Coping With Calamity

How Well Does Health Care Disaster Planning Work?

On August 17, 1969, Hurricane Camille, the most destructive North American hurricane since 1935, made landfall on the Gulf Coast. The storm devastated coastal Mississippi, Louisiana, and Alabama and inland areas in the South. It killed between 250 and 400 people and caused damage estimated at $1 billion, a stunning sum at the time.

The 25th anniversary of that catastrophe is cause enough to ask how much has been learned about disaster planning since; but the United States and its health care system have had several more recent unfortunate opportunities to consider the question. Among these trials have been Hurricane Andrew in south Florida on August 24, 1992; Hurricane Iniki on the Hawaiian island of Kauai on September 11, 1992; massive flooding in the Midwest in the summer of 1993; and the Northridge earthquake in the San Fernando Valley of southern California on January 17, 1994. In each case, health care facilities suffered problems—in some instances, extensive ones.

Be Prepared

Health care organizations take disaster planning seriously. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that hospitals have emergency plans “designed to manage the consequences of natural disasters or other emergencies that disrupt the hospital’s ability to provide care and treatment.” Such plans must cover the hospital’s role in communitywide emergency preparedness, how specific procedures will be implemented, management of key materials and activities, staff deployment and roles, management of patient care services, staff preparation, disaster drills, and monitoring and evaluation of hospital performance. Medicare accepts JCAHO accreditation as evidence of readiness.

The JCAHO requires that hospitals be able to cope with problems “both within the organization and in the surrounding community.” However, in practice, hospitals are usually better prepared to receive and treat casualties from an external calamity than to respond when the event hits the facility itself. In the words of John Wright, chairman of the disaster committee at Saint John’s Hospital and Health Center in Santa Monica, Calif, which suffered severe damage during the Northridge quake and aftershocks: “In their disaster plans, hospitals see themselves receiving large numbers of victims following a disaster; it was only in the past year or so that we had begun seriously looking at our hospital as a potential victim.” Yet time and time again, hospitals take some of the worst hits.

For the 7% of US nursing homes that are accredited by the JCAHO, standards similar to those for hospitals must be met, including having the ability to deal with a disaster at the facility itself. For the rest, according to a spokesperson for the American Association of Homes and Services for the Aging, disaster preparedness standards are set by the Health Care Financing Administration, which operates the Medicare and Medicaid programs. The Health Care Financing Administration standards require detailed written plans for “all potential emergencies and disasters” in the facility or the community, training of all employees as soon as they begin work at the facility, periodic reviews of procedures with staff, and unannounced drills.

Governments have other requirements. States are mandated by the Federal Emergency Management Agency to have overall disaster plans. Many localities have plans as well. Hospitals in the six counties of the greater Los Angeles metropolitan area developed a regional disaster plan in 1992 through the Hospital Council of Southern California; that plan proved invaluable during the Northridge quake. The San Francisco Bay area suffered from the lack of a regional plan after the 1989 Loma Prieta temblor, according to Roger Richter, senior vice president of the California Association of Hospitals and Health Systems.

There are also state disaster statutes that cover life safety building codes, fires, and mass-casualty situations. Some states have gone further; one example is California’s Hospital Seismic Safety Act of 1973, passed after the 1972 San Fernando quake severely damaged some hospitals, causing patient injuries and deaths. The act requires that any hospital built after its enactment be able to withstand earthquakes up to 7.0 to 7.5 on the Richter scale that are caused by horizontal forces.

Finally, there is the National Disaster Medical System (NDMS), a joint program of the federal Departments of Health and Human Services, Veterans Affairs, and Defense and the Federal Emergency Management Agency. The NDMS was initiated in 1981 to create a national network that can address health care needs in the case of catastrophic natural or technological disaster and that ensures the availability of civilian hospital services to the wounded in time of war.

The NDMS includes the Disaster Medical Assistance Team (DMAT) program. It establishes “stand-alone” teams of physicians, nurses, and other health care professionals, usually numbering five, that can be brought quickly into a disaster area to provide services to victims when the local health care infrastructure has been obliterated or is simply overwhelmed. The DMATs are designated by the US Public Health Service and must meet NDMS standards. Some teams are specialized, such as mental health DMATs; others are generalist. There are approximately 60 teams located around the country. Although
DMAT members are volunteers, if they are activated, they become temporary federal employees and are paid.

But how well does all this preparedness pay off when calamity strikes?

**Hurricane Andrew**

On August 24, 1992, Hurricane Andrew smashed into south Dade County, Florida—the most damaging storm since Camille, and probably even stronger; it was the third most powerful hurricane in US history.

Sarah Grim was president of the South Florida Hospital Association at the time and was deeply involved in storm recovery operations. She recalls the damage as almost unimaginable. “There were 58 deaths. Estimated property damage was $30 billion. We have no idea of the total number of victims treated, but the estimate is that more than 67,000 people were cared for in the field and 17,000 more in emergency rooms between August and December, although the majority were seen in the first 2 or 3 weeks. Later there were injuries associated with the cleanup.

“There was more than $25 million in damage to health care facilities; 58 hospitals and other institutions were damaged. Eight hospitals were partially evacuated and some closed; three were evacuated after the storm. Most pharmacies were leveled. At least 1,000 physicians’ offices were destroyed.

“At least 4,000 hospital employees were left homeless; it is estimated that between 90% and 100% of hospital workers who lived south of Coral Gables lost their homes.”

Incredibly, no hospital patient died as a result of the storm.

The path of Andrew was uncertain until the last minute. As a result, six hospitals were given less than 24 hours to evacuate 1,500 patients. Two could not complete the job, due to a shortage of ambulances and personnel; remaining patients were placed in interior corridors. One facility that lost its roof had to evacuate patients in the middle of the storm.

Still, the hospitals were luckier than the nursing homes. Grim reports that a poststorm evaluation by the Army Corps of Engineers found that “nursing homes were inadequately prepared for evacuation. They were not given the same access to disaster plan information as hospitals, and were not given equal status in terms of priorities.” Many nursing homes had planned to transfer patients to hospitals that, in many cases, were themselves being evacuated. Furthermore, nursing homes are often one-story structures and are not necessarily subject to building codes as stringent as those applied to hospitals.

To make matters worse, the storm made landfall 2 or 3 days before it was expected to do so. When it speeded up, panic hit, according to Grim: “A million people tried to leave the area, thereby depleting the pool of people available to evacuate health care facilities.”

Government was both a problem and a help, she reports. On the negative side, “No one seemed to have any idea of who was in charge. I don’t think it will ever be determined who was at fault; a state task force later stated that all agencies seemed ill equipped to deal with coordination of the massive relief effort that was needed.” Another observer of the situation says starkly: “No one was prepared—not the hospitals, not the nursing homes, and not the state.” However, Grim points out, there has rarely been damage as severe as what Andrew wrought.

The state of Florida had a disaster plan, according to Cathy Allman, vice president of the Florida Hospital Association. However, she says, the impact of Andrew was overwhelming, and not everything worked well. She adds that “all the hospitals had disaster plans, some more extensive than others. But they didn’t realize the ramifications of such a storm; their plans are much better now.”

Grim thinks more should be done. She believes that federal or state funds must be made available for upgrading of hospital facilities so that evacuations are not necessary. This is a special problem in Florida, which has an unusually high concentration of frail elderly patients who need high-technology care. “There are not enough beds to accommodate nursing home patients who need respiratory support, life support, and similar critical services. We estimate that 100,000 people in south Florida fall into that category. There is no alternative site for them; they are not allowed in Red Cross shelters. Where can they go? The receiving hospitals were all damaged.” Richter of the California Association of Hospitals and Health Systems agrees that “the last thing you want to do in a disaster is evacuate a hospital.”

On the positive side, Grim says, the military was “quick and effective.” Some 29,000 troops helped prevent major public health problems, and military helicopters were invaluable in removing debris. “This was the first military occupation of a southern state since the Civil War—and that, incredibly, became an issue between the state and the federal government. The military has never received proper recognition for its efforts after the storm.”

She also cites regulators’ sensitivity to the exigencies that health care institutions were facing: hospital beds were allowed to become “swing beds” for patients from nursing homes that no longer existed; the state waived its prohibition on hospital pharmacies offering retail dispensing; and most payers relaxed their usual standards and restrictions.

**Hurricane Iniki**

Less than a month after Andrew, Hurricane Iniki passed directly over Kauai, with winds of 160 miles per hour. It flattened the Garden Isle, destroying thousands of structures and damaging most others. It caused more than $2 billion in damage on an island with a population of less than 52,000. Communications were devastated; not one telephone pole was said to be left standing. Rich Meiers, president of the Healthcare Association of Hawaii, which represents both hospitals and nursing homes, reports that until shortly before it rammed into Kauai, the storm was expected to hit Honolulu. Meiers warned every Oahu hospital administrator and planned to meet with them after the disaster sirens sounded at 6:30 AM the day of the storm.

At the last minute, Iniki made a tiny course shift and headed for Kauai, narrowly sparing an island with nearly 1 million people. Meiers reports that the readiness of the Oahu hospitals ended up being a boon to the facilities on Kauai.

Those hospitals had their hands full. Kauai has three acute care hospitals that also have significant numbers of long-term care beds. Samuel Mahelona Memorial Hospital in Kapaa suffered extensive damage; Kauai Veterans Memorial Hospital in Waihoku had fewer problems, but its communications capacity was nonexistent and no one could reach it because the roads were impassable. Wilcox Memorial Hospital in Lihue, a newer facility, suffered little damage but had only emergency power and no water supply. Meiers, who had been a military hospital administrator, set up a command post on
Oahu to coordinate volunteers and provision of relief supplies and to work with state authorities. His task was complicated by the fact that the only way to get to Kauai is by air or water. Furthermore, there were 4000 vacationers waiting at the Kauai airport in Lihue, trying to get out. Hawaiian Air provided free flights for health care and disaster personnel, but there was no security at the Kauai airport, and relief supplies began disappearing. The lack of communications capacity was dreadful; Meiers ended up using a military telephone system routed through Alaska.

The command center operated for 9 days and sent 96 volunteers to Kauai, including physicians, nurses, optometrists, laboratory technicians, security personnel, and others. After 4 days, telephone service was restored to Kauai Veterans Memorial Hospital, but other problems emerged. "There were 60 dialysis patients on the island, and when the power went out, they were at great risk. We had to find them through a variety of means, including going out in all-terrain vehicles," Meiers recalls.

Furthermore, hospital staff members were starting to burn out. "At first," says Donna Maiava, chief, emergency medical services system branch, Hawaii Department of Health, "they were busy determining needs so that resources could be mobilized. Their response to us was, 'We're okay; we can handle it.' Then, after 48 or 72 hours, panic set in when they realized the extent of the damage and the magnitude of the need."

Daily needs assessments were made by Hawaii Department of Health teams for the next 2 weeks. Huge amounts of debris presented a public health threat; it rotted quickly in the tropical summer. John Lewin, MD, then state director of health, invoked an old public health statute and obtained National Guard assistance to remove the debris to emergency landfills.

As in Florida, no hospital patient died as a result of the storm.

Both the state and the counties of Hawaii have disaster plans that included regular drills in which hospitals participated, Meiers says. However, "these plans were insufficient in that nobody had considered the possibility of a disaster of this magnitude. You plan for something smaller, not a 160-mile-an-hour storm that sweeps an entire island. We learned much, and those lessons have now been incorporated into everyone's disaster planning."

Midwest Floods

During the summer of 1993, the Mississippi River and its tributaries went over their banks in the worst Midwest flooding in a century. It most severely affected North and South Dakota, Minnesota, Wisconsin, Missouri, Iowa, and Illinois.

Jill Egan, director of communications for the Illinois Hospital Association, reports that the association began tracking hospitals that were at risk in mid July. "We had 11 hospitals that were either on the Mississippi or on a significant tributary that was blocked up. Without exception, the hospitals were built on high ground and were not subject to flooding themselves."

Hospitals suffered, anyway. Near Blessing Hospital in Quincy, Ill, the bridge over the Mississippi to Missouri was lost. There was no other crossing for 200 miles. One of every three of the hospital's patients, and one in four of its employees, lived on the other side. The hospital's head nurse lived on the Missouri side and coordinated establishment of a helicopter site and triage center at a college there; it was operational within 8 hours of the loss of the bridge. This was possible, in part, because the college had a microwave communications system that still worked; telephones did not.

Additional help came from ambulance communications systems and local radio stations.

Several nursing homes in the area had to be evacuated, so hospitals admitted the patients and, through a simple lease arrangement, allowed nursing home staff to continue to care for them. Hospitals also became critically important to thousands of National Guard troops, "who depended on them heavily for laundry and linen services, food, and other assistance," according to Egan. The National Guard reimbursed the facilities.

For weeks, staffing patterns were disrupted; in Quincy, workers either had to drive 4 hours to get to the nearest bridge, or else were forced to use ferries across the flooding river. Hospital employees set up carfare funds for those who were providing carpool service. Things did not get back to near-normal until late in the year; but again, no patients died, and no hospital had to be evacuated.

As for the effectiveness of the state's disaster plan, Egan reports, "I heard no complaints; in fact, health care people were pleased that the state public health department provided vaccines and other services. There were no outstanding problems." She adds that the hospital association's existing statewide communications system worked well: "Although it is not specifically designed for disasters, it works in the same way as a targeted system."

The Northridge Earthquake

The temblor that shook the San Fernando Valley on January 17 of this year was the most publicized US disaster of recent times. The death toll was 56; 25,000 people lost their homes. After all expenses have been counted, the quake may prove even more expensive than Andrew; its costs have been estimated to be as high as $30 billion, the total for the Florida storm.

Roger Richter of the California Association of Hospitals and Health Systems reports that 73 hospitals suffered structural or nonstructural damage or incurred additional costs. Immediately after the quake, hospitals treated 8649 outpatients and admitted an additional 1567. Total hospital damage was estimated at $1.3 billion. "No lives were lost due to structural damage," Richter reports, "although one person who was terminally ill apparently died when a ventilator failed." He adds that since 1973 "not a single patient has died as a result of earthquake structural damage to a California hospital."

Two hospitals—Saint John's in Santa Monica and the Veterans Affairs Hospital in Sepulveda—had severe damage to inpatient buildings. Saint John's survived the main quake, but subsequent damage from aftershocks led the hospital to voluntarily evacuate patients 3 days later.

Still, Richter reports, "Even those hospitals that had major evacuations kept their emergency rooms going." Indeed, one of the lasting television images of the quake was the fallen Kaiser Permanente medical office building (which was unoccupied at the time) lying within a few hundred feet of the busy Granada Hills Community Hospital, where staff were providing emergency care in the parking lot.

Saint John's president, Sister Marie Madeleine Shonka, reports that during the quake, many patients went into labor—a common phenomenon during temblors. "We had to move patients away from the regular labor and delivery area, so nurses and physicians set up shop in another part of the hospital. Some of our nurses are licensed midwives, and they were able to
assist births with no difficulty, even though some deliveries were made by flashlight.” At the Kaiser Permanente hospital in Woodland Hills, Vicki Schuster gave birth to a son as the walls shook; not surprisingly, she named him Joshua.

As was the case in Florida, although many medical-surgical beds were available after the quake, high-tech beds became scarce. David Langness, vice president for communications of the Hospital Council of Southern California, reports that “hospitals took in an enormous number of patients whose conditions were exacerbated by the quake,” including nursing home patients. At one point, of 1930 intensive care unit beds, only 150 were unoccupied. “People talk about Los Angeles being overbedded, and maybe we are; but the redundancy in critical care saved us.”

The aftermath of the quake was distressing. Saint John’s stopped offering inpatient services, although it reopened them on October 3; as a result, the hospital had to terminate 1700 employees. Its physicians needed to affiliate temporarily with other hospitals, where they were warmly received, according to Sister Marie Madeleine.

The quake also touched off several public policy debates. Many hospitals lost water, usually because external water mains or pumps failed; some state legislators suggested that hospitals be required to have a 3-day internal water supply. The California Association of Hospitals and Health Systems opposes this; as Richter points out, the expense of constructing seismically safe tanks, filtration systems, and so forth would be prohibitive. Sewage systems also failed, and there was talk of requiring hospitals to have sewage treatment capacity for 24 hours; Richter points out that this would force hospitals to compensate for inadequate municipal infrastructures.

The biggest debate, however, was over increasing seismic resistance standards for hospitals, which already are subject to codes whose stringency is exceeded only by that of standards for nuclear reactors. A flurry of bills was submitted, but after intense debate, only one survived: Senate Bill 1953, which requires that by the year 2008, all potentially hazardous hospital inpatient buildings must comply with the 1973 Seismic Safety Act, through retrofitting or other means. All inpatient buildings would be required to meet that standard by 2030. The California Association of Hospitals and Health Systems supported the legislation, which passed the legislature in August and was signed by the governor.

**Hard Lessons**

What wisdom has health care gleaned from its recent misfortunes? A large body of knowledge has been obtained, admittedly at a very high price.

**Preparedness.—** Those who have been through calamity stress that it is necessary to customize disaster plans for the type of event most likely to happen in the area. A good example is use of industrial-strength Velcro by hospitals in earthquake-prone locations. Richter reports that “it became obvious from the Loma Prieta quake how important Velcro is; hospitals that used it to secure equipment and file drawers did not lose microscopes or other expensive equipment,” although some drawers and files will still come open in a strong quake.

Even more important, hospitals, nursing homes, and individual health care workers should be prepared to rough it without adequate power, fuel, or water for at least a week. Grim reports that Florida hospital disaster plans “assumed 3 days of inconvenience, and that the majority of the population

and the infrastructure would not be affected; instead, we had 200,000 homeless and the infrastructure was destroyed.” She urges planning for a week of bad problems as well as for long-term recovery.

Meiers adds, “Think about what to do if the lights don’t come back on for 2 weeks, or if there is no water above the first floor for 10 days, or, if there is water, it isn’t potable. The one big lesson is that we must think of everything that could go wrong over a period of days. The worst problem is not planning for disaster; it’s planning for recovery.”

Part of being prepared, he says, is regular participation in drills by all relevant community entities—and sharing of critical information. Often, he laments, health care workers do not even know where the local civil defense disaster command center is located, or who is in charge of it; he urges that all staff know where disaster authority is vested in the institution, in the state associations, and in the government. An additional point comes from Richter, who stresses that “even in an emergency, the CEO is still in charge of the hospital.”

During the Northridge quake, some medical staff members began acting on their own, including issuing evacuation orders that were not necessary, he says.

Contingency plans with sister organizations can come in handy. Meiers is establishing such relationships with West Coast hospital associations. Florida hospitals are setting up “buddy systems” so that they can support each other; some in northwest Florida are making arrangements with facilities in Alabama and Mississippi. Grim urges each hospital to adopt and staff an emergency shelter, which eases pressure on emergency departments.

Wendee Riegner, RN, former director of emergency medical services and disaster management for the Hospital Council of Southern California, suggests that facilities plan to share resources; if one’s refrigerator or surgical suite cannot be used, the sister facility can provide one. Don Martin, director of human resources for Kaiser Permanente, says his organization is creating an emergency plan that would allow any Kaiser region to provide support to any other region that is in trouble. However, warns Arthur Southam, MD, president of CareAmerica, a California health maintenance organization, make sure there is a way to get to the point to which services are being transferred; his organization had a backup data collection site, but the freeway leading to it collapsed in the quake.

**Water and Supplies.—** No matter what the disaster, the water supply is likely to be disrupted. Even if the internal system is working, external mains and pumps probably will not. Ed Carlson, Kaiser Permanente regional administrator for southern California, reports that Kaiser has a contract with a dairy that provides milk to its hospitals; the trucks were used for water delivery after the quake. This was also done in Illinois during the floods. CaliforniaCare, another health maintenance organization, rented a fire truck and used water from a fire hydrant.

With more and more facilities using low-inventory “just-in-time” systems, supplies can become scarce in a hurry. Jill Carter, vice president for public affairs of Baxter International, says that Baxter meets with each customer to determine what its emergency needs are likely to be. After the Northridge quake, a Baxter command center outside the damaged area directed drivers by radio to deliver needed supplies. Baxter drivers also visited hospitals whose communications were down to determine and fill supply needs;
some trucks also delivered water. Carlson thinks that pre-arranged contracts for delivery of key equipment, such as generators, are advisable.

Even if supplies are on-site, says Richter, they are of little use if they cannot be located; employees always should know where they are stored. And supplies should be kept in seismically safe, easily accessible buildings. He adds that “during the Loma Prieta quake, some hospital employees did not know that only certain areas are on the emergency generator system, and sometimes those areas are not contiguous.” Flashlights, heavy gloves, a shovel, and a pick or axe should be stored in each hospital department, he says; staff can then at least reach areas that are on generator power.

Staff and Personnel Issues.—In an emergency, it is common for staff at affected facilities to insist they do not need help. This admirable spunk can become counterproductive when workers start suffering from shock, fatigue, and post-traumatic debilitation. Carlson advises, “You have to help them understand that their high energy levels will start to go downhill at some point.”

Also, says Grim, in a big disaster, “expect to lose 30% to 50% of staff,” a significant percentage of whom may never return. “People are not willing to put their kids or their pets through it again.” Also, staff members will likely lose homes; shelter (for human beings and pets), child care, food, and other necessities may have to be provided by the hospital.

Paying employees is an enormous headache when banks and automatic teller machines have been destroyed. Some hospitals paid workers in cash, which presented security problems; others hand-wrote checks; still others made arrangements for direct deposit with banks that were still functioning. However, electronic funds depositing is not an option if there is no electric power. Many health care employers offered low- or no-interest loans to workers; others provided financial assistance that did not have to be repaid.

A vexing personnel issue is that many physician and nurse volunteers appear in the affected area and offer to help; the problem is that there is no way to check their credentials. Richter says California hospitals assigned them to paperwork and non-patient care duties. Langness reports that it became necessary to execute mass credentialing of physicians who were on staff at quake-damaged hospitals and needed to admit patients to other facilities. In Florida, says Grim, the state waived licensure requirements for volunteers who came in from out of state. “I would not support doing that again. As far as we know, there were only a couple of cases of people claiming to be physicians who were not, and no one got hurt. But there was a chance of someone coming down and killing people.” Cathy Allman of the state hospital association says that next year Florida is expected to pass legislation requiring out-of-state volunteers to bring valid credentials with them.

Communications.—As with water, communications systems can almost be guaranteed to fail. In the storms and quakes, even sophisticated microwave and satellite repeater systems went down when rooftop dishes were destroyed or pushed out of position. Cellular phones are useful to the point phone service will probably cease. In California, a backup system of hand-held, battery-operated radios, which had been considered virtually obsolete, proved invaluable.

As for communicating with patients, Carlson says that “newspapers will always find a way to publish.” Printing information in newspapers and broadcasting public service radio announcements seem to work best.

For some patients, time is of the essence. In both Hawaii and Florida, there were no hard-copy lists of the locations of patients on dialysis or home ventilators; Grim and Meiers both urge that detailed nonelectronic records be kept of patients whom physicians and nurses must find in a hurry.

Public Health.—Two problems that require quick response are inoculation and debris removal. Grim says that both staff and volunteers must be inoculated before going into cleanup areas; Egan urges that physicians and hospitals know the location of nearby vaccine stocks.

As for debris, the removal program in Hawaii prevented serious outbreaks of disease; in Florida, where piles of rubble sat for weeks and months, sometimes rotting, Grim reports that there were instances of typhoid, typhus, dysentery from bad water, and hantavirus from rodents in the debris. Rabies from thousands of abandoned domestic, farm, and zoo animals running loose was also a danger.

Health Care Workers' Basic Decency

This report has necessarily focused on what goes wrong when disaster strikes. But much also goes right, largely due to the basic decency of people who work in health care.

In Florida, physicians from Memorial Hospital in Hollywood realized that all the pharmacies in the Homestead area were gone. They loaded a van with insulin, antihypertensives, and other needed drugs, and went into the devastated area to provide medical care and pharmaceuticals. In Hawaii, 96 health care people volunteered to go to a rainy island that had little or no food, water, shelter, or clothing.

The employees of one California hospital used their car headlights to light an outdoor emergency department after the quake, risking losing their batteries at a time when it would be profoundly difficult to replace them. Prudential set up a tent for employees after the quake damaged their offices; for days, they worked outdoors and ate lunch cooked on a makeshift barbecue. In every case, health care workers stayed on the job to the point of exhaustion and beyond, sometimes not knowing if their homes still stood. Across the country, health care people and facilities sent money and supplies to those in distress.

In its Principles of Medical Ethics, published in 1905, the American Medical Association stated that “the broadest dictates of humanity should be obeyed by physicians whenever and wherever their services are needed to meet the emergencies of disease or accident.” It appears that physicians and those with whom they work still take that charge seriously. In the words of Brad Billings, senior vice president at Blessing Hospital in Quincy, Ill, “The press often reports that the social fabric of this country is eroding. From the outpouring of concern that Illinois hospitals received and showed during the floods, I would say that the social fabric of this country is doing just fine.”

Emily Friedman

References