WHEN THE NEW YORK TIMES INVESTIGATES

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Media waves from the levee failures and subsequent flooding that ruined New Orleans after Hurricane Katrina regularly ripple our city. But in late August, just in time for Katrina's fourth anniversary, a journalistic tsunami of biblical proportions rolled in from the North.

The New York Times Magazine published a 13,000-word treatise with new insights that will be in the core curriculum of every medical school ethics course for decades to come. The author is Dr. Sheri Fink, a physician living in New York. Rather than rehash Fink's article about what happened in Memorial Medical Center in those horrible post-Katrina days, I believe there is a need to address some local and national responses to her report.

Katrina ignorance grows with time. In response to the story, one blogger on The New York Times Web site faulted the hospital authorities for not bringing in "fresh doctors and nurses" along with "a public official" to take over and allow the police or National Guard to evacuate the hospital.

For years Memorial Medical Center was beloved Southern Baptist Hospital, occupying a prominent presence on Napoleon Avenue in Uptown New Orleans since 1926. Rex cavalcaded by each Mardi Gras. On at least one occasion, a medical staff member – masked as a duke – rode his horse to the Emergency Room to fetch some medication needed by the reigning Rex.

Mercy Medical Center and "the Baptist" merged in 1990, raising many eyebrows in the local medical community. Nothing about the union worked for either hospital or their respective frustrated medical staffs. A few years later the fugleman who engineered the shotgun wedding bailed out. He spun off a foundation to employ him, and the Mercy portion of the buyout went upriver to the nun's motherhouse in St. Louis.

The sale to Tenet Healthcare meant the city and state began to receive sizeable property taxes. These days there is a blur between nonprofit and for-profit hospitals, but in many ways "the Baptist" thrived under Tenet with an infusion of system and policy updates, including the development of a regional Medicare HMO. On the downside, aggressive billings increased how much locals paid for healthcare.

When I first met Fink, she was a visiting professor teaching a disaster medicine course at the Tulane School of Public Health and Tropical Medicine. She returned to our city many times, conducting scores of interviews with physicians, nurses, administrators and patients, including survivors of deceased patients who died in those horrific days post-Katrina. She had an obvious grasp of what it took to deliver disaster medicine to a population in need from her experience in war-ravaged countries. She also had a way of winning the confidences of those she met. She oozed with empathetic qualities that are so valuable in both medicine and media.

Fink has a strong public health background, and knew then that the implementation of working systems was far more important than efforts towards fragmented, direct patient care. For example, a war- or disaster-ravaged country needs computer software to help people establish their identities more than they need boxes of old medication samples from a doctor's office.

"Why reopen old wounds?" was the most repeated criticism of her report from the doctors and nurses who were there. The editors at The New York Times no doubt had anticipated this response:

Why now? Why return in such detail to something that happened four years ago? For one thing, we found the story inherently fascinating. Beyond that, ours is a world not immune to pandemics and terrorist attacks or natural disasters. The issues surrounding medical care in such dire situations require a public conversation our country has yet to really have.

The second most-voiced criticism was that Fink shouldn't have written about those things that doctors and nurses talk about among themselves; they faulted Fink for breaking some sort of professional code. She quoted a physician who told her in blunt terms what all knowledgeable medical personnel know: Medications necessary to relieve pain and suffering during terminal illnesses do indeed hasten death. The physician who told her this is one of the finest and caring doctors I know. He is the one I would want by my bedside if I had a terminal illness.

How accurate was her report? I spoke to more than a dozen doctors and nurses who were there. Nobody could point to a single inaccuracy in her report. One person reportedly said, "Her story did not portray what I experienced." And Attorney Rick Simmons held no punches in an online attack of Fink's story: "The article depends too heavily on rumor, innuendo, hearsay and third party comments"

(www.drannapou.com/legalreply.html).

Two aspects of her report were new and troubling to me. Even though I wasn't at Memorial during Katrina, I've been on the medical staff there since 1978. The racist comments attributed to a single physician didn't reflect the opinions of the doctors I know at Memorial.

The second was the revelation that the chair of the medicine department, a position I once held, instituted a novel triage system. Those patients with "Do Not Resuscitate" orders were put in the "last to leave" category along with the most hopeless. Most DNR patients I have cared for aren't on death's doorstep, and DNR has never meant "leave me on a stretcher to die."

Fink's report is necessary. Disasters aren't going away, and our nation deserves insights into how current day disasters affect medical care. I agree with the blogger who wrote on The New York Times Web site that sunshine is the best disinfectant and that "those who do not read history are doomed to repeat it."