Cancer Care During Natural Disasters

By Kurt Ullman

When natural disasters occur, everyone is focused on survival. But for cancer patients, this challenge is all the more arduous—because hospitals and other health care infrastructures may be destroyed, wiping out their medical records, and both physicians and patients may be forced to flee.

“Cancer patients are especially susceptible to the disruptions that natural disasters can cause,” said Anna Pou, M.D., professor in the department of otolaryngology–head and neck surgery at the Louisiana State University Health Sciences Center in New Orleans. “Lapses in treatment can have an effect on treatment outcomes.”

Pou, who experienced Hurricane Katrina in August 2005, said communication was the biggest challenge after the hurricane hit. “In cancer treatment, contact with colleagues is a very important part of the process,” she said. “Proper treatment involves working with pathologists, radiation and medical oncologists, surgeons, and other services.”

Hospitals were destroyed, and paper records were underwater. Contacting patients proved to be mostly useless, because phone numbers either were disconnected or rang constantly because no one was home. Cell phone service was spotty at best.

Pou’s group reassembled quickly in Baton Rouge. They had their physicians together during the week after Katrina and began seeing patients within 2 weeks.

“We had patients, but little else,” she said. “We did not have pathology reports, information from medical oncologists on chemotherapy dose, or anything to know how much radiation they had received. Worse, we did not have any way to get it.”

Although some patients were prepared and had at least some information with them, most did not. People would show up in Pou’s office, saying they had cancer. Many had no idea as to specific type of cancer, stage, or how it was being treated.

According to Marcello Blaya, M.D., assistant professor of medicine at Tulane, “This meant quite a bit of detective work was needed. Physicians in Louisiana and throughout the U.S. had to track down the information. They weren’t always able to find what was needed.”

Many physicians were unwilling to blindly give radiation or chemotherapy to patients. And patients who found treatment options faced other concerns.

“Cancer care was fragmented across the state,” said Blaya. “They were having their workup done in one place and then the treatment in another.”

Although Katrina’s widespread devastation may be an outlier among natural disasters, smaller tornados and floods disrupt cancer care throughout the country.

Floods in Indiana

June 8, 2008, was a quiet Sunday in Columbus, Ind. But Haw Creek, which runs sedately past the Columbus Regional Hospital, was rising. The culprit was rain up north. Adding to water flow was the breaching of some levees upstream.

“The water came out of the banks and flowed into the hospital’s basement,” said Pat Cruser, manager of the Cancer Center. “We had so much water that the Cancer Center on the first floor was flooded. Information Technology was closed and all power to the campus was cut off.”

As in New Orleans, staff’s first priority was contacting patients—difficult because they had only Monday’s schedule; the rest of the week’s schedule was on the computers in the basement.

“We had to wade through water to get our charts out so we could rebuild our schedule and contact our patients,” said Cruser.

On Monday morning, staff went looking for space. The hospice’s building was on higher ground and not flooded, so they occupied some unused space in its attic, where they set up a makeshift administrative office. They went back and forth between the center to salvage patients’ charts. They combed through them to see when each patient was due for treatment, and staff members then contacted patients according to how soon they were scheduled.

Next they had to find a place for the doctors’ offices. “A group of local physicians had some extra space, and we set up our medical staff with them,” said Cruser.

Meanwhile, staff continued to look for all the things that make running a cancer center possible. They scavenged up recliners for patients. They used cell phones until landlines could be established. Pharmacists looked for replacement medicines. “By day 3, we had the general outlines of where our medical oncology patients would be going,” said Cruser. “By day 8, we were able to begin treating them.”

For patients undergoing radiation therapy, the logistics were more challenging. The radiation oncologists in Columbus worked out a deal with the physicians from Franciscan St. Francis Hospital in nearby Greenwood to use their facilities after regular hours.

“We rented a van and had a hospital employee drive them roughly 35 miles to Greenwood,” said Cruser. “Our patients were seen after 4 p.m.”

Six months passed before the staff and doctors could return to the Cancer Center. At Pou’s LSU Health Sciences Center in New Orleans, the wait was 3 years and is ongoing.

“The most valuable lesson we learned from Katrina was the need for patient education,” said Blaya. “Our biggest investment from that point was in making sure everyone knew about their disease, their treatment, and how to get the resources they need if uprooted again.”

Disaster Planning for Patients

According to the experts interviewed, patient teaching on disaster planning should occur at least yearly. The actual timing would depend on where one lives and the natural disasters common to the area. The most critical information includes the name of the disease, the intent of treatment...
(curative or palliative), the regimen patients are on, surgery and pathology reports, and health insurance information. The last factor can be helpful if a person is displaced, because the insurance company would have much of the needed information available.

“Cancer care is complex. Patients don’t always know their exact diagnosis and stage, names of the chemotherapy drugs they are receiving, or where they are in their treatment cycle,” said Deborah Pearson, a public health adviser for the National Cancer Institute. “Being able to clearly articulate their situation to an unfamiliar provider is critical.”

To address some of these issues, the NCI together with the American Society of Clinical Oncology designed a wallet card for patients to carry. It includes spaces for the physician to fill in the needed information. For more information on the patients’ wallet cards, see http://www.cancer.net/patient/Publications+and+Resources/ASCO+and+NCI+Patient+Information+Wallet+Card.

Contact information for doctors should be known before a disaster occurs. However, as Katrina underscored, the doctor’s address and phone number may be of little use. The front of the card includes the national toll-free number and website for the NCI and the website of the American Society of Clinical Oncology.

“The NCI has a national communications infrastructure in place,” said Pearson. “If there is a disaster, physicians could be advised to call 1-800-4-CANCER and let us know how to get in touch with them, and they could let their patients know to call us for help if they lose contact with their health care team.”

Although the widespread adoption of electronic medical records might sometimes be helpful, depending on computers could cause other problems if the records are not also stored offsite, if, for example, flooding or power outages occur.

“As treatments for cancer become more individualized, the more we know the better we can treat the patient,” said Blaya. “In the context of natural disasters, it will be nearly impossible to personalize without an educated patient and complete medical records.”

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