Letter to the Editor

Critically Assessing the Haiti Earthquake Response and the Barriers to Quality Orthopaedic Care

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To the Editor:

As one of the approximately 130 registered members of the American Academy of Orthopaedic Surgeons (AAOS) who presented within the first 30 days of the Haiti earthquake, I must admit that I initially read the article entitled “Critically assessing the Haiti earthquake response and the barriers to quality orthopaedic care” by Sonshine et al. [1] with great interest. Although I commend the authors for their efforts in documenting some of the general themes taken from a few of the Haiti earthquake volunteers, I also object to some of their notions and comments.

In their paper, they opined that the performance of certain surgeries suggested inappropriate care. They stated that “revision surgeries, guillotine amputations, fasciotomies, and internal fixation, suggestive of inappropriate disaster care, were frequently reported” [1]. I am surprised and disappointed with this statement. This was an over-generalization. For example, fasciotomies for compartment syndrome are absolutely appropriate in many disaster relief

scenarios. I would like to know what Sonshine et al. suggest as appropriate treatment of compartment syndrome if fasciotomy is not appropriate? Do they mean to suggest amputation or perhaps benign neglect is more appropriate? As another example, internal fixation may be appropriate in certain cases when sterilization of the implant can be adequately assured and when the clinical situation warrants its use. I presume that the point Sonshine et al. tried to make is that damage-control orthopaedics should be practiced in a mass casualty situation. I would encourage the authors to be more careful when suggesting that certain procedures are inappropriate without qualifying their statement or explaining what they mean in greater detail; this may have misled some of your readers.

In addition, they also stated that “inexperienced and untrained volunteers were urged to stay home because they lacked security, equipment, patient followup systems, and cultural sensitivity.” Again, in my view this statement was an unfair generalization of the Haiti earthquake experience. I do agree that ill-prepared healthcare providers may, in certain circumstances, make the situation worse. However, many surgeons without formal disaster training and other individuals who traveled alone to Haiti did provide valuable and self-sacrificing services to fellow humans in need.

As one of the earliest responders, my team from the United States was deployed to Haiti within the first few days after the earthquake. We were affiliated with a formal relief organization and this made our mission more successful. I worked with independent orthopaedic surgeons who came to Haiti alone and at great personal risk, to help others after one of the worst natural disasters in the history of our modern world. Furthermore, none of these surgeons had previous mass casualty experience. These physicians became a critical part of our evolving medical team in Haiti and ended up helping and saved countless lives.

(Re: Sonshine DB, Caldwell A, Gosselin R, Born CT, Coughlin RR. Critically assessing the Haiti earthquake response and the barriers to quality orthopaedic care. *Clin Orthop Relat Res*. 2012;470:2895–2904.)

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In my opinion, it does not take someone with fellowship training in trauma or someone who has enrolled in a weekend course provided by the AAOS to help others in this type of situation. Anyone with basic orthopaedic training during residency can and did help. Granted, each surgeon must know their limitations. Simply having other medically trained men and women to help apply a cast, wash out a wound, hold surgical retractors, or go triage a patient in a make-shift emergency room was invaluable. Those who suggest that untrained volunteers should have stayed home after the Haiti earthquake are off-base in their overall assessment of that crisis. With more than 250,000 Haitian people injured (many severely) after the earthquake, just about anyone could have made themselves invaluable as part of the response effort. As for their personal safety, that is a consideration every man or woman must make for him- or herself. Whether to risk one's life is not up to me or the authors of this article, but it is up to each individual.

I do agree with Sonshine et al. on several common themes. For instance, providing medical care as a team rather than as an individual was absolutely critical. Whether you went as a formal team before deployment or came to the country as an individual, team work was the first priority. Electing an operating room supervisor or medical director responsible for oversight and leadership is an important first step in any medical relief mission.

Furthermore, cooperation with the military was essential as they provided valuable resources that no civilian medical organization could have provided on their own. They also helped to keep the peace among many Haitian citizens and foreign aid-workers at a time of enormous turmoil and unrest.

Finally, resources that allow for further training in disaster preparedness are important for orthopaedic surgeons who wish to volunteer in these situations. However, I believe it is not accurate to suggest that formal training should be an absolute necessity in situations like Haiti where human devastation was so palpable and resources were so limited. There is no type of formal training that could have prepared an individual for this type of experience. Organization skills and surgical judgment are critically important in this type of disaster situation. Thus, courses that provide some basic training on mass casualty scenarios would likely prove to be a valuable asset to individuals involved in medical relief efforts in the future.

Reference

1. Sonshine DB, Caldwell A, Gosselin R, Born CT, Coughlin RR. Critically assessing the Haiti earthquake response and the barriers to quality orthopaedic care. *Clin Orthop Relat Res.* 2012;470: 2895–2904.