



Alan Roth

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Alan Roth giving a breathing treatment to a young Haitian.

One of the major functions for Alan Roth was monitoring the respiratory status of those who needed conscious sedation for major procedures, as they could not deliver general anesthesia.



RTs in Haiti: In Their Own Words

AARC members share their experiences in Haiti after the earthquake

In the following three stories, AARC members Alan Roth, MS, RRT-NPS, RPFT, FAARC, Francis Almonor, BS, RRT, and Frank Caminita, RRT, share very different but equally heart-wrenching experiences in Haiti shortly after a massive earthquake struck the country last January. Roth went as a member of the California Six (CA-6) Disaster Medical Assistance Team (DMAT) out of Santa Clara, CA. Almonor, who is a native of Haiti now living in North Carolina, traveled to his homeland to find his father, nephews, and sister. And Caminita and his colleague, Robert Dutruch, RRT, went to help their company set up donated ventilators at a field hospital established in Port-au-Prince by the University of Miami.



On the Ground with the CA-6 DMAT

by Alan Roth, MS, RRT-NPS, RPFT, FAARC

The automated response system notified me of the deployment at 2:36 p.m. on Wednesday, Jan. 13. I confirmed the message and awaited orders. Since January was our on-call month, I already had my “ready bag” and my “24 hour bag,” which contains all the equipment and supplies I need to begin working immediately in any environment, in my car. I changed into my uniform and was ready to go.

Members of our team are required to be available to

leave from either headquarters or the airport within four hours of getting the call. For me, this meant an almost immediate deployment because I am about 100 miles from the airport or headquarters in Modesto, CA.

I left a meeting, notified my boss and my assistant manager with instructions, and departed. I called my wife, as she had just returned from the Philippines, and told her to call the kids.

On the Ground with the CA-6 DMAT (Continued)

Utter devastation

Upon arrival in Atlanta, the team assembled and was briefed as to our mission. We were given anti-malaria drugs and a typhoid inoculation. Upon our arrival in Port-au-Prince, we were assigned by the embassy to the Forward Operating Base in Petionville, an area in southwest Port-au-Prince.

Our drive from the airport — escorted by U.N. forces and the U.S. military — revealed devastation in all directions. In the area we were assigned to, between 30,000 and 50,000 homeless people were living at the base of a ravine, as all structures were gone or uninhabitable.

Our team consisted of 38 medical professionals. I was the only respiratory therapist deployed. My primary medical responsibility was to serve as an RT in an expanded role of triage and assessment. Our hospital tent was divided into three treatment areas. Green was for ambulatory and triage, yellow was for the seriously wounded or sick, and red was

for critical patients. We had a total of 19 beds.

We evaluated and treated 400 to 600 patients a day suffering from a wide variety of injuries and illnesses, including traumatic amputations, open compound fractures, and complicating conditions of pneumonia, asthma, and bronchiolitis. We also saw patients with open abscessed wounds, dehydration, burns, and sepsis. We delivered babies, and I worked stabilizing the newborns.

A major function for me was monitoring the respiratory status of those who needed conscious sedation for major procedures, as we could not deliver general anesthesia. We only had a limited supply of oxygen in the cache, so it was critical to use my handheld pulse oximeter and keep my hand on the person's chest to monitor respirations. We had only one nebulizer compressor, but we did have metered-dose inhalers. I fashioned mini spacers out of used water bottles to treat the smallest children.



Roth was the only respiratory therapist on his DMAT of 38 medical professionals.



We worked from first light at around 6 a.m. to dusk and sometimes beyond to see all the patients who had made it to our tent. We also had a helicopter landing zone so that a helicopter could bring in water and food and, when available, transport our most critical patients to the U.S. Navy hospital ship, the Comfort, which was docked off shore.



"It is always the children you help or cannot help who stay vivid in your mind," Roth says.

With only a limited supply of oxygen, it was critical for Roth to use a handheld pulse oximeter and keep his hand on the person's chest to monitor respirations.



Challenging conditions

Our team was joined by elements of DMAT teams from New Jersey, New Mexico, and Massachusetts. Six strike teams of three to five medical practitioners would go down from our base camp to the people and identify patients to be brought back up to us, escorted by the 82nd Airborne for Force Protection. Many times, I would give the young children a breathing treatment, followed by 15 cc of electrolyte solution given by needleless syringe. If the child could keep the fluid down, we would give liquid antibiotics the same way; if not, then by injection.

Each member of our team also had a secondary function. Mine was logistics. This meant going to the airport to uncrate the supplies needed to continue operating. We would repack the supplies into sizes that individuals could carry in this terrain.

We slept on the ground outside, with our ground cover and sleeping bags. Aftershocks were always present. We did have a 6.2 second earthquake that was pretty scary. The temperature in our tent hospital was around 110 degrees, with a heat index in the dangerous level. We were required to drink 0.5 liters of water every 20 to 30 minutes. We kept track of our water use using wooden beads on our lapels — this way all team members could see at a glance who needed a hydration break. This device was invented by one of our team members, Mark Weston, RN. It saved us from serious complications of the heat.

We ate when we could grab some time. Meals consisted of the Humanitarian Food Package, a 2,000-calorie, high-protein, high-fat meal similar to the military's meals ready to eat (MREs). They did not include coffee, but luckily my craving went away after three days.

“USA, USA”

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Every person we met, treated, and spoke to (with the assistance of Creole translators from the U.S. Public Health Service and the Centers for Disease Control and Prevention) was warm, thankful, and appreciative. We saw no violence or disturbances. They

even chanted “USA, USA.” All the patients were very stoic, even in the face of despair. All the children we treated had an extended family member or neighbor to care for them. We gave them hope for another day. With limited resources, we were not able to treat the patients who had malaria, tuberculosis, AIDS, or pneumocystis (PCP) pneumonia.

I have been a therapist for 30 years; and over the past 15 years I have worked overseas on missions in Cambodia, China, Guatemala, the Dominican Republic, and the Philippines. It is always the children you help or cannot help who stay vivid in your mind. The bringing of new life into the world is amazing, and that first cry is indescribable. We may have known only a few words in Creole, but the unspoken words on the faces of the Haitian people, and their spirit, will be with me the rest of my life.

When you really need an RT...

We were deployed for two weeks, then rotated back out to the world. When I returned to California, I went back to work and resumed my “normal” day-to-day routine. We are on call again in April, ready to serve those who need us.

Of the five teams I had contact with, none included respiratory therapists. I do not know if any of our replacements had team members who were deployed as RTs. One of the medical professionals told me she had never met a therapist like me. I explained that I was not unique in my skill set or dedication and that many people were just as skilled as I was in our profession. As we left the country, she turned to me and said, “You never know you need a respiratory therapist, until you *really* need a respiratory therapist.”

We did some amazing things with a group of dedicated professionals who gave it their all (even to the point of exhaustion) to make a difference. We do not know how the ripple effect of the people we saved will extend into the future. But we need to hold onto the possibility that they will do good things, otherwise the knowledge of at least 112,000 known dead and the estimated two to three times that buried in the rubble would be too much to bear.

I am proud to be a member of this team and a respiratory therapist. People may never know who I was or what I did. But whether I was singing lullabies to babies or comforting people who knew someone cared, I know I made a difference in their lives. I will also be haunted by the ones I could not save. ■