Statement

of

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Three Years After 9/11: Is the Nation Medically Prepared? What Should VA's Role Be in Preventing and Responding to National Medical Emergencies and Terrorist Attacks?

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Good morning and I want to thank you for the opportunity of testifying before the Committee today.

I am Neil C. Livingstone, CEO of GlobalOptions, Inc. I am the author of nine books on terrorism including America the Vulnerable: The Threat of Chemical/Biological Warfare. This book followed publication of my 1982 monograph, "The Poor Man's Atomic Bomb," which was, I believe, the first major publication in open sources regarding the threat posed by terrorists using chemical or biological weapons. At the time of its publication, some, even in the defense community, dismissed the growing threat of terrorists armed with chemical or biological weapons as "science fiction." Today, unfortunately, we know how wrong they were.

As I have stated publicly on many occasions, the evidence clearly indicates that it is not a question of "if", but only a matter of "when" the U.S. will suffer a major chemical or biological attack at the hands of terrorists or a rogue nation.

Let me give you some sense of what a major attack might look like based simulation data and immunological studies.

A rogue nation could launch a biological attack simply by infecting a number of its citizens with an agent like plague (pasteurella pestis) and using them as vectors, or carriers. This would be done under the pretext of administering a normal inoculation to them as a requirement of traveling abroad. They would then be sent, perhaps under some humanitarian program or as a part of a visiting delegation, to the United States, where they would infect others on the plane, in the airports they pass through, and wherever they stay once they arrive.

Rodents, fleas, birds, and arthropods, to cite just a few examples, might also be used as vectors. Certain bacteria could also be released in aerosol form. There are countless ways that an epidemic might be introduced into the United States.

Depending on the agent and incubation period, cases would soon start to appear. Plague, for example, has an incubation period of approximately three days, whereas Q-fever can take up to three weeks.

Depending on how contagious the agent is, soon doctors and emergency rooms would begin to receive patients and local health officials would declare an emergency. Depending on the morbidity and lethality of the agent, panic would soon sweep the affected city or region. People would try to flee the city and authorities would have to address the issue of whether or not to impose an area-wide quarantine, including suspension of all travel in-and-out of the city. And here's where some of the really thorny issues arise: for example, should federal troops or the National Guard be used to seal a city off form the rest of the world? If people challenge the quarantine, should lethal force be used to stop them? What about people trying to get into the city to help their families?

Hospitals will have to set up elaborate triage systems to address thousands of potential victims, probably in their parking lots, even in inclement weather. How will they protect other patients from those infected by the agent? Will there be enough vaccine to inoculate health care professionals and other key workers like police and firefighters? How will they dispose of the bodies of those who expire as a result of the infection?

The situation would likely get totally out-of-control with tens of thousands of stricken people, some armed, flocking to hospitals and demanding treatment. What then?

This is why it is imperative that the U.S. be adequately prepared, with all contingencies fully explored and appropriate policies, procedures, facilities, personnel, and supplies in place to address any biowar attack that could conceivably occur.

It is in this context that I would like to focus on the role of the Veterans Administration (VA) in response to a mass casualty biowar terrorist attack.

Hundreds, if not thousands or even tens of thousands, of Americans are likely to be afflicted by such an attack, especially if the terrorists use a contagious agent rather than a toxin.

The VA is the nation's largest direct provider of health care services. It maintains more than 1,300 facilities, including 163 hospitals and 850 ambulatory care and community-based outpatient clinics. By comparison, the Defense Department oversees 75 hospitals and about 460 medical clinics.

The VA also is the nation's largest pharmaceutical purchaser and boasts the largest health professionals training program in the United States. Each year the Agency trains 85,000 health care professionals and is affiliated with almost 1,400 medical and other schools.

Since the Veterans Administration is the closest thing this nation has to a national health care delivery system, it can be anticipated that the VA will play a major role in addressing any biowar crisis.

By contrast to military hospitals, which are often located on restricted reserves and in rural areas, the VA maintains hospitals and clinics in virtually every major urban area in the United States. In many respects, the VA is the healthcare equivalent to the National Guard, standing by to be mobilized in the event of a major disaster.

But is the VA able to respond effectively in the event of a major biological attack? Sadly, the answer is no.

The VA plays a supporting role in the National Disaster Medical System (NDMS), which coordinates federal medical resources to assist state and local authorities when health care facilities are overwhelmed following an emergency. In the event of an attack, VA hospitals are available to provide medical assistance as part of a local health care network.

In the aftermath of the 9/11 attacks, the VA has improved its emergency response and continuity of operations. Training has been provided to staff, as well as decontamination equipment and medical supplies.

In 2002, legislation was signed by President Bush to establish four research centers at VA hospitals to develop responses to biological, chemical, and radiological attacks. The new law also created an Assistant Secretary for Operations, Security, and Preparedness within the VA, and it directed the Agency to develop bioterrorism medical response education programs.

While $100 million was authorized to implement the new law, no funds have been appropriated since then. The Agency has not been able to move forward with the research centers, although it has developed and distributed medical educational materials on bioterrorism.

The hesitancy to fund the research centers stems, in part, from a concern about the VA's primary mission, which is to provide care for our veterans. There is a fear this mission may be diluted if the Agency becomes too involved in bioterrorism preparedness.

As a result, the basic role of the VA has changed very little since the 9/11 attacks and the creation of the Department of Homeland Security.

Restricting the VA's role to providing health care for our veterans may appear laudable, but in practicality it is a disaster waiting to happen – no pun intended.

In the event of a biological terrorist attack, local hospitals – including VA facilities – will likely be overwhelmed with patients. Some bioterrorism scenarios predict more than 100,000 casualties.

It is critical that we actively prepare now for a bioterrorism attack. "Most hospitals across the country," according to the General Accounting Office (GAO), "lack the capacity to respond to large-scale infectious disease outbreaks." Few hospitals have adequate equipment to handle a large increase in patients. As of July 2004, no state has the ability to respond to an epidemic involving at least 500 beds.

While most hospital staff has received training on biological agents, fewer than half has participated in an exercise related to bioterrorism.[1] Major gaps remain in disease surveillance systems and laboratory facilities. GAO reports there are also major deficiencies in regional planning and coordination. Some states have yet to negotiate basic agreements just to share physicians.

The federal government has plans to deploy medical teams to disaster sites to supplement care. But more is required. As previously mentioned, in a bio attack, there will be

[1] "SARS Outbreak: Improvements to Public Health Capacity are Needed for Responding to Bioterrorism and Emerging Infectious Diseases. General Accounting Office. May 7, 2003.

widespread panic, with victims demanding emergency care at local hospitals, while others seek to flee the city.

ER-One Project

Several years ago, my company, GlobalOptions, worked with the Washington Hospital Center on the ER-One project, to design the emergency room and related facilities and capabilities of the future. As part of the project, we examined the challenges hospitals will face from a mass casualty attack.

In a major event involving chemical agents, the first task for hospitals will be to triage casualties before they are decontaminated and moved into a facility for emergency care. The purpose of triage is to prioritize the injured and determine the best use of available resources, with the purpose of saving as many lives as possible.

In a biological attack, the first responders will most likely be health care professionals at a hospital or clinic. Based on early symptoms, it may not be apparent that patients have been contaminated with an infectious disease. But once diagnosed, vaccines and antibiotics will need to be quickly administered and patient isolation will be essential.

Most hospitals are poorly equipped to deal with an infectious agent, and do not have air filtration and over-pressure air flow systems to prevent contamination. At best, sections in a hospital can be quarantined, with medical staff protected by gowns and masks. Many hospital rooms do not even have double-paned windows to prevent the escape of an infectious agent.

Another key issue for hospitals in preparing for a chemical, biological or radiological attack is ensuring the availability of safe, potable drinking water. Few facilities have water purification systems. In a water emergency, the standard procedure is to rely on tanker trucks to bring potable water to a hospital. But this option is problematic in a terrorist attack. The source of water for the tanker trucks also may be contaminated. In the chaos that would follow an attack, trucks may have difficulty reaching hospitals, and once they do, distributing the water becomes a burdensome process.

Another issue often overlooked at hospitals is security. Crowd control is essential. After the 9/11 attacks in New York, hospitals were inundated by people looking for family members. Workers who escaped from the towers were treated in more than 100 different hospitals, and family members roamed from hospital to hospital looking for their kin.

In a biological attack, people will be desperate for medical care. Hundreds of people may descend on hospitals to demand treatment and could even threaten violence to gain access to care. Hospitals must have security systems in place to protect staff without compromising the efficient and compassionate delivery of health care services.

Retrofitting every hospital to respond to a bioterrorism attack would be financially prohibitive. But as new hospitals are constructed, preparing for such scenarios should be a consideration.

Very early detection and isolation is the most effective strategy to contain a bioterrorism attack. If thousands of people are contaminated before an infectious disease is diagnosed, it will already be to too late to manage the crisis by isolating victims in hospitals equipped with the most modern technology. But if we are able to detect an attack in its earliest stages, such facilities will be critical to preventing a pandemic and treating victims.

Recommended Changes

Everyone agrees the VA's primary mission should remain unaltered – providing quality health care for our veterans. But this role would not be jeopardized by utilizing the VA's national heath care network and educational resources to prepare for a biowar attack so long as additional resources are made available to get the job done.

Organizing our vast health care system to respond to a biological attack is a daunting task. Much work remains unfinished.

Enhancing the VA's role in communities where VA facilities already exist could be a far more cost-effective and efficient answer to the biowar threat than relying on the present structure where local communities are expected to address such emergencies until they are overwhelmed and federal resources mobilized.

As the nation's largest health care network, the VA has broad reach into our communities and established relationships with medical professionals. The Agency is actively training health professionals and is in a unique position assist in bioterrorism preparedness. Consideration should be given to enhancing the VA's role in training and coordinating medical resources to respond to a biowar attack.

Funding the four research centers at VA hospitals to develop responses to biological, chemical, and radiological attacks would further enhance the Agency's expertise and ability to assist communities in preparing for, and responding to, a biowar attack.

The VA's national health care network is an underutilized resource that can be readily harnessed to focus, enhance, and accelerate our preparedness. By elevating the Agency's national role in bioterrorism, needed resources can be uniformly deployed throughout the United States in an expeditious and cost-effective manner to protect communities from a biowar attack.

Conclusion

Time is running out. A biological, chemical or radiological catastrophe will happen; it's inevitable. It may come from abroad or conceivably even from a domestic hate group. There have been, after all, dozens of incidents where domestic terrorists have attempted to acquire chem/bio weapons, including ricin, anthrax, and various viruses.

Twenty years ago followers of the Bhagwan Shree Rajneesh sought to infect local politicians and voters in The Dalles, Oregon, with salmonella and other pathogens. In Japan, the Aum Shinrikyo, which was responsible for the 1995 sarin attack in the Tokyo subway system that killed a dozen people and sent 5,000 to the hospital, was actively trying to perfect an anthrax weapon and even acquire a filovirus (Marburg, Ebola) culture.

And even if it is not a hostile act, with the advent of modern jet travel and global commerce, we must be prepared for the emergence of new diseases, often viruses, that dwell in the deep recesses of primeval forests and other remote places that could break out of their environments as the result of a mutation or if the appropriate host appears.

The threat of germ weapons being unleashed on unsuspecting populations is real and growing. While we are constantly developing new vaccines and detection systems, far more needs to be done to protect America, and the Veterans Administration is one of the few institutions with the knowledge, facilities, laboratories, and personnel necessary to defend this nation.

It is time to make the VA the shock troops in this potential war against an invisible enemy. As Judith Miller, Stephen Engelberg, and William Broad conclude in their study, Germs: Biological Weapons and America's Secret War, "We remain woefully unprepared for a calamity that would be unlike any this country has ever experienced."[20]

[2] Judith Miller, Stephen Engelberg, and William Broad, Germs: Biological Weapons and America's Secret War, (New York: Simon & Schuster, 2001), p. 320.