

# American Samoa Fall 2009

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*Dr. Linda Halderman was a Breast Cancer Surgeon in rural central California until unsustainable Medi-Cal/Medicare payment practices contributed to her practice's closure. While in practice, she became a friend and yoga partner of CSA President Linda Hertzberg, M.D. Determined to make an impact on state health care policy, Dr. Halderman took a position as a top advisor to State Senator Sam Aaenstad, himself an oral surgeon. But all that stopped when she heard that medical help was urgently needed to deal with the devastation caused by the Pacific tsunami that hit the U.S. territory, American Samoa. She packed, said good-byes to family and State Capitol colleagues and made the 7,000-mile trip. Her messages from that disaster-stricken isle combine a sense of compassion and commitment to rendering care to those in need.*

It's Saturday night in Pago Pago. As I write this from a little tropical hospital in the middle of the Pacific Ocean on a tiny island called American Samoa, I'm trying hard to make sense of the last 72 hours. I remember sleeping at one point, eating some Ramen noodles yesterday and wondering often—but without much interest—if it was light or dark outside. I can't wrap my brain around what has happened, so I'll just report it and let you make your own assessment.

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For almost ten days, I watched my 5-year-old patient as he healed from Dengue Fever and a set of superimposed infections, any one of which could have taken his life. But he had so many medical victories. Three days ago, I sat with him on the regular pediatric ward and watched him play with his brothers and eat Bongos (a Samoan version of Cheetos ... yuck) and smile at me. He breathed the same air I did, needing no extra oxygen or any of the dozens of treatments he had required when I first arrived on the island. I had drained infected fluid from around his heart three hours into my assignment at the LBJ Tropical Medical Center. And he was getting better! Just a little boy recovering nicely, surrounded by parents and siblings who spoiled him.

For the past three days, I have watched my 5-year-old patient try to die. Three days ago, I walked by his bed on the pediatric ward and was stunned. He was short of breath and miserable. The muscles between his ribs were visibly moving in and out, trying to keep his lungs full of air. By 4 o'clock in the morning, he was in the ICU intubated. The rest of that day and most of the next, his team of pediatricians and I struggled to stabilize him. I put in chest tubes and placed

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intravenous lines. There were four powerful antibiotics and a pharmacy's worth of drugs. The ancient ventilator we have for children gave us few options, but we tried all of them. I put my head together with my colleague, Dr. John DePasquale, a pediatrician from New York who came to us from the CDC in Atlanta. We were losing the war and could not even identify the enemy. Tuberculosis? Bacteria? Fungus? A novel virus or a vicious strain of a known one? We had no answers. Every time I met with his helpless parents, they thanked me. I thought to myself, "For what?" I could not help this child.

When it became clear that this remote facility had no more resources to make a difference in the outcome of a 5-year-old who had been happily munching on artificially-colored orange snacks 24 hours earlier, my colleagues and I struggled to get the closest hospitals, those on Hawaii, to consider accepting the boy in transfer. We were unsuccessful. I don't really know which of the two dozen phone calls was the one I placed to Dr. Bill Dominic, a Burn Surgeon/mentor of mine from Fresno, California. But after I described to him what was in front of me, he offered to make some calls himself. A few minutes later, Dr. Kathleen Murphy, a Pediatric Intensivist with the *Children's Hospital of Central California* called me. "We'd be happy to take care of him." She was unfazed when I explained that although the child was a U.S. National, the care would be charity. There were no family or island resources for the kind of care he needed. "It's what we're here for."

Then the logistical nightmare began. There was no transportation to California for this child. He was far too sick for commercial travel even if he could survive the four days until the next flight left American Samoa. An air ambulance was essential. But such a trip would carry an astronomical cost and require at least an overnight stay with a medical team on the way to the mainland. That presupposed he could survive 11 or 15 hours in transit. I left a desperate message for U.S. Congressman Jim Costa of California's Central Valley. He called me back. I explained the situation in what must have sounded like an incoherent medical rant against bugs and bureaucracy and one doctor's frustration at having the child's only hope of survival destroyed by 7,000 miles of ocean. Congressman Costa told me to keep doing what I did as a doctor and let him deal with the rest.

The next call I received was from David with the office of Congressman Eni Faleomavaega of American Samoa; then a call from his Chief of Staff in Washington, D.C., Lisa Williams. Then the State Department, then Homeland Security, then the United States military medical transport people in the Pacific region. There were at least five of those guys and a high ranking lady named Captain Ellenberg.

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The U.S. Coast Guard's Chief Petty Officer Smedley and Lt. Max Sada both intervened to help the sick boy, investing hours trying to cut red tape for a child they'd never meet at the request of a surgeon whom they'd never heard of. And finally there was a call from the military doctor with the Pediatric ICU at Tripler Army Medical Center in Hawaii. She said that the facility would be happy to care for the child if logistics were overcome and gave us good suggestions for his care, which we instituted.

Between all of these calls and a series of late night and 5 a.m. conferences with Dr. Jim Marrone, head of Pediatrics at LBJ Tropical Medical Center, we spent our time in the ICU with our critically ill patient. I depended heavily on LBJ Surgery Chief Dr. Kamlesh Kumar and the seriously overworked doctors of LBJ's Emergency Department to cover cases and shifts while I worked in the ICU and fought cell phone battles. They are buried under the workload but never complain.

My favorite call was from Major Matthew Nims, M.D., United States Air Force Anesthesiologist, Medical Transport team leader and all-around superhero. It was his commitment to care for a dying 5-year-old child en route to Tripler that made the impossible possible. At 2:30 p.m., a United States Air Force C-17 (a flying Intensive Care Unit) landed at the Tafuna International Airport in American Samoa. In addition to the pilots, there were two physicians, two Pediatric ICU nurses and a Respiratory Therapist. Did I mention that these people had volunteered for this mission?

For four hours, the Army/Air Force and the LBJ Hospital teams worked to stabilize the boy. At some point, the child began to show noticeable improvement.

The little boy's parents expressed their gratitude to everyone who entered the ICU doors. They gave the same grateful recognition to the X-ray Technician as they did to Congressman Faleomavaega.

Transporting a critically ill 5-year-old with every available monitor, tube and life support device is no simple task. I rode in the ambulance with the boy and three other team members.

The sight of the C-17 waiting for us on the runway had me repeating "Holy Cow!" I couldn't find any other words to describe the impossibly massive jet, nicknamed "The Globemaster." It is the only aircraft in the world to have a self-contained onboard oxygen system. After the little boy was safely delivered to the warehouse-sized interior of the jet, I hugged Major Nims and his colleagues and walked down the ramp to find Ele, the LBJ Social Worker who had conquered limitless paperwork hurdles in the past three days.

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I looked back from a distance at the giant plane. When I saw the words “United States Air Force” on the nose, I choked up. “She’s ours,” was the thought I had. During the ride back to LBJ, all of the exhaustion and hopes and fears and frustrations and victories and grief of the past 72 hours hit me. I didn’t have the luxury of indulging my emotions while caring for a child for whom death was a much greater likelihood than survival.

I don’t know if my patient will survive. I don’t know if the beautiful long dark eyelashes I looked at in the ambulance ride to the airport will open again. But I do know that if he has a chance, it is inside the C-17 that left American Samoa tonight. And in the Pediatric ICU of a Hawaiian military hospital. And in the greatness of a Nation that can aim its military might at saving the life of a little boy on a tiny tropical American island in the middle of the Pacific Ocean.

### Death and Life on American Samoa: Update

*November 19, 2009*

Whoever destroys a soul, it is considered as if he destroyed an entire world.

And whoever saves a life, it is considered as if he saved an entire world.

—Jerusalem Talmud, Sanhedrin 4:1 (22a)

This morning, a little boy died. His name was not Abe, but I call him that. He was five. I was one of a massive team who cared for Abe. Our work was made possible by three members of Congress, two governors, and a U.S. senator. The heavy lifting of red tape was done by their staff members in Pago Pago, Honolulu, Los Angeles, Fresno, and Washington, D.C.

Much of what we did for Abe depended on decades of research by scientists and innovators in medical technology.

Abe was my patient, but he was not only my patient. He belonged to all of us who stood at his bedside, entered his test results in a computer, or just made a phone call on his behalf. His father was with him constantly after he was transferred off the island to a Pediatric Intensive Care Unit on Hawaii, and his mother never left the hospital here on American Samoa. The American Red Cross is arranging Abe’s last trip home. As is tradition, he will be buried in his family’s village so his brothers and sisters can visit him as they do his ancestors. And his mother and father will never be far from his side.

The financial burden of caring for this little boy during the last weeks of his life is staggering. The U.S. Air Force’s C-17 medical transport plane trip alone cost hundreds of thousands of dollars. This is America, but the island does not even share the same side of the equator as California. I’ve been criticized for

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participating in this outrageously expensive attempt to salvage the life of a single child. Was Abe's life worth it?

I understand the criticism, and it is logical: if we spent less on Abe and allowed him to die, we could theoretically take that money and allocate it to help many more children. I'll leave that debate to others who can view this "case" more objectively than I can. I was Abe's doctor. I will attend his funeral service. His family includes me in their nightly prayers. As did the army of caregivers who tried to save Abe's life, I did everything I could. When our remote medical facility reached the limits of its resources, we called for help. The call was answered—by elected officials, by the United States Air Force, by Tripler Army Medical Center, by Kapi'olani Women and Children's Medical Center—even by the Children's Hospital of Central California, which volunteered to care for this child if he could have been transported the 7,000 miles.

Was Abe's life worth it? He was a five-year-old who liked to eat potato chips and tease his older brothers, not a head of state or a Nobel Prize nominee or even a famous athlete. He was just a boy whose family loved him. He was just my patient.

Was Abe's life worth it? It's not a question I can answer as a health care policy wonk. I can't answer it as a writer, or even as a doctor.

I can answer it only as one person who was there and served as a witness to modern medicine's miracles and one family's painful tragedy.

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