

STATEMENT

of the

American Medical Association

to the

**Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
United States House of Representatives**

Presented by

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**RE: PROGRESS BY THE DEPARTMENT OF VETERANS' AFFAIRS
IN THE DEVELOPMENT OF A MEDICAL EDUCATION PROGRAM
MANDATED BY SECTION 3 OF THE DEPARTMENT OF VETERANS'
AFFAIRS EMERGENCY PREPAREDNESS ACT OF 2002 (PL 107-287).**

April 10, 2003

Mr. Chairman and members of the Subcommittee, my name is John C. Nelson, MD. I am a member of the American Medical Association's (AMA) Board of Trustees and serve as its Secretary-Treasurer. I am also a practicing obstetrician-gynecologist from Salt Lake City, Utah. On behalf of the physician and medical student members of the American Medical Association (AMA), we are honored to have been invited to discuss with the Subcommittee the level of preparedness in the medical community to respond to casualties resulting from unconventional weapons or catastrophic events, and what other opportunities exist for the medical community to collaborate with the Department of Veterans' Affairs (DVA) to improve knowledge in this area.

Introduction

For the medical community – for all our communities – the world turned upside down on September 11, 2001. In the aftermath of the unprecedented September 11th attacks on America and the subsequent anthrax events, the medical community and our nation now confront a new potential type of terror on the home front – casualties resulting not only from catastrophic events but also from weapons of mass destruction. The elevation of the country's terrorism alert status to orange, the second highest level, and the current war with Iraq, have only heightened the need to ensure that the medical community is prepared to respond to bioterrorism and other catastrophic events.

The events of late 2001 were a wake-up call to the medical community. In their immediate aftermath, there was a dramatic surge in physicians' education and training, particularly in bioterrorism. The primary challenge now is continuing to reach out to and educate physicians in order to sustain that knowledge and maintain their sense of urgency as a priority. The Fall 2001 events demonstrated the need for a sustained, comprehensive medical response to disasters, both inflicted and natural. The effort required by the medical community, just like the President's determination to bring terrorists to justice, must be multi-faceted, broad-based, and implemented with a long-term approach. The AMA is prepared to meet this challenge, but we cannot do it without the help and support of other organizations in the private sector and the federal government, such as the DVA.

AMA Policy and Activities

This country, like many other countries, had already faced events involving mass destruction prior to the September 11th attacks and the anthrax events. Whether resulting from natural disasters, such as earthquakes, hurricanes or tornadoes, unintentional events, or terrorism (Oklahoma City), medical professionals have a long history of treating mass casualties and responding to disasters.

The Fall 2001 events were a reminder that physicians are individuals who make a critical difference and have distinct, critical roles to play in the nation's response to disasters. Indeed, physicians have an ethical obligation to do so. One of the long-standing, basic principles of the AMA's Code of Ethics is the physician's responsibility to participate in activities contributing to the improvement of the community and the betterment of public health. This public health obligation has been continuously reaffirmed since the Code was first adopted, but in recent years, the relationship between medicine and public health had drifted apart. The September 11th attacks and the ensuing anthrax events suddenly reversed this trend and sharply revealed the need for interdependence.

Given the physician's obligation to the health and safety of communities and the nation, organized medicine has a duty and responsibility to ensure that every physician is equipped with the knowledge and skills to discharge his or her public health responsibilities, especially in helping our nation respond to disasters. As the leading voice for physicians, the AMA has taken this obligation to heart by establishing a new initiative, the Center for Disaster

Preparedness and Emergency Response, to address what is necessary in order to have a ready and prepared physician workforce. Through this Center, the AMA is developing methods to prepare physicians to deal with terrorism or natural disasters, how to field test these procedures, and how to disseminate them to the physician community. More information on the Center is provided later in this testimony.

The AMA has a long tradition of involvement in helping to lead the response to terrorism and disaster preparedness. AMA policies relating to terrorism and disaster preparedness have been shaped by contemporary events, ranging from informing the Executive and Legislative branches of government (as well as physicians and the public) on the medical consequences of nuclear war, to condemning the use of chemical, nuclear, and biologic weapons. For instance, since the early 1980s, the AMA has maintained policies directing the organization to prepare appropriate educational materials for the physician community and the public on the medical consequences of nuclear weapons, while supporting cooperative efforts in responding to national emergencies.

Other AMA policies also discuss weapons of mass destruction and define the importance of the Department of Defense (DOD) and the DVA in our national response. Historically, the AMA has supported collaboration with the DOD to explore ways in which we could cooperate to assure the nation's medical preparedness in the event of a national emergency. The AMA also supported implementation of the current National Disaster Medical System. As the nation's attention shifted from nuclear to chemical and biological scenarios, the AMA's attention also was directed to these potential weapons.

Over the last several years – even prior to the September 11th attacks – the AMA was at the forefront in addressing the public health implications and the level of this country’s readiness to respond to bioterrorism and other means of mass destruction. For example, the editorially-independent *Journal of the American Medical Association (JAMA)* devoted a series of articles to bioterrorism, and more specifically, to the diagnosis and treatment of a variety of biological agents. The AMA’s Council on Scientific Affairs (CSA) devoted at least five of its reports and many of its activities to ways in which organized medicine can become more closely involved in disaster preparedness for bioterrorism and other weapons of mass destruction. Under the auspices of the CSA, the AMA held a series of successful town meetings in conjunction with a conference on bioterrorism sponsored by DOD in 2000. A broad cross-section of specialty, state, and county medical society representatives, community responders, as well as members of the military, who are engaged in disaster response planning and deployment for such events, attended the meetings. The focus was on how organized medicine and community-based physicians can become better prepared (through education and development of core competencies) and more active in local disaster response planning. Specific elements related to treatment (drugs, vaccines, liability issues) and local response (national stockpile preparation and local delivery) also were discussed.

AMA Activities Post- September 11th

Building on its response to the events of 2001, the AMA is uniquely positioned to play a continued leadership role through the Federation of state, county, and specialty medical societies represented in the AMA’s House of Delegates, which is comprised of over 150 separate groups that work together to advance the agenda of physicians and their patients.

Working in collaboration with the Federation, the AMA can act as both a facilitator and convener, with the ability to disseminate information rapidly to thousands of physicians and bring together interested parties, in both the private and public sectors, to develop and implement educational programs and disaster response initiatives.

Our AMA activities have included the development of a comprehensive Web presence for clinicians and the public; outreach to and involvement of the AMA Federation; collaboration with both federal and private sector agencies; communications through press releases; and personal representation by AMA officers. Many of these activities are ongoing and include the following:

- Contact with HHS/CDC began very quickly to determine the level of response that might be needed in communicating more widely to the Federation, AMA members, and physicians at large. Similarly, contact with the Medical Society of the State of New York was established very soon after the attacks. The AMA has maintained ongoing contact with the appropriate sections of the CDC, HHS, DOD, the Office of Emergency Preparedness (OEP), the Federal Emergency Management Agency (FEMA), and the Department of Homeland Security.
- The AMA cosponsored with the Centers for Disease Control and Prevention weekly video telecasts on bioterrorism. These telecasts were designed to educate physicians on a whole host of issues about bioterrorism and preparedness, including one on diagnosing and treating anthrax, and another more recently on smallpox. The AMA continues to work with CDC in notifying the physician community about satellite broadcasts, web casts, bulletins and other resources, as appropriate, and continues an

ongoing dialogue with the Administration to identify creative ways to educate physicians and the public about bioterrorism and preparedness.

- The AMA created a mechanism for gathering names of physician volunteers to assist in the immediate response to disasters, if needed. This has provided a way to augment regional response planning. More than 3,000 physicians responded, and a list of volunteers was sent to HHS. We also sent sample information from our Physician Profiles database, as an example of information that could be provided upon request and should be available to DVA and DOD facilities as part of any National Medical Response System. The physicians who answered the AMA's call to action were personally contacted and sent a follow-up letter that urged their involvement in local and state disaster efforts. The AMA continues to work with the Administration to identify additional volunteer physicians as part of our effort to respond to the President's call for the development of local volunteer networks.
- AMA elected leadership and staff have answered hundreds of calls from the media, physicians and the public regarding the medical implications of various types of terrorism. These activities are ongoing. In addition, there have been numerous articles in AMA publications, such as *AMNews*.
- A web presence on terrorism/disaster response was designed in the immediate aftermath of September 11th to provide resource materials for physicians and the public. In fact, the AMA's website on this issue quickly became, and continues to be, a national and international resource, with the most up-to-date and reliable information for the physician and public on bioterrorism and disaster preparedness. The site includes recent articles from *JAMA*, along with a series of AMA Council on Scientific

Affairs Reports, and links to the CDC and other government agencies. The website is in the process of being strengthened and enhanced, and made more user-friendly.

- The AMA's advocacy team has an ongoing exchange of information with the Executive and Legislative branches of the federal government regarding the clinical and public health implications of terrorist attacks. Activities have also included advocacy for adequate staffing and funding for the new Department of Homeland Security so that it can coordinate the needs of medical disaster response; increased funding for HHS agencies, state and local health departments, hospital emergency response systems and municipal/regional response systems, so that the public health infrastructure can be improved; and increased funding for research, development and production of new antiviral and antibiotic treatments and increased stockpiles of vaccines and antibiotics.
- In addition to the activities mentioned above, the AMA's educational efforts have included special sessions on bioterrorism and disaster preparedness at its regularly scheduled meetings; distribution to physicians of pocket reference guides on the diagnosis of illnesses resulting from biological weapons; distribution of an HHS Smallpox Vaccination Reference Guide; and the creation and distribution of CD-ROMs containing state-of-the-art medical and clinical information on bioterrorism awareness and preparedness, which were mailed to all physician members of the AMA. The AMA also has collaborated with the CDC to distribute the CDC's Health Alerts to physicians across the country.

Recent AMA Initiatives

Post-September 11th, it has become obvious that the challenge is to “fill in the blanks” for practicing physicians to ensure that they have the requisite skills and training to respond to disasters. The AMA’s most recent initiative to respond to this need was the creation of a new Center for Disaster Preparedness and Emergency Response. Dr. James J. James, MD, DrPH, MHA, joined the AMA in December 2002 as the first director of the Center. Dr. James served 26 years with the U.S. Army Medical Corps, from which he retired as a Brigadier General. Serving as director of Florida’s Miami-Dade County Health Department from 2000 through 2002, Dr. James was intimately involved in dealing with the anthrax-related incidents that occurred in the fall of 2001, and in the subsequent development of the smallpox response plan for South Florida.

As director of the AMA Center, Dr. James is responsible for managing and developing a comprehensive medical and public health program for the AMA to respond to terrorism and other disasters. Planned initiatives of the Center include the following:

- 1) development of an evidence-based educational/training model that will identify specific needs for physicians and other licensed health care providers, the responder community and the public at large, and ensure competency of physicians in disaster response;
- 2) development of a dynamic surge model that will help communities assess their ability to respond to a given event by type and magnitude, and take into account in real-time the current status of a community in terms of the factors impacting it;

- 3) development of a community mental health model that will target both increasing community resiliency pre-event and the ability to better mitigate post-event psycho-social morbidity;
- 4) development of an updated website that will provide for accurate and timely communication of information pertaining to intended and unintended catastrophic events;
- 5) further definition of the bioethical basis of physician responsibilities to respond to catastrophic events and, also, to recognize their role in ensuring the use of biotechnology for the betterment of man; and
- 6) creation of a public private entity that the AMA has previously recommended, within the context of a medicine-public health initiative (discussed below).

With regard to the educational/training model noted above, the AMA, in partnership with others, is developing two sets of courses targeted to licensed health professionals. These courses, Basic Disaster Life Support (BDLS) and Advanced Disaster Life Support (ADLS), are patterned after two sets of courses that are widely recognized and accepted by the health care community, Basic and Advanced Trauma and Cardiac Life Support. These new courses (BDLS and ADLS) will set a standard for providing valid, standardized, certifiable content to all physicians and other health care practitioners. The committee appointed by the AMA to oversee this educational activity will also address the whole continuum of medical education and how we ensure our physicians and other practitioners are trained in and updated on this critical content.

The BDLS course, developed in partnership with the Medical College of Georgia, the University of Georgia, Southwestern Medical School (Dallas), and the University of Texas School of Public Health, is intended to provide physicians and other health care professionals with the basic knowledge and skills needed to enable them to contribute to the health and safety of their communities, especially in the aftermath of a natural or intended catastrophic event. This course is both intensive and comprehensive, using an “all-hazards” approach as opposed to looking at anthrax or a chemical attack or some other specific scenario. In its present configuration it is presented in a didactic format over a two-day period. A distance-learning capability will also be fielded. The course content is broken down into 13 modules and covers such areas as federal and state roles, Incident-Command, community mental health, disadvantaged/at risk populations, and the public health system.

The most important aspect of BDLS is that it addresses all of those areas that are critical to physicians being able to effectively respond to disasters, but that are not otherwise covered in more general medical education curricula. For example, the role of incident command systems has been clearly established in disaster response. The physician needs to understand his or her role to maximize effectiveness. Other areas in the curriculum provide the physician with understanding vertical/horizontal communication, use of media tools, local, state and federal roles in disaster response and mitigation, and licensure and liability issues.

Another ongoing effort with which the AMA has been intimately involved is the CDC’s Smallpox Vaccination Program. The AMA worked closely in developing and implementing the recommendations of the Advisory Committee on Immunization Practices, and continues

to work with the CDC and HHS in monitoring the smallpox vaccination program and in educational outreach to physicians and the public regarding not only smallpox itself, but the status of the vaccine and the risks and benefits of the vaccination.

Educating Physicians: Where are the Gaps and What Role Can the DVA Play?

Much has been accomplished since the events of the fall of 2001 in educating and training our physicians. We know that our physician population is much better informed about and more aware of the risks of an intended or unintended catastrophic event, as well as where to go to get the most up-to-date information. We know this because of the large amount of material that the AMA and other medical specialty societies, government agencies, and health organizations have developed and distributed via multiple outlets. We know physicians have accessed this information from the number of website contacts reported and also the number of CME certificates issued relating to disaster response content. The websites, whether AMA or CDC, for example, have dramatically improved and are much more clinician-friendly.

Yet, while we indeed have made good progress, much remains to be done, especially in shoring up the public health infrastructure. While physicians are better educated and prepared, much more needs to be done to bridge the gap between the practicing physician and the public health networks. Clinical communication, as noted above, has dramatically improved, but information on how to get physicians plugged into their own local or regional public health networks is still poor, and public health infrastructure is still weak. The next step is to prepare a physician workforce that is not simply informed, but that also has the practical skills to respond competently to disasters.

Disaster response teams have been in place for many decades. Now, it is vital that these systems be upgraded to include potential intentional disasters, and that surge capacity be increased by linking up with local, trained physicians. For example, it is not clear in most parts of the country how interested physicians could participate in their local regional disaster response teams. This deficiency could prove to be extremely critical, particularly during the time between when an event occurs and the state and federal response teams arrive at the scene.

Multiple exercises that have looked at disaster response in individual communities have clearly demonstrated that the most significant weakness is “command and control” and effective communication. The response to the anthrax event in South Florida was a good example of the benefits to be derived from active coordination and interaction between the medical community and the public health system at the community level. As a result of expeditious and open communication between the health care provider community and public health community, a clinically suspicious case was quickly identified and diagnosed, and appropriate epidemiological and health care activities were undertaken. The media were quickly involved, and a consistent message was provided and delivered in a timely manner. As a result, public fears were kept at a manageable level. Much of this resulted from the pre-event coordination and interaction that existed between the local health department, the local medical society and other elements of the public health network.

The AMA believes that it can and should play a critical role in bridging the gap between medicine and public health not only through its current mission of physician education and training, but also through its ability to convene and bring to the table the appropriate partners from the private and public sectors to develop and activate a system to link local physicians with the public health system seamlessly. One of the ways in which this can be done, we believe, is through the creation of a public-private entity (including federal, military, and public health content experts) that, collaborating with medical educators and medical specialty societies, would (1) develop evidence-based medical education curricula on disaster medicine and the medical response to terrorism; (2) develop informational resources for civilian physicians and other health care workers on disaster medicine and the medical response to terrorism; (3) develop model plans for community medical response to disasters, including terrorism, with a mechanism for testing and evaluation of such plans and an assessment of their impact; and (4) address community physician reporting of dangerous diseases to public health authorities.

The public-private entity, as envisioned by the AMA, would be comprised of key participants, including DVA and DOD. This core group would identify specific tasks designed to enhance local preparedness and response, including educational components, and then would engage the necessary additional participants in order to accomplish relevant goals. Activities would focus on bridging the gap between the local incident and mobilization of federal resources. Creation of the Department of Homeland Security to coordinate all federal response agencies does not lessen the potential value of this concept, which ultimately would serve to integrate more efficiently local responses with existing federal components. The AMA previously

raised this concept the last time we testified before this Subcommittee in November 2001; unfortunately, the proposed entity remains only a concept due to the lack of resources.

We believe that the DVA and DOD could play a critical role in making the private-public entity a reality, through their financial resources and staff expertise, and we would welcome their participation in this venture. The DVA, through its extensive network of medical facilities and affiliations with residency training programs, would be a natural partner with the AMA to help prepare the medical community for responding to disasters, whether intentional or natural. While the details of this partnership obviously would need to be worked out, the AMA envisions creating a committee, under the leadership of the AMA and the DVA, that would bring together other interested parties to develop and field education curricula for undergraduate, graduate and continuing medical education programs.

Many practicing physicians are part of the national defense medical system through hospital affiliation that has, as the organizing entity in their region, a DVA or DOD medical facility. These are natural alliances for collective education. These facilities could also play a critical role in providing surge capacity when disasters occur. The DVA could play an instrumental role in linking education and training programs into the regional response preparation of the National Disaster Medical System. Additionally, there could be greater coordination between regional and local education and training programs, which could be incorporated into hospital disaster exercises which are a mandatory standard for hospital accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

Another area where we believe a gap exists is the lack of federal legislation providing limited immunity for medical liability claims for care provided during an emergency. Also, expedient recognition of medical licenses from other jurisdictions is needed. While many states have enacted “Good Samaritan” laws that provide immunity to physicians who provide volunteer care to others, there is no comparable federal law granting immunity across state lines. In the 107th Congress, legislation was introduced (H.R. 4634) to address this problem in the National Capital Area (the bill was later amended to be applicable across the country). This legislation would allow physicians to provide services to victims of emergencies regardless of the jurisdiction of their licensure in the event of a declared public health emergency. The bill would protect physicians from liability for all but willful, criminal, or reckless misconduct, gross negligence or a conscious, flagrant indifference to the rights or safety of others while performing such volunteer emergency service. No action was taken on this legislation in the 107th Congress, and no similar legislation has been introduced to date in the 108th Congress. AMA believes that the protection provided by such legislation would help to promote greater physician volunteerism without fear of being sued or fined.

Conclusion

The AMA stands ready, able and willing to work with the federal and state governments to assist in educating medical students, physicians and other health care professionals and preparing them for any mass catastrophe. We would be greatly honored to help in any way possible.

Thank you once again for inviting us today.