

who simply caved in to the pressure.

This unexpected consumer demand, combined with pre-September 11 production trends, led to a national shortage of Ciproflaxin. Some hospitals removed the drug from their formularies to help maintain their supply.

Hospitals and doctors need to factor this trend into their calculations when determining drug supplies for their population base. In the event of a terrorist attack, civilians who have grown used to treating themselves will likely show great determination in obtaining these drugs.

The trend toward self-treatment not only increases the risk of a drug shortage during the crucial period right after a terrorist attack, but it is also potentially dangerous. Drugs used to treat a Sarin nerve gas attack, for example, have powerful physiological effects. In a layman's hands, they are dangerous.

Doctors and nurses need to be prepared to deal with the consequences of mass self-treatment.

To prepare for the hysteria and panic that will likely follow a biological, chemical, or nuclear terrorist attack, citizens need to be assured that sufficient quantities of drugs are available to treat them. Doctors may want to decentralize the supply of these drugs to improve consumer confidence: if people know that a supply of life-saving medication is housed at several nearby facilities and not simply at the pharmacies of major medical centers, they likely will be calmer. Finally, doctors need to talk with their patients beforehand about the role of medical treatment in the event of a terrorist attack. Solid information will prevent a patient's imagination from inventing some horrific scenario, which only increases panic behavior.

2. T f b a e b e e e , e a c a e f e , a

Over the past twenty years, there have been a large number of "turf" battles between doctors and their co-professionals. Nurses, for example, have encroached on the prescription power traditionally reserved for physicians. In some states, nurses have won the right to diagnose and treat patients without a doctor in a supervisory role. Physicians have vigorously fought this trend. The struggle for autonomy and control can also be seen among ophthalmologists and optometrists, anesthesiologists and anesthesiologists, and psychiatrists and psychologists.

These battles are important ones. Quality of care and patient safety hang in the balance.

However, doctors and their co-professionals need to come up with a separate arrangement in case of a terrorist attack. While doctors have good reasons to preserve control of patient care, a terrorist attack is likely to produce mass confusion and a shortage of health care providers. Nurses and other co-professionals will have to act quickly and independently, much more than during peacetime. Because the agents used in biological, chemical, and nuclear terrorist attacks are finite, as are their treatments, nurses and other health care professionals can be taught to manage the consequences of a terrorist attack if no supervising physician is present.

The autonomy that is to be given nurses and other co-professionals during a terrorist attack must be discussed well in advance. Doctors hesitate to do this. Understandably, they fear that it will prejudice their position in the debate over how much autonomy co-professionals should have during peacetime. But doctors and nurses must have this discussion as part of a response plan. It should be understood by both parties that a terrorist attack is an unusual and unlikely event, and that the freedom given to co-professionals during a crisis should not be taken as a sign of how things should proceed at other times.

3. M a c c e e

It is sad, but true, that the first instinct among some physicians these days who confront a medical emergency in a public space is to avoid involvement. This is because doctors fear being sued if they intervene as Good Samaritans.

Doctors have good reason to fear this. In Maryland, for example, doctors volunteering during school lacrosse and football games only recently were insulated against law suits. The fact that the sons and daughters of legislators participated in these games was probably no small incentive to pass such legislation. But Maryland doctors, and

volunteer doctors even more important. For this reason, the federal government should pass very specific and clear legislation protecting doctors who help during terrorist attacks. It may seem unreasonable to have to reassure (almost handhold) an entire class of professionals, but America's lawsuit culture has made many doctors nervous. It would be tragic if their anxiety caused them to hesitate during a terrorist attack.

4. T e e f b c e a

In the early twentieth century, public health was equated with community health. Sanitation, food inspection, and the control of epidemics were viewed as legitimate areas of government involvement because they benefited the general public, not simply one or two interest groups. In the 1970s, however, popular attitudes toward public health began to change. It came to be seen as the provision of health care for the poor, including free clinics, drug rehabilitation, teen pregnancy counseling, and the like.

Public health advocates encouraged this trend by joining their political fortunes to an expansionist welfare state and concentrating their attention on the health of society's disadvantaged. This strategy provided a useful way of obtaining project-specific federal money, but in the long run it had a ruinous effect on the nation's public health activities. As public health became synonymous with health care for the poor, the average person no longer saw it as a common social enterprise, which is one reason why it has fallen down the public's list of priorities.

Planning for biological, chemical, and nuclear terrorist attacks is a public health priority. It requires the cooperation of not just state and federal agencies, and health care professionals, but an entire citizenry. People must become involved on the local level, and hospitals and doctors need to be in contact with the neighborhoods they serve if a response to an attack is to proceed quickly and effectively.

This does not mean being in contact with a neighborhood's elected officials. When a terrorist

tact with whom they can consult on a suspicious case. At Stanford University Medical School, for example, this contact is called the Infectious Control Practitioner.

The diseases resulting from bioterrorism can be confused easily with other disorders. Coughing, vomiting, fever, and rashes are non-specific signs. Prior to public awareness that an attack has occurred, it is unlikely that the victim of a bioterrorist attack will come to an emergency room complaining that he or she is the victim of such an attack. Instead, patients will call up their primary doctors with complaints about specific symptoms. In fact, the first doctors to encounter diseases resulting from a bioterror attack might be specialists in fields other than infectious diseases. Gynecologists, for example, are the primary care doctors for many women. For these reasons, all practicing physicians must be given basic instruction in how to identify bioterror diseases.

Equally important, each physician or nurse must have a contact with whom to discuss a patient's case. Right now, the typical course for physicians who encounter an unusual case that might be an infectious disease is to consult an

much more serious partnership between the public health authorities and private community hospitals is necessary, because these hospitals are where most Americans seek care and where, in many cases, the first victims of bioterror will be identified.

Re **e d e a e**

Once a bioterror disease is diagnosed and confirmed, it must be reported to the public health authorities, to nearby hospitals, and to physicians. Communication among these three parties is essential. Doctors in the area need to know when a bioterror-related disease has been diagnosed so that they can be more vigilant when examining their patients. Hospitals also need to inform their emergency rooms to be on the lookout for the relevant symptoms.

trauma hospitals to receive large numbers of casu-

fire departments will handle the decontamination, but in the event of a radiation bomb attack, firemen probably will be busy at the scene, which means that the hospital will be the major site for decontamination. If decontamination fails to proceed in an orderly fashion, the entire hospital will be contaminated.

As in the case of a chemical attack, doctors and other health professionals must be educated not only to save victims but also to help these professionals protect themselves. For example, many doctors will naturally reach for common X-ray shielding to wear while managing radiation bomb victims. Such outside wear, however, gives a false sense of security: gamma rays pass right through it. Most injuries caused by a dirty bomb attack will fall into the category of conventional trauma, but the radiation consequences would be sufficiently severe that hospitals and doctors must plan to deal with them.

Conclusion

International terrorism poses a new kind of threat to America's civilian population. This new threat, however, is one that the U.S. health care system can plan for and respond to.

Doctors and hospitals are eager to do their part. But to do so, they will need leadership, access to knowledge and resources, and a more serious partnership with the nation's public health and military authorities.

Good doctors try to look several steps ahead when making judgments about treatment. It is in their professional nature to do so. The nation's civil authorities and entire health care system will have to manifest that same reflex today if we are to cope with a terrorist attack involving a weapon of mass destruction. Planning probably will save more lives than drugs. Right now, we are still unprepared.

Ronald W. Dworkin, M.D., Ph.D., is a Senior Fellow of the Hudson Institute.



*Herman Khan Center • 5395 Emerson Way • Indianapolis, Indiana 46226
Telephone: 317.545.1000 • Fax: 317.545.9639 • www.hudson.org*