

The Line

THE LINE STARTS FORMING AT ABOUT 5:30 AM, AL- though, in fact, it never really disappears. By the time our bus pulls into the hospital compound at about 7:10, there are 75 to 100 people waiting. The “emergency triage” area has three 40×15-foot tents and is staffed by 7 doctors, about 6 nurses, and a couple of midlevel providers. We see 350 to 475 patients by 5:30 PM. The tide is unrelenting, in numbers, in illness, in injury, and in heartbreak. Three weeks after the earthquake, most of the patients now have relatively minor health problems, although 10% to 15% still present with untreated earthquake injuries, and some are critically ill with infections. All of them have overwhelming social and emotional problems: dead husbands, wives, children, or parents, or maybe all of the above. They live in tents in parks and football fields. They have no money; there is no money. There is no work. Food is fairly, but not consistently, available. The water situation is getting better. And they come to us with “tingling skin,” “headaches,” “dizziness and weakness,” and so many other vague or whole-body complaints. All of these symptoms have been present for 3 weeks, all since the earthquake that crushed their city, their family, and their lives. They have nowhere to go and want us to provide answers, to give them a place, to make things better. But we don’t have the resources or the answers. And then there is The Line. The Line never ends. It is an unrelenting surge of humanity whose stories are repetitive and so very achingly sad.

We work in the emergency triage area at a destroyed hospital in Port-au-Prince. Triage (“to sort”) is only needed when the resources that are available are fewer than the needs. In normal times in the emergency department, we triage everyone as he or she arrives because we cannot see them all immediately. Patients are categorized by the severity of their illness or injury, and the most acutely ill are treated first. We triage individuals, but all get the maximum amount of care needed to resolve their health, and often social, issues. In disasters, triage is different; we are taught to categorize patients into 4 groups: Red: those who are critically ill, but with immediately treatable and survivable injuries. Yellow: those with serious injuries, but with no short-term life risk. Green: The “walking wounded,” with minor injuries. And Black: those who are alive, but with injuries too severe to be expected to survive. Studies show that in the aftermath of almost any disaster, we “overtriage.”¹ That is, we categorize most people as red or yellow, and a few green, but rarely black. It is our human nature as much as our medical training that prevents us from walking away and letting someone die. We believe in hope, we want to rescue.

Here, we start with our routine severity triage and identify the most ill and bring them into the tent first, but once inside, once the initial medical evaluation and stabilization are complete, we triage the population, matching inadequate resources to outrageous need. We hope for some greater good, but know that, for these individual humans, logic fails. It because of The Line. The Line is a force that never stops its pressure. It is the pressure of the massive imbalance of needs and resources. Our resources include eager and skilled expatriate medical professionals, most necessary medications, and a little bit of equipment. But the needs are buildings and clinics and operating rooms, local physicians and nurses, electricity and houses and medicine for daily use, psychiatrists, food and water, crutches, and a job, and a place to mourn. The needs are endless, and only a small portion are medical.

Emmanuel is a 46-year-old woman with an untreated and partially healed fractured femur that has caused her upper leg to angle in an awkward V. She can’t walk. She was brought in by a friend because the rest of her family is dead. She has been living/lying under a tarp in a park near her destroyed house for 3 weeks with all of the other survivors from her neighborhood. The x-ray film confirmed the obvious diagnosis of a shattered and poorly healed bone, so we tried to find the necessary definitive therapy: surgery to rebreak her leg and pin it back in place. We tried the local orthopedist and then the expatriate surgeons: American, Norwegian, and Nepali. We then tried to transfer her to another facility, or even to one of the hospital ships, to no avail. Triage was her enemy: each surgeon triaged her case, with intent or not, and concluded that her needs could not be reconciled with their resources. So once again she was ours, but she had already received the full extent of our resources. The emergency area was jammed and chaotic, the hospital was full; there are no social services. The Line presses on. We discharged her to lie under her tarp. Her friend carried her out.

This behavior is learned. When new medical staff arrive, they first try to apply the standards of care that they are so used to—the maximum benefit for each person. They want to admit and treat and start central lines and prescribe antihypertensives and treat tuberculosis. They come to the “old-timers” (those who have been here more than a week or two) looking for the answers, looking for a way to meet that standard of care. We have no answers. There are no answers. The standards have to change in the face of the imbalance of resources and needs. The standards get lower, must be lower than anything these clinicians have ever imagined before. We worry about a slippery slope toward inhumane

A PIECE OF MY MIND

medicine.

What happens to our moral responsibilities as physicians when such unforgiving triage becomes part of the standard of care? What is the ethics of triage? What is the ethics of population triage? Again, in normal times the duty of the physician is to promote the well being of each patient as an individual. We avoid bedside rationing as inappropriate to the goals of medicine and the patient-physician relationship. I could have admitted Emmanuel, squeezed just one more cot into a dark and dirty hallway or courtyard in this overflowing hospital. But what about all the other inpatients who rarely get seen by a physician? More urgently, what about The Line? There are another hundred Emmanuels waiting to see us today, and another 400 tomorrow and each tomorrow after. How do I know what is right? How do I choose Jean Dennis over Emmanuel? What sort of calculus makes sense? Our moral framework seems

to have shifted with the ground in the earthquake. The outrageous imbalance between needs and resources demands a utilitarian sensibility of “for the greater good” that is perfectly out of sync with our usual practice and our deepest desires.

I know this won't last. This is a disaster and not routine even for Haiti, whose health care system has been a shambles for years. But today, right now, I must move on—there is another Emmanuel waiting in The Line.

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1. Kilner T. Triage decisions of prehospital emergency health care providers, using a multiple casualty scenario paper exercise. *Emerg Med J.* 2002;19(4):348-353.