

Handout to accompany K. Brad Ott's November 18, 2014 APHA IHRC Presentation

PRESENTER'S NOTE: Perhaps because of the need to hold myself accountable for what potentially could be viewed by some as use of the American Public Health Association (APHA)'s International Human Rights Committee (IHRC) as a forum for a polemical diatribe, but also in keeping with the rigorous expectations of my sociological discipline Participatory Action Research (PAR) paradigm which sociologists *can* account for inherent bias one cannot otherwise ever hope to escape or overcome, I present this *handout* to attenders of my "Human Rights and Healthcare in the aftermath of Hurricane Katrina" presentation during the *The NEW New Orleans: Nine Years Post-Katrina* APHA IHRC panel, scheduled for November 18, 2014.

Operating under the Participatory Action Research paradigm (PAR),¹ my presentation combines my 'healthcare as a human right' activism, my standing as a former Charity Hospital patient and an advocate for its reopening, with my role as a sociological researcher. The participant observations expressed herein are solely my own. They also were successfully defended as part of thesis requirements for a Master of Arts degree from the University of New Orleans, Department of Sociology College of Liberal Arts received in May 2012. The thesis: *The Closure of New Orleans Charity Hospital after Hurricane Katrina: A Case of Disaster Capitalism*, subsequently has remained since its publication among the top ten most downloaded articles in several sections of the "Medicine and Health Sciences Commons"² of the Digital Commons Network. This APHA IHRC presentation herein represents a portion of my thesis work related to my APHA IHRC – in the hope *and* expectation that you may engage me in further discussion and accountability. – K. Brad Ott

¹ See West, Alcina, Peterson and Laska (2008). Also known as *Advocacy/Participatory*: Creswell (2007, pp. 21-22) and *Action Research*: Brydon-Miller, Greenwood and Maguire (2003) and Hilsen (2006).

² See for example Medical Education Commons of the Digital Commons Network: <http://network.bepress.com/medicine-and-health-sciences/medical-education/>.

I think we have a clean sheet to start again. And with that clean sheet we have some very big opportunities.

Joseph Canizaro, Member, Bring New Orleans Back Commission (BNOB), quoted by Gary Rivlin, *The New York Times* (Rivlin 2005)

[Charity Hospital's closure] created a significant barrier to return for displaced residents in need of medical care.

Chris Kromm and Sue Sturgis, Institute for Southern Studies (ISS 2008, p. 26)

Charity's closed psychiatric CIU was "the number one cause for the mental health crisis" in New Orleans.

(American College of Emergency Room Physicians 2006, p. 3).

The emergency medical services provided at Charity Hospital are an essential public service that needs to be restored and maintained to avoid further tragedy.

(Robert E. Suter, President of the American College of Emergency Room Physicians 2005).

[Charity Hospital's closure] was the single greatest obstacle to return of the black community.

Dr. Lance Hill (2008)

Human Rights and Healthcare in the Aftermath of Hurricane Katrina in New Orleans

Handout by K. Brad Ott for the APHA IHRC Panel, November 18, 2014

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Considering Charity’s closure as a human rights violation of the internally displaced

In virtually any other global setting, failure to open a working hospital would have sparked a United States government condemnation. Federal authorities, apart from FEMA, however never seriously contested the forced end of Charity’s disaster recovery operation.

News of Charity Hospital’s forced closure, together with reports of the abandonment of Orleans Parish Prison inmates to drown in their cells, the mass firings of teachers and municipal workers, and demolition of public housing while its residents were internally displaced, aroused notice of human rights activists and organizations from around the world.³

The American Civil Liberties Union’s (ACLU) National Prison Project, investigating charges of some Orleans Parish Prison inmates being left to drown in their locked cells, also uncovered “the criminalization of mental illness” as a result of the closure of Charity Hospital’s psychiatric Crisis Intervention Unit’s (CIU). In the ACLU’s 2007 follow-up report:

Perhaps the biggest blow to the region’s mental health system is the loss of Charity Hospital ... With so few psychiatric services available to the public, mentally ill people are being funneled into the criminal justice system. Some families have grown so desperate that they have sought to have their mentally ill relatives arrested in the hopes of getting them psychiatric care... (ACLU 2007, p. 22).⁴

Even with significant improvements to community-based treatment programs under the purview of the Metropolitan Human Services District, the combination of inpatient hospital unit closures (particularly the New Orleans Adolescent Hospital (NOAH) and outpatient program budget cuts has continued to hobble the mental health system (Levin 2010). Indeed the city has just half the inpatient beds, with double the need, since the storm (Hudson 2009).

³ National Economic and Social Rights Initiative / NESRI (2008); Institute for Southern Studies / ISS (2008); The Brookings Institution (2008); Center for Constitutional Rights / CCR (2009); Amnesty International / AI (2010); Advisory Group on Forced Evictions / AGFE (2010); Advocates for Environmental Human Rights / AEHR (2011). Two additional reports with human rights and Charity Hospital analysis include Quigley (2008) and Luft (2009).

⁴ *Abused and Abandoned: Orleans Parish Prisoners in the Wake of Hurricane Katrina*, ACLU (2006).

Underscoring the impact of the loss of Charity's psychiatric CIU has had on the criminal justice system, Orleans Parish Sheriff Marlon Gusman, in a sworn affidavit in support of a lawsuit to reopen Charity, said the closure of the CIU added to his "incredible burden":

As Sheriff of Orleans Parish, I have been confronted with the incredible burden of dealing with mental health issues in the criminal and prison systems. While the prison in New Orleans has a facility for mentally ill inmates and can treat inmates who are suffering from mental health issues, before the storm police officers could take people whom they suspected were exhibiting criminal behavior as a result of mental problems to Charity Hospital. Since the closure of Charity's Crisis Intervention Unit, police officers have limited options as to where they can take people with mental health problems outside of jail (Gusman 2008).

The ACLU report indicated that in addition to Orleans Parish Prison's 60-bed psychiatric unit, "300 prisoners in the general population receive psychiatric medication." Many of these prisoners have been declared incompetent to stand trial by reason of insanity, or not mentally competent to stand trial. The lack of outside psychiatric beds often results in prisoners languishing for months "and in some cases years" at Orleans Parish Prison and other jails. Once able to enter Louisiana's only forensic mental hospital, the Feliciana Forensic Facility, many prisoners then cannot leave because of the lack of community outpatient group and nursing home placements willing or able to accept them (ACLU 2007, p. 22). The ACLU report noted:

Without community mental health services and a functioning emergency system for acute psychiatric care, mentally ill people will continue to be incarcerated for behavior that is a product of their illness, and will spend increasingly long periods of time in jail, rather than in a proper therapeutic setting (ACLU 2007, p. 23).

NESRI's report on Charity Hospital's closure cited Article 25 of the United Nations Universal Declaration of Human Rights: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services..." (NESRI 2008, p. 2).

Principle 18(2) of the UN's Guiding Principles on Internal Displacement states:

At the minimum, regardless of the circumstances, and without discrimination, competent authorities shall provide internally displaced persons with and ensure safe access to: a) Essential food and potable water; b) Basic shelter and housing; c) Appropriate clothing; and d) Essential medical services and sanitation.⁵

Charity Hospital's closure "created a significant barrier to return for displaced residents in need of medical care." With Charity's psychiatric CIU closed, Orleans Parish Prison's 60-bed unit was the largest inpatient facility "(contradicting) Guiding Principle 28, which calls on authorities to establish conditions allowing (internally displaced persons) to return home "in safety and with dignity" (ISS 2008, p. 26).

The AGFE report highlighted the inherent loss of healthcare *space* with LSU's choice to restore the smaller University Hospital rather than the much larger Charity facility:

University Hospital has just one-fourth of Charity Hospital's capacity. This forces many uninsured, underinsured and poor residents of New Orleans to travel long distances to receive treatment at one of Louisiana's other public hospitals. In fact, many residents simply forego needed medical care. More than one in three New Orleans residents postpone needed medical care and one in four report that they had no doctor, clinic, or pharmacy to turn to for needed care (AGFE 2010, p. 43).

Amnesty International's report echoed the ACLU and ISS reports on the loss of mental health care, but also emphasized Charity's closure as a disproportionate loss for the working poor and the uninsured:

Charity served a largely poor, predominately minority population through inpatient care, a network of outpatient clinics and the busiest emergency department in the city. Nearly three-quarters of its patients were African American, and 85 percent had annual incomes of less than \$20,000. Over half of the indigent care provided by (Charity and University hospitals) was for patients without insurance, representing two-thirds of the care to the uninsured in the city (AI 2010, pp. 17-18)

⁵ NESRI (2008, p. 4); ISS (2008, p. 33) AI (2010, p. 27).

The forced expropriation and demolition of the Lower Mid-City New Orleans neighborhood for the proposed LSU/VA Medical Center, resulting in the internal displacement of hundreds of residents and dozens of businesspeople and their enterprises, have been according to the AGFE mission no less human rights violations than the internal displacement and forced relocation of public housing residents. Citing the U.S. as a signatory of the International Covenant on Economic Social and Cultural Rights (ICESCR), the AGFE mission reiterated that under articles IX and XXIII of the 1948 American Declaration of the Rights and Duties of Man, “every person has a right to own such private property as meets the essential needs of decent living and helps to maintain the dignity of the individual and of the home” (AGFE 2010, p.36).

Both the AGFE and CCR reports also referenced that planning for the LSU/VA project was accomplished without the effective consultation of those facing forced internal displacement as the result of the plans – in violation of human rights covenants (CCR 2009, pp. 20-21; AGFE 2010, pp. 28, 34-45, 49).⁶

Walter Kalin, Representative of the U.N. Secretary General on the Human Rights of Internally Displaced Persons, and Brookings-Bern Project on Internal Displacement observed the U.S. governmental response before, during and in the aftermath of Hurricane Katrina:

The U.N. Human Rights Committee, a body of independent experts entrusted with the task of monitoring the implementation off the International Covenant on Civil and Political Rights, when examining the report submitted to it by the USA, expressed its concerns “about information that the poor, and in particular African Americans were disadvantaged under the reconstruction plans” and recommended to the U.S. “review its practices and policies to ensure the full implementation of its obligation to protect life and of the in matters related to disaster prevention and preparedness, emergency assistance and relief measures ... that the rights of the poor, and in particular African Americans, are fully taken into consideration in the reconstruction plans with regard to access to housing, education and healthcare” (Kalin 2008).

⁶ The author contributed testimony and documents for the NESRI, CCR, AGFE and AI reports.

Nearly ten years after Hurricane Katrina, there *remains an unprocessed conversation about human rights that first arose when the BNOB Commission plan to leave fallow much of the city of New Orleans that flooded deeper than four feet failed to take hold.* The conversation is rooted in the fact that most white residents were able to immediately return to the city and determine the course of their storm recovery, while many African Americans remained internally displaced for months and even years.⁷ It also remains within the still contested terrain of a “recovery” climate set up by the mass firing of mostly African American female certified public school educators from New Orleans’ public schools, facilitating mass the arrival of privately-managed “non-profit” charter schools to occupy new school buildings constructed with public disaster relief funds; closure and demolition of the city’s public housing developments, to be replaced by market-rate, privately-managed apartments; *and the closure of Charity Hospital.* This *disaster capitalist paradigm* has contributed to the continuing internal displacement of our poorest citizens and the profound abridgement of their human rights.⁸

Indeed, predominate is the mindset of those who proclaim *that storm “recovery” has ended.* This is epitomized best by New Orleans Mayor Mitch Landrieu’s often spoken response:

We are no longer rebuilding. We are now creating. Let’s stop thinking about rebuilding the city we were and start dreaming about the city we want to become (Davis 2010; Landrieu 2011).

The 118,000-fewer African American residents and 24,000 fewer white residents according to the 2010 U.S. Census seem to represent the *failure* of recovery. In fact many represent what Robertson dubbed “a shadow city” of people wanting, but unable to return.⁹ Also caught up within the shadow city, this author suggests, is Charity Hospital.

⁷ See Louisiana Family Recovery Corps (2007); Hill (2008); RAND (2010, p. 3); Robertson (2010); Krupa (2011).

⁸ See Reed (2005); Ouroussoff (2006); Hill (2008); Penner and Ferdinand (2009); Davis (2010); Perry and Schwam-Baird (2010); Mildenberg (2011).

⁹ See Louisiana Family Recovery Corps (2007, pp. 4-5); Plyer (2010); RAND (2010, p. 3); Robertson (2010-11); Gill (2011).

The healthcare consequences of Charity Hospital's forced closure

After rebuffing Task Force Katrina's efforts to reopen Charity Hospital, LSU had attempted to retain the U.S. Navy hospital ship *USNS Comfort* to become Charity's substitute. The ship had arrived at the Port of New Orleans September 29 after spending nearly three weeks on the Mississippi Gulf Coast treating more than 1,800 people in Hurricane Katrina's aftermath. The 800-bed floating trauma center however saw no more than 100 patients during its two week New Orleans stay. Charity Emergency Department (ED) Dr. James Aiken said he was "very concerned" that the *Comfort's* departure would leave "New Orleans without a fully functioning public hospital as residents began to return" (*The Associated Press / AP* 2005c; Moller 2005d).

Following the closure of Charity Hospital and the *Comfort's* departure, Charity's remaining medical staff practiced medicine in several makeshift locations. First, six tents were set up outdoors as an urgent care MASH unit five blocks away in a parking lot from the Charity campus they had restored just days before. More serious trauma cases were treated in a joint Army Special Forces-Charity ED unit inside the Morial New Orleans Convention Center (Young 2005). Dr. Peter DeBlieux, director of resident training at Charity, responding to the provision of "E-MED" emergency medicine tents, rather than just reopening the hospital:

Now my fear is the entire country will think it's appropriate to care for our patients in a tent. I don't think the rest of the country appreciates we are seeing people in a tent (Connolly 2005).

DeBlieux said the unit, dubbed "The Spirit of Charity," saw about 150 patients daily. Because of the makeshift nature of E-MED tents, it failed to meet federal health standards – and hence was unable to receive Medicare, Medicaid or private insurance reimbursement. The unit's funding was drawn instead from Charity hospital system state budget allocations for its physical building – monies that LSU officials acknowledged were running out (Connolly 2005).

After Charity's closure, just 250 out of nearly 4,000 Charity and University hospital employees remained working, with the rest placed on unpaid furlough (Connolly 2005).

Displaced health professionals warned that these job losses could become permanent – and would compromise the very recovery of the city:

We read in the paper that the governor wants to keep as many people as possible in the state; that the mayor wants to repopulate the city soon and start building business again. I could not agree more. But not addressing Charity Hospital / MCLNO and leaving employees' employment status in limbo is not the way to do this (Danos 2005).

Two months after Charity's closing, over 2,600 hospital employees would be fired (Moller 2006c). LSU and Tulane graduate medical education programs were destabilized, leading to the reassignment of 550 medical residents and fellows. The Delgado Charity School of Nursing and other schools, in addition to LSU allied education and dentistry programs were also impacted by the displacement of 2300 nursing and allied health students (LSU-HCSD 2005).

And "The Spirit of Charity" was forced to wander again, as the Morial New Orleans Convention Center sought to prepare the site where the tent hospital stood for pre-storm booked conventions (Callimachi 2006). They moved to a once-flooded department store next to the Louisiana Superdome (still used as outpatient clinics); while a mothballed hospital in Jefferson Parish was reopened as a temporary 40-bed Level 1 trauma center. LSU-HCSD spent nearly \$5 million for the makeshift facilities, which were later reimbursed by FEMA (Louisiana Public Records Act request 2006; United States General Accountability Office / U.S. GAO 2006a, p. 6).

Charity Hospital's closure in the months and years following Hurricane Katrina underscored its utter centrality to southeast Louisiana healthcare, both public and private. Charity's Level 1 trauma center was the only one on the Gulf Coast – forcing remaining hospitals to receive patients with medical conditions rarely experienced (Barringer 2006).

Coupled with the near-total closure and / or destruction of area nursing homes and rehabilitation facilities, the few remaining open hospitals quickly filled with patients that would not be so easily discharged (Barringer 2006). A severe shortage of nurses, aides, home hospice and service workers compounded the crisis. A veritable *Katrina Doctors' Diaspora* – “the largest single displacement of doctors in U.S. history” – added pressure to those remaining (American College of Emergency Physicians / ACEP 2006). This loss of health workers, federal officials said, resulted in “staffed hospital beds (inside New Orleans’ city limits) that were about 80 percent *less* in February 2006” than before the storm (U.S. GAO 2006a, p. 35).

Charity’s closure also compromised trauma services beyond New Orleans -- especially in Baton Rouge – the latter where many evacuees endured lengthy wait times that threatened to adversely affect patients’ health (ACEP 2006). Many primary care practices and outpatient clinics citywide, already decimated by flood damage and the dislocation of their patient bases, lost the only hospital which would accept their referrals (Ferdinand 2006).

The *finances* of remaining private and non-state hospitals also hemorrhaged due to the virtual overnight inundation with patients that Charity would have normally seen. Charity’s sudden closure sent shock waves of pain – even on those which had proclaimed this iconic but neglected hospital to be outmoded (Zigmond 2006; Larkin 2007, p. 58; Sternberg 2007).

Testifying before a U.S. House subcommittee on post-Katrina healthcare, Colorado U.S. Representative Diana Degette remarked about the private providers’ apparent underlying stance when it comes to Charity Hospital – and especially its care for the uninsured:

I asked the panel of the private hospitals if their long-term business plans included providing care to the population previously served by Charity; and everybody got a look of shock on their face and said no, that was not in their business plan for assuming the care of Charity’s patients in the long term (Degette 2007, p. 7).

Diane Rowland, Executive Director of the Kaiser Commission on Medicaid and the Uninsured, characterized Louisiana healthcare as “a two-tier system” with private hospitals and providers serving those with insurance and Charity system hospitals serving the uninsured – and that the closure of Charity after Hurricane Katrina had a profoundly negative impact on both:

Our household interview survey (revealed) the fact that 90 percent of our respondents did not feel there were enough services, hospitals, clinics, medical facilities in the New Orleans area to meet their needs and that it was one of the most troubling factors in their decision of whether (to return or stay) in New Orleans (Rowland 2007, p. 21).

Though licensed at 714 beds in two campuses at the time of Hurricane Katrina, there were 300-500 regularly staffed beds between Charity and University hospitals (LSU-HCSD 2005; Hartley 2012). Before Katrina, Charity had 70 ED beds and University 14 (Moises 2009a, p. 1). Charity also had a 128-bed psychiatric “Crisis Intervention Unit” (BKA 2007). Pre-Katrina, Charity had more than 160 outpatient clinics on its MCLNO campus (Smithburg 2007, p. 176). Another 21 free clinics apart from LSU were situated throughout metro New Orleans (Partnership for Access to Healthcare / PATH 2003). Six years later, 76 safety net clinics¹⁰ are open, including ones run by LSU-HCSD inside LSU Interim Hospital and other locations (Greater New Orleans Community Health Connection / GNO CHC 2011).

Charity’s sister facility, University Hospital, once declared “unsalvageable,” *reopened* in late 2006 as *LSU Interim Hospital* (Smithburg 2005, Moran 2006). Staff shortages initially led to only 60 of 150 beds available for its opening (Moller 2006c). Its Level 1 trauma center did not return until February 2007 (LSU-HCSD 2007f, p. 19). Six and a half years later, LSU Interim has 255 staffed beds with 38 intensive care unit beds (Hartley 2012). FEMA has reimbursed LSU \$101 million of the hospital’s total repair costs (FEMA 2011).

¹⁰ “Safety net” indicates access to free inpatient and outpatient healthcare, exclusive of prescription drugs and certain tests, for those with incomes of 200% of the federal poverty level for family size, qualifying under either under the 1115 Medicaid waiver (DHH 2010) or LSU-HCSD Free Care (LSU-HCSD 2011b).

Nowhere has the impact of Charity's closing been more acute than with inpatient psychiatric care. The closure of the hospital's psychiatric Crisis Intervention Unit (CIU) – once the city's largest facility – left Orleans Parish Prison's 60-bed psych-ward to become the default provider and the largest place for inpatient psychiatric care (Stephens 2007). A clinician noted:

Without Charity Hospital and the VA Medical Center, the psychiatric public sector bed capacity was reduced 96% four months after the disaster; one year later the reduction remained at 70% (Calderon-Abbo 2008, p. 305).

Years after Charity's closure, the inundation of area general hospital emergency rooms with mental health patients continues to be a seemingly insurmountable obstacle. Such patients often remain for weeks and crowd out other acute care patients. Within the first year of the storm, hospitals effectively were closed to new admissions – even as ambulances and police continued to drop off emergency patients (Potash and Winstead 2008, p. 122).

The American College of Emergency Physicians said psychiatric care was “deficient before the storm (and) now close to non-existent” – and that Charity's closed psychiatric CIU was “the number one cause for the mental health crisis” in New Orleans (ACEP 2006, p. 3). Three years after the storm, 20 beds were staged *in trailers* outside LSU Interim as a “Mental Health Emergency Room Extension (MHERE) (Egglar 2008). This makeshift unit received more than 350 people in September 2010 alone “with a mental health crisis” (Tebo 2010).

Baton Rouge Mayor Melvin “Kip” Holden noted that his city was also adversely impacted with the loss of “900 of the state's 2,100 licensed beds when New Orleans was evacuated” (Holden 2005). Baton Rouge mental health professionals “reported a 72 percent increase in patient volume at their three mental health clinics, 100 additional cases per month of patients in mental health crisis presenting to area emergency rooms” ... and a near doubling of “commitment orders for mental health treatment” (Potash and Winstead 2008).

A study conducted in early 2006 of all Tulane University faculty and staff (including administrators) found “a significant burden of (Post Traumatic Stress Disorder) PTSD symptoms was present 6 months following Hurricane Katrina among a large group of adults who had returned to work in New Orleans” – and this was from a workforce, researchers said, that had “universal health coverage and the benefits of an employee assistance program” (DeSalvo, Hyre, Ompad, Menke, Tynes and Munter 2007). Meanwhile a study of LSU Interim ED patients surveyed right after the hospital was reopened found a PTSD prevalence of 38.2 percent – *ten times higher than the national PTSD prevalence* of 3.6 percent (De Wulf, Mills, Levitan, Macht, Afonso, Avegno and Mills 2007). In a 2007 survey by the Henry J. Kaiser Family Foundation, access to mental health services *declined* – and “that three out of four people support the restoration of Charity Hospital as a primary health care resource for the poor” (Shields 2007).

New Orleans had “15.8 suicides per 100,000 persons in 2009 – well above both the pre-Katrina rate of 9.8 and the national rate of 10.96” (UNITY for the Homeless of Greater New Orleans / UNITY 2010). A rash of suicides at Orleans Parish Prison, compounded by inadequate staffing and procedures, underscore the need for more outside treatment options (*T-P* 2009b).

Heightened levels of violence also have come define the post-storm landscape. Incidents such as the killing of two children by their uncle, who suffered from schizophrenia, led New Orleans Police Department Crisis Commander Cecile Tebo to observe:

This is what happens when a city does not provide in- and out-patient services for people with mental illnesses (Urbaszewski 2011).

Tebo has long warned of “the ticking time bombs” of people suffering from debilitating mental illness and lacking mental health resources, who are “poised to harm themselves or someone else.” She also said that many in prison wouldn’t be there if proper treatment options were made available (Tebo 2007).

Some public education, healthcare and homeless advocates have sounded the alarm that the failure to replace the mental healthcare services once provided by Charity Hospital has heightened disaster-induced PTSD – leading to enhanced rates of chronic homelessness and an intractable wave of crime since Hurricane Katrina (UNITY 2010; Andrews 2011).

Following demands from New Orleans Mayor C. Ray Nagin and the City Council to restore or replace Charity’s psychiatric CIU, the state and LSU announced in 2007 a slight expansion of inpatient mental health services, with 20 additional adult psychiatric beds each at DePaul Hospital and the New Orleans Adolescent Hospital (NOAH) (Nagin 2007; Hong 2007; Calderon-Abbo 2008, p. 307). The state also evaluated whether Charity could be reopened for just its psychiatric CIU – finding that Charity’s “deficiencies are correctable” (Blitch Knevel Architects / BKA 2007a and BKA 2007b).

Despite the expansion of adult psychiatric beds, mental health capacity remains strained. Planners for the proposed replacement of Charity Hospital acknowledged that the current 38 beds “are nearly 100 percent occupied and the unit is frequently on ‘diversion’ status” – and that 22 additional beds for 2015 “rapidly will be filled” (Verité 2011, p. 17).

Health professionals from around the nation decried Charity Hospital’s closure. Robert E. Suter, President of the American College of Emergency Physicians (ACEP) wrote to LSU:

The emergency medical services provided at Charity Hospital are an essential public service that needs to be restored and maintained to avoid further tragedy (Suter 2005).

Charity’s workers never waned, though their patience frayed. Dr. DeBlieux said:

Within 2 weeks after the storm, our entire residency contingency and many of the academic faculty were back in the building salvaging, in hopes of delivering care in that facility. The leadership at the state level told us to stand down. They did not think that was a salvageable enterprise. It was very difficult [to accept] (Flynn 2006, p. 311).

Charity was closed when New Orleans was virtually emptied of its populace; Its patients were the heart of the Katrina Diaspora; Fears of exclusion from recovery decisions

Nossiter’s 2005 *New York Times* report on Charity broached another controversy –

whether, by keeping Charity Hospital and other institutions serving the city’s poor closed, that the entire cultural and economic complexion of New Orleans could be permanently transformed:

As one of the two oldest hospitals in North America – it was founded in 1736, the same year as Bellevue Hospital in New York – Charity has from the beginning been a symbol of a social commitment to the poor, and its wards are empty at a moment when thousands of poor New Orleans residents are struggling to return home and fear that government has abandoned them. In many ways, the debate over its future parallels that of New Orleans itself, as it chooses whether to become a more middle-class city or return to earlier traditions (Nossiter 2005).

The closure of Charity Hospital slowed recovery of the region and blocked the return of many of New Orleans’ poor, elderly and most vulnerable residents who relied on Charity for care (Connolly 2005; Eaton 2007). Months after the storm, many displaced residents were scattered around the nation; having lost their homes, schools, community and their main source of healthcare, while navigating the whirling tempest of *the Katrina Diaspora*.

Roberts and Durant (2010, pp. 226, 243) noted that since the Civil Rights movement, Charity system patients have been predominantly African American. Citing LSU figures, in the 2004-2005 year, Charity/MCLNO* black patients constituted over 70 percent of the total. ¹¹

Table 1: Charity/MCLNO* Inpatient Admissions/Outpatient Encounters by race, 2004-05

Inpatient	Admissions (Percent)	Outpatient	Encounters (Percent)
Black	16,549 (70.2%)	Black	331,320 (75.9%)
White	5,548 (23.6%)	White	84,521 (19.3%)
Other	1,465 (6.2%)	Other	20,834 (4.8%)

Source: Roberts and Durant. 2010. *A History of the Charity Hospitals of Louisiana*. p. 243. *Table by K. Brad Ott*
 *Totals include both Charity and University hospitals of the Medical Center of Louisiana at New Orleans (MCLNO)

¹¹ LSUHSC Planning, Program Development and Governmental Affairs, Baton Rouge, LA. FY 2004-2005.

Table 2: Charity system* Inpatient Admissions / Outpatient Encounters by race, 2004-05

Inpatient	Admissions (Percent)	Outpatient	Encounters (Percent)
Black	33,161 (58.2%)	Black	888,515 (55.6%)
White	20,758 (36.4%)	White	660,646 (41.3%)
Other	3,088 (5.4%)	Other	50,051 (3.1%)

Source: Roberts and Durant. 2010. *A History of the Charity Hospitals of Louisiana*. p. 243. Table by K. Brad Ott
*Totals include nine LSU hospitals including New Orleans (but excluding LSU-HSC Shreveport)

VanLandingham (2007, p. 1614) said “New Orleans was essentially emptied by Hurricane Katrina at the end of August 2005.” Guin, et al (2009) adjusted VanLandingham’s austere-stated population amounts and departure by another few weeks – 12,000 people rode out the storm at the Louisiana Superdome; 25 area hospitals held 2,500 patients and 11,000 staff and their families; another 130,000 didn’t leave until a week after the storm, with 65,000 of those being rescued. Guin, et al said that with the close of the evacuation by mid-September 2005, “an estimated 10,000 people remained in Orleans Parish” (pp. 34, 45, 51).¹²

A RAND Corp study said the city’s December 2005 population was about 91,000; and projected it at 155,000 by March 2006 (McCarthy, Peterson, Sastry & Pollard 2006, pp. xi-xiii). It often swelled on the weekends to 275,000 as displaced residents cleaned up (Connolly 2005).

Fears arose that decisions about the future of the city would be made absent the most impacted storm victims. New Orleans public housing and public schools reports noted *that the lack of stakeholder participation significantly impacted policy outcomes* (Rose and Tuggle 2010, pp. 2-3; Perry and Schwam-Baird 2010, p.6). Proponents of privatization to supplant Charity Hospital’s public health mission also admitted the widespread absence of public participation – but were more circumspect about the impact (Louisiana Public Health Institute/LPHI 2005, p. 6). At the time of Charity’s September 2005 closure, the city was virtually emptied of its populace.

¹² The Louisiana State Medical Examiner said 1,464 people died between August 28 and October 1, 2005 (Guin, et al, p. 45). Another 2,300 “excess deaths” were recorded in a study comparing *Times-Picayune* obituary listings from the first six months of 2006 with 2004 (pre-storm): Stephens, Grew, Chin, Kadetz, Greenough and Burkle (2007).

The Bring New Orleans Back Commission attempts to capitalize on the Katrina Diaspora

Just days after the last of the mass evacuations from New Orleans were completed, about 60 corporate and political leaders met in Dallas with Mayor C. Ray Nagin to plot out the city's future (Scott 2005). The 17-member Bring New Orleans Back (BNOB) Commission, formed out of the Dallas meeting, held its first public session one month after the storm (Donze and Varney 2005). Commission member Jimmy Reiss, Chair of the Regional Transit Authority, voiced what many African Americans and advocates for the poor were the worst fears:

Those who want to see this city rebuilt want to see it done in a completely different way: demographically, geographically and politically. I'm not just speaking for myself here. The way we've been living is not going to happen again, or we're out (Cooper 2005).

Largely *void of its populace at the time of Charity's late September closure*, the city's population status in the months following the storm remained a paramount issue. The BNOB Commission, joined by the Urban Land Institute (ULI), proposed a building permit moratorium and permanent land buyouts in areas flooded greater than four feet in depth (ULI 2005). A Brown University study found that "if nobody was able to return to (these) damaged neighborhoods – New Orleans is at risk of losing 80% of its black population" (Logan 2006, p. 1; Dao 2006). BNOB commissioner and developer Joseph Canizaro observed:

As a practical matter, these poor folks don't have the resources to go back to our city just like they didn't have the resources to get out of our city. So we won't get all those folks back. That's just a fact. It's not what I want; it's just a fact (AP 2005d).

The outcry over the BNOB Commission proposal granting just four months for residents to decide on their neighborhood viability before being "green-spaced" dominated the headlines (Donze and Russell 2006). Mayor Nagin joined the New Orleans City Council in ultimately *rejecting* implementation of BNOB Commission / ULI land use provisions.¹³

¹³ Nossiter (2006); Rivlin (2006) and Powell (2007).

In contrast, BNOB Commission co-chairs Mel Lagarde, head of the Hospital Corporation of America's Delta Division, and Barbara Major, director of the St. Thomas Health Clinic (Scott 2005), along with BNOB "Health and Social Services Committee" chair and attorney Kim Boyle (Henderson 2009) recorded virtually no public outcry over Charity Hospital's closure. Much the same way the BNOB Commission attempted to couch its land use planning in the language of safety and equity, its Health and Social Services Committee proclaimed "the need for courageous conversations to change the delivery of health and social services" (BNOB Health 2006a, p. 4). As would be the case with most post-storm "health reform" initiatives, the BNOB Commission *ignored* the attempt of Charity's workers and the U.S. military to restore hospital services, and formulated the transformation of the healthcare landscape from one which held Charity Hospital as its historic epicenter. The BNOB Health and Social Services Committee effectively recommended Charity's continued closure in order to realign its public healthcare mission and financial resources toward corporate medicine; while also endorsing LSU's academic medical center model (BNOB Health 2006a; Webster 2006).

Nelson, Ehrenfeucht and Laska (2007, p. 27) posed that the BNOB Commission deliberations, though nominally open to the public, "were not designed to include nonprofessional residents." The BNOB meetings "out of perceived necessity, occurred before most people returned, residents had to seek them out, and engaging residents as participants was not a priority. Subsequently many residents opposed the BNOB Commission's proposals."

In comparison with the land use deliberations, few patients, non-health professionals or others without a pecuniary interest participated in the BNOB Commission's Health and Social Services deliberations. BNOB participants overall were predominately white males.¹⁴

¹⁴ BNOB Health (2006b): Attendance substantiated via review of a BNOB "Members and Meeting Participants" list. Also see Lake to the River Foundation for Legal Aid & Disaster Relief (2005); Nolan (2006a); RAND (2010).

It has been said many times that “Hurricane Katrina ... laid bare deep, social, economic and cultural divisions that have long plagued New Orleans” (McKiven 2007, p. 742). McKiven’s critique of the political advantage taken (or lost) during New Orleans’ 1853 yellow fever epidemic presaged the parade of “reform” initiatives abounding in New Orleans in the months and years following Hurricane Katrina’s August 2005 landfall. For example, backers of the BNOB / ULI plan to shrink the city’s inhabitable footprint attempted to forge lines of support based on avoiding “racial polarization” and supporting “the common good” toward creating a new city that would be more equitable and humane for the displaced to return – while clamoring *for the active silencing or disregarding of active dissent to discourage community disunity in a time of crisis* (Cowen 2006). These appeals also attempted to extol the fear of avoiding “real estate speculators and unchecked market forces” (Nolan 2006a). Curiously, *the leading supporters of the BNOB plans were real estate interests and developers* (Davis 2006).

The idea of viewing a catastrophe as a chance for societal reordering *and* investment opportunities has been heightened in recent decades by what Naomi Klein (2007) calls “*disaster capitalism*.” She defines the term in its broad scope as the use of a disaster or major event for the deliberate re-engineering of economic, political and community spheres while affected populations are internally displaced; by its “military speed and precision” and in its “treatment of disasters as exciting market opportunities” (pp. 5-6). Klein quotes New Orleans’ developer and BNOB commissioner Joseph Canizaro’s response to a *New York Times* reporter on the city’s future in the wake of the storm: “I think we have a clean sheet to start again. And with that clean sheet we have some very big opportunities” (p. 4; Rivlin 2005). Klein lambasted “using moments of collective trauma to engage in radical social and economic engineering” when most disaster survivors seek the opposite: *to rebuild, not remake* their homes and communities (p.8).

LA. Health Care Redesign Collaborative also attempted to capitalize on Charity’s closure

Klein (2007) suggests disaster capitalism has transformed the provision of crisis relief and social reconstruction to reflect *neoliberal* values – that is to instill classic *private* free market economic attributes through the marshalling and reallocation of once *public* resources:

Disaster capitalists have no interest in repairing what was. In Iraq, Sri Lanka and New Orleans, the process deceptively called “reconstruction” began with finishing the job of the original disaster by erasing what was left of the public sphere and rooted communities, then quickly moving to replace them with a kind of corporate New Jerusalem – all before the victims of war or natural disaster were able to regroup and stake their claims to what was theirs (p. 8).¹⁵

Emboldened by acceptance of the BNOB Commission Health and Social Services Committee recommendations, advocates of “Louisiana healthcare redesign” laid the groundwork for a massive reworking of the state public hospital system along medical neoliberal lines. U.S. Department of Health and Human Services (U.S. DHHS) Secretary Michael Leavitt joined Louisiana Governor Blanco’s administration with consent of the state legislature in 2006 to launch the *Louisiana Health Care Redesign Collaborative*. Its chief aim was the redirection of federal Medicaid DSH financing, garnered predominately by Charity system hospitals and clinics to care for the poor, toward funding *vouchers for the purchase of private health insurance*.¹⁶

Like the BNOB Commission, the “Collaborative” held its meetings in public, yet the public sparsely attended. The Collaborative’s decision-making body included healthcare and hospital administrators, private foundation interests and health lobbyists, Blanco administration health officials, state House and Senate Health and Welfare committee chairs, along with LSU graduate medical education and LSU Health Care Service Division (LSU-HCSD) officials.¹⁷

¹⁵ For international examples following disasters, see Bello (2006) and Srinivas (2010).

¹⁶ See Leavitt (2006); U.S. Department of Health and Human Services / DHHS (2006); Center on Policy and Budget Priorities / CBPP (2007); Solomon (2007); DeSalvo and Sorel (2009); Clark (2010b).

¹⁷ Review of Collaborative attendance lists, board members and affiliations; and minutes of meetings, 2006.

LSU-HCSD officials professed support for “the broad objectives” of the Collaborative, including the proposed “medical home” outpatient model, and use of “health information technology” and “electronic medical records.” But they cautioned that Collaborative deliberations had not addressed “the unlikely prospect of being able to effectively achieve zero *un-insurance*,” and challenged the redirection of DSH funds away from the Charity system:

Retention of DSH funds for safety net providers will still be needed in the event that reforms are only partially successful [as] patients who depend on the safety net are as important as those we can move into insurance programs (Comments from Collaborative members 2006).

Like the BNOB Commission, many Collaborative sessions revolved around mapping out a redesigned healthcare system that was *without* Charity Hospital. Much to the displeasure of the Bush administration and private healthcare interests, state legislative authorization of the Collaborative limited any healthcare redesign to the New Orleans area (HCR 127 2006).

Ultimately, state officials *rejected* the federal scheme of replacing Charity Hospital system coverage with insurance vouchers, saying it would cost \$500 million more per year than having Charity care just in the New Orleans area – and cover only 80 percent of those eligible. If extended statewide, state health officials said the cost could double and leave nearly 500,000 people that use the Charity system without coverage (Moller 2006e; Moller 2007c).

Many healthcare redesign supporters in response called for *dissolution* of LSU-run Charity, apart from their teaching hospitals in New Orleans and Shreveport. Citing Louisiana’s poor health standing in national rankings, researchers, private foundations and medical lobbyists issued papers detailing the woeful state of Louisiana healthcare pre- and post-storm.¹⁸

¹⁸ E.g., Louisiana Hospital Association / LHA (2003, 2006); Louisiana Public Health Institute / LPHI (2005); RAND Health Research (2005); BNOB Commission (2006); Louisiana State Medical Society / LSMS (2006); Council for a Better Louisiana / CABL (2006-2008, 2010); Public Affairs Research Council of Louisiana / PAR (2006-2008); Pricewaterhouse Coopers / PwC (2006); Tulane University (2006-2008); Blueprint Louisiana (2007, 2011); American Association of Retired Persons / AARP (2008); The Heritage Foundation (2008).

Though many critics attributed the entirety of the state's poor health outcomes to the "inefficient" Charity hospital system, very few of them acknowledged the data that showed *private medicine* was far more responsible than Charity for failing to improve these woeful indicators. For example, the nation's highest Medicare costs with the worst health outcomes occurred *not at Charity, but in private settings*.¹⁹ Oddly, Charity had been also criticized by the same forces for *causing* the "two-tier" system because of its disproportionate care for the uninsured, often the same patients *excluded* from private healthcare. Based on 2005 inpatient discharges, just 2.6 percent of Charity/MCLNO patients were covered by private insurance, 12.6 percent on Medicare, 21.5 percent on Medicaid, and 63.3 percent uninsured (Verité 2010, pp. 8-9). Costs would be *much higher* if uninsured patients' only access was via private providers.²⁰

Paradoxically, the sternest admonitions *against* changing or devolving Charity's inspired statewide safety net hospital network came from the same LSU apparatus whose closure of Charity Hospital sparked the Collaborative in the first place. LSU responded to research reports suggesting that it concentrate on its *educational rather than safety net healthcare missions*, divest some or all of its public hospitals to local control, and generally recast its public operations entirely under free market outlines. Much in the spirit of its 1997 acquisition of the Charity system from the Louisiana Health Care Authority (LHCA), LSU extolled the virtues of Charity's public system being far superior to the vagaries of private insurance coverage²¹

¹⁹ Amongst the few non-state sources to acknowledge this was Pricewaterhouse Coopers (PwC) (2006, p. 6) PwC also said that there were "too many hospital beds in the private sector"; "Hurricane Katrina essentially right-sized the overbuilt hospital system..." PwC curiously offered no private sector reforms; yet called for significant cuts in the Charity Hospital system under assumptions that private providers would then care for all Charity's patients – an unlikely outcome. For example see "Making Profits and Providing Care..." Horwitz (2005).

²⁰ e.g., Moller (2006d): Louisiana spent almost \$935 million in Fiscal Year 2006-07 for Charity hospital safety net care serving 850,000 residents lacking insurance; "Blue Cross and Blue Shield of Louisiana spends more than three times that amount to finance care for about 1 million policyholders," said BCBS/LA CEO Gery Barry.

²¹ LSU-HCSD on PriceWaterhouse Coopers (2006a); Medical Homes (2006b); the Leavitt proposal on healthcare vouchers (2006c) & PAR (2007a); Blueprint Louisiana (2007b) reports' on the Charity Hospital system.

Legions of healthcare lobbyists and foundation reformers in New Orleans in Hurricane Katrina's aftermath said that a "medical home" was possible now that Charity was closed. An independent community clinic network did arise in a laudable attempt to meet healthcare needs once met by Charity's 160 pre-storm primary care clinics. Priding themselves on moving the entry away from emergency rooms. Lovell (2011b) observed this discourse as "ripe terrain for modernizing and rationalizing healthcare provision," but it cannot ever hope to replace Charity:

This network has provided New Orleans a nationally-heard narrative of redemption, not only from disaster; but from corruption, collective ineptitude, widespread poverty and supposedly antiquated ideals of pre-Katrina healthcare embodied in Charity Hospital. But primary care clinics cannot meet the tertiary care needs of an already chronically ill, disabled and aging New Orleans population.

In fairness, what would become "504 Health Net" did not physically close Charity Hospital, LSU and the State of Louisiana did.²² Yet few of the 504 providers have honestly addressed the reasons for Charity's closure. Indeed, several supported the Louisiana Health Care Redesign Collaborative attempt to reallocate Charity's operating funds toward the purchase of private insurance vouchers. And their collective failure to demand the full restoration of Charity's safety net hospital and clinical services limits their own viability to fully serve Charity's former patients, too many of whom remain without a medical home since the storm.

Interest in reopening Charity Hospital persists years after its closure primarily because the healthcare that it provided has never been fully replaced (Walsh and Moller 2006).²³ Yet LSU continues to divest itself from areas of healthcare "not core to (its graduate medical education) mission" and which no other entity public or private can adequately or expeditiously fill (Cerise 2005, p. 13; Spiegel 2007). Without Charity, *many have become medically homeless*.

²² See <http://504healthnet.org>: a non-profit organization of 15 community health service provider safety net...

²³ See *T-P* (2009): "Poll backs Charity rehab" – "...voters prefer by a 2-to-1 margin gutting Charity and rebuilding."

Continuity or Rupture? Comparing LSU's pre-storm plans to close Charity Hospital with its disaster capitalized closure following Hurricane Katrina ²⁴

Lovell (2011b) juxtaposes the hallmark of Charity's iconic safety net network with the new challenge arising from the federal government's creation of the Medicaid program, which concentrated the poor and uninsured exclusively to Charity system hospitals:

The uniqueness of Louisiana Charity Hospital system is rooted in the principle that everyone has a right to medical care – certainly anathema to American neoliberalism and hardy individualism, but founded in the 1930s populist doctrine of the Long dynasty that governed Louisiana for decades. However, the arrival in the 1960s of Medicaid, the major program to assist low-income individuals with obtaining health services, intensified a two-tiered system of healthcare (Lovell 2011b).

Though LSU gained administrative control of Charity in 1997, it has not freed it from *dueling* with state administrations against reallocation of much of its self-generated DSH budget. Thus LSU has sought to “(avoid) replicating the ‘old Charity model’ of reliance on State funding” (ADAMS 2007, p. 5.1). Lovell suggests *LSU's planning process was already underway in the months before Hurricane Katrina toward the replacement of Charity Hospital:*

Burdened with hospital accreditation problems and a deteriorating facility, LSU had long envisioned building a new hospital, in part to attract a private patient base and unburden itself of nonpaying patients ... Lack of adequate financing for new facilities stood in the way of that plan. Katrina provided the opportunity to narrow that gap by accessing federal funds to replace the old facility (Lovell 2011b).

Vice President of Communications and External Affairs Charles Zewe clarified that LSU's *new academic medical center model* “turns it more from a charity matrix to a university teaching hospital matrix.” One part of this matrix shift is to replace the pre-storm Charity's 160 on-site outpatient clinics with a network of neighborhood clinics (Moller 2006b). LSU and its new University Medical Center (UMC) announced it will qualify for the Jindal administration's privatized Medicaid HMO clinic network (Maginnis 2011a; Verité 2011, pp. 18-19).

²⁴ Regarding the “conceptual tools” of *continuity and rupture* in social change analysis, see Borocz (1997).

Louisiana's Department of Health and Hospitals' (DHH) Coordinated Care Networks (CCN), once known as "Community Care," historically have been arranged to favor individual physician and group practices dispensing fee-for-service care. Their new program, dubbed "Bayou Health," *shifts this payment and delivery model to private managed care organizations*. Medicaid participants must sign-up or be assigned a private Medicaid HMO plan. LSU officials acknowledged their public discomfort with the CCN privatized contract process (Verité 2011, pp. 18-19; Shuler 2011c). LSU public hospitals and clinics will now have to compete for Medicaid patients amongst a group of private insurers, narrowing even further its indigent patient pool. The DHH CCN process also serves to interrupt LSU's process to cultivate its *own physician network to make referrals exclusively to the new LSU UMC*, as LSU already has with its highly-regarded "Shreveport model" out of LSUHSC Shreveport. In effect, DHH undermined LSU's attempt to transcend its "Charity model" by reinforcing dependency Louisiana Medicaid funding, rather than move towards a more diverse private insurance and Medicare payer mix.²⁵

The new CCN scheme fulfills a long-time ideological goal of Governor Jindal, who favors neoliberal / neoconservative *privatized purchase of services rather than supporting public healthcare delivery and administration* (Shuler 1996b). These private CCN contracts are now "the most lucrative in state government" (Shuler 2011b). The program was passed into law over state legislative objections through an inserted "technical amendment" on an unrelated bill during the final hours of the 2011 Regular Legislative Session. The inserted CCN language, while serving as "fine print" that most legislators simply overlooked, had the profound impact of instituting privatization over the objections of legislators by removing requirements of prior legislative approval and codifying CCN rule making exclusively within DHH (Maginnis 2011b).

²⁵ See Deslatte (2007) and Egler (2007).

After more than five years of planning, winning the FEMA Arbitration and legislative budget scrutiny (and withstanding several lawsuits), LSU and the state won final approval from the Louisiana state Joint Legislative Committee on the Budget on September 16, 2011 to begin construction of its Charity Hospital replacement known as the University Medical Center (UMC) (Barrow 2011f; Deslatte 2011).²⁶

Despite pledges by local, state and federal officials to consider meaningful public input of alternatives to the abandonment of Charity and the demolition of a federally-designated historic Lower Mid-City neighborhood, LSU's academic medical center plans, along with new Veterans Administration Medical Center plans, have for the most part remained intact since their inception. Indeed, decisions on how the process would unfold were finalized before much of the affected public even knew they were made (Moran 2008).²⁷ The state legislature originally demanded Charity's reopening for interim use in the year after Katrina. Yet it has largely afforded Charity's replacement to proceed even as legislators scrutinized the financial details.²⁸ New Orleans officials in particular, also initially demanding Charity's reopening, enabled fruition of LSU/VA plans by authorizing the expropriation and destruction of Lower Mid-City.²⁹

Though LSU appears to have received its crucial "green light," many uncertainties remain. Ironically, those unknowns, coupled with LSU agreeing to scale back and self-finance parts of their UMC, afforded its ultimate approval since it reinforced perceptions that LSU must move beyond "the old Charity model" to have a viable project (Barrow 2011c). But this outcome underscores that the result will be *far fewer hospital services* than offered by "Mother Charity."

²⁶ See *Leblanc et al v. Thomas et al* (2008); *Thurman et al v. Nagin* (2009); *NTHP v. VA and FEMA* (2009).

The author contributed legal research in *Leblanc v. Thomas*; and was a plaintiff in *Thurman v. Nagin*.

²⁷ SCR 99 (2006); VA-City MOU (2007); http://www.valsumedcenters.com/index_files/T2meetinginfo.htm.

²⁸ HCR 89 (2006); SCR 99 (2006); SCR 76 (2007); Moller (2007a-b, e-f); Barrow (2011e).

²⁹ See R-06-143 (2006); M-07-237 (2007); MCS 22944 (2007); Head (email stream) (2008); Egger (2011).

In the months after the storm, LSU spokesperson Marvin McGraw said one thing that was certain: “When we build a new hospital in New Orleans to replace Charity, we would plan to at least return with the services that we had there before” (Moller 2005e). Its 2011 business plan approved by the legislative budget committee however states that LSU’s new UMC *will be less than what Charity provided*. In general, increased numbers of beds available for the new UMC as projected are compared to 275 available before current fiscal year budget cuts *in LSU Interim Hospital*, as opposed to those that were in operation at Charity in 2005 (Verité 2011, pp. 3, 11).

To underscore the previous example, “expansion of inpatient psychiatry services” plans 60 beds, an increase of 22 from Interim LSU Hospital levels. Yet officials acknowledge the beds “rapidly will be filled” with patients (Verité 2011, p. 17). Charity *had* a 128-bed psychiatric Crisis Intervention Unit (BKA 2007) – apart from 84 emergency department beds (Moises 2009).

The proposed UMC also projects an increase in “urgent care clinic” visits (Verité 2011, p. 18). Yet LSU Interim Hospital’s urgent care center, originally open 24 hours a day, has reduced service hours as of July 1, 2011, belying the stated assumptions of the proposed UMC.³⁰

Gauging the continuity of pre-storm plans, LSU in this instance has experienced a profound rupture. Medicine clinics and services which once defined Charity Hospital and trained generations of medical professionals have been discontinued. Nor will these services necessarily be a part of the new UMC. LSU-HCSD closed “its inpatient pediatrics program in the face of a diminished population of children” which severely impacted pediatric training across the region (Berggren and Curiel 2006, p. 1551). On August 1, 2010, LSU Interim Hospital also ceased labor and delivery services, closing its neonatal intensive care and nursing care units (McGraw 2010). If this decision stands, a major New Orleans legacy will end – the creation of “Charity babies.”³¹

³⁰ MCLNO (2011a-b): Clinic hours’ change substantiated via: <http://www.mclno.org/mclno/menu/>, p. 3.

³¹ Lovell (2011a): “Debating Life After Disaster: Charity Hospital Babies and Bioscientific Futures...”

LSU announced its opening of the UMC will be 2015 – ten years after Hurricane Katrina (Barrow 2011a). There will likely be a change in its management, to the UMC Management Corporation; “a non-profit corporation (which) will retain a CEO.” The “destination programs in identified specialties” have not been identified. The UMC will also have an immediate impact upon the six LSU-HCSD hospitals outside of New Orleans, as “activities that were displaced by Hurricanes Katrina and Rita will be transferred (back) to the new (UMC)” (Verité 2011, p. 3). The result could be more service cuts and hospital closures.³²

The UMC Business Plan notes that if the federal Patient Protection and Affordable Care Act (PPACA) insurance purchase mandate requirements are overturned, “UMC’s safety net services may be greater than assumed” (Verité 2011, pp. 27-28). Nevertheless, the fiscal impact upon DSH funding, the main source of safety net hospital operating receipts, is projected to be curtailed sharply from current levels after 2014 if the PPACA is fully implemented (Kulkarni, 2011). LSU-run Charity Hospital system facilities already face the loss of DSH funds from DHH reallocation and from the “DSH Audit Rule” that came effective at the close of 2010 – the latter limited the amount of allowable healthcare services that can be federally reimbursed (CMS 2009; Moller 2010a; National Association of Public Hospitals / NAPH 2011; Shuler 2011a).

Business conditions for public and non-profit safety net hospitals, many with aging facilities and out-of-date diagnostic equipment, are driving many to merge with for-profit providers, redesign their healthcare delivery for the consumer marketplace, or face bankruptcy and closure (Landsberg 2004; Harrison and Sexton 2004; Darcé and Pope 2006; Stone 2006). Yet these healthcare marketplace adjustments may also conflict with their charitable missions, *leading to their demise as charity safety net providers* (Landsberg 2004; Stone 2006).

³² Baton Rouge’s Earl K. Long has closed and merged into Our Lady of the Lake in 2013; (Shuler 2010b). See Maginnis (2010); Hasten (2008) (Huey P. Long/Pineville); and Roberts (2010) (Lallie Kemp/Independence).

Once threatened with the potential loss of a half-billion dollars in DSH funds, DHH officials and Senator Mary Landrieu scrambled successfully to defend Louisiana's adjusted "Federal Medical Assistance Percentage" (FMAP) to reflect the influx of storm relief funds as well as the displacement of thousands of Medicaid recipients to places outside of Louisiana (Shields 2011). Nationally known (derisively) as "the Louisiana Purchase" – Landrieu's 2010 rider was reportedly added in exchange for her support of the PPACA. This political carve out supposedly safeguards LSU Charity hospitals and Louisiana Medicaid until 2014 (Alpert 2011). But this experience yet again urges LSU to move beyond its DSH-reliant "old Charity model."

LSU Health Sciences Center Chancellor Dr. Larry Hollier said that he is "absolutely committed to keeping us away from the charity model" (Moller 2006e). He noted that while Charity for decades "drew young physicians for training and helped keep them in Louisiana to practice" LSU's ability to continue to train seventy percent of physicians that remain in the state must have a "magnet" academic medical center "that is financially sustainable" (Griggs 2010).³³ In this regard, LSU post-Katrina planning is solidly in a continuous line with pre-storm plans to diversify its patient base with a greater concentration of insured, healthier patients.

Hollier said that shifting from "a Charity model" to "an academic medical center model" bypasses the limitations of relying on DSH funding. By attracting more Medicaid patients through the PPACA expansion, Hollier said "more matching federal funds (can) come in because there's not a cap on Medicaid eligibility and matching," unlike DSH funds that are capped. Hollier said this will also expand education opportunities since the subject patient base will become more varied with its expanded payer mix (Hollier Deposition 2009, pp. 71, 94).

³³ For lists of research breakthroughs made while New Orleans' Charity Hospital was in operation, see Yakubik, Brown, Greer and Lee (2011, pp. 4, 11-13) and LSUHSC (2011): <http://lsuhscimportantwork.com/importantfacts>. More UMC superlatives: Moller (2007d): The UMC would mean "a new emphasis on teaching and research"; Barrow (2011b): The new UMC will be "an elite facility that would draw patients from across the Gulf Coast."

While reaffirming LSU's *public* academic medical center status, Hollier elaborated that LSU is "changing the entire way the uninsured receive care." He contrasted the current ten-hospital *state-owned Charity safety net system* with LSU's "*public/private partnership*" model:

The state legislature ... approved a public/private partnership between (LSU/Earl K. Long and Our Lady of the Lake medical centers). The result is a fully funded infrastructure, because 98% of the patients will be insured. This will dramatically reduce our dependence on state health care dollars, and produce a major change in care for the uninsured ... A similar project replicating that public/private enterprise model is underway in New Orleans, where we are building a new academic health center which will serve both uninsured and insured patients ... The private institutions with whom we are partnering have service goals that match well with ours. ... By reducing the hospital funding needs, we can ensure that state dollars are available to be redirected to advance education, infrastructure, and the development of new treatments (Hollier 2010, p. 17).

Legnini and Waldman (1999) investigated tensions within academic medical centers (AMCs) forced to contend with the private healthcare market environment while upholding their once unquestioned mutual provision of medical training *and* safety net healthcare:

AMCs play another important function in the medical system – as safety net providers. Since the establishment of the first hospitals in this country that served the poor exclusively and also trained physicians, academic medical centers have provided large amounts of free care and have been an important source of access to highly specialized services without regard to ability to pay. AMCs have the largest pool of physician labor available to care for the poor – namely physicians in training (both often located in inner cities...) (p. 1).

Even LSU's private healthcare critics suggest that the key for revitalizing LSU's teaching hospital enterprise is to escape the "stigma" of a "Charity Hospital" (Deslatte 2007).³⁴ Yet Dr. George Thibault, a professor at Harvard Medical School, said "local history, local culture and local relationships" impact desired changes. Thibault said LSU's challenge will be: "Can you create that *de novo* if you do not have that 100- or 200- year tradition?" (Eggler 2007).

³⁴ For viewpoints on *charity* and its association with the stigma of poverty and need: see Fothergill (2003): "The Stigma of Charity: Gender, Class and Disaster Assistance" and Frey (2005): "Big Charity in New Orleans."

In proposing before Hurricane Katrina the consolidation of Charity with University Hospitals through the construction of an entirely new medical campus, Adams Management consultants heavily predicated their assumptions *on discarding the Charity heritage*. Yet their report reflected both divided sentiments amongst LSU-HCSD and LSUHSC professionals (e.g., divided for / against having the new academic medical center in the midst of LSUHSC between Charity and University hospitals due to their proximity to Charity, with those in favor desiring continuing Charity heritage; those opposed suggesting “the charity stigma may be too strongly a part of this neighborhood”) *but most decidedly in favor* for the Charity Hospital mission and clinical research traditions, especially with Tulane clinicians, *to remain in place as an ethic*.³⁵

Though LSU has largely remain consistent with its plans with regards to the project intent as proposed by their consultants, its post-Katrina size has taken a decidedly *suburban scope and look* (moderate-story buildings of five to six floors versus 16 to 17 floors on a smaller land footprint before the storm. This is in stark contrast with pre-Katrina plans when the preferred option amongst both LSU-HCSD and LSUHSC was the South option. Likewise the needs for community consultation in the pre-storm planning was seen as crucial; whereas post-Katrina, *the effective decisions have already been made before public input was even sought*.

Grimly, the 2005 Adams pre-storm report noted about the possibility of the closure of the Medical Center of Louisiana at New Orleans (MCLNO) combined Charity and University hospitals campus if steps were not taken to supplant the hospitals with a new combined facility:

Other than replacement, the only option would be to ultimately close MCLNO and redistribute medical education and patients throughout the private hospitals in the region. This would have a negative impact on the medical education component due to the absence of sufficient clinical mass at any one site, present access challenges for patients, and shift the uncompensated care burden to private hospitals and physicians (ADAMS 2005, p. 3)

³⁵ See ADAMS (2005, pp. 95-97). Post-storm LSU UMC comparisons made via <http://www.newhospital.org>.

Administratively since Hurricane Katrina LSU has made its decision to do away with even the institutional memory of Charity. Indeed, LSU has been in a process of 'rebranding.' In addition to exorcizing all references to "Charity hospitals" LSU has also moved away from "LSU Hospitals," first in favor of "LSU Health System;" and the latest name: "LSU Health."³⁶ Mapped out as part of a "complete logo hierarchy" in order to ensure "consistency" in LSU Health brand "(presentation, usage, messages)... strengthening the overall impression of quality and professionalism for LSU Health as a whole." It answers the question: "Why a new identity?"

Regardless of what we know (about our health system), it's what others know about us that defines our brand. Because a brand is not what we say it is. It's what those who perceive us say it is. That's why it is essential for us to seek relevance and to connect with the public... As we update our brand to better reflect who we are and how we are perceived in today's world, it is imperative that we develop a strong visual identity to underscore our commitment to the future. Our new logo and its various versions, is designed to make a simpler, yet more powerful, statement about who we are – one that is both easy to grasp and relevant ... The new logo serves as the springboard for all of our brand identity efforts, the cornerstone around which we will build a more relevant and more focused message about who we are at LSU Health (LSU Health Graphic Standards 2010, p. 2).

Changing cultural perceptions however are likely to be a tall order. According to national surveys, healthcare consumers prefer "*hospital*," associating hospitals with better and more comprehensive healthcare than "*medical centers*," contradicting rebranding efforts by hundreds of hospitals across the nation (Mueller 2011; Jacobson 2011; FierceHealthcare 2011).

LSU's institutional response has taken dramatic shifts since Hurricane Katrina. Particularly with regards to LSU / Charity's predominately African American patient base "a change in culture" has taken on a decided tone, one that may yet result *in a rupture that could be greater than the closure of Charity itself*.

³⁶ See <http://www.lsuhschools.org/Media-Relations/Newsletter.htm> newsletters and releases (2008, 2010-2011).

As previously noted in this case study, Charity Hospital during both Jim Crow segregation and following the Civil Rights movement has often been the only comprehensive acute facilities in Louisiana to admit African Americans as patients, albeit with varying degrees of actual dignity and personal treatment. And given Charity's history, substantial numbers of poor whites as well as blacks have been Charity system patients.³⁷ Both Salvaggio (1992) and especially Roberts and Durant (2010) extensively document the rise of African American health professionals and hospital administrators since the advent of Medicare and Medicaid. Yet indications of a shift based on race would arise soon after Charity's late September 2005 permanent closure. For comparison, the pre-storm Adams Management report noted:

Further, MCLNO will expand the volume of insured patients through focused programmatic development efforts and a marketing strategy centered on building market share of Medicare and Medicaid populations within the African American community in the core market [of Uptown and Mid-City New Orleans] and New Orleans East (ADAMS 2005, p. 2)

Likewise as noted by McDonald (2002) and reaffirmed in the 2005 Adams report and other venues, LSU Shreveport became the professed model before Hurricane Katrina of culture change away from New Orleans "two-tier system" of predominately African American poor and uninsured going to Charity Hospital and predominately white with health insurance receiving care from non-state private and parish hospital district facilities. Beyond the profound rupture caused by Charity Hospital's post-Katrina closing, LSU leadership lodged their contention for abandoning Charity Hospital and charity care in racial-code class terms:

I have a deep feeling that a lot of this is just a way of putting the least enfranchised people in a dilapidated, damaged, obsolete structure that will allow the upper-class citizens of New Orleans not to be bothered by the likes of them. Not in my backyard. Going into Charity Hospital is inappropriate, even temporarily, by any reasonable standards. (LSU Chief Medical Officer Dr. Michael Butler quoted by Webster 2007).

³⁷ See Table 2 on p. 106 and Table 3 on p. 107 for Charity Hospital system and New Orleans data by race.

LSU System President John Lombardi wrote to *The Shreveport Times* proposing “the time has come (to modify the newspaper’s) official style regarding hospitals run by LSU.” He said their “Charity’ system references are “anachronistic and simply inaccurate”:

Those who advocate an alternative to the old “charity hospital” model have become fond of the buzz word “health care redesign” even though they don’t know exactly what the term means or how much more redesign will cost. LSU has been quietly “redesigning” health care for many years and improving outcomes while living within its legislatively approved budget. LSU believes that phrases like “charity hospital” and “charity hospital system” is a part of the state’s proud heritage and a testament to the compassion conveyed by the Great Seal of the State of Louisiana, but they no longer describe the modern approach to medical care being pursued by LSU. In fact, no hospital among the 10 LSU public hospitals is legally known as a “charity hospital.” University Hospital in New Orleans that used to be a part of the Medical Center of Louisiana at New Orleans is now legally known as the Interim LSU Public Hospital (Lombardi 2007).³⁸

Lombardi also asserted LSU thinks “the term ‘charity hospital’ has become racially charged and is tinged with a pejorative undertone that not only negatively skews public debate over health care reform, but also feeds perceptions that unfairly challenge the quality of medical care delivered by our medical staffs...” (Lombardi, 2007).

Yet LSU officials apparently had no problem subjecting returning patients of any race to tents and other makeshift accommodations. The closure of Charity Hospital, charged historian Dr. Lance Hill, was “the single greatest obstacle to return of the black community...” Hill, executive director of the Southern Institute for Education and Research, called LSU and the state’s decision to close Charity the cause of “barbarous suffering and pain for people” especially in light of the loss of many black middle class jobs with insurance since the storm. Hill also suggested Charity’s post-Katrina closure elsewhere would not have been tolerated (Hill 2008).

³⁸ Actual legal name: HB 1 (2011, p. 242): “Charity Hospital and the Medical Center of Louisiana at New Orleans.”

Lovell (2011b) concurs with Hill and others that “for poor and African American residents who had struggled to return and rebuild broken lives, Charity Hospital’s closure reinforced their sense that the city was being redesigned for white, middle class residents and tourists.” Unlike many scholars, Lovell details the attempt by Charity’s workers and the U.S. military to reopen the hospital in the weeks following Hurricane Katrina – as well as highlighting the “broad social movement to reopen Charity Hospital, intensified by LSU’s announcement” of the planned razing of the predominately African American working class neighborhood of Lower Mid-City for the future complexes replacing Charity and the original VA Medical Center.³⁹

Though this author found no evidence of a *pre-planned conspiracy* to capitalize on the Hurricane Katrina disaster, the catastrophe nevertheless provided a clear opportunity to speed up LSU’s pre-storm plans to replace Charity Hospital with a “market-ready” facility. LSU and the state could have acted to reopen the hospital in the weeks after the storm. Indeed not to do so seemed to belie a “*First do no harm*” medical principle for its health system and its patients.⁴⁰ And the closure of Charity Hospital set into motion consequences that invariably have had a disproportionately negative impact on New Orleans’ African American populace and Diaspora.

Skepticism that the new LSU University Medical Center will be different from what “white New Orleanians and Louisianans that view Charity as ‘a black hospital’” runs deep, even as LSU UMC supporters extol it as the next “destination hospital” for everyone, including those with insurance (Barrow 2011d). More disturbingly, by closing Charity Hospital and dispersing its core indigent patient base *before building its new academic medical center*, LSU risked the loss of meeting both its safety net healthcare and graduate medical educational missions.

³⁹ The razing of Lower Mid-City is complete. See Vogel (2011): <http://insidethefootprint.blogspot.com/>.

⁴⁰ *Primum Non Nocere*: “Latin for ‘first do no harm.’ A guiding principle for physicians that, whatever the intervention or procedure, the patient’s well-being is the primary consideration.” <http://medical-dictionary.thefreedictionary.com/First+Do+No+Harm.>; See also Krause (1997) and Lakhani (2011).

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