

Big Charity in New Orleans

In September 2005, Charity Hospital in New Orleans, the oldest continually operating hospital in the US and the safety net for the poorest patients in one of the poorest cities in America, was closed by a hurricane. It is closed for good. 'Too far gone' is the recurring phrase in the news. There is brave talk about rebuilding at another site, but the appetite in this country for public hospitals is non-existent. The fantasy of the market solution to health problems is still strong. The likelihood of something like a Charity II is zero to nil. The era of the public hospital is over.

When I was looking at internships in 1969, I drove with a classmate all over the US visiting public hospitals. Having done much of my training in the largest public hospital in the US, Cook County in Chicago, I knew I wanted to be at a public hospital for my residency. I visited New York, Los Angeles, San Francisco, Boston and then ended my trip at Charity in New Orleans. When the woman at the medical education office gave me a meal ticket for lunch, I was escorted to a doctor's dining room that was unlike any I had ever seen before — a white tablecloth and silverware setting with black waiters in short white coats and bow ties and a choice of crawfish etouffee or gumbo with a dessert of warm bread pudding.

But, other than the dining room, the hospital itself was not a white tablecloth place for either patients or doctors. It was in some ways, even then, an example of the racial and economic contrasts in the American South. Separate wards for black and white patients had been recently merged and the place was, indeed, what its name stated, a charity hospital, where anyone with means would only be caught dead by accident. In the US there has been a long-standing belief that if you get something for free it will weaken your resolve and sap your moral fibre. This attitude leaves large city public hospitals, like Charity, to serve an almost completely medically indigent populations, heavily black or Latino depending on the city.

The hospital had suffered from decades of disrepair and lack of maintenance. Air conditioning was a sometimes thing in a tropical climate which, at the beginning of the 20th century, had one of the last yellow fever epidemics in the US mainland. It was situated in a part of the city that, even then, was being eaten away by urban decay. But the attitude of the staff was wonderful despite the neglect, and the almost missionary spirit of service and a fascination with the culturally rich and historic place of New Orleans in American history was almost enough to make me go there. I didn't.

The hospital continued to struggle and fail financially and was taken over by Louisiana State University Medical School, was renamed and spiffed up a bit. Everyone still called it Big Charity, although and it served a needed purpose in New Orleans. Now Big Charity is no more.

Just as the catastrophe of the hurricanes exposed the lack of planning for disasters in the US, the nationwide diaspora of the poor and dispossessed has exposed the fundamental rot in the structure of financing and accessing health care. Even if the estimated 6000 physicians who have been dislocated by the storms were able to deliver care, most patients would not be able to afford it. In the US, health insurance is tied to employment. Millions of people are out of work as a result of the hurricanes. No job, no health insurance. No health insurance, no way to pay for care. Hundreds of thousands of people have become charity cases. The problem is, there are no more public hospitals left to provide charity and not nearly enough federal community health centres to absorb the newly disenfranchised.

Ironically, the largest number of displaced victims who will have health insurance are the elderly on Medicare, which is an assured, portable health insurance programme that is national. Medicaid, on the other hand, the insurance programme for a large portion

of low income families, is a state sponsored programme. Louisiana or Mississippi Medicaid aren't honoured by the other 48 states. If you land in Texas with Louisiana Medicaid, you are out of luck.

National discussion about assuring health care for displaced Gulf Coast families has incurred the wrath of communities that have not received such largess from State or Federal government. 'If they can do it for the hurricane evacuees, why can't they do it for the people who have lived in communities with no health care for years?' Political refugees from US wars or foreign incursions have always received better health and social benefits than low income people who live in the US. We seem to be sufficiently embarrassed by the ineptitude of the response to these hurricanes to try to do the same thing. Guilt, it seems, makes us ante up. But we don't seem to have the same national guilt about our own long-term working poor and uninsured. If we screw your country up, it seems, we will try to make amends, but if we continue to screw up our own country — except of course where that screw up has been on worldwide television for 2 weeks — we don't feel the same obligation.

Beyond the obvious public health issues in this disaster, the blow to the American sense of self has been devastating. I was in teaching in China when the second hurricane hit the coast and a Chinese physician who sponsored our visit leaned over at dinner and, in a sorrowful rather than accusatory tone, whispered to me, 'how could you possibly let this happen in a country which is the richest country in the world?' I wanted to answer that 'they' did it, not me. But those who are committed to social justice, in the world's eyes, share the blame with the robber barons who run the government. The country elected this administration and the world is watching the results. But the Gulf Coast disaster could be a turning point in the country's

Flora medica

Richard Lehman

From the journals, September–October 2005

New Eng J Med Vol 353

1095 Scanning the specialist cardiology journals and the general medical ones, no week goes by without at least one new paper on immediate percutaneous intervention (PCI) for acute coronary syndromes. Here's one from the Netherlands; the *Eur Heart J* (**26**: 1956) has one from Leipzig, and *Heart* (**91**: 1284,1330) has one from both Arezzo and Middlesbrough. Each has a slightly different twist, and two carry the message that immediate PCI has no significant benefit over delayed PCI after thrombolysis in real-life settings. However, Leipzig, Arezzo and the three RITA trials (*Lancet* **366**: 914) suggest otherwise. Meanwhile, *JAMA* (**294**: 1224) demonstrates that all these PCI patients should have clopidogrel too.

1209 This trial compared the effect of new antipsychotic drugs with perphenazine. Its main finding was that you cannot get 75% of schizophrenic patients to take the same drug for 18 months. Olanzapine takers keep on the longest, but get fat.

1224 It's now possible to create autoantibodies for cancer detection (prostate in this case), which may soon lead to personalised vaccines for cancer prevention. I have seen the future, and I hope it works.

1350 Cytomegalovirus is common, and can cause fetal damage: this Italian trial offered hyperimmune globulin to all CMV-positive pregnant women, and those who chose it had far fewer affected babies.

1363 A review of neuraminidase inhibitors, our best hope of treating influenza if we get a pandemic. This could be avian influenza A (H5N1), described on page 1374. Cheap old amantadine may not be much good as resistance soon develops (*Lancet* **366**: 1175).

Lancet Vol 366

895 The hypertension market is so huge that trials will continue forever, often contradicting each other. ALLHAT's now off for ASCOT, and I guess we should start moving patients away from their atenolol/bendroflumethiazide combination to an ACE inhibitor and perhaps a calcium blocker.

991 Bad news for those of us who were hoping that human papilloma virus screening might soon replace cervical cytology: there is a complex world distribution of subtypes with different predictive values.

1059 'Metabolic syndrome' is a combination of central obesity, hypertension, insulin resistance and a bad lipid profile, seen every day. For a tighter definition, read this editorial.

1079 *Clostridium difficile* is getting more difficile — it is developing strains that produce more toxin.

1165 The season of mists and mellow influenza vaccination is well upon us, but this systematic review shows that it makes little difference to the elderly except in nursing homes.

JAMA Vol 294

1240 Wherever you look in medicine, it's not difficult to find an inverse care law. Here it's in heart failure — the patients at most risk of death are the least likely to get life-prolonging treatment.

1493 Phytoestrogens are found in a great variety of plant foods and oils, and they may protect smokers against lung cancer. Better to give up smoking, of course, but (page 1505) if you smoke less, you reduce your cancer risk too.

1526 A paper with startling implications: we may have to test patients for β -receptor polymorphisms before using β -blockers to treat coronary disease. One common genotype gets no benefit, and may be harmed.

Other Journals

Arch Intern Med (**165**: 1890) looks at a big cohort of women from Shanghai and suggests that high phytoestrogen intake (mostly from soy products) protects against postmenopausal fractures. *Ann Intern Med* (**143**: 317) reports a 6-month trial of daily tiotropium in chronic obstructive pulmonary disease — small benefit. On page 427, a big meta-analysis shows that self-management programmes can reduce blood pressure and glycosylated haemoglobin, but not the pain of osteoarthritis. Scepticism about dyslexia has recently been aired, but *Brain* (**128**: 2453) finds a replicable pattern of abnormal brain activity in dyslexics, using voxel-based morphometry, no less. *Gut* (**54**: 1402) suggests a new treatment for irritable bowel syndrome: melatonin. It was tried out for sleep disorder, but improved bowel symptoms instead. Addicts of the qualitative literature may wish to browse the latest issue of *Scand J Caring Sci*, which mixes studies of Andrex-like softness (**19**: 268] Do all health and social care professionals interact equally: a study of interactions in multidisciplinary teams in the UK) with others of stony theoretical rigour (**19**: 280] The structure of Antonovsky's sense of coherence in patients with schizophrenia and its relationship with psychopathology).

Plant of the Month: *Mahonia japonica*

Sprays of yellow flower, scented of lily-of-the-valley, break the gloom of early winter. A big evergreen shrub, but easily kept in check.

history, where we realise that the war of all against all lurks in our neighbourhoods like the plague, and we collectively decide once and for all to deal with the inequalities that have bred the conditions where it could be loosed. These communities may not be where you or I would choose to live, but for a million of my countrymen they were both home and history and their destruction will have a more lasting effect on their health than the medical care they receive from us. The biggest public health disaster, in the long run, will be the death of communities, of the social fabric of neighbourhoods and towns where, despite differences or deeply historical poverty, people found ways to work to help each other.

As Yeats wrote in *The Second Coming* (1919):

*'Things fall apart; the centre cannot hold;
Mere anarchy is loosed upon the world,
The blood-dimmed tide is loosed,
and everywhere
The ceremony of innocence is drowned'*

American innocence — and I hope arrogance — was drowned on the Gulf Coast, in September 2005. Big Charity will never reopen. The displaced and the sick roam the country. The centre is not holding. Can we find our way?

John Frey