The Threat of Bioterrorism

BY REV. MICHAEL D. PLACE, STD

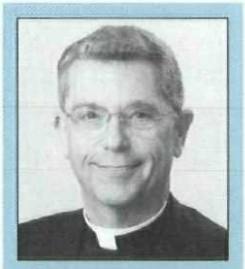
Catholic health care is a vital component of our nation's health care delivery system. One of every 10 U.S. hospitals is Catholic and, on average, 16 of 100 persons hospitalized each day will be admitted to a Catholic hospital. For almost 275 years, as the health care needs of individuals and communities have changed, the ministry has evolved in response to those needs. In recent years, for example, many Catholic hospitals were among the first to develop services and treatment for HIV/AIDS patients.

Since September 11 and the subsequent anthrax scare, Americans have become increasingly aware of a new challenge for which we must be prepared: *bioterrorism*. As the United States Commission on National Security in the 21st Century reported in 1999: "For many years to come Americans will become increasingly less secure, *and much less secure than they believe themselves to be*. . . . While conventional conflicts will still be possible, the most serious threat to our security may consist of unannounced attacks on American cities by subnational groups using genetically engineered pathogens."[1]

Bioterrorism experts, such as D. A. Henderson, MD, MPH, the newly appointed director of the Office of Public Health Preparedness, U.S. Department of Health and Human Services (HHS), point out that the impact of biological weapons might be equivalent to that of a nuclear weapon, but could be potentially *more* problematic. Conventional responses to nuclear and chemical threats will not be adequate when responding to bioterrorism. Therefore, we must reconsider both the strategy and structure of a possible response to bioterrorism.

A Four-Pillared Strategy

Fortunately, work already is being done that can contribute to that reconsideration. For example, the American Public Health Association (APHA) has proposed what it terms four major "pillars" of a comprehensive bioterrorism strategy. They were outlined at November's Health Sector Assembly by Mohammed N. Akhter, MD, president of APHA.



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Prevention Even as we try to rid the world of terrorists, we must work as a nation to minimize the possibility that future conflicts will engender terrorist acts. In addition, we need to improve our intelligence services so that we can gain control of bioterrorist weapons and laboratories.

Preparedness Essential to being prepared is an effective early warning system and an integrated response mechanism with a single chain of command and single spokesperson. We also must have medical services readily available for those affected by bioterrorism acts, no matter what their insurance status may be. These services must be comprehensive in nature and include counseling and rehabilitation services in addition to medical care.

Capacity Building The third APHA pillar includes:

- Expanding the skills and services of the Centers for Disease Control and Prevention
- Stockpiling adequate amounts of needed drugs and vaccines
- Improving hospital capacity, such as isolation facilities, and expanding professional education for frontline health workers, emergency responders, and public health workers

In addition, we must improve our local and state public health departments, both qualitatively and quantitatively, and establish a "24-7-365" presence developed at the regional level to ensure an immediate and appropriate response to a bioterrorism event. To respond successfully, we must improve the public health laboratory system significantly and replace our frighteningly fragmented local emergency response systems with integrated systems. Finally, we must inform the public about the potential health consequences of terrorist acts and tell people how they can protect themselves against such acts.

Immediate Action Steps These steps include the immunization against anthrax and smallpox of all frontline health and emergency response workers

and all high-risk individuals. We also must make antibiotics available for health workers and victims in the event of an attack.

We are fortunate that HHS and the executive branch in general (from the perspective of national policy), the APHA (from the perspective of the public health professional), the American Hospital Association (from the perspective of acute care delivery), and the American Medical Association (from the perspective of medical science), as well as other groups, are seriously engaging this frightening new challenge. Because of the richness of these efforts, CHA has not initiated its own project or task force on bioterrorism. Although our ministry colleagues in Florida and the District of Columbia have experienced the anthrax events directly, it is not clear at the present time that the Catholic health care ministry could contribute a useful bioterrorism study group or task force of it own.

Illustration by José Ortega

Ministry Concerns

Nevertheless, I suggest that our particular values and commitments cause us to enter into the public dialogue concerning bioterrorism with some clear concerns. I will outline a few, using the APHA pillars as a framework.

Regarding *prevention*, the United States Conference of Catholic Bishops, in its pastoral message "Living with Faith and Hope after September 11," noted:

> No grievance, no matter what the claim, can legitimate what happened on September 11. Without in any way excusing indefensible terrorist acts, we still need to address those conditions of poverty and injustice which are exploited by terrorists. A successful campaign against terrorism will require a combination of resolve to do what is necessary to see it through, restraint to ensure that we act justly, and a long term focus on broader issues of justice and peace. . . . Our nation must join with others in addressing policies and problems that provide fertile ground in which terrorism can thrive. Years ago, Pope Paul VI declared, "If you want peace, work for justice." This wisdom should not be misunderstood. No injustice legitimizes the horror we have experienced. But a more just world will be a more peaceful world. There will still be people of hate and violence, but they will have fewer allies, supporters and resources to commit their heinous acts.[2]

Concerning *preparedness*, we clearly are champions of a broader social agenda that insists that everyone in this nation have access to basic health care services, including being treated for bioterrorism. A terrorist event does not discriminate between the insured and the uninsured, the citizen and the undocumented immigrant. If anything, the threat of bioterrorism should be a reminder of the injustice found in our current national policy.

As for *capacity building*, our understanding of the social nature of the human person, the importance of community, and the demands of the common good prompts us to pay particular attention to our public health system. In recent years, a once effective and critically important public service has been allowed to deteriorate along with other vital parts of our nation's social infrastructure.

As the Pew Environmental Commission pointed out, the absence of a national system for monitoring public health problems linked to environmental toxins has limited our ability significantly to respond adequately to health crises such as childhood asthma.[3] If we should similarly fail to develop public health tracking systems to collect and report data about bioterrorist events and the health and mental health consequences of terrorism on victims, responders, and communities, we will be unable to plan and execute a comprehensive and effective response. I would suggest that supporting a robust public health system is a Catholic priority.

Finally, turning to *immediate action steps*,

I will note that participants at CHA's recent Physicians Forum in Amelia Island, FL, raised several ethical issues during a discussion of last fall's anthrax events. Although these issues are not new—and have, in fact, occasioned significant theological, ethical, and legal reflection over the years—they could take on a new immediacy in the event of a bioterrorism attack that affected a large number of people.

By what ethical criteria, for example, would we triage emergency treatment of those with symptoms, or—an even more complex question—allocate potentially limited supplies of antibiotics

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REFLECTIONS

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among people who have been exposed but are asymptomatic? What ethical guidelines should influence a strategy to contain an outbreak of smallpox in a large population? Can the common good require enforced vaccinations even if they put some people at substantial risk? Catholic clinicians and ethicists must not just be prepared for these conversations; they must play an active role in them.

A Silver Lining?

The threat of bioterrorism is no longer the stuff of spy novels—it is now a very real part of our daily life. The question, many would say, is no longer *whether* but *when* another terrorist attack will occur.

Although we must be diligently attentive to our responsibility to be institutionally prepared, and work together to ensure a fair and equitable provision of financial resources so that we can finance that preparedness without doing harm to other aspects of our service, we should attend also to the other issues noted above. Perhaps the silver lining in this dangerous situation is that it will force us to realize the broken nature of our nation's entire health care delivery system. Our desire to be prepared for all of the aspects of bioterrorism could become an invitation to craft the policies and develop the systems and structures for truly effective health care of people and communities. Without these changes, we will never be *really* prepared. □

NOTES

1. U.S. Commission on National Security in the 21st Century, *New World Coming: American Security in the 21st Century: Major Themes and Implications*, Washington, DC, 1999, p. 8 (available at www.nssg.gov/Reports/NWC.pdf).
2. U.S. Conference of Catholic Bishops, "Living with Faith and Hope after Sept. 11," *Origins*, November 29, 2001, pp. 413-420.
3. See Michael D. Place, "Needed: A Warning System for Environmental Health Risks," *Health Progress*, September-October 1999, pp. 8-9.

VALUES IN ACTION

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The core values of an institution offer some stability in moving forward in an ever-changing environment.

Processes In the fall of 1999, we conducted a "Mission Resource Assessment" through individual interviews with managers. The goal was to determine the usefulness of the processes and resources used to help nourish institutional integrity. In response to the assessment, we developed an action plan to strengthen the processes.

Fidelity At the request of the CEO and board of directors in 1998, and again in 2000, we developed a report on fidelity to the values. We used documentation compiled for other purposes: staff, family, and patient/resident surveys; accreditation reports; results of a review by Catholic Charities of Toronto; and a values survey of patients, residents, clients, and their families. The information was compared with the "Values in Action" document, which names behaviors necessary to ensure fidelity.

Interesting observations emerged from this approach. For example, for the value of human dignity, Providence Centre has indicated that "meaningful participation decision making is encouraged and enabled through the provision of information and support." Yet when we compared the results of the satisfaction surveys, we found that staff felt Providence needed improvement in this area—the value of human dignity was not being put into action by the facility corporately as well as it could. Currently Providence is implementing council structures, which, we hope, will enable more effective participation of front-line staff in decision making. In the next round of surveys, we will evaluate whether staff satisfaction has increased in this area.

Nourishing institutional integrity in the midst of confusion requires strategy. Mintzberg points out that "strategy is a concept rooted in stability, not change. Organizations pursue strategies for purposes of consistency. But they sometimes need strategic change, too – they have to discard their established directions in response to a changed environment."[6] The core values of an institution offer some stability in moving forward in an ever-changing environment.

Ultimately, of course, the extent to which a facility is successful in ensuring its values are put into action is measured in the quality of care that is extended to patients, residents, and clients and the extent to which employees are treated with dignity and compassion. This work nourishes institutional integrity—consistency between what an institution says it is and how it behaves. Statements on the wall mean little if the values of an institution are not visible in actions from the bedside to the boardroom. □

NOTES

1. Charles Dougherty, "Tradition, Mission, and the Market," *Health Progress*, July-August 1997, pp. 44-51.
2. Paul C. Nystrom, "Organizational Cultures, Strategies, and Commitments in Health Care Organizations," *Health Care Management Review*, vol. 18, no. 1, Winter 1993, p. 43.
3. Christopher K. Bart, "Mission Statements in Canadian Not-for-Profit Hospitals: Does Process Matter?" *Health Care Management Review*, 2000, vol. 25, no. 2, pp. 47, 58.
4. Peter M. Ginter, Linda M. Swayne, W. Jack Duncan, *Strategic Management of Health Care Organizations*, 3rd. ed., Blackwell Publishers, Malden, MA, 1998, p. 345.
5. Thomas D. Maddix and Claudette Savard, "Mission and Diversity: An Experience in Integration," *Health Progress*, January-February, 1999, p. 47.
6. Henry Mintzberg, Bruce Ahlstrand, Joseph Lampel, *Strategy Safari: A Guided Tour through the Wilds of Strategic Management*, The Free Press, New York, 1998, p. 364.