

# Blue ribbon panel hears how to respond to biological and chemical threats

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*This article reports on the final session of a Panel of former officials and Congressmen of the Clinton, Bush, and Obama administrations formed to recommend changes to U.S. policy and law to strengthen national biodefense while optimizing resource investments.*

If America were to be beset by a biological or chemical weapons attack, who would be in charge of responding? According to the consensus of the post-9/11 Commission *Blue Ribbon Study Panel on Biodefense* arrived at during its fourth and final meeting last week, "The federal government doesn't have a good answer to that question."

"The last thing we want to do is experience a successful bio-attack in the United States and not be in a position to respond," said former Rep. Mike Rogers (R-Mich.). "It's hard to get people's attention about biological and chemical threats that can't be seen or touched but have devastating consequences nonetheless. We have to make this a public health issue."

Following Rogers's testimony, panel co-chair Tom Ridge presided over five discussions that explored methods of re-

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sponding to biological and chemical weapons attacks--and the "leadership vacuum" that plagues response efforts--especially the response to a large-scale, mass casualty bio or chemical attack. "The federal government has stated that a public health disaster or pandemic is one of the top strategic threats our country faces," said Dr. Kenneth Bernard, a former biodefense official in the Clinton and Bush administrations. "Yet, we were still largely unprepared for the Ebola outbreak this year. We're not managing our leadership properly."

Three veterans of the Clinton and Bush administrations spoke of a "balkanized" response to biological and chemical threats. They called for future presidents to make biodefense a bigger priority--and to delegate authority to a White House official to coordinate the activities of federal agencies.

The Blue Ribbon Study Panel on Biodefense will identify and recommend changes to US policy and law to strengthen national biodefense while optimizing resource investments. The panel will produce a report that will: assess ongoing efforts; articulate ac-

tions to improve the nation's ability to prevent, deter, prepare for, detect, respond to, attribute, recover from and mitigate biological and large-scale chemical incidents; and identify near and long-term actions by current and future Congresses and presidential administrations. The Report of the Blue Ribbon Study Panel on Biodefense will be issued later this Spring.

#### **‘AMERICA HAS NOT LEARNED FROM PAST TERRORIST ATTACKS OR NATURAL DISASTERS’**

In his keynote address, Dr. Irwin Redlener, Professor of Health Policy and Management at Columbia University, lamented that America has not learned from past terrorist attacks or natural disasters. "We haven't defined what it means to be 'prepared' for a major disaster," he said. "America remains more vulnerable and less resilient than it should be. Instead of engaging in random acts of preparedness, we must be proactive." "Biological and chemical threats are among the most sinister our nation faces," Ridge said. "Terrorist groups have voiced their desire to obtain and use biological and chemical

weapons. The Ebola crisis revealed significant gaps in US public health and medical preparedness. We must consider our current ability to defend against such threats and provide for the health and welfare of our citizens."

*Homeland Security Today* has consistently reported on the nation's ill-preparedness for a catastrophic biological or chemical attack--the former of which carries with it the worst case scenario --beginning with the inaugural issue's report, *The Trauma in America's Trauma Care*.

"In the past 13 years and with a seemingly endless parade of domestic disasters that continue to challenge our health care response (in some cases to the point of collapse and beyond), it still appears our health care infrastructure writ large has failed to embrace the readiness mission. And it's not for any lack of important and knowledgeable voices who continue sounding the klaxon alarm regarding the risk we face in perpetuating the health care community's failure to embrace the preparedness paradigm," wrote CBRN/Public Health Preparedness Contributing Editor Dr.

Peter Marghella in his June/July *Homeland Security Today* cover report, *When the Crossroads of Health Care and Public Health Never Meet*.

Former director of the New York State Office of Emergency Management, Marghella was a career Naval officer who served as a plans, operations and medical intelligence officer in the Navy Medical Service Corps, retiring as director of medical contingency operations for the Office of the Secretary of Defense. Previous assignments included chief of medical plans and operations for the Joint Chiefs of Staff, chief of medical plans and intelligence for the US Pacific Command, and chief of medical plans and intelligence for the Office of the Chief of Naval Operations. His national-level planning credentials include authorship of the nation's first Catastrophic Incident Response Plan and the National Smallpox Response Plan.

#### **LESSONS LEARNED BY THE NEAREST TRAUMA CENTER TO THE WORLD TRADE CENTER**

"Just one year after the Al Qaeda attacks on Sept. 11, 2001, David Campbell, the former CEO

of St. Vincent's Medical Center in New York City, was invited to address the plenary session of the annual American College of Healthcare Executives (ACHE) Congress in Chicago. Shortly after the attacks, Campbell had written an important article about the experience he and his staff encountered as the closest Level I trauma center to the World Trade Center site. In that article, Campbell detailed lessons learned which were intended to help health care organizations become better prepared for dealing with the aftermath of mass casualty events," Marghella wrote.

"In addition to discussing those important lessons learned for hospital organizations as a result of the historically unprecedented attack, Campbell issued a clear warning to the assembled health care executives: '9/11 should be considered a catastrophic casualty anomaly, in that there were more fatalities than there were survivors requiring critical care support. Had the reverse been true, it is arguable whether the health care infrastructure of New York City and its surrounding environs (i.e., surrounding states) could have absorbed the casualty load

and provided adequate resources to support the victims.'"

Marghella said, "Campbell went on to opine that the findings of the 9/11 Commission would have been radically different if such an important critical infrastructure and key resource sector had suffered a catastrophic failure in its capacity to support the incident management mission of such a nationally significant and, at the time, historically unprecedented event. He further argued that this recognition called for enhanced disaster planning at the organizational level of all hospitals, and that it is vital that it is coordinated into community-wide planning for all major hazard events."

In her Pulitzer Prize-winning book, *Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital*, Dr. Sheri Fink "takes readers on a nightmarish journey through the ravages of Hurricane Katrina in 2005, and the consequences related to health care organizations having failed to embrace the preparedness mission and the role that they would take on in sustaining community-based resilience," Marghella said. He emphasized though that readers "can only be left shaken and

bewildered relative to how we continuously fail to take on the hard lessons for adequately managing future catastrophic and mass casualty events. Health care professionals who read *Five Days at Memorial* should quake with fear that they might be faced with the same life and death decisions because their organization's leadership decided to give short shrift to the issue of preparedness in advance of the panoply of hazards we now face as a nation."

### **HAVE THE 21ST CENTURY WAKE UP CALLS BEEN SNOOZE ALARMS?**

As Dr. Irwin Redlener, one of the nation's most vocal proponents of health care and public health preparedness--recently noted at a conference sponsored by The Atlantic on public health emergency preparedness, "The wake-up calls," of the first 14 years of the 21st century "have all turned out to be snooze alarms," Marghella noted, adding that, "In an interview with *Homeland Security Today*, Dr. Len Singer, medical director of the Healthcare Preparedness graduate program at Boston University Medical School, was even more forceful about the situation. 'We have to stop living in a fantasy

world and face reality,' he said." Marghella said, "Singer agrees with the contention that the common denominator to all disasters is human casualties, and, inasmuch, no other critical infrastructure and key resource sector resource will be at the epicenter of our readiness capacity."

"We can have all the best wishes in the world and all the best plans in the world," he said, "but unless we have buy-in by the proper stakeholders"--hospital and health care system leadership--"we are in no better shape that we were pre-9/11." Redlener "also believes we are not going to see any substantive changes to our medical and public health response capacity until we begin to approach preparedness differently," Marghella wrote.

### **PUBLIC HEALTH VS. PRIVATE HEALTHCARE PREPAREDNESS**

"There is no CINC [Commander-in-Chief] of preparedness" that can function as a cabinet-level lead for domestic preparedness and response--with all of the attendant (and required) control of forces that are medically-centric in their response capacity, Redlener said. "Once the bell goes off and we're in a disaster, the barriers between

health care and public health should disappear, as [the incident management prosecution mission] becomes a jurisdictional governmental responsibility," Singer said. "Right now, if the private health care system collapses, the public health system--underpinned by government--must be prepared to step up to the plate."

"But neither the government is as prepared as states or local jurisdictions think it is, and private sector assets expect them to be available," Marghella warned.

"In an attempt to ready the public health care sector in a post-9/11 world, the newly formed Department of Homeland Security (DHS) in 2002 decided to treat the public and private health care sectors as similar in terms of emergency management requirements. In retrospect, it might not have been the best approach," wrote Jim Blair in his *Homeland Security Today* report, *Forcing Emergency Preparedness on Health Care*. "The private sector has a long history of avoiding and delaying regulation, i.e., maintaining inventory of personal protective equipment, seismic upgrading in earthquake zones, installing redundant utility systems in flood zones, securing

radiological materials vulnerable to theft and in-place detonation, among other things." A 50-plus year career in progressive levels of responsibility within the private, public and military health care sectors, including serving as a CEO at military hospitals, Blair has spent 15 years in preparing health care organizations to meet their expected role in the nation's strategy for CBRNE and all-hazards preparedness.

"While federal resources could be (and were) mandated to achieve a higher level of readiness, the remaining 90 percent of the nation's public health care sector could not be enticed or coaxed into following suit," Blair wrote, pointing out that, "Public health sector emergency readiness became a hot potato issue, passed back and forth among DHS, Department of Health and Human Services and Centers for Medicare & Medicaid Services (CMS)--with no ultimate authority to enforce a standard of preparation. The private sector dragged its feet, and even DHS could not entice hospitals to adopt suggested guidance, despite the private sector's receipt of federal grant programs and resources."