have exceeded $485 million, and the work continues. As of this date, the University has received approximately $125 million in insurance recovery dollars, $2 million in FEMA recovery monies, and $59.7 million in Federal Relief Funds.

Ours is a great university built on the strength of its faculty, alumni, and friends. We are committed to moving forward to achieve our mission as one of the great academic institutions of this country. We thank all of you who have supported and continue to support us in this mission. Special thanks go out to our friends and colleagues at Bay-
for and the other Texas schools that “adopted” us in our time of need.

Conclusions

Hurricane Katrina struck New Orleans on Monday, August 29, 2005, causing multiple breaches in a fragile levee system, which resulted in massive flooding. The School of Medicine at Tulane University, Tulane University Hospital and Clinic, the Medical Center of Louisiana, New Orleans, and many of our other affiliate institutions were among the casualties of the flood. No disaster plan for such a devastating event had been formulated and, thus, the University, as well as individual departments, was left to develop onsite plans to address such needs as location of personnel (faculty, staff, and trainees), remote education of medical students, and treatment of displaced patients. The Department of Psychiatry and Neurology set up headquarters at the state hospital in Jackson and began to pull the department back together again through Yahoo group forums and departmental meetings (with teleconference accessibility) held in Baton Rouge and Jackson. Faculty were assigned to shelters, as well as health and mental health clinics where needed in Louisiana and Houston. Students and residents were reassigned to Baylor and the University of Texas medical schools until academic and clinical facilities could be reopened in New Orleans. With the loss of clinical revenue came the most painful piece of the survival process: cuts in faculty (25 total) and staff (24 total). All 25 faculty members from our department who were separated from the University were given separation packages and clinical (volunteer) faculty appointments with the hope that they will continue to actively support the academic and research missions of the department. We hope to recruit and rebuild once the clinical facilities are fully functional again. The significant lesson learned in the aftermath of this tragedy is “Recovery is a marathon, not a sprint!”
APPENDIX 1. Various Tools and Strategies to Help Sustain a Working Environment Post-Disaster

Evacuate when told to do so
Take important papers
  • Phone directories
  • E-mail addresses
Take computers, hard drives, flashdrives, etc.
Take valuables
  • Photographs
  • Jewelry
  • Legal papers
Take pets
Each department/section needs its own disaster plan
  Communications officer with pertinent evacuation contact information on each person
  • Text messaging
  • BlackBerrys, Palm Pilots
  • Yahoo groups, blog sites
  Central check-in procedure
  Alternate mail drop (distant P.O. box)
Remote computer back-up
Check safety and welfare of faculty, staff and trainees
Patient needs
  Electronic medical record
  • Flashdrives
  Detailed education regarding their condition, medications, and treatments
Set up temporary departmental headquarters
Reassign/redploy people where needed
  Disaster shelters
  Community mental health centers
  Health centers
Stay connected with department team
  Meetings
  Phone calls
  Conference calls
  E-mail messages
Network with other departments, agencies, national organizations
Extend hope for future with reasonable timelines
Recreate learning environments for trainees
Anticipate extraordinary delays
Anticipate faculty/staff cuts to balance budget
Help people understand that a return to your previous quarters does not mean a return to “normal”
Explore new training sites and affiliations for resident and student rotations as clinical facilities will be slow to return to previous level of functional activity
APPENDIX 2. Three Stages of Post-Katrina New Orleans Losses and Incurred Problems: Changes and Effects

I. Immediate
Compromised Mental Health System
- Major teaching hospitals lost
- Community Mental Health Centers lost or compromised
- Psychiatric services compromised

Mass Destruction Leads to Loss of Quality of Life
- 80% loss of housing
- No water, utilities, phone service, waste disposal
- Limited retail outlets to supply basic needs
- No local suppliers of materials to rebuild
- School closures compromising educational base
- Church/synagogue/temple closures compromising formal religious base

II. Intermediate
Compromised Mental Health
- Increased reports of depression, posttraumatic stress disorder, alcohol and substance abuse
- Increased rate of suicide attempts/completions
- Emergency rooms overwhelmed by psychiatric patients with nowhere locally to refer

Increased Crime
- Drugs and gangs return to Greater New Orleans
- Murder rate skyrockets
- Increased law enforcement presence (e.g., National Guard, State Police)
- Increased numbers of “Death by Cop”

Crisis Intervention
- FEMA/SAMHSA funds crisis counselors for brief interventions (e.g., Louisiana Spirit)
- SAMHSA funds visiting psychiatrists via Wellstone/APA to visit displaced persons
- Special treatment services put in place for First Responders

III. Long-Term
- Revamped/improved health care system
- New modern inpatient and ambulatory care facilities
- New relationships and affiliations for medical schools
- Questionable impact on local mental health care system
- Opportunities for residential care facilities, half-way houses, etc.
- Increased number of psychiatrists in rural settings

FEMA = Federal Emergency Management Agency, SAMHSA = Substance Abuse and Mental Health Services Administration

References

