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RISK COMMUNICATION: NATIONAL SECURITY AND PUBLIC HEALTH

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS AND INTERNATIONAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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RISK COMMUNICATION: NATIONAL SECURITY AND PUBLIC HEALTH

THURSDAY, NOVEMBER 29, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS AND INTERNATIONAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:17 a.m., in room 2154, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Putnam, Gilman, Schakowsky, Tierney and Lynch.

Staff present: Lawrence J. Halloran, staff director and counsel; Kristine McElroy and Thomas Costa, professional staff members; Michael Bloomrose, intern; David Rapallo, minority counsel; and Earley Green, minority assistant clerk.

Mr. SHAYS. We call this Subcommittee on National Security, Veterans Affairs and International Relations of the Government Reform Committee hearing to order.

The title of the hearing is "Risk Communication: National Security and Public Health."

I welcome our witnesses. I welcome our guests to this hearing.

Anthrax is not contagious. Fear is.

In the battle against bioterrorism, fear is one of the most infectious diseases we face. For the terrorist, it is a potent force multiplier, capable of amplifying a minor, manageable outbreak into a major public health crisis. Driven by fear alone, hordes of the "worried well" could overwhelm emergency rooms and clinics, impeding diagnosis and treatment of the genuinely ill. Many would needlessly expose themselves to the risks of antibiotic treatments, incurring individual side effects and increasing the general threat of antibiotic-resistant criteria. Fear-based worst-case scenarios can draw scarce medical supplies and vaccines to the wrong places at the wrong times, diluting response capabilities to meet the real threat.

The only antidote to terrorism's toxin of fear is the truth.

When something as unthinkable as a biological attack occurs, the public and the media need to hear one authoritative voice conveying the unvarnished truth about the extent of risk and the public health response. During a disease outbreak, the right information at the right time can save lives. Rumor, speculation, implausible optimism and mixed messages fuel panic and endanger public health and safety.

In the Dark Winter exercise earlier this year, a lack of information about the extent and pace of three simultaneous smallpox outbreaks paralyzed national leadership decisionmaking. Opportunities to contain the epidemic were missed, irreplaceable vaccine stocks were wasted, public order decayed, State borders were closed, and communications were disrupted. National security was compromised, and for want of the facts our very sovereignty as a Nation dissolved.

The recent anthrax attacks also taught some hard lessons about effective communication of critical public health information. In the hours and days after the first case was discovered, Federal, State and local officials struggled to rebut inaccurate, sometimes sensational, reports about the risks of a rare, little-understood disease, inhalational anthrax.

We heard inconsistent assessments of the virulence of the pathogen and the sophistication of its manufacture. An epidemiological tool, nasal swab culture, was widely mischaracterized as a diagnostic test. It took some time for the voices of public health and medical experts to be heard as law enforcement and political officials gathered and disseminated information on rapidly unfolding events.

To be prepared for the next biological attack, frank and frequent communication of medical information, risk parameters, treatment options and response plans should begin now, while the information can be heard and deliberated calmly.

The draft response protocol for smallpox recently released by the Centers for Disease control and Prevention [CDC], recognizes the significance of public health education and pre-emptive communication as integral parts of an effective outbreak control effort. But in the event of a widespread biological attack, one that threatens agriculture, food supplies, water and human health, who will collect, synthesize and reliably convey complex but critical information to a nervous public?

One voice well suited to address public concerns about bioterrorism is that of the Surgeon General, Dr. David Satcher. As a former head of CDC, Dr. Satcher brings unique experience and unquestioned credibility to our discussion of public health information, public health infrastructure and medical data technologies. In past oversight efforts on blood safety and hepatitis-C, he was an indispensable partner to the Human Resource Subcommittee. We appreciate his expertise and his candor then, and we look forward to his testimony today.

All our witnesses this morning bring important information and expertise to our discussion of better ways to fight terrorism with the simple truth. We welcome them.

At this time we would recognize Dr. David Satcher, U.S. Surgeon General, and invite him to stand. I'll administer the oath, and then we'll take his testimony.

[Witness sworn.]

Mr. SHAYS. Thank you. Dr. Satcher, it is very nice to have you here.

STATEMENT OF DAVID SATCHER, U.S. SURGEON GENERAL

Dr. SATCHER. Thank you very much, Congressman Shays and members of the Subcommittee on National Security, Veterans Affairs and Intergovernmental Relations, the Committee on Government Reform. I'm delighted to be able to join you and certainly the outstanding members of panel two in discussing this very important issue.

As you know, I'm David Satcher, the U.S. Surgeon General, and I'm speaking to you about the public health response to bioterrorism and the threats of bioterrorism, and specifically the role which the Department of Health and Human Services plays in information dissemination and risk communication.

The terrorist events on and since September 11th have been defining moments for all of us. Both as a Nation and as public health officials we have been taken to a place where we have not been before. It sometimes was uncertain what we were dealing with and to what extent. We had very little science of past experience to draw upon, and we literally learned more every day. The Nation's focus on issues related to public health has been greatly sharpened. There has been fear, shock, confusion and, in some cases, even panic; and panic when it occurs, as you said, supports the aim of the terrorists.

We have certainly encountered some bumps in the road, but it is somewhat remarkable how well-coordinated our efforts have been overall. The challenge was great. We were faced with the task of coordinating communications among local governments, State governments and the Federal Government. Each level came with its own set of elected officials and public health officials, all with their own concerns. The Department of Health and Human Services tried to deal with it by being forthcoming. We tried to inform the public quickly. We let them know what we knew and when we knew it. When the information changed because we learned something new, we tried to let them know that. Through it all, vital public health information has been disseminated promptly and we have delivered medicine and expertise where needed.

I believe it is fair to say that, as a result, while we have lost five people too many to this bioterrorist attack, we have saved countless lives. Casualties were kept far below expectations, in that the fatality rate for inhalation anthrax has been thought to be around 80 to 100 percent.

Mr. SHAYS. Now, if you had been courteous, you would have stumbled over inhalation to make me try to feel——

Dr. SATCHER. Let me try it again. No, you did great.

The fatality rate to date in our experience has been only 40 percent. All of this demonstrates why effective communication based on a strong and flexible public health infrastructure is so critical.

I think under the leadership of Secretary Thompson, HHS has been working to strengthen the overall public health infrastructure so that we're prepared to respond to a range of disasters and emergencies, including bioterrorism. Since September 11th, we have intensified our efforts, resulting in a heightened level of preparedness. We are committed to increasing our preparedness based on lessons learned in recent months.

Now, because I believe that the public health infrastructure is a critical issue here and communication before, during and after such an attack is so critical, I want to discuss the public health infrastructure as it exists and its role.

Our public health infrastructure consists of several interrelated components at many different levels. Communication within and among each level is critical, as is the need for mutual support.

At the government level, the Public Health Service, the Department of Health and Human Services, works closely with State and local health departments. Our philosophy is to help support local officials, rather than to try to replace them.

Throughout the recent crises, the CDC's Health Alert Network and Laboratory Alert Network immediately notified State and local health departments of the latest developments on anthrax and the possibilities of other bioterrorism attacks. In fact, the Health Alert Network was used September 11th to immediately put State health departments on alert for anything suspicious following the attack on the World Trade Center.

Now, the role of the Surgeon General in all of this, of course is, No. 1, to command the Commissioned Corps, and the Commissioned Corps consists of about 5,600 health professionals—physicians, nurses, dentists, veterinarians, environmental health specialists. That Commissioned Corps was activated on September 11th and has been activated since. These are people who are on call 24 hours a day, 7 days a week. We have deployed hundreds of them to New York City and to other places as needed.

The second role of the Surgeon General is to communicate directly with the American people based on the best available public health science. Usually this results in a report from the Surgeon General after months and years of study of a particular topic, such as smoking and health, mental health, suicide prevention. But in the case of a bioterrorist attack, the role of the Surgeon General in this communication has never been clearly defined, and that is one of the things that we have been struggling with.

The anthrax cases in Florida provided a good example of how CDC works with State and local health officials. After the first case there resulted in death, the CDC moved quickly to confirm the case of the second victim early on the evening of October 7th. The Centers for Disease Control and Prevention and other components of HHS, the Federal Bureau of Investigation, the Department of Justice, the Florida Governor's Office, the Florida Public Health Department and local public health departments quickly formulated a plan that got word out overnight to the AMI employees that they needed to come to the clinic for medicine and testing the very next morning. The CDC shipped medicine to Florida overnight and immediately deployed epidemiologists to Florida; and CDC and Florida officials issued a joint release at 11 p.m. on October 7th notifying the media and the public of the second case. So it was a good example of local, State and Federal officials working together to get the message out to send medicine and to mobilize people to come to get treatment—literally overnight on a Sunday evening.

In a Federalist system, there are going to be communication challenges between Federal, State and local government. In all of the anthrax situations, for example, once the CDC receives initial

test results, it promptly begins doing more accurate confirmatory tests. But a mayor or Governor may decide to go out and talk to the media before the confirmatory tests are concluded. Those officials make the decision whether to do that based on their perception of the needs of the community, and we respect those decisions. At the same time, when you try to communicate that tests are merely preliminary, you hope that the public and the media will hear that and appreciate what that means.

That is the first layer of the public health infrastructure.

The second layer of the public health infrastructure is the health care delivery system, and it consists of not just the private sector but also there are public components like community health centers, community mental health centers and others. It is a very critical front-line part of the public health infrastructure.

The Department of Health and Human Services and especially the CDC worked extensively to reach out to various groups within the delivery system to inform them of what we knew. The Secretary met early on with the medical associations, the biotech industry, the pharmaceutical industry, the food industry to address bioterrorism concerns. Together with the CDC, a conference call with the State and territorial health departments took place immediately.

We also realize that there are tremendous opportunities to strengthen our lines of communication at this level through the use of conference calls and through satellite and video technologies, and we should not wait until there is a bioterrorist attack. CDC and HHS have done two major satellite conferences with physicians and hospitals on anthrax, smallpox and bioterrorism. We must continue to look for new ways to reach out aggressively.

The third layer of the public health infrastructure is really the general public. The third level is by no means any less important than the other two, especially since it actually serves as the real front line: the public. Bioterrorism attacks first impact the public, either individually or in groups. We rely on the public to seek treatment or advice regarding unusual occurrences and to assist health care providers in the efforts to detect disease early.

The public must also be informed and educated about good public health habits, such as handwashing after handling foreign objects, safe handling and washing of foods, thoroughly cooking meats, for example, and the careful handling of suspicious mail and other packages. Good public health habits are individual and community in nature.

After October 4, we immediately made available to the media an array of medical/scientific spokespersons, in addition to myself and Secretary Thompson, and that included CDC Director Jeffrey Koplan, Tony Fauci at NIH, the Secretary's recently named special adviser D.A. Henderson, and other officials at CDC, NIH and the FDA. The CDC also made officials available to the local media during the news conferences conducted by local officials, whether that was in Florida, New York or in Washington.

One challenge that we faced in these situations was the volume of demand—and I want to really make that point. There were so many news shows and networks who wanted to interview, there was no way that one person could have met the media demands.

By making several people available with expertise, we could more readily service this demand and at the same time draw upon the diversity of expertise that we had available, and there were times when the media requested specific people based on what they saw as a specific area of interest or expertise.

Now, the second week in October, the Secretary and senior members of the HHS team began holding daily teleconferences with the media. The CDC began doing daily press calls with the media about a week later.

Now, the interesting thing about bioterrorism, of course, and the way it differs from the public health response to other problems and infectious diseases, is that it requires a partnership with the criminal justice system. In instances of naturally occurring disease outbreak, those three levels would be sufficient. But because the disease outbreak is bioterrorism, it is intentionally triggered, a public health emergency response must include the criminal justice system as part of this infrastructure, while striving to maintain the appropriate independence of the public health system. That has been an ongoing challenge, but I think, for the most part, communication with the Department of Justice has been good.

I would make four types of recommendations for strengthening risk communication before, during and after a bioterrorist attack.

First, it is critical that we continue to strengthen the public health infrastructure, and we must ensure that all components of that infrastructure are strengthened. And this is not just about treating diseases or emergency. This is about promoting health and preventing diseases. That is right now, in my opinion, the Achilles heel of the American health system. We have not adequately invested in the public health infrastructure, especially as it relates to health promotion and disease prevention, and that is why we have trouble with antibiotics and antibiotic resistance and people understanding why it is not appropriate to take antibiotics when not prescribed—or not as prescribed.

We must continue to improve educational opportunities and information sharing between the Public Health Service and front-line health providers. This is critical. Many doctors at the local level still fail to report disease diagnosis to Federal officials, and this has been a long struggle to get any reportable diseases, unusual cases reported to the Public Health Service. By the same token, Federal officials sometime fail to provide local providers with a national picture on a timely basis that they can use in terms of their index of suspicion. This can be strengthened, and it must. The mechanism must be put in place to ensure that we have an ongoing dialog that will make it easier for providers to access information.

In the minds of some people, and it is an old saying, that all public health is ultimately local, and there is a lot of truth to that saying, so there must be local efforts as well as Federal and State efforts to educate the community as well as health care providers.

We have a tremendous opportunity to improve our system of risk communication and to be much better prepared for the next major bioterrorist attack, which hopefully will not come, but, in order to do that, we must work together, and we must begin by making a commitment to strengthen the public health infrastructure.

Thank you, Mr. Chairman. I will be happy to respond to any questions. As you know, I have submitted a more extensive written statement for the record, but the Department would also be happy to respond to any questions that you would like to submit.

Mr. SHAYS. Thank you very much.

[The prepared statement of Dr. Satcher follows:]

Testimony
Before the Committee on Government Reform, Subcommittee on National Security, Veterans Affairs and International Relations
United States House of Representatives

Risk Communication: National Security and Public Health -- The HHS Role

Statement of
David Satcher, M.D., Ph.D.
Surgeon General
U.S. Public Health Service
Department of Health and Human Services

For Release on Delivery
Expected at 10:00 am
on Thursday, November 29, 2001

Good morning, Mr. Chairman and Distinguished Members of the Subcommittee:

I am Dr. David Satcher, U.S. Surgeon General, and I appreciate this invitation to speak with you about the public health response to the threat of bioterrorism, specifically the Department of Health and Human Services' (HHS) role in information dissemination and risk communication. These have been issues of growing concern among those of us in public health and I am pleased to have this opportunity to discuss them with you today.

The terrorist events on and since September 11th and the bioterrorist activities that began in the first week of October have been defining moments for all of us. Both as a nation and as public health officials, we have been taken to a place where we have not been before. It was uncertain what we were dealing with and to what extent; we had very little science or past experience to draw upon; and we literally learned more every day. The Nation's focus on issues related to public health has been greatly sharpened. There has been fear, shock, confusion, and – in some cases – even panic.

While we may have encountered some bumps in the road initially, it is actually quite remarkable how well-coordinated our efforts have been. The challenge was great. We were faced with the task of coordinating communications among local governments, state governments and the federal government. Each level came with its own set of elected officials and public health officials, all with their own concerns. HHS dealt with it by being forthcoming. We informed the

public quickly. We let them know what we knew and when we knew it. When the information changed because we learned something new, we let them know it. Through it all, vital public health information has been disseminated promptly and we have delivered medicine to people who needed it.

As a result, while five people too many have lost their lives, we have saved countless other lives. Casualties were kept far below expectations, in that the fatality rate for inhalation anthrax was thought to be around 80 percent. The fatality rate in these attacks has been about 40 percent. All of this demonstrates why effective communication based on a strong and flexible public health infrastructure is critical.

Defining the Public Health Infrastructure
Components of a Plan for Bioterrorism

The Centers for Disease Control and Prevention (CDC), as HHS's lead agency for bioterrorism response, has developed a strategic plan for addressing bioterrorism. That plan has five basic components: preparedness and prevention, a surveillance and early detection, diagnosis and characterization of chemical agents, response and communication. Each component integrates training and research.

A strong and flexible public health infrastructure has within it the ability to carry out the components of that plan. Under the leadership of Secretary Tommy Thompson, HHS has been

working to strengthen the overall public health infrastructure so that we are prepared to respond to a range of disasters and emergencies, including bioterrorism. Since September 11th we have intensified our efforts, resulting in a heightened level of preparedness, and we are committed to further increasing our preparedness based on lessons learned in recent months.

HHS and the Public Health Service

This well-prepared and well-rehearsed public health infrastructure must consist of several interrelated components at various levels. Communication within and among each level is critical, as is the need for mutual support.

The federal component is within the Department of Health and Human Services. The Centers for Disease Control and Prevention is the lead agency for bioterrorism response and is closely allied with the Office of Emergency Preparedness. Recently, the Office of Public Health Preparedness was added by Secretary Thompson to respond to bioterrorist attacks.

Also within HHS is the National Institutes of Health (NIH), which focuses on research to facilitate development of new drugs and diagnostic agents and effective antitoxins and vaccines to fight bioterrorism. NIH works in tandem with the Food and Drug Administration (FDA), which has oversight of pharmaceutical and vaccine approval and must ensure their safety and efficacy. Also critical is the Health Resources and Services Administration (HRSA), which is responsible for ensuring access to that the poor and underserved have access to health care

services. This is a critical component considering how much we depend on the public to respond early to unusual occurrences. Finally, the Agency for Healthcare, Research, and Quality is responsible for monitoring the quality of care provided.

My role as Surgeon General has included oversight of the Commissioned Corps of the Public Health Service. The Commissioned Corps is one of the federal government's seven uniformed services and comprises 5,600 health professionals, including physicians, pharmacists, nurses, dentists, dietitians, therapists, veterinarians, and others involved in health services. Commissioned Corps members are highly-trained and mobile health professionals who carry out programs to promote the health of the Nation, understand and prevent disease and injury, assure safe and effective drugs and medical devices, deliver health services to Federal beneficiaries, and furnish health expertise in time of war or other national or international emergencies. They are on call 24 hours a day, 7 days a week.

The Surgeon General is also responsible for communicating directly with the American people based on the best available science. To date, most communications with the Surgeon General have been based on topics for which there has been extensive research and investigation. While the role of the Surgeon General in communicating in response to bioterrorism has never been clearly defined, I can assure you that the Office of the Surgeon General has been directly and substantially involved in public communications related to the anthrax outbreaks.

Between October 4 and November 14, 2001, I participated in roughly 40 TV programs, interviews, HHS and White House media briefings, and other press outreach events on the subject of the anthrax mailings. At the direct request of Secretary Thompson, I also made Deputy Surgeon General Kenneth Moritsugu available to act as a full-time liaison between HHS and Capitol Hill on the anthrax situation. Dr. Moritsugu took part in numerous briefings of Congress as well as Congressional and White House press briefings. He also represented HHS at a Town Hall Meeting with D.C. Del. Eleanor Holmes Norton, and appeared alongside Rep. Shays at a similar meeting that was televised live on WJLA-TV in Washington.

Internally, HHS faced challenges with fluidity of information and the geographic divide. We had staff in the field in the affected states, as well as in offices in Atlanta, Bethesda, and Washington. The Secretary instituted daily conference calls with all involved offices to make sure everyone had the latest information.

The Department of Health and Human Services works closely with state and local health departments. The challenge maintaining communications increases, considering that local health departments vary widely in their size and scope. Some do not even have local boards of health.

Throughout the recent crises, the CDC's Health Alert Network and Lab Alert Network immediately notified state and local health departments of the latest on anthrax and the

possibilities of other bioterrorism attacks. In fact, the Health Alert Network was used September11 to immediately put state health departments on alert for anything suspicious following the attack on the World Trade Center.

The cases in Florida provided a good example of how CDC worked with state and local officials. After the first case there resulted in death, the CDC moved quickly to confirm the case of the second victim early on the evening of October 7. The CDC, HHS, FBI, DOJ, Florida Governor's Office, Florida Public Health Department and local public health department quickly formulated a plan that got the word out overnight to AMI employees that they needed to come to the clinic for medicine and testing that very next morning. The CDC shipped medicine to Florida overnight so it was there when people arrived in the morning. And CDC/Florida officials issued a joint release at 11 p.m. on October 7 notifying the media and public of the second case. So it was a good example of local, state and federal officials working together to get out a message, send medicine and mobilize people to come get treatment – literally overnight on a Sunday evening.

In a federalist system, there are going to be communication challenges between federal, state and local government. In all of the anthrax situations, for example, once the CDC receives initial test results, it promptly begins doing more accurate confirmatory tests. But a mayor or governor may decide to go out and talk to the media before the confirmatory tests are concluded. Those officials make the decision whether to do that based upon their perception of the needs of the

community. We respect those decisions. At the same time, when you try to communicate that tests are merely "preliminary," you hope the public and the media hear that and appreciate what that means.

The Health Care Delivery System

The second level consists of the health care delivery system, including the private sector, which, although we refer to it as "private," is very much a part of the public health infrastructure. Health care providers have a major role to play in limiting the prevalence of disease and in reporting unusual occurrences on a regular basis, not only in times of high alert. They serve on the front lines and play a valuable role in our ability to ensure rapid detection of outbreaks through regularly reporting unusual diseases to the Public Health Service. Likewise, the Public Health Service must provide feedback to providers.

HHS and CDC worked extensively to reach out to various groups within the delivery system to inform them of what we knew. The Secretary met early on with the medical associations, the biotech industry, the pharmaceutical industry, the food industry to address bioterrorism concerns. He and CDC did a conference call with the State and Territorial Health Departments Association. He gave a speech, along with the SG, at the annual meeting of the American Public Health Association.

We also realized that there are tremendous opportunities to strengthen our lines of communication at this level through the use of conference calls and through satellite and video technologies. CDC and HHS has done two major conferences with physicians and hospitals on anthrax, smallpox and bioterrorism. We must continue to look for new ways to reach out aggressively.

The General Public

The third level is by no means any less important than the other two, especially since they also serve on the front lines: the public. Bioterrorism attacks will first impact the public, either individually or in groups. We rely on the public to seek treatment or advice regarding unusual occurrences and to assist health care providers in their efforts to detect diseases early. In order for this to happen, they must have access to quality health care. Moreover, the public must cooperate with health care providers by taking prophylactics as prescribed and avoiding panic.

The public must also be informed and educated about good public health habits, such as handwashing, safe handling and washing of foods, thoroughly cooking meats, and careful handling of suspicious mail and packages.

After October 4, we immediately made available to the media an array of medical/scientific spokespeople in addition to myself and Secretary Thompson, including CDC Director Jeffrey Koplan, Tony Fauci at NIH, the Secretary's recently named special advisor D.A. Henderson, and

other officials at CDC, NIH and FDA. The Secretary remained readily available, and other specialists were made available when needed. The CDC also made officials available to the local media during the news conferences conducted by local officials, whether in Florida, New York, or Washington.

One challenge we faced in these situations was the volume of demand. There were so many news shows and networks who wanted people to interview, there was no way one person could have met the media demand. By making several people available, we could more readily service this demand and at the same time draw upon the diversity of expertise that we had available.

On the second week in October, the Secretary and senior members of the HHS team began doing daily teleconferences with the media. These teleconferences allowed us to overcome geographic divides and bring in people from various offices with different areas of expertise. About a week or so after the Secretary began doing his conference calls, the CDC began doing daily press calls as well.

In the face of this unprecedented threat, our communication got stronger as each day passed. When bumps were hit, they were quickly addressed.

The Criminal Justice System

Let me also add that in instances of naturally occurring disease outbreaks, those three levels would be sufficient. But because the disease outbreak in bioterror is intentionally triggered, public health emergency response must also include the criminal justice system as part of its infrastructure, while striving to maintain appropriate independence.

Recommendations

Let me outline several recommendations in terms of where we believe we should go from here.

1. We must continue to strengthen the public health infrastructure. We believe that the best and most successful response to bioterrorism is to have a well-prepared, well-rehearsed, strong and flexible public health infrastructure. We must ensure that all components of that infrastructure are strengthened.
2. We must continue to improve educational opportunities and information sharing between the Public Health Service and front-line health providers. Many doctors at the local level still fail to report disease diagnoses to federal officials, and federal officials sometimes fail to provide local officials with a national picture on a timely basis. The mechanisms must be put in place to ensure that we have an ongoing dialogue that will make it easier for providers to access information. One of the ways to do that is through regularly scheduled satellite broadcasts that they can tune into in their offices or at a local site within their community.

3. The old saying is still true that all public health is local, so there must be local efforts as well to educate the community, as well as health care providers.
4. We believe the nation will benefit from a clear and coordinated communications strategy for responding to acts of bioterrorism.

Mr. Chairman, the optimal response to bioterrorism requires a well coordinated response before, during and after an attack. Communication is the glue. We realize that there are many opportunities for us to strengthen our communications role, and we will continue to strengthen our ability to respond to such situations in the most timely and accurate manner possible. The people of this country deserve nothing less.

This concludes my testimony. I would be happy to answer questions from you or Members of the Subcommittee.

Mr. SHAYS. I want to just first get some housekeeping out of the way. I appreciate your statement. It was thorough and very helpful.

I ask unanimous consent that all members of the subcommittee be permitted to place an opening statement in the record and that the record remain open for 3 days for that purpose. Without objection, so ordered.

I ask further unanimous consent that all witnesses be permitted to include their written statement in the record. Without objection, so ordered.

And I would note the presence of Ms. Schakowsky from Chicago and Mr. Tierney from Massachusetts.

I'd be happy to start with questions, but I'd be happy—if you're all set, we could start with you. I recognize Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman; and thank you very much, Dr. Satcher, for being here.

I have to tell you that I was somewhat surprised by your description of the administration's handling of the anthrax crisis, that it was so glowing, frankly, especially considering some of the major missteps that we have all seen. You call these mere bumps in the road, and you said that actually you thought coordination was remarkable in your statement. But I was surprised because the administration has, in fact, been highly criticized by many highly qualified experts, especially in the arena of risk communication, which we're mainly focusing on today, and especially in light of several deaths, which at least some people say might have been averted.

I'd like to direct your attention to some of the statements that were made—and some of the individuals are going to be on our second panel with—well, there are four—remarks were made on the record, so you'll excuse me if you're being quoted here.

But Dr. C. Everett Koop, former U.S. Surgeon General, said that, "I'm communicating information to the public on bioterrorism. I would not give the administration a high mark."

Dr. Mohammad Akhter, executive director of the American Public Health Association, said, "health departments have obtained information from CNN more rapidly than they have from each other or from the CDC." It went on to say that law enforcement, intelligence agency and public health officials, "stumbled over each other in responding to the anthrax outbreak."

Dr. Kenneth Shine, President of the Institute of Medicine, believes, "the effectiveness of communications to the public and to health professionals about the anthrax terrorism were found wanting."

And, finally, Dr. Joseph Waeckerle, editor of the Annals of Emergency Medicine, found that, "crisis communication was often inaccurate and misleading or too scanty. No centralized leadership, no voice of authority and inconsistent information resulted in the American public remaining in an informational vacuum."

My concern, therefore, in terms of your remarks is that I think it's important that we take a very cool eye as we look back and take a studied look at what exactly happened in order to put in place what needs to be done, and so I'm wondering really, in light

of those comments, how your interpretation of the events could be so different from those that I just quoted to you.

Dr. SATCHER. Well, let me first say, as you know, I have tremendous respect for the four people you've quoted. I've worked very closely with them over the years, and even since this outbreak. And clearly, as I said in my statement, there were problems in our response to this outbreak, and it is true that, since I knew that they were going to emphasize the negatives, I thought it was important to also point out that there were many positives. And we don't point that out. We do a great injustice to the people at the local, State and Federal level who have been working so well together. There have been problems, but they have saved a lot of lives.

I could go into that in more detail, about what could have happened and what the terrorists intended to do and what anybody would have projected would have happened if we had discussed this 6 months ago, what would have happened when you had the first anthrax attack. Most people would have projected that we would have lost many more lives, especially dealing with aerosolized anthrax.

So the rapid response of getting medication to anyplace in the country within a few hours, the rapid response of getting epidemiologists on the scene within a few hours and acting in such a way as to determine who was exposed and therefore who needs to be—receive prophylactic antibiotics—over 30,000 people, perhaps 35,000 to 40,000, have been started on antibiotics, and at least 5,000 continued it for 60 days. Many of those people could have gotten inhalation anthrax.

We deeply regret the five deaths that have occurred, and obviously we keep retracing what could have been done differently to save those lives. But I think the point of the matter is we have to also build on our strengths. We have to know what they are.

And we have to also know what our weaknesses are. I've tried to point out what I think those weaknesses are.

It is going to be very difficult to satisfy the media with one person being the spokesperson, for, No. 1, there are—I have done 40 interviews on television and radio within the last few weeks, and that doesn't begin to tell you how many requests there have been. What about all the other people—Tony Fauci, Dr. Fauci from NIH, who has done many interviews, Dr. Henderson, the Secretary? There have been many people.

The problem—and I think you're right, and I would agree—we have to figure out a way to better coordinate the message that we send out. But the difficulty is, this is a dynamic situation. I mean, it's changing every minute, and we don't actually know what the terrorist is going to do next, and we don't necessarily know how he or she is going to do it. And in that environment to try to communicate a message——

The public wants to hear from you on a very timely basis, but they also want your statements to be definitive. They don't want you to say, our preliminary information is the following. The CDC is continuing to do tests. And then tomorrow you come back and say, well, on further testing, that sample was not negative. It was positive. Well, that, in fact, is accurate, that is true, but the fact

of the matter is it's a dynamic situation, so if you're going to keep the public informed——

And there is a lot to be said for that in terms of dealing with the kind of panic that Congressman Shays described. You try to give up-to-date information.

But the question is, do people really appreciate that a test may be preliminary, that using nasal swabs to screen people at the outset was not necessarily a bad idea in terms of determining who might have been exposed in a given situation?

The problem was that the public misunderstood that nasal swabs were not definitive tests. And so when people came back and said, even though your test was positive, when we did further tests at CDC it was negative, so you don't have to continue Cipro—or, in other cases, even though you had a negative nasal swab, because we have determined that you could have been exposed, we're going to put you on Ciprofloxacin or Doxycycline for the next 60 days.

Those are not easy messages to communicate to the general public, and I think anyone could be justified at selecting the negative things that have happened and weaknesses and focusing on those. And I think there is something to be said for that, and I think it makes a contribution to the whole distribution, but I also think somebody needs to stop and say, some things went right here, and we've got to build on those things that went right and to make sure that in the future more things go right.

That is the perspective that I'm taking. Because it is very clear to me that you have the experts here to criticize what happened.

Mr. SHAYS. What I'll do is I'll ask questions. Then we'll go to Mr. Tierney, and then we'll go to Mr. Putnam.

I think it's very clear that it's been a pretty dramatic few months, and I think it's pretty clear that we had some people who were not only having to deal with this issue but they were new to the job as well. But you have been around for a while, and I consider you a pretty steady hand. I'd like to have you give me an assessment of whether you felt you were playing the role you should have played as the Surgeon General. I view you as, you know, the chief health care spokesperson for the government.

Dr. SATCHER. Well, let me say a couple of things.

I think I could have played a more impactful role. The Surgeon General functions best—and there is a lot of history, Dr. Cooper and others—when the Surgeon General has the ability to base his or her statements on the best available science. Throughout history, Surgeon General's reports have been based on extensive examination of the research that has been done in an area. The American people have come to trust those reports because they are so solidly based in public health science, not politics, not personal opinion.

We have not been here before where you have to respond to an ongoing bioterrorist attack. You really don't have time to assemble all of the science, and the science is also changing, and therefore there are a lot of questions that people want to ask. Some of them relate directly to the science. Some of them relate to organization and management. And so there have been interviews done in all of those areas.

I think Secretary Thompson saw himself as responsible for a department that included the Centers for Disease Control and Prevention, the National Institutes of Health that is responsible for the research to produce better drugs and vaccines and supplies——

Mr. SHAYS. You can move the mic a little away because——

Dr. SATCHER. I'm sorry.

Mr. SHAYS. No, you don't need to apologize that you have such a nice voice. It carries well.

Dr. SATCHER. Thank you—the Food and Drug Administration. So he is responsible for all of these agencies, and I think he felt there was a responsibility to communicate about the overall picture within a department.

Now, has the Secretary—has the Surgeon General in the past been in a position to speak for the entire Public Health Service? Yeah, many years ago before the structure was changed. But the structure is completely different today than it was when the Surgeon General was the head of the Public Health Service, and so the situation in terms of day-to-day communication about what is happening in a department is not a role that the Surgeon General has played in recent years.

The Surgeon General has reported on specific issues based on the best available science. Surgeon General Koop reported on HIV/AIDS in 1986. The AIDS epidemic started in 1981. We learned a lot about AIDS in those years before the report went out. I could say the same thing about my report on mental health.

So I think one of the problems we have here is we have not done the job that we need to do at redefining the role of the Surgeon General, communication about a dynamic bioterrorist attack, that are ongoing, where the science is evolving on a day-to-day basis. We think we need to do that because I think there is a critical role.

Mr. SHAYS. I'm going to have you turn the mic a little closer but not too much closer. That's perfect.

You basically said that we've learned a lot. Just about say, anthrax, just walk me through some of the things. One of the things we learned was that inhalation anthrax was something we thought could kill somebody. I mean, when we had hearings on the anthrax vaccine in the military, it was, you know, if you inhaled it, you were dead, and we learned that is not so, where also it's conceivable that—we're learning that—some of the people that died were people who were dealing with some—who were either older or were dealing with some physical challenges, that they become more susceptible to the inhalation anthrax, killing them, as opposed to being healed through antibiotics.

Just walk me through some of the things we've learned.

Dr. SATCHER. Well, let me just say I think one of the most painful lessons that we have learned involved the deaths of the two postal workers at the Brentwood facility, because I think, up until that occurrence, the assumption and the public health line was that people exposed to an envelope in an office that had been opened were susceptible to anthrax and needed to be treated prophylactically. But many statements of the CDC up until that time had said we have no reason to believe that a closed envelope passing through a post office could expose people. We know better than

that now, and it would have been greater if we had known that before.

We know more about, for example, how mail can be handled and how envelopes can be ripped apart, but there was no evidence in this case that had happened. So let me just say we still don't have the full answer to what happened in the Brentwood post office, but we do know that somehow at least two postal workers were exposed.

You would have to assume, Congressman Shays, that many more workers were exposed; and the question is, why haven't they come down? Because, obviously, we got to them early enough. If we had known beforehand of the potential of the spores to escape in a post office setting and infect people in that environment, we could have perhaps saved those two people.

By the same token, getting back to the second level, if people on the front lines who take care of patients had been more acutely aware and had the appropriate level of suspicion, it might well be that we could have saved those two postal workers. But all of that is in retrospect. I think that is the most painful lesson we've learned, is how critical it is to really have the kind of working relationship with the front line that leads people on the front line to have the appropriate level of suspicion at a time like this and to make sure that everybody is asked about their work environment. If they show up with an upper respiratory infection—but, remember, there were hundreds of thousands of people who showed up with upper respiratory infections during those 2 days.

I think we've also learned that the American public needs much more information about the use of antibiotics and vaccines, the appropriate use. I know CDC has had a strategy going to try to reduce drug resistance in recent years, and part of that has been to make sure that people understood that if you take antibiotics inappropriately you do great damage not only to yourself potentially but other people. I can tell you that the American people are going to a doctor's office today asking for antibiotics for the common cold, as we speak. There are people going saying, I want a penicillin shot or I want this antibiotic, because I believe that will help me get over this cold that I have. So we have a lot of education to do so that the American people really understand and appreciate the dangers, and we take that responsibility——

Mr. SHAYS. Just a second—and I appreciate Mr. Tierney's patience here, but it is absolutely imperative in that circumstance that the physician tell the patient it would be a terrible mistake to have an antibiotic. Correct? I mean, it's——

Dr. SATCHER. That brings you to the second level. You know, I've trained primary care physicians in my career; and I remember in an area like Watts training them and counseling them about when you go out there to take care of patients make sure that you do this and that. And they come back and say, well, if we don't do it, the patient goes to find another physician who will.

So we're caught up in a situation here where many physicians on the front line—and we've talked about this with—the American Academy of Pediatrics and the American Academy of Family Physicians feel an unusual pressure to prescribe antibiotics for patients,

and they've done it within recent weeks, patients who have requested antibiotics and even other things that they wanted.

So it is a team, it is a partnership, and I think everybody in that partnership has to be empowered and better informed.

Mr. SHAYS. I look forward to asking some more questions of you, but let me recognize Mr. Tierney for a good 7 minutes.

Mr. TIERNEY. I don't need all that time. Thank you.

I have a question to followup on——

Mr. SHAYS. Could I just interrupt? I apologize. I didn't acknowledge the presence of Mr. Putnam or Mr. Lynch and appreciate both of them being here. I'm sorry. Thank you. Thank you.

Mr. TIERNEY. Thank you.

I want to followup on what you have just spoken about in a minute, but first let me ask you, there was a Dark Winter—it was the name of a program or the exercise I guess that was gone through by a number of people. During the course of that, former Senator Nunn made a comment that there is an inherent conflict between health and law enforcement when you have a situation like we have with anthrax, and then there were reports in the newspaper in Florida that the FBI had actually told public health officials that they couldn't speak publicly about what was going on. Would you talk about what happened in Florida and what happened and a little about that conflict and how you would remedy that?

Dr. SATCHER. Well, let me just say that I'm not going to give details about what happened that you might want, but let me just say there is a difficult situation when you have a bioterrorist attack. Everybody wants to find out who is doing this. And I think whether you're in public health or law enforcement your first priority is how do we stop this from happening. So if the Department of Justice or the FBI say to us, we really want to treat this information carefully so that we don't tip off the terrorists as to what we have, we have to cooperate with that.

I mean, when there's a natural occurrence of influenza or something, we can control the prevention. We can't when it's a bioterrorist attack until we find the person or persons who is doing it. Our hands are tied, and we don't know what they're going to do next.

So I would say those of us in the Public Health Service appreciate the role of the criminal justice system in dealing with a bioterrorist attack, and when they need cooperation that is critical to carrying out their responsibilities we believe that it's our responsibility to cooperate.

Mr. TIERNEY. Do you see that conflicting sometimes with the need to get information to the public?

Dr. SATCHER. Most definitely.

Mr. TIERNEY. And how do you reconcile that?

Dr. SATCHER. Well, we've tried to do that, and you've seen several interviews done even with the White House and Governor Ridge where people have asked questions and we've just said we can't respond to that right now. That's in the hands of the FBI and Department of Justice, if they were not there to respond themselves. So we have tried to explain that in some cases we were not able to give information because we felt that it might endanger the investigation. That is what we've tried to do. It's not easy, and it

is a very difficult conflict to deal with, as Senator Nunn pointed out in that exercise.

Mr. TIERNEY. Do you think that we're properly using technology that is available to us to get the public health message in a crisis situation down to doctors at the local level and hospitals at the local level community centers?

Dr. SATCHER. I think we are now, but I think we should have done it before there was an attack. I think we educated and communicated with hundreds of thousands of physicians since the attack. But what it says to me is that, whereas in the past we have relied on physicians to go to meetings and conferences to become educated about bioterrorism, we could have used the satellite system for ongoing communication with providers, and hopefully in the future that is what we will do. I think it's an area where we can make a lot of improvement, and I made that as a recommendation.

Mr. TIERNEY. You have.

Dr. SATCHER. Yes, and included it in the testimony.

Mr. TIERNEY. Last, let me just ask you this. The end of your answer responding to the Chairman Shay's question, you talked about doctors going out and saying that they've got a great deal of pressure from patients to give antibiotics to others. How much of that do you attribute to this phenomenon of advertising by the manufacturers and placing their seed in the mind of patients?

Dr. SATCHER. Yeah. I think in recent years, with the Internet especially but with advertising in general, I think many patients come to physicians asking for drugs that they've heard about through the newspaper or through the Internet. So it is a major part of the problem. I don't think it's a problem that we can't solve, because I think there are a lot of positive things about a better-informed patient and patient community, but somehow we've got to get to the point where we have everybody on the same wave length as to how we protect the health of the public.

Again, my opinion is—and I had this opinion for many years and I've stated it for many years—there's no place in the world better than this country when it comes to treating diseases and crises. The problem is, how do we protect the health of the public? How do we promote health and prevent disease? I think that's the Achilles heal of our health system, and it's reflected in that interaction.

Mr. TIERNEY. Thank you.

Dr. SATCHER. Uh-huh.

Mr. TIERNEY. Yield back.

Mr. SHAYS. I recognize—thank the gentleman and recognize Mr. Putnam.

Mr. PUTNAM. Thank you, Mr. Chairman.

Dr. Satcher, to followup somewhat on the previous line of questioning, there have been a number of complaints from local law enforcement officials about the FBI's refusal to share information with them that were critical to their mission. Have you found the FBI unwilling to share information, even if it may be of—information you don't share publicly, but have you found them to be willing to share with you the information you need to accomplish your mission as a public health officer?

Dr. SATCHER. Well, because that's handled at a departmental level, I can only say to you that Secretary Thompson's position has been that he's had good communication with the Department of Justice and the FBI, and that communication would take place at his level. And that is—you know, his official position is that he's had good communication with the Department of Justice and the FBI.

Mr. PUTNAM. I've just been handed something that indicated that the Secretary has admitted to being frustrated at times in attempting to acquire and pass on information to the public on anthrax due to the classifications or other FBI restrictions.

Dr. SATCHER. Well, I think that is a different issue. I think clearly, as I said in answer to Mr. Tierney's question, it's frustrating when the public wants you to pass on information that you can't pass on because it's a part of the investigation. But I thought your question was, are we getting information that we need from the FBI, as opposed to can we pass on information that we'd like to pass on to the public? In the latter case, it has been very frustrating, as Senator Nunn defined it. But I thought you were asking me, is the communication between the Secretary and Attorney General and the FBI satisfactory? I have not heard him complain about that. I've heard him complain about being limited in his ability to then pass on this information to a public that expects him to pass it on.

Mr. PUTNAM. You're correct. The first question you did answer adequately.

With regard to sharing of the information with your local health officials, State and local health departments, how many of them have access to your Health Alert Network and Lab Alert Network?

Dr. SATCHER. The Health Alert Network is actually now available to all State health departments. As you know, the State and local health departments vary tremendously in their capability. That is one of the weaknesses of the public health infrastructure, the tremendous vulnerabilities among State and local health departments. There has been a program in place now for over 5 years and Congress has provided funds through the CDC to strengthen State public health laboratories. We still have a long ways to go, as you know.

There are States in this country that don't have a trained epidemiologist. There are local health department—there are local communities that don't have a local board of health. And so the problem in the country today as I see it is a great heterogeneity among the various States and local communities.

I think the Health Alert Network needs a lot of support. It needs more funding. We also need the Laboratory Alert Network to be continually developed and strengthened.

So the official statement I think from the CDC is that 50 States are receiving funding under the Health Alert Network grant program, in addition to Guam, the District of Columbia, New York City, Los Angeles and Chicago. You know, we fund some localities as if they were States because they are so big.

Thirteen States are connected to all of the local health—all of their local health jurisdiction, only 13. Thirty-seven States have begun connecting to local providers.

So it is true that 50 States are receiving funds, but there's a lot of difference—there is a lot of heterogeneity in terms of what happened within those States and their ability to use the information.

Mr. PUTNAM. It's essentially—in terms of disseminating information quickly, it's little more than an e-mail or a fax, isn't it? I mean, please——

Dr. SATCHER. Well, the Health Alert Network is based on the best technology.

Mr. PUTNAM. So, I mean, surely the technology and the price pressures for cheap technology would be such that there shouldn't be any States or any health department or any hospital or any doctor's office out there that not have access to——

Dr. SATCHER. Well, I would like to refer you to Senator Frist's statement when he and Senator Kennedy introduced legislation to provide $3.5 billion for strengthening health—the public health infrastructure. He pointed out how many health departments did not have a computer in this country. So, as strange and shocking as it may seem, there is tremendous heterogeneity among—especially among health departments but also State health departments. But I would refer you to his testimony about the major problem that we have in terms of the technology that is available in many different situations.

Mr. PUTNAM. And very quickly, as my time has expired, because of the crossover of anthrax, for example, being essentially an animal disease and some of the—how much coordination is there between the HHS and USDA and between the medical professionals and veterinarians to coordinate information as the entry points for some of these may actually be through animal or agricultural products?

Dr. SATCHER. Yeah. I think there's room for improvement in this area, but I do want to say that the Commissioned Corps, which I oversee, which has 5,600 health professionals, has over 100 veterinarians; and we have sent people from our department to areas where there were outbreaks that involved animals, including outbreaks recently in England and in places in Europe in terms of mad cow disease. So we do have veterinarians in the Public Health Service, and we do have a working relationship with the USDA. I think everyone would agree that we can do much to strengthen that working relationship.

Mr. PUTNAM. Thank you, Dr. Satcher.

Mr. SHAYS. I thank the gentleman.

At this time, I would recognize our newest member. It's wonderful to have you here, Mr. Lynch. Do you have questions?

OK. Thank you.

Mr. Gilman, do you have any questions you would like to ask? Or I have some that I could quickly ask and give you some time.

Mr. GILMAN. Well, thank you, Mr. Chairman. I want to thank you for holding today's hearing to examine the overall level of communications between the Federal Government and the public health system regarding bioterrorism risks, and I want to thank our panelists who are here today.

For many years discussions about the possibility of a biological terrorist attack occurring in our Nation was relegated to the academic and policy discussions. Regrettably, the terrible events of

September 11th and the subsequent anthrax incidents in New York and Washington sharply focused on our national attention on terrorism and underscored our vulnerability.

You and I attended a hearing earlier today with our arms Secretary in the State Department, and he noted how many nations there were who have been developing biological weapons. It's certainly an important element for us to take a good, hard look at, both in terms of where the threat originates and what specific agents pose the greatest danger. So far, the media has focused its attention only on anthrax and smallpox, yet those represent only two out of the many agents which could conceivably be utilized. Still, those two agents are the ones that have garnered the most attention.

In the case of anthrax, the events following the contaminated mail incidents in October have shown that there is much room for improvement on the part of our own government and the communication process, and while officials at CDC and HHS have demonstrated improvement in their communication strategy over time, their early missteps, particularly in downplaying the initial risk of exposure, has led to additional complications as the situation—it's vital, therefore, that these Federal health officials have learned from those past mistakes and are able to ensure the public that they will not be repeated in the future.

So I want to just ask one question. Have the various Federal and public health services considered adopting a daily briefing program similar to those conducted by the White House, the Department of Defense with regard to the bioterrorism situation?

Dr. SATCHER. Yes. Congressman, I mention in my testimony that both the Secretary of Health and Human Services and the CDC have initiated daily briefings for the press since the second week in October. So there have been ongoing interactions. I think that is the part of the strength of the communication, but it is also a part of the things that people are going to be able to criticize. Because by having daily briefings, you're also going to give information that is evolving, which means that some of it is preliminary, and therefore how do you deal with preliminary information where the results are going to change.

But I think the daily briefings are important and think they have been very helpful to members of the media and, therefore, to the general public.

Mr. GILMAN. Dr. Satcher, who has the overall responsibility of conducting our Nation's defense against bioterrorism? Is there any one person or any one agency?

Dr. SATCHER. Well, it's really the Justice Department that has the overall responsibility for defense against bioterrorism——

Mr. GILMAN. And is——

Dr. SATCHER. And all of the bioterrorists, including the exercise that was discussed earlier with Senator Nunn. It is understood that the first responsibility in terms of protecting the American people and guarding against criminal behavior, which we're talking about here—we're talking about criminal behavior, where there is a criminal somewhere attacking——

Mr. GILMAN. But, Dr. Satcher, what I'm trying to pinpoint is where is the overall responsibility for coordination and to make certain all of the agencies are working together on this.

Dr. SATCHER. Oh, right now, of course, it's the new Office of Homeland Security in the White House, but that's a new office.

Mr. GILMAN. And does that Homeland Security Director have the responsibility then of coordinating——

Dr. SATCHER. Coordinating, yes.

Mr. GILMAN [continuing]. All of our efforts on bioterrorism?

Dr. SATCHER. Governor Ridge, the head of homeland security today, has the overall responsibility for coordinating all of the efforts.

Mr. GILMAN. And do you report to him with regard—or do you work with him with regard to——

Dr. SATCHER. I report to Secretary Thompson in the Department of Health and Human Services, and he deals directly with Governor Ridge.

Now, Governor Ridge has often asked me as Surgeon General to join him at the White House for conferences with the media. But, in our department, that relationship is with the Secretary, as it is with—you know, with other departments, Department of Justice, Attorney General.

Mr. GILMAN. Dr. Satcher, do you sit in with other agencies to explore what has to be done on bioterrorism?

Dr. SATCHER. Agencies within the Department of Health and Human Services?

Mr. GILMAN. All of the agencies.

Dr. SATCHER. No. Again, that interaction would be at the level of Secretary Thompson.

Mr. GILMAN. And do you sit in with Secretary Thompson on that kind of direction?

Dr. SATCHER. There are times, but that is really not the major role of the Surgeon General. If the Surgeon General did that——

Mr. GILMAN. I realize that.

Dr. SATCHER. If the Surgeon General did that, it would be very difficult then to be responsible for the Commissioned Corps and deploying people under an emergency basis and continuing to speak with the American people all over the country. So it is not a day-to-day responsibility of the Surgeon General.

Mr. GILMAN. So the Surgeon General then doesn't have any responsibility on planning with regard to bioterrorism or——

Dr. SATCHER. Well, the Surgeon General has input to planning, yes, definitely, but not to be involved in meetings with departments. Because when you say—you're talking about meetings with the Department of Justice and——

Mr. GILMAN. Well, I want to ask you, if you had some thoughts, constructive thoughts on what should be done on bioterrorism, who would you pass that on to?

Dr. SATCHER. Secretary Thompson of the Department of Health and Human Services.

Mr. GILMAN. Thank you.

Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

Dr. Satcher, we could ask you a lot more questions. We have another panel we want to get to. I want to ask you just a few, though.

I want to ask you how you would define the role of the Surgeon General in terms of you and anyone who follows you as it relates to bioterrorism.

Dr. SATCHER. The Surgeon General has two major areas of responsibility as I see them today. The first area is the responsibility for the Commissioned Corps, the 5,600 health professionals who are on call 24 hours a day, 7 days a week to respond to any threat to the health of the American people, whether it's a bioterrorist attack or whether it's a natural outbreak. And we often deploy people when there are floods, tornados, an epidemic in this country or even in another country if it's a threat to the health of the American people.

So September 11th, while on the way to the airport, I stopped and activated the Commissioned Corps readiness force, and we have sent many of those people to New York City and other places to respond. That's a very important day-to-day responsibility of the Surgeon General; and, as you know, we deployed the Deputy Surgeon General to Capitol Hill, Dr. Ken Moritsugu, who has been intimately involved with briefings on Capitol Hill since the letter to Senator Daschle.

The second and perhaps in some ways most important responsibility of the Surgeon General when you really think about it is the direct communication with the American people based on the best available public health science. The context of that communication historically for the most part has been to look at an area of concern to the American people, does smoking cause lung cancer? So Dr. Luther Terry's report was the first ever Surgeon General's report on smoking and health.

There have been many reports on that topic since, and during my tenure, of course, I have released reports in areas of mental health, suicide prevention, youth violence prevention, oral health. I released three reports on smoking and health, including women and smoking. Those reports were all based on thorough public health science examination of those areas.

So when we speak to the American people, we speak with the kind of authority based on a lot of the investigation.

But I believe that we have to define a clearer role for the Surgeon General in terms of bioterrorist attack. I think that's one of the things that we've learned that the American people do, in fact, want to be able to rely on the voice of authority and credibility in public health science. And so I think that as we look at how to improve the system of communication, I think the role of the Surgeon General is critical in this. But it's got to be very clear that there are political issues involved in responding to an outbreak, there are organizational issues. And the question is, which of those issues are we going to look to the Surgeon General to speak on? And I think the Surgeon General has to speak on the public health science.

Mr. SHAYS. It strikes me that the Surgeon General has consistently over the years, you and those who preceded you, as basically being the voice where the science takes you and not an office that can be manipulated by political considerations. Obviously, political

considerations can come in terms of typing of a report and so on, but in the end, what you issue is viewed to be the truth untainted by political considerations, and I mean, you and those who preceded you.

In other words, I consider you, kind of your position, an honest broker, an honest voice, and is that a view that I should consider or should I consider you basically under a secretary, and if the secretary says change your report, you have to change your report?

Dr. SATCHER. Well, I think the first description is the one that is accurate for a Surgeon General. But I also want to add something to that.

Mr. SHAYS. Sure.

Dr. SATCHER. As you know, there are times when there are disagreements. I've issued a report on promoting sexual health and responsibility for sexual behavior, which was not supported by the Secretary or the White House, but they did allow the report for the public health science, but it was not necessarily politically a report that was supported.

I do want to make it very clear, Congressman Shays, that the Surgeon General's office is, in fact, impacted by politics. The budget of the Surgeon General's office has been virtually depleted since 1994. So there is virtually no budget. The Surgeon General relies upon NIH, CDC, other agencies when we do a report even. Because there is no—the funding is not there. A lot of the changes that have taken place have resulted from disagreements with things that came out of the office of Surgeon General.

I have been very fortunate, I think it has something to do with the fact that I was director of CDC before, and I've had an ongoing working relationship with people in these various agencies now for several years, so I have not had difficulty getting support to do a report on mental health, for example. I didn't have the money in the Surgeon General's office to do that. I didn't have the money to do the youth violence prevention report. I had some.

So in every one of these areas, I've had to rely upon other agencies within our department. So while on the one hand I say to you that it is the responsibility of the Surgeon General to issue reports that are based on the best available public health science and not politics and not personal opinion, I would not be honest if I said those things don't impact upon the strength of the Office of the Surgeon General. As you imply, clearly, organizationally, the Surgeon General reports through the Secretary.

That's the way the organization is. That affects budget, that affects everything. And that's the reality. I would like to see it—to be honest with you, I would like to see it different. I would like to see the Surgeon General able to have a strong office and able to report on based on the best available public health science, even when there is disagreement about that. I'm talking about the future, not talking about myself.

Mr. SHAYS. I appreciate your candor. I know you're talking about the future. I apologize that I haven't been as aware that since 1994, this office has gotten less and less resources.

Dr. SATCHER. You might want to look at the budget of the Office of Surgeon General.

Mr. SHAYS. There's a lot we should look at. I would ask this one last question. You have to respond to the FBI. But do they ever have to respond to you? Can you ever trump the FBI? They trump you, they trump the health care side. Can the health care side trump the FBI? You go from detection and prevention of a terrorist attack, you have crisis management, investigating the crime, you got the consequence of the act. But isn't there times when the consequence of the act should trump the crisis management?

Dr. SATCHER. Yeah. I don't know if I would use that term because it implies expedition when I think it ought to be looked at as a partnership. The FBI is very dependent upon the public health service for information. Whether it's the CDC and, of course, there is the U.S. Army Medical Research Institute for Infectious Diseases [USAMRIID], that does a lot of the analysis. But the FBI is often dependent upon the public health service for information that they will use in their work. And that's certainly been true with the anthrax outbreak. They have looked to the CDC for information about the nature of the strain, for example.

It is very important that in all of the four letters that have been sent with anthrax, they have all been of the same strain. It's upon, it seems as if to date, the letter sent to Chile may well be a different strain. All of this is information that comes out in a laboratory. It is all information that the FBI uses in its investigation.

Mr. SHAYS. But would it be wrong for me to make the assumption that if someone's life is in danger, that trumps their trying to protect evidence? In other words, if an envelope is there that could be dangerous, and if we could have that envelope and we could begin to see what's in it, should I believe that because they may want to protect the evidence that——

Dr. SATCHER. Oh, I see your point, yeah. I don't think that the decision would ever be made. You know, at least I don't think so. I can't think of an instance where someone's lives have been put at danger because the information was protected for the investigation. I think the overall goal here is to save lives. And we believe that in the case of a bioterrorist outbreak, finding the person who is behind it is very critical to saving lives. But I can't think of an instance where we have endangered lives of people because, you know, we don't get information where it was suppose to. We didn't take action. We may not have explained to the public why we took a particular action.

Mr. SHAYS. As always, I appreciate you coming before our committee. Appreciate your candor. I appreciate your good work. I would just invite you to make any closing comment if there is anything you wanted to say or question you wish we had asked, I invite you to make a comment before we go to our next panel.

Dr. SATCHER. One of the things that we've talked about is the dynamic nature of this situation. And when the exercise that Congressman Tierney mentioned with Senator Nunn took place, we were actually in a different place in this country than we are now. The FBI had the lead for crisis management with bioterrorism. FEMA had the lead for consequence management and the department reported through them. There was no homeland security office. So even since the bioterrorist operation took place, we have seen changes even in how we're organized and how people report.

This is a dynamic situation and hopefully moving in the right direction. I think this hearing is so important in that regard.

Mr. SHAYS. Thank you very much. Appreciate you being here. We'll call our final panel and obviously thank them for their patience. All of them are busy people and I know have other places to be. I invite Dr. C. Everett Koop, former U.S. Surgeon General; Dr. Kenneth I. Shine, president, Institute of Medicine representing the National Academy of Sciences; Dr. Mohammad Akhter, executive director, American Public Health Association; Dr. Joseph Waeckerle, editor and chief, Annals of Emergency Medicine, representing the American College of Emergency Physicians. I will invite you gentlemen to stand. I will catch you before you all sit down and administer the oath.

[Witnesses sworn.]

Mr. SHAYS. Note for the record that our witnesses have responded in the affirmative. I would invite you to give your testimony as I called you. We'll start with you, Dr. Koop, and go to Dr. Shine, Dr. Akhter and Dr. Waeckerle. What I'll do is I'll—we'll have a 5-minute clock. We'll roll it over, but hope that you could stay within the 5 minutes, but if you roll over, you have another 5 minutes if it's necessary.

Dr. Koop, it's always wonderful to have you here. Thank you. We'll start with you. Let's make sure that mic is on.

STATEMENTS OF DR. C. EVERETT KOOP, FORMER U.S. SURGEON GENERAL; DR. KENNETH I. SHINE, PRESIDENT, INSTITUTE OF MEDICINE, REPRESENTING THE NATIONAL ACADEMY OF SCIENCES; DR. MOHAMMAD AKHTER, EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION; DR. JOSEPH WAECKERLE, EDITOR AND CHIEF, ANNALS OF EMERGENCY MEDICINE, REPRESENTING THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Dr. KOOP. Good morning, Mr. Chairman and members of the committee.

Mr. SHAYS. It's not on yet, Dr. Koop.

Dr. KOOP. Now?

Mr. SHAYS. Yeah.

Dr. KOOP. Sorry. I am C. Everett Koop, a pediatric surgeon by training and the Surgeon General of the United States for two 4-year terms, from 1981 to 1989. I appreciate much your invitation to testify before you.

Our public health care system has been weakened in the past 8 years and the recent bioattacks have stressed its ability to protect the American public. We were not prepared for the anthrax bioattack, regardless of its source, and the fear generated by it far outweighed the health threat.

Morally, I think we really never thought anyone would do it, but they did and the public is still uncertain, that they would deliver a catastrophic attack by some other bioterror. Think of the distraction and chaos involved with fewer than 50 anthrax victims, real or uncertain, in the anthrax scare, how would our resources handle not 50 but 5,000? How about 50,000? How about 5 million?

The public health service has a long and distinguished history of protecting America in the past from many threats that have

reached our border or have originated domestically. However today's threats are unique in a world without borders, and therefore require new strategies and policies coupled with operational plans to combat the threats to our Nation's health care and to our people.

Our domestic defense system has not been able to protect the American people or their economy from the present small bioterrorism attacks. What will we do with weapons of mass destruction or weapons designed to maximize panic and mistrust in our health care system?

Mr. Chairman, your staff asked me to answer a few questions on communicating information to the public on terrorism. And I would not give the government high marks in this recent episode. The spokesperson in such situations is usually the Surgeon General, and usually in the setting of a press conference and not a talk show. And yet I have heard almost nothing from him and those who were his surrogates, except Drs. Fauci and Koplan, who have not been accurate.

I don't mean Fauci and Koplan, I mean the others. That is particularly egregious because as you know, the current Surgeon General was, for some time, director of the Centers for Disease Control and is eminently qualified in this area.

Communicating threats to the public are based, I think, on common sense. And I have a few rules that I don't really think about when I talk, but I made them up in response to the question. First of all don't make statements especially predictions that are not based on fact. Deliver warnings with enough information to prepare and protect without causing panic. Choose words understandable to a 10th or 12th grader, and go over the draft again and again so there is no ambiguity. Make certain that the public understands the difference between an immediate threat versus a long-term outcome, and between fatal and a nonfatal threat. Inform the public frequently and in increasing depth. Squelch rumors that are untrue, such as AIDS can be transmitted by contact with door knobs and toilet seats. Translate science for the non scientific public and never speculate or indulge in opinions. And finally, and perhaps most important, keep the press on your side through honesty and forthrightness.

There will likely be a series of biothreats, chemical threats, agro threats and cyberthreats, nuclear threats and threats to our food supply and our water supply over the next months and years until we win our international war against terrorism. While recent actions were designed to cause maximum panic and economic harm, future threats may indeed be aimed at causing catastrophic numbers of casualties.

This likelihood needs a new strategy where all of America is linked together using our strengths of command communication and control technologies to defeat future attacks. We need to be able to rapidly mobilize all of our health care resources to be concentrated on wherever the threat appears, even if it appears in multiple sites simultaneously. The defense against bioterrorism is not to be found in the military, their responsibility is primarily strategic offense. Anticipated threats against civilians cannot be prevented unless we destroy the source or have extraordinary and credible intelligence for a specific site at a specific time. But we can

mount multiple plans tailored to the threat aimed at managing the assault, containing its spread, treating victims and controlling the ensuing panic.

A new biodefense system needs to address the possibility of weapons of mass destruction such as contagious weapon that will overwhelm the limited surge capacity of our health care system, our pharmaceutical industry, and the public health service. These weapons can be unleashed from abroad and move silently within individuals traveling throughout our country, undetected, until the first sentinel case is found.

At a similar time in history, Winston Churchill, deeply troubled by England's lack of preparation for World War II said this, "the responsibility of ministers (that is, government officials) for the public safety is absolute and requires no mandate. It is, in fact, the prime object for which governments come into existence."

A new biodefense system must be created based on a net centric command information and control technology, based on advances in biotechnology, telemedicine and robotics that can reduce the effect of bioattacks on us with weapons of mass destruction. A terrorist attack designed to cause catastrophic levels of casualties by spreading a contagious disease or a chemical or radiation illness across America needs to be met with a health care system that increases dramatically that surge capacity to respond within hours and not days. This will protect the health of America and provide security to our people, our economy, and ultimately to our freedom-based way of life.

Fortunately, most of the bioterrorist agents are treatable with antibiotics, with the exception of smallpox, a deadly disease without treatment with a latency of incubation period of 12 days. Again, fortunately, the victim of smallpox is usually rendered sedentary by the severity of the illness by the 14th to 16th day after exposure. Smallpox, as you know, has been eliminated from the globe since 1977. And few people have been vaccinated since that time.

The doses of vaccine on hand are minuscule compared to the number needed to immunize the public. We have no experience at all that says our vaccine is efficient against modern smallpox, which may have mutated or have been bioengineered. There is, indeed, frightening evidence published this year suggesting it is possible to make people more susceptible to a pox virus, while at the same time, turning off the victim's own natural immune protection.

After a dirty nuclear bomb or radioactive material in conventional explosives goes off in some major city, or we have a smallpox epidemic, the country will settle down in disarray to establish a widespread protection plan. And if we will do it then, why not now. I don't know if CDC's plans announced in the Washington Post 2 days ago are inclusive of this knowledge.

The creation of this new system should be done as a large-scale project. It will be expensive, but not nearly as expensive as doing nothing. It would take advantage of the strengths of America and can be accomplished rapidly if we start now to build it. If we commit to this plan, this administration can assure the American public that we can protect them from any biothreat. We cannot not

stop all threats, but we can help to reduce the harm to both our people and our economy.

Without such a plan in place, I don't think we can reduce the present panic which many of our people feel. We need to uphold the trust in our health care system and the ability of our government to provide security to the American people. To win the war, we need both a successful offensive strategy that will work in time, and a defensive strategy that will protect America while we wait for this win in the war against terrorism.

Mr. Chairman, I would be pleased to, as you and your members of the committee choose, to elaborate further.

Mr. SHAYS. Thank you very much, Dr. Koop.

[The prepared statement of Dr. Koop follows:]

BEFORE THE COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRSAND INTERNATIONAL RELATIONS

CHRISTOPHER SHAYS, CHAIRMAN

REMARKS BY C. EVERETT KOOP, M.D., Sc.D.
NOVEMBER 29, 2001

Good morning, Mr. Chairman and Members of the Committee.

I am C. Everett Koop, a pediatric surgeon by training and the Surgeon General of the United States for two four-year terms from 1981-1989. I appreciate much the invitation to testify before you. Our Public Healthcare System has been weakened in the past eight years and the recent bioattacks have stressed it and its ability to protect the American public. We were not prepared for the anthrax bioattack - regardless of its source - and the fear generated by it far out weighed the health threat. Morally, we really never thought anyone would do it, but they did and the public is still uncertain whether they would deliver a catastrophic attack by some other bioterror. Think of the distraction and the chaos involved with fewer than 50 anthrax victims, real or uncertain, in the anthrax scare; how would our resources handle not 50 but 5,000 victims - or 50,000 - how about 5,000,000? Seventeen nations have lethal biochemical weapons. Disruption is as effective against an enemy as destruction.

The Public Health Service although seriously underfunded for years has a long and distinguished history of protecting America in the past from many threats domestic or foreign in origin. However today's threats are unique in a world without borders and therefore require new strategies and policies coupled with operational plans to combat the threats to our nation's healthcare and our people. Our domestic defense system has not been able to protect the American people or their economy from the present small bioterrorism attacks; what will we do with weapons of mass destruction or weapons designed to maximize panic and mistrust of our health care system?

Your staff asked that I answer questions on communicating information to the public on bioterrorism. I would not give the government high marks. The spokesperson in such situations is usually the Surgeon General; I have heard little from him and those who were his surrogates except Doctors Anthony Fauci and Jeffrey Koplan have not been accurate. That is particularly egregious, because the current Surgeon General was for some time Director of the Centers for Disease Control and Prevention and is eminently capable in this area.

Communicating threats to the public is based on common sense.

1. Don't make statements, especially predictions that are not based on fact.
2. Deliver warnings with enough information to prepare and protect without causing panic.
3. Choose words understandable to a 10th - 12th grader and go over the draft again and again so there is no ambiguity.
4. Make certain the public understands the difference between an immediate threat vs. a long-term outcome and between fatal and non-fatal threats.
5. Inform the public frequently and in increasing depth.
6. Squelch rumors that are untrue, such as, AIDS can be transmitted by contact with doorknobs and toilet seats.
7. Keep the press on your side through honesty and forthrightness.

There will likely be a series of biothreats, chemical threats, agrothreats, cyberthreats, nuclear threats, and threats to our food and water supply over the next months and years until we win our international war against terrorism. While recent actions were designed to cause maximum panic and economic harm, future threats may be aimed at causing catastrophic numbers of casualties. This likelihood needs a new strategy in which all of America is linked together using our strength in command, communication and control

technologies to defeat future attacks. We need to be able to rapidly mobilize all of our healthcare resources to be concentrated on wherever the threat appears, even if it appears in multiple places simultaneously.

The defense against bioterrorism is not to be found in the military; their responsibility is primarily strategic offense. Anticipated threats against civilians cannot be prevented (unless we destroy the source or have extraordinarily credible intelligence for a specific site at a specific time), but we can mount multiple plans tailored to the threat, aimed at managing the assault, containing its spread, treating victims and controlling the ensuing panic.

A new biodefense system needs to address the possibility of weapons of mass destruction such as contagious weapons that will overwhelm the limited 'surge capacity' of our healthcare system, our pharmaceutical industry and the public health service. These weapons can be unleashed from abroad and move silently within individuals traveling throughout our country undetected until the first sentinel case is found.

At a similar time in history, Winston Churchill, deeply troubled by England's lack of preparation for World War II, said, "The responsibility of ministers (i.e. government officials) for the public safety is absolute and requires no mandate. It is in fact the prime object for which governments come into existence."[i]

A new biodefense system must be created based on a net centric, command, information, and control technology, based on advances in biotechnology, telemedicine, and robotics that can reduce the effect of bioattacks upon the U.S. with weapons of mass destruction. A terrorist attack designed to cause catastrophic levels of casualties by spreading a contagious disease or chemical or radiation illness across America needs to be met with a healthcare system that uses worst-case scenarios for preparation to dramatically increase our surge capacity to respond within hours not days. This will protect the health of America and provide security to our people, our economy and ultimately to our freedom-based way of life.

Fortunately most of the bioterrorist agents are treatable with antibiotics with the exception of smallpox, a deadly disease without treatment, with a latency or incubation period of twelve days. Again fortunately, the victim of smallpox is rendered sedentary by the severity of the illness about the fourteenth to sixteenth day after exposure, leaving a four-day window when a victim of smallpox is very contagious. Smallpox has been eliminated globally since 1977. Few were vaccinated since. Potentially we have fewer than half the doses of vaccine on hand that we need to immunize the public. We have no experience that says our vaccine is efficient against modern smallpox, which may have mutated or have been bioengineered. Frightening evidence published this year suggests it's possible to make people more susceptible to a pox virus while at the same time turning off the victim's immune protection.[ii] And remember there are poxes that are animal species specific to say nothing of contagious diseases like foot and mouth disease. And then there are low-tech diseases that don't kill but incapacitate people rendering them really unable to respond to a fatal bioattack. Research agendas must be broadened.

After a dirty nuclear bomb or radioactive material in conventional explosives goes off in some major city or we have a smallpox epidemic, the country will settle down in disarray to establish a widespread protection plan. If then, why not now? I do not know if CDC's plan as outlined in the Washington Post on Tuesday is inclusive of this knowledge.

The creation of this new system should be done as a large-scale project; it will be expensive but not as expensive as doing nothing. It would take advantage of the strengths of America, and can be accomplished rapidly if we start now to build it. The infrastructure created with this system can also benefit America by increasing normal healthcare to the American public.

If we commit to this plan, this administration can assure the American public that we can help protect them from any biothreat. We cannot stop all threats, but we can help to reduce the harm to both our people and our economy. Without such a plan in place, we cannot reduce the present panic many of our people feel. We need to uphold the trust in our healthcare system and the ability of our government to provide security to the American people. To win the war we need both a successful offensive strategy that will work in time, and a defensive strategy that will protect America while we wait to win this war against terrorism.

Mr. chairman, I will be pleased as you and members of the committee choose, to elaborate further.

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[i] Martin Gilbert, *Churchill: A Life* (New York: Henry Holton Company, 1991), 565.
[ii] Jackson, R.J., et al, "Expression of Mouse Interleukin-4 by a Recombinant Ectromelia Virus Suppresses Cytolytic Lymphocyte Responses and Overcomes Genetic Resistance to Mousepox," *J. Virol., no.* 75 (2002): 1205-1210.

Mr. SHAYS. Dr. Shine.

Dr. SHINE. It's a privilege to meet with you. I'm Ken Shine. I'm president of the Institute of Medicine. For the last 3 years, I've also served on the Commission of—congressionally mandated Commission on Weapons of Mass Destruction, chaired by Governor Gilmore of Virginia.

I should preface my comments based on the discussion with Dr. Satcher that 2 years ago, we recommended the creation in the Executive Office of the President of an entity which provided overview of threats of weapons of mass destruction including bioterrorism. That office as a consequence of September 11th has been created with Governor Ridge in charge.

One of the recommendations we made was that there ought to be an associate director of that office for health. And that's not happened. We believe that it's extremely important that there be such an individual because that's the site at which the interface between HHS, the criminal justice system, the Department of Agriculture, a lot of other places would come together and that's the place where relationships between the medical professions, the public health community also could come together in an overall approach to bioterrorism.

As the chairman pointed out, terrorism is about creating fear, rumors, anxiety, misinformation and chaos. I would argue, sir, that credible information is critically important as medicine for that terrorism. We did not do well in the anthrax outbreak. There were multiple talking heads on television, including a number of pseudo experts, one identified himself as an expert on the anthrax virus, anthrax is not a virus, it's a bacteria. We had situations in which the Web was covered with all kinds of information about anthrax which was incorrect. We had all kinds of promoters promoting all kinds of variety of materials that you should purchase or promoting antibiotics and so forth.

We were so concerned about this that the Presidents of the National Academy of Science Engineering and myself issued a statement early in October identifying what we thought were reliable Web sites, those at the National Library of Medicine, the CDC and, at that time, Johns Hopkins. But we believe that we did not do a good job with regard to communication with the American people.

There are four issues that I would like to just briefly touch upon. First, within the government, within the Department of Health and Human Services there needs to be a single credible medical public health expert who is the spokesperson for the Department. That doesn't mean that other people can't speak on the subject, but it means that that individual should be responsible for communicating with the public about these issues, that individual is credible because he or she has professional knowledge, has current information, and in coordination with law enforcement, is articulate, knows, like Dr. Koop has shown over and over again, how to translate information to the public, and doesn't talk down to the public.

That individual ought to be able to stand next to political leaders and administrators and be available so that when a question is asked by the media, that the political leader to turn to that individual and get an immediate answer. That individual has to be so credible that when he or she doesn't know, she can say he or she

doesn't know. And in a report we did in 1996 on understanding risk, our evidence is that if the person is credible, if the person provides information, saying I don't know in fact increases the credibility. Does not diminish it.

Tony Fauci performed that function extremely well when he was put into use in this area. But that didn't happen until well into the outbreak. And the fact that there was no individual doing that was a clear deficit. The Associate Director of the Office of Homeland Security, if that individual were a health person, could serve a similar function. But if that's the case, they ought to coordinate their activities so the same information is provided that does not confuse the public.

Second, we need much more attention to the Internet, the Web sites within government, in this case, the CDC. The CDC does have a Web site. We identified it as one of the more reliable ones. But, in fact, there were times when you couldn't get into it. It was not always easy if you were a health professional to get the information you needed. And I should emphasize that we heard at our commission hearings from people in local public health departments about the number of calls they got from health professionals about what to do. And they were not informed during the early stages of the outbreak.

The role of the Internet in this regard needs to be enhanced. And Mr. Chairman, that would require resources because it is necessary that all public health departments have computers, that you can have the use of the Internet as a way of getting them information. I would emphasize that the people working in this area work 24 hours a day, 7 days a week during this outbreak. In fact, that was the testimony to how poorly staffed they were and how poorly prepared we were. But we need to invest in the Internet the Web site communications.

Mr. Chairman, I would emphasize we need to learn from the lesson in anthrax so that if there's a problem with agriculture, the Department of Agriculture is prepared with a spokesperson and a Web site. If there's a problem with the radiologic episode, that the Department of Energy is. We don't know who the spokesperson would be if there was a chem outbreak. It seems to me that we need to think about that.

Third, we need to do a better job in both understanding and doing risk communication with the public. What is the risk, what is the benefit, how do you measure those. Dr. Satcher has made reference to some of the problems with antibiotic use. I would use the smallpox debate as an excellent example. Here we have an agent where once we have stores of vaccines, we got to decide how to use them. The public needs to understand, if we vaccinate the entire population, we will kill several hundred people by the act of vaccinating. In fact, we're going to probably kill and make sick a lot more than that because of the large number of immuno-compromised people that were not around at the time that smallpox was being protected against.

And I would remind you that choosing not to vaccinate such individuals may not protect them from the virus of vaccinia if we did mass vaccination. On the other hand, we know how to use the vaccine to surround cases of smallpox. That was how it was eradicated

from the globe. So if you have adequate stores, you can follow the cases, you have several days after exposure in which you can vaccinate. There is probably some residual immunity in our population. And so if you look at the risk benefit, you can come up with some logical ways to develop a policy that the public can understand. I'm very worried about the potential in agricultural terrorism of hoof and mouth disease. But in contrast to the situation in Europe in which cattle were slaughtered by the tens of thousands, you can immunize animals against hoof and mouth. Do we have the vaccine and did the public understand that meat would be safe if, in fact, you stopped an epidemic using it?

Finally you already heard the concerns about public health. I would emphasize in 1988, the Institute of Medicine issued a report called the "Future of Public Health." In that report, we said that the public health system was in disarray. And everything has been downhill since. The reality is that we missed hantavirus for a significant period of time because reporting systems for hantavirus were inadequate. We know that West Nile virus got going because we laid down on the mosquito abatement programs and allowed mosquitos to proliferate, so when a bird got infected we now had an outbreak.

You've heard about the problems with regard to resources. We need people, facilities, research and particularly communications. And may I emphasize that we need that for the entire system all the time. We had an outbreak of two cases of meningococcus meningitis in a town in the middle of the country earlier this year. Thousands of people took antibiotics and vaccines because of one uninformed statement by a doc on a television station. It was entirely inappropriate. The point is that the communications become absolutely critical.

Finally, there are communications about risk which are based on science and are based on the need for the truth, as you put it. But remember, there are many irrational kinds of fear and anxiety. And we need to understand what those are. And it is entirely possible that we ought to have a mechanism by which the CDC either through focus groups or through networks similar to what Nielsen uses or others can test what the public is, in fact, frightened of and communicate information which will be addressed to their fears as well as addressed to the scientific truths. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you very much Dr. Shine.

[The prepared statement of Dr. Shine follows:]

Testimony of
Kenneth I. Shine, M.D.
President
Institute of Medicine
The National Academies
For a Hearing on Risk Communication: National Security and Public Health

before the

Subcommittee on National Security, Veterans Affairs, and International Relations
Committee on Government Reform
U.S. House of Representatives
November 29, 2001

I am Kenneth I. Shine, President of the Institute of Medicine of the National Academy of Sciences. For the last three years I have also served as a member of the congressionally mandated Commission on Weapons of Mass Destruction, chaired by Governor James Gilmore of Virginia, otherwise known as the Gilmore Commission. My comments reflect the opinions of the National Academies, as represented by Bruce Alberts, President of the National Academy of Sciences, and William Wulf, President of the National Academy of Engineering, whom I joined in signing a statement on October 3, 2001. In this statement, we advised the American public and health professionals to seek authoritative information on Anthrax from three websites, those at the Centers for Disease Control and Prevention, The National Library of Medicine, and the Johns Hopkins University. We made the statement because of our concern about the amount of misinformation being conveyed about the Anthrax incidents and the confusion that had resulted from multiple sources of analysis, commentary and advice.

Mr. Chairman, in 1988 The Institute of Medicine issued a report called *The Future of Public Health*. The report described the state of infrastructure for public health in America as in "disarray". The report recommended renewed national attention to the infrastructure, human resource needs, educational capacity, and programs in public health in America. In 1992, the Institute of Medicine issued a report on *New Emerging Infections: Microbial Threats to Health in the United States,* from a committee chaired by Nobel Laureate, Joshua Lederberg, and Dr. Robert Shope. In that report, additional recommendations were made for strengthening the capacity of public health and medicine to deal with new and emerging infections including those presented by terrorism. Although some additional resources were provided to the Centers for Disease Control and Prevention in response to these reports, these were limited. Over the past decade

the overall condition of the public health system in America has continued to erode. Many of these weaknesses were graphically displayed during the anthrax episodes. Laboratory capabilities, adequate staff for investigations, the relationship and responsibilities of public health to law enforcement and especially for purposes of this hearing, the effectiveness of communications to the public and to health professionals about the anthrax terrorism were found wanting.

Key to the role of public health is education and information for the public and for health professionals. Whether an epidemic is a naturally occurring one such as that involving west nile virus, or whether produced by a terrorist, public health professionals and public health departments around the United States need timely, accurate, and reliable information.

Every epidemic results in new knowledge as it is studied and understood. In the case of anthrax, information about the inhalation form of the disease was limited to a very small number of cases over an extended period of time. Medical practitioners and public health officials in the United States never had direct experience with inhalation anthrax. Not only is it important to learn in an ongoing way as such an epidemic develops, but it is also important to rapidly translate that knowledge into reliable guidance to health professionals and to the community.

In this testimony I will focus on two critical methods of communication about these issues in the 21st Century: verbal communication -- particularly via Television -- and the Internet. I begin with remarks concerning verbal communication.

Within the Department of Health and Human Services, there must be a single credible medical/public health expert spokesperson that reports regularly, most likely daily, to the American people in regard to any outbreak with national significance. This is analogous to the situation in local communities where there is a need for such an individual to communicate on behalf of the local health department. Several months before the anthrax outbreak, uninformed statements on local television in a community with two cases of meningococcal meningitis resulted in thousands of individuals taking antibiotics or seeking immunizations that were not indicated. Local stores of antibiotics were depleted and many people were subjected to risk from unnecessary treatment. This episode emphasizes the need for credible medical/public health information during natural events, as well as during those that are produced by terrorism.

In the case of the anthrax episodes, the media responded by interviewing countless numbers of individuals. Among them was a self-professed pundit who announced he was an expert on the "anthrax virus." Anthrax is a bacterium, not a virus. In many cases, well intentioned infectious disease specialists who knew a good deal about the literature on anthrax could provide accurate retrospective information, but when pressed about the current events, they were not privy to the information about the cases that had occurred. They were then forced to either acknowledge their limitations, which the responsible experts did, or in the case of others less responsible, to speculate based on news reports, rumors and a variety of other kinds of incomplete or false information.

In a national emergency, such as that experienced with anthrax, the regular appearance on television of a credible medical/public health expert spokesperson who has up-to-date knowledge of the outbreak is important. Such a responsible

individual can of course consult with law enforcement agencies with regard to information that might be important in an ongoing criminal investigation. However the goal of the terrorist is to produce terror. Terror arises from fear magnified by an exaggerated sense of risk, and perpetuated by misinformation and rumors. In these episodes, the balance should be biased in favor of providing good information to protect the public health.

In addition to the Department of Health and Human Services, the other major stakeholder that must provide public information in the case of terrorism is the Office of Homeland Security. The Gilmore Commission has urged that one of the associate directors of that office be an Associate Director for Health. We know far too little about the availability of hospital beds, burn units, decontamination capability and a variety of other parameters required by the health system to deal with terrorism. Moreover, the necessity for dramatically improved communications between the public health system, the medical care system, and law enforcement all require a high level of coordination and communication. If this individual is also to be a spokesperson on such episodes as the anthrax outbreak, it is critical that his or her statements should be carefully coordinated with the principal credible medical/public health spokesperson within the Department of Health and Human Services. These messages must be well thought out and consistent to avoid confusion and misdirection. And clearly both individuals must be kept completely up to date with the most recent information, including the complete results of scientific and forensic analyses.

It is understandable that political leaders and Administration officials wish to be the spokespersons for their departments or agencies in the face of a threat to the national security or to the nation's health. It is important that they do so. But the

impact of their communications are not diminished when they are joined by a credible medical/ public health expert spokesperson who is knowledgeable about the nature of the disease and is also privy to up-to-date information about the outbreak. Turning to such an individual when technical questions are raised does not diminish, but rather enhances, the authority of the non-medical leader in addressing the public's concerns. For example, the presence of Dr. Anthony Fauci at hearings and press conferences came late in the sequence of events but his appearance was extremely valuable. Furthermore, his interviews by the media were paradigms of clarity, accuracy, and relevancy. It is noteworthy that, in one of his appearances with a number of so called experts, he was forced to correct inaccurate statements made by others during the program.

The other major issue that was identified by the October 3 statement from my colleagues and me is the importance of authoritative, well presented, up-to-date websites where health professionals, the public, and others can quickly obtain good information. The Internet has been flooded with multiple websites concerning anthrax. Many are reliable. But, as noted in our message, many are incorrect, inaccurate, misleading, and in some cases are downright scams. Identifying the most reliable during an emergency is important for those who seek such information.

The CDC maintains a website for this purpose. Ultimately, as we indicated in our statement, excellent information appeared at that website, though it was not as well organized as it might have been. The capacity of the CDC website to respond to inquiries was, for a period of time, limited. Access was limited by the large number of inquiries. In view of the importance of credible and accurate information, accurate resources should be made available so that the CDC can

provide information using the most modern technologies, the most professional presentations, and have both the bandwidth and the human capacity to respond to a large number of inquiries. The spokesperson for the Department of Health and Human Services/and or the office of Homeland Security should regularly remind the public and health professionals that they can get such reliable information at the CDC website.

There is an important lesson in this experience for other government agencies. We do not know where other terrorist events may occur. Does the Department of Energy have the capacity to respond to inquiries from the public and professionals with high quality, rapidly updated information should there be an incident involving radiological materials or a nuclear event? Can the Department of Agriculture respond with the type of credible expert to whom I refer and have a website with the capacity required for all inquiries, should there be any problems in the areas of agriculture or animal husbandry? Where will the appropriate website be located for information about an episode involving terrorism using a chemical agent? There are many agencies involved in these issues, but if information for the public is crucial the principles that I have outlined for the Department of Health and Human Services and the office of Homeland Security should also apply in each of these other areas. A single preferred information source should be assigned now to a single government agency in each case, and resources must be dedicated by this agency to maintaining this capability on high alert.

Mr. Chairman, many individuals in both the public and private sector work very long hours, seven days a week in coping with the anthrax episodes. They deserve enormous credit for their efforts in this regard. As the Institute of Medicine reports have emphasized for 13 years, the public health infrastructure at the state, federal, and local levels requires substantial upgrading. Strengthening the size and

configuration of the Epidemic Intelligence Service, the facilities at the CDC, and the surveillance capacity at the federal, state, and local public health and medical entities are crucial. The Gilmore Commission has recommended that the Associate Director for Health in the Office for Homeland Security have an advisory panel consisting of representatives from a wide variety of hospitals, medical organizations, and first responders who can develop methodologies to rapidly communicate throughout the country the information required about how to meet emergencies in a timely way. The Institute of Medicine has published a preliminary report (to be followed by a full report next year) on the methodologies by which we can assess the capacity of local communities to respond to an episode of terrorism. The American Medical Association has developed an excellent plan to create educational programs and disaster planning efforts through their State and local Societies. The Joint Commission on Accreditation of Healthcare Organizations has developed a plan for hospitals to improve their capabilities to cope with disasters. Resources will be necessary to make these happen, some of which will require federal help.

Additional research to deal with biological agents is essential. For example, the current anthrax vaccine requires six doses over 18 months. While studies are underway to determine the efficacy of fewer doses we desperately need a much better, purer, and effective vaccine against anthrax. The Council of the of the Institute of Medicine has called for the establishment of a national vaccine authority or its equivalent to assure supplies of vaccines which are not available through the market or which require public/private collaborations to assure adequate supplies, as exemplified by shortages of anthrax and smallpox vaccines. This should include vaccines for childhood diseases, adult infections, and in the

case of preventing the spread of hoof and mouth disease, for animals. Improved diagnostic and therapeutic options are also required.

Central to all of these efforts is information and communication: information, which the American people can understand, and information about the concepts of risk and how to apply them. In the case of anthrax, less than 20 cases resulted in thousands of people taking antibiotics that were not indicated. Perhaps twenty percent of these individuals experienced some side affects from these drugs. These antibiotics changed the bacteriological environment and may have rendered some organisms resistant to the antibiotics employed. Several effective antibiotics were available and better early information might have prevented the exhaustion of stores of Ciprofloxacin. A clear recommendation that one not take Ciprofloxacin unless one is a member of a specifically defined high risk group, e.g. postal workers or those with potential exposures on Capitol Hill would also have been very helpful in this situation.

The debate about smallpox vaccination will be much more straightforward if the American public understands the concept of risk/benefit. Smallpox was controlled throughout the world by vaccination of the populations who had been potentially exposed to a case ---that is, by surrounding the cases as soon as they were observed with vaccinations. Even two or three days after exposure, vaccination will prevent the disease. The public needs to be informed that this represents an excellent alternative to mass vaccination--which is likely to kill hundreds of people and seriously damage many more. We also need additional research to determine how many Americans who were vaccinated years ago have persistent immunity. This would help further refine the risk/benefit analysis and the needs for vaccine.

In summary, I have emphasized the critical role of a credible medical/public health expert spokesperson, knowledgeable about the current events, who speaks for the Department of Health and Human Services and stands side by side with the Secretary in his communications. If a similarly qualified spokesperson on bioterrorism is to be designated in the Office of Homeland Security, the credible medical/public health expert spokesperson(s) must carefully coordinate their statements so that they are accurate, authoritative and understandable, and consistent. Much more serious attention should be paid to the role of well organized, well presented, and technologically sophisticated web-sites for providing information to the public, health professionals, the media, and others. Such sites should be developed and be on alert (and when needed be well advertised) for each of the areas relevant to a potential terrorist attack.

Thank you Mr. Chairman, for this opportunity and I would be happy to answer any questions.

Mr. SHAYS. Dr. Akhter.

Dr. AKHTER. Thank you, Mr. Chairman, members of the committee. I really appreciate the opportunity to be here this morning. My name is Mohammad Akhter. I am the executive director of the American Public Health Association. We represent the public health workers in this country, both Federal, State, local level of protecting the health of the American people every single day. So what I'm going to say is not——

Mr. SHAYS. You don't represent, say, the directors of the public health?

Dr. AKHTER. Many of them are our members, yes, sir. It's a professional organization. We are a professional organization, scientific organization, and as such, many of the members are professional directors. Like Dr. Satcher is, for example, one of the members of the American Public Health Association. So we speak on the basis of science and actual on the ground experience.

So, Mr. Chairman, despite what my senior colleagues and some of the other folks in the government may have said before, I want to say one thing about the previous anthrax attack and that is, that a lot of people worked very hard, but the fact is we got lucky. We were very fortunate that there were handful of cases and that took place in an area where we have very good resources.

And we were able to deal with it. If the same situation would have taken place in another part of our Nation, we wouldn't be so lucky. And so my comments are based upon what can we do for the future. And there are four areas of risk communication that I very quickly want to run by you for your consideration: The first is the communication between the front line workers in bioterrorist attack. It's not the fire chief who pulls the alarm. It's not the disaster preparedness director who pulls the alarm. It is the physician, a paramedic, a nurse, an EMT on the front line. If those people were not connected with the health department, there is no communication. Then we have difficulty.

Handful of health departments right now have that capability. Where the cases are reported, as long as somebody sees a suspicion case, the case gets reported to the health department. So that this system could be activated, we could do the followup, do the tracking. So the capacity needs to be built at the local level, the local health department, particularly those health departments that are 50,000 or less population. They are the ones who really do not have that capacity.

My second area of communication, risk communication deals with the communication between the Federal Government, State government and local government. Despite the grants that were given, despite the health alert network that's been in place, the reality on the ground as we speak, Mr. Chairman, today, is that 10 percent of the local health departments do not have e-mail capability. 50 percent of the local health departments do not have high speed Internet connection. So you can give them the information. Even if they receive it, they cannot forward that information to their physicians in their area, to the hospitals in their area, to the ambulance providers in the area. So there is a bottleneck there. And we really don't have the full communication in place that

could be very effective in saving lives and protecting against disease.

The third area, Mr. Chairman, is the area of communication between the public health community, the Department of Defense, and the Intelligence Community. I had the great honor of serving for 30 years of public health positions, including being the director of health for the State of Missouri.

Not until I became Health Commissioner in Washington, DC, did I ever have the opportunity to work with the Defense Department or the Intelligence Community. These communities have not worked very well together. We don't have the history, we don't have the tradition of working together. So when they come together, as is the case is imperative now that we all work together to deal with this new situation, we don't have any structure. We don't have any authority, any way to really do this thing together. And collaboration between different agencies at the State level, even within the agency, is a very difficult task. And it will not take place, Mr. Chairman, until and unless there is a directive from the very highest level of our government, perhaps from the President, to make sure that the Defense Department that has a wealth of information on these areas, Intelligence Community, law enforcement, and public health community, work together to share information. And if necessary, give several key health officials the FBI clearance so they can get the information on a need-to-know basis they can prepare and protect the health of the American people.

And finally, Mr. Chairman, I come to the major issue of communication with the public. When it comes to bioterrorist attack, we aren't dealing with anthrax or smallpox virus, we are dealing with people who may have been exposed to anthrax, who may have been affected by the anthrax and who are afraid of anthrax. And what these people need is clear, concise, usable information from an authoritative source. And I'm sorry to say and I agree with my colleagues here that we were unable to provide that in the past. And I see no change as we speak today, Mr. Chairman, to be able to do that. All the things that I've learned in the communication is that you need to have a single, centralized person responsible who could provide that information to the American people.

Dealing with bioterrorism is a public private partnership. All the doctors, the hospitals, the ambulance providers are private people. They work with the Health Department very closely to be able to protect the health of the American people. One of such entity out there is the American news media. Frankly, many of our people learned—got the information from the news media faster than they got through our own channels of communication in public health. And we should bring the news media in on the table so that we could have the news media sit down with the key folks.

So here is what I recommend in my closing. That at each level of our government, Federal Government, State government, and the local government, a single source be identified for communication with the public and that the news media be brought in in communication, and we need to work out the protocols and the way how we're going to provide the information to the people so people get the right and accurate information so we can get the support

and the confidence of the American people to deal with this new and emerging situation.

Mr. Chairman, I thank you very much for this opportunity. Be glad to answer any questions you might have.

Mr. SHAYS. Thank you, Dr. Akhter.

[The prepared statement of Dr. Akhter follows:]

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TESTIMONY OF
THE AMERICAN PUBLIC HEALTH ASSOCIATION

CONCERNING RISK COMMUNICATION:
NATIONAL SECURITY AND PUBLIC HEALTH

Mohammad N. Akhter, MD, MPH

Presented to the Subcommittee on
National Security, Veterans Affairs, and International Relations
of the
House Committee on Government Reform

November 29th, 2001 at 10:00 a.m.

TESTIMONY OF THE AMERICAN PUBLIC HEALTH ASSOCIATION CONCERNING RISK COMMUNICATION: NATIONAL SECURITY AND PUBLIC HEALTH

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Mr. Chairman and members of the Subcommittee, my name is Mohammad Akhter, and I am the Executive Director of the American Public Health Association. APHA is the oldest and largest public health association in the world, representing approximately 50,000 public health professionals in the United States and abroad. On behalf of our members, I appreciate the opportunity to express our views on the application of risk communication strategies to federal efforts to disseminate information on bioterrorism threats.

Never before has the essential role of public health infrastructure been so publicly acknowledged, and we thank you for recognizing our unique function as the only segment of the health care system that includes prevention, detection, and response to a bioterrorism event. We are pleased to work with you to enhance the ability of public health to work with all sectors, including the federal government, in addressing threats of the magnitude that we currently face. In this regard, I would like to address several aspects of risk communication that our collective efforts can improve.

The Speed and Effectiveness of Communications among Emergency Responders, Healthcare Providers and Health Departments

There is already in place a system whereby identification of an individual with suspicious symptoms can be communicated from an emergency room to the local health department. This is generally done by phone, as electronic communication is absent in most cases. Whether or not the message is received by the health department in a timely manner is dependent on whether it is communicated during business hours, as communications are not received and acted upon on a twenty four hours a day, seven days a week basis in most health departments. The installation of e-mail communication from emergency rooms to health departments, with continuous monitoring and response, is no longer an option but a necessity. We can and must make this a reality.

In Washington DC, when there had been four cases of inhalation anthrax from the same location, and two deaths, a mere twenty four hours from detection to treatment made the difference between life and death. We believe that the optimal length of time for risk communication by an emergency room to a health department should be within four

hours. Clearly, we must improve our capability, and meet the goal of one hundred percent compliance within two years. It is possible if we start right now.

The legislative and appropriations processes have come a long way toward understanding the need to bolster infrastructure at its front line, and the additional efforts of congressional health leaders like Senators Kennedy and Frist, and Representatives Burr and Stupak, have greatly enhanced the likelihood that preparedness and response will vastly improve in the near future. We salute their efforts, and those of likeminded legislators like yourselves.

The Ability of Local and State Health Departments to Communicate with Each Other, and with the Centers for Disease Control and Prevention (CDC) in a Timely and Effective Manner

The same problems that plague communications between healthcare providers and health departments are present in the emergency interaction among local, state, and federal entities. On many recent occasions we have witnessed the unacceptable fact that health departments have obtained information from CNN more rapidly than they have from each other or from CDC. Mechanisms must now be put in place to make these essential communications seamless and continuous, twenty-four hours a day, seven days a week. We must also include in this information loop at the local level all emergency personnel who are the first responders in the event of bioterrorism, such as law enforcement, firefighters, emergency medical technicians, and others. This calls for a new commitment to coordinating all communication among all interested parties in a health emergency, and an overhaul of the existing communications capability of the public health infrastructure. We must engage in a comprehensive approach that recognizes the need for continuous automatic communication among parties that may not have previously seen the need for it. This will require not only new dollars, but also a new way of looking at emergency communication in a way that includes a greater array of players.

Communication Among Health Entities, Law Enforcement, and the Intelligence Community

The advent of bioterrorism has presented a new challenge that requires new partnerships to be formed and a new network of communication to be firmly established. Specifically, there must now be a much closer relationship among the public health, law enforcement, and intelligence communities. Whereas law enforcement and intelligence may have entertained a sporadic relationship up until now, public health has never been a viable part of that interaction. This is no longer acceptable, as was seen in the manner in which the three entities appeared to stumble over each other in responding to the anthrax outbreak. The need for secrecy that is emblematic of the intelligence and defense communities must yield somewhat to solve the unique challenges presented by a bioterrorism event. Each entity has a distinct but interrelated role in preventing,

detecting, and responding to such an event, and only by sharing information in a transparent manner can the maximum effectiveness of their collective role be realized. Only a directive from the highest levels of government will bring about this unprecedented level of communication, but we have received the wake-up call and are not at liberty to ignore it.

An Appropriate Communications Role for the Private Sector

The heightened threat presented by bioterrorism calls for the participation of the private sector in the chain of players required to effectively address its effect. Radio, television, and print media can and must become effective partners in the sharing of accurate and consistent information in the event of a bioterrorism emergency. Competition must turn to collaboration in the best interest of the public. In the event of an emergency, all elements of the media must act as one to communicate a consistent message to the American people to convey whatever emergency instructions are appropriate in the particular instance. Standards would need to be developed to determine what constitutes an emergency; and a single authority, such as the Surgeon General, would be appointed as the clearinghouse and sole source for all messages to be delivered to the public, via the media, for the duration of the emergency. We all witnessed and were subjected to a wide variety of changing interpretations by the media regarding the recent and ongoing anthrax crisis. Americans must be informed, in a correct and consistent manner, regarding the nature of the problem and what they can do about it. In the instance of anthrax, a media message might have indicated which groups were considered to be at the highest risk, and where to go for evaluation and drug therapy. The media must reinvent itself as the powerful partner that it needs to be in this era of escalated threats to the health and welfare of the American public.

Conclusion

In this country we are fortunate to have a public health infrastructure that is capable of preventing, detecting, and responding to public health emergencies of a conventional nature. The advent of bioterrorism has presented us with terrifying new challenges that mandate the interaction of additional partners to combat the heightened ill effects of this new threat. We must think in a new way, with new partners, to be effective in addressing this challenge. Our collective responsibility is to review our current communications structure, add new parties, and allocate assets effectively. The American Public Health Association is eager to assist in this endeavor.

Mr. Chairman, this concludes my remarks, and I appreciate the opportunity to share our views with the subcommittee. I will be happy to address your questions.

Mr. SHAYS. Dr. Waeckerle.

Dr. WAECKERLE. Chairman Shays, members of the subcommittee and fellow panelists, good morning. It's a privilege to be here.

Mr. SHAYS. Privilege to have you.

Dr. WAECKERLE. I'm Joe Waeckerle. I'm a practicing emergency physician, board certified and residency trained. I live in Kansas City, MO. I currently serve as editor-in-chief of the Annals of Emergency Medicine of the American College of Emergency Physicians and have chaired the Task Force on Health Care and Emergency Services Professionals on Preparation for Nuclear Biologic and Chemical Attacks. I also have worked as a consultant to the Federal Bureau of Investigation. I have served on the task force of the Defense Science Board for the Department of Defense looking at biologic threats to the American people and the American continent and have worked closely with the CDC and the Office of Emergency Preparedness.

I'm here today to testify on behalf of the American College of Emergency Physicians who currently has 23,000 members. We take of over 100 million patients per year, and hopefully I will represent them well.

Emergency physicians as earlier stated are in the front line of biologic preparedness in this country. We are the new first responders along with our colleagues, the nurses and the EMT paramedics. And the new scene of terrorism in this country will be the emergency departments of America where the patients present for care.

To that end, we must be clinically able to recognize and initiate a response because early detection will save lives and mitigate any biologic terrorism in this country. We have attempted to foster that in our membership and across the country by the task force educational programs and the development of curricula for the public and our patients as well as for our members.

Today we're going to focus on a discussion of the challenges of crisis communication. This is appropriate since the September 11th incident has centered on a tragic and senseless loss of innocent lives. More importantly, however, we have witnessed what many of us have feared most for a long time and have discussed with you previously, including my visit here in September 1999 before you. And that's the use of biologic agents by terrorists. America has unfortunately learned that the consequences of a biologic attack are incredibly severe, even of the small isolated incidents that we have faced recently, much less a large scale attack. Biologic weapons are formidable weapons of uniqueness and complexity that a specific defense strategy is fundamental to our protection.

As many of you know in the room, good communication is absolutely essential to any national strategy. That's what we're here for today. In times of crisis, the citizens of America look to you, other elected leaders and government officials, for information and direction. At no time in contemporary history was this more evident than after the recent tragic events that we've experienced. In the early stages of this event, it was apparent that crisis communication strategy was evolving. There was no obvious centralized leadership, no voice of authority, and inconsistent information that was soon outdated or required correction on a daily basis. This resulted

in the American public remaining in an informational vacuum as stated earlier. The public did not have a steady flow of updated information, so seized any information from anyone, no matter how unproven, to reassure themselves. For example, many patients presented to our emergency departments across the country asking for diagnostic nasal swabs to determine if they had anthrax. Because they thought this was the right thing to do. They did not know and were not told by anybody that nasal swabs were not diagnostic entities but were, in fact—they did determinations of exposure and use for epidemiologic investigation. Therefore, they were erroneously informed. The appropriate treatment of anthrax caused an unnecessary public controversy as well. Initially, the public was appropriately told that cipro was the treatment of choice. Later the public was told that doxycycline was the preferred treatment.

Many of those who were potentially exposed and therefore prophylactically treated, including many in this area in the United States, in the Washington, DC, area, became concerned that they did not receive the best treatment. This issue, in fact, became contentious at some point, but it could have been prevented with proper communication. Appropriate authorities, all they had to do was explain to the American people that ciprofloxacin was initially chosen because we didn't know if the bacteria had been genetically enhanced to be weaponized. Once tested, determined that it had not and was sensitive to standard therapy, standard therapy was appropriate and preferred.

During difficult times, it is also natural for the general public, who is uneducated in these areas, to respond with unreasonable solutions. The preoccupation of the media with the question of gas mask use was likely provoked by the public's unanswered concerns for personal protection. Although the use of gas masks was repeatedly dismissed by many experts, the public look for a credible Federal authority to convince them that the use of gas masks and other protection devices was unnecessary.

Finally, there was the dilemma of how to balance the release of sensitive information to inform and protect our American public versus when to keep it confidential to maintain national security or prevent public panic. This decision should have been carefully analyzed on a case-by-case basis. And despite the fact that it may have been, mistakes occurred. The controversy surrounding the release of potential threats to the Golden Gate Bridge in California was an example. The FBI and the governmental authorities were in a no-win situation, as was the Governor of California. If they released it and it did not occur, they were wrong. If they didn't release it and it did occur, we suffered a tragic event unnecessarily.

Fortunately, many of these communication deficiencies can be corrected. Consistency is an absolute must. The American public expects leaders who are knowledgeable authorities, and more importantly, who can effectively communicate the knowledge to the public. A consistent message is usually best conveyed by a recognizable voice, regularly scheduled press conferences located at the same site and time to be considered. The media deadlines also conveys a message of reliable and responsible leadership. The message delivered should be clear, for all to understand, concise and

to the point without much elaboration or any speculation and above all, credible and correct.

The public can appreciate, in my opinion, that the situation may change if they are told it may change so that the message may vary from moment to moment. The partnership with the media established prior to any incident will promote the goals of crisis communication. I have not seen evidence of the partnership in our national strategy. Disseminating correct and helpful information will control rumors, limit the use of pseudo experts, foster cooperation and thereby enhance our ability to respond. The partnership with the media is critically important because they are the public's primary source of information. Go to any emergency department in America and we had on CNN so we could learn what was going on. We only have to remember the most trusted man in America during his tenure was Walter Cronkite, not a Federal, State or local official, and that's because he demonstrated those areas of crisis communication that we just discussed.

These communication deficiencies are not limited to just the public. My colleagues have talked about it, we have discussed in the past, they include the Federal agencies' ability to deal among themselves to deal with the State and local officials, and to deal with the private sector as well as State and local officials have failed, in my opinion, to deal effectively with the Federal Government, with, or, and other State and local officials including, of course, the important private public health and medical sector.

In conclusion, crisis communication using a partnership with the media to provide clear concise credible information consistently delivered by a recognizable authority, is, in my opinion, an absolute requirement. We must also develop principles for communication to the public that address the dilemma between the public's right to know and the Nation's national security.

Congress must provide the leadership, financial investment and organizational and logistical support to develop not only a comprehensive national strategy with solid domestic preparedness and response plans, but also a comprehensive communications strategy. Good communication provides knowledge that results in an informed and cooperative America. Without information, fear prevails. And as President Roosevelt once said, the only thing we have to fear is fear itself. Thank you for the opportunity to be here. I look forward to answering any questions.

[The prepared statement of Dr. Waeckerle follows:]

Testimony of Joseph F. Waeckerle, MD, FACEP

Editor in Chief
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And

Chairman of the Task Force of Health Care and Emergency Services Professionals on Preparedness for Nuclear, Biological, and Chemical Incidents

On

Risk Communication: National Security and Public Health

On Behalf Of

The American College of Emergency Physicians

Before the

House Committee on Government Reform,
Subcommittee on National Security, Veterans Affairs, and International Relations

November 29, 2001

Introduction

Chairman Shay, members of the Subcommittee, and fellow panelists, good morning. I am Dr. Joseph F. Waeckerle, a board certified emergency physician practicing in Kansas City. I currently serve as Editor in Chief of the *Annals of Emergency Medicine* and as the American College of Emergency Physicians' Chair of the Task Force of Health Care and Emergency Services Professionals on Preparedness for Nuclear, Biologic, or Chemical Incidents. I also am a consultant to the Federal Bureau of Investigation on terrorism, have worked on a recent task force for the Department of Defense's Defense Science Board, and work closely with the Centers for Disease Control and Prevention and the Office of Emergency Preparedness.

I am here today to testify on behalf of the American College of Emergency Physicians (ACEP), which represents more than 23,000 emergency physicians who provide care to more than 100 million patients each year. Emergency physicians are on the front lines in the war against biological terrorism, we are part of the new first responders. Their emergency departments will be the scenes of biological incidents. The ability of emergency physicians to recognize a biological attack early will allow the mobilization of a guided response thereby lessening the causalities and preserving the infrastructure of America. To that end, ACEP's journal, *Annals of Emergency Medicine*, and ACEP's educational efforts are focused on improving the diagnostic and management acumen of emergency physicians, and fostering emergency physicians' involvement in their communities' disaster planning and preparedness activities.

I want to thank you for the opportunity to appear before you today to discuss the challenges of communications as related to preparedness and response activities in the event of a biological terrorist attack.

The focus of the nation since September 11 has centered on the tragic and senseless loss of innocent lives caused by terrorists willing to fly airplanes into skyscrapers and public buildings. This unspeakable crime was a horrific event demonstrating a lack of moral restraint and willingness to go to any extreme to wage asymmetric war against America and her citizens. Subsequently, however, we have witnessed what many of us have feared most; the use of biological agents by terrorists who willingly and indiscriminately infected innocent citizens with a deadly agent producing sickness and death. We have also seen these acts result in psychological and economic hardship and political unrest inflicted by attacking small populations in multiple sites over a protracted period.

America has learned that the consequences of a biological attack are great, adversely affecting every aspect of our daily lives and imposing unparalleled demands on all areas of our government and our societal infrastructure that must be met. Biological agents are such formidable weapons of uniqueness and complexity that a specific defense strategy is essential. Comprehensive preparation against the use of biological weapons is the *sine qua non* of future defense readiness.

Denial of this threat — or using the excuse it is too difficult to plan for — is no longer tenable.

Communication with the Public

In times of crisis, America's citizens rightfully look to their elected leaders and government officials for information and direction. At no time in contemporary history was this more evident than after the September 11th event. The public reliance was only accentuated by of the subsequent anthrax incidents. These horrific crimes reminded Americans of their vulnerabilities and mortality. Innocent citizens going about their daily lives died unexpected and frightful deaths while many watched the tragedies unfold on live television. It is these aspects of the threat that make it all the more critical for the public and to have faith in their leaders and others who report on the latest developments and strategies to mitigate those threats. As many of you in this room know, good communication is absolutely essential to an effective national strategy.

In the early stages of the anthrax terrorism, crisis communications was often inaccurate, misleading, or too scanty. When the first case of anthrax hit the airwaves, driving home that the hard to imagine had become a frightening reality, a coordinated and authoritative communication plan was absent. It was apparent that a crisis communication strategy was evolving as new information became available. Moreover, no apparent centralized leadership, no voice of authority, and inconsistent information that was soon outdated or required correction resulted in the American public remaining in an informational vacuum. Furthermore, the public did not receive a steady flow of updated information. As a result, a frightened public, in search of answers and quick steps to safeguard their own health, seized any information, no matter how unproven, to reassure themselves. Reports of stores running out of gas masks and other protective gear appeared in the media. Many believed a visit to the nearest emergency department for a

nasal swab was the most prudent step to take. However, the public did not know, and was not told, that nasal swabs are used to determine exposure and for epidemiologic investigations but are not sensitive and specific enough to be used as a diagnostic test. Americans inappropriately went to emergency departments and doctor's offices across our country asking for nasal swabs to determine if they had been infected with anthrax. This had the added effect of creating an unnecessary burden on already overloaded emergency departments.

The appropriate treatment of anthrax caused another unnecessary public controversy. In the first few days and weeks after the first anthrax incident, the public was told that ciprofloxin, commonly known as Cipro, was the treatment drug of choice. Later, the side effects associated with the use of Cipro gained attention and the public was told that doxycycline, rather than ciprofloxin, was preferred. Appropriate authorities should have explained to the American public that ciprofloxin was chosen as the initial medication because authorities were unsure if the anthrax bacteria were genetically altered to be resistant to standard therapy. Once testing determined that the bacteria were sensitive to the standard therapy, doxycycline was an appropriate treatment, and in some cases a better treatment than Cipro. However, many of those potentially exposed and prophylatically treated became concerned that they did not receive the "best" drug. This became a contentious issue that could have been prevented with proper communications from the start.

During times of panic, accompanied and fostered by lack of accurate information, it is natural for the general public who is uneducated in this area to respond with

unreasonable solutions. This phenomenon was evident as the press continually inquired as to whether or not the public should wear gas masks to protect themselves from anthrax inhalation. The preoccupation with this question was likely provoked by the public's unanswered concern for personal protection. Although the use of gas masks was repeatedly dismissed by a variety of experts, the public looked for a credible authority to convince them that the use of gas masks was unnecessary.

What should the public know and what does the public have a right to know? When, under what circumstances does national security outweigh the public's right to know?

The decision about whether or not to release sensitive information to the media, and therefore to the public should be carefully analyzed on a case by case basis. Despite careful considerations, mistakes can even then occur. The controversy surrounding the release of potential threats to the Golden Gate Bridge is an example. The FBI gave threat information obtained from a marginal source to the governor of California (the FBI had not evaluated the source but due to the time frame involved gave what information it had). The governor made the decision to release the information to better inform his residents. The threat information further magnified our feelings of vulnerability and affected our behavior. As we now know, a terrorist act did not happen. Subsequently, the FBI, after evaluating the source, informed the public that the source was not credible. The media was critical of the FBI for releasing the information prior to analysis and criticized the governor's decision for jumping too fast to pass the information along. This in turn magnified the public's fear of vulnerability because authorities did not seem to know

anything. This incident has passed. However, the dilemma of how to balance the release of sensitive information to inform and protect Americans, versus when to keep it confidential to maintain national security or prevent public panic remains.

Fortunately, many of these communication deficiencies can be corrected. The tenets of crisis communication can and should be applied. Consistency is an absolute must. The American public expects leaders who are knowledgeable authorities and, more importantly, who can effectively communicate that knowledge to the public. A consistent message is usually best conveyed by one recognizable voice. Regularly scheduled press conferences located at the same site and timed to be considerate of media deadlines also convey a message of reliable and responsive leadership. The message delivered should be clear for all to understand; concise and to the point without much elaboration or any speculation; and above all correct at that moment in time. The public can appreciate that the situation may change if they are told that it may change so the message may vary from moment to moment. All disaster incidents are dynamic, which is what makes them disasters. If the leader is honest and sensitive to this fact, the public will be as well.

Partnering with the media will form an alliance of benefit to all, most importantly the public. A partnership will promote the goals of crisis communication. Disseminating correct and helpful information will control rumors and limit the use of "pseudo experts." Good communication will also foster cooperation and thereby enhance the responses needed to deter or mitigate the incident.

It is desirable to establish a communication system and partnership with the media prior to any incident. Just like disaster planning; if there is no plan, then plan to fail. The communication system must be in place and used. The American College of Emergency Physicians' Task Force of Health Care and Emergency Services Professionals on Preparedness for Nuclear, Biologic, or Chemical Incidents has developed an awareness curriculum that will aid the American public in evaluating media messages. Disseminating this information through the media prior to an incident will bring about a better informed and more cooperative public. The partnership with the media is critically important because it is the public's primary source of timely information. We only have to remember the most trusted man in America during a former time of crisis - Walter Cronkite; not a Federal, state or local official, but a respected news broadcaster.

Communication Issues

Communication deficiencies are not limited to the public. The problem is ubiquitous, occurring at all levels of domestic preparation and response. As we saw in New York City and Washington, DC, typical communication systems such as cellular phones and e-mail that we depend upon in emergencies for real-time communication were all down. In addition to unplanned communication systems problems, little real communication exists among the federal participants involved in domestic preparedness. Equally disturbing is the lack of communication between the federal partners and the state and local communities, and almost none of the current communication involves local health care providers. There is also insufficient communication among state and local communities. As a result, all aspects of preparation for the possible use of weapons

of mass destruction, especially biological weapons, have suffered and officials have not fulfilled their responsibility to protect and serve the American public.

Communication among Federal Partners

The United States has a multitude of federal agencies and departments with vested interests in bioterrorism preparation and response. Unfortunately, there is no authority structure and the outcome is a lack of unity that decays the federal effort. There is a void in federal leadership and consequently communication suffers. The intelligence and law enforcement communities may not share pertinent information with each other much less other agencies and departments. Within HHS, a department that is central to any preparation and response, there is much fragmentation and redundancy that yields little communication or beneficial productivity. Defense has traditionally and appropriately isolated itself from the civilian sector and has remained relatively so in this endeavor. Transportation, Energy, Commerce, Agriculture, Treasury, VA and EPA all have responsibilities related to public health and medical consequences of a bioagent attack but lack coordination. As a result of this, there is no unity of effort. The development and implementation of a coherent national strategy is fragmented, uncoordinated, redundant and inefficient.

Communication between the Federal Partners and State and Local Authorities

Any response to a weapon of mass destruction on American soil will first be local and community-based — perhaps for an extended period of time. This means that communities must have well-conceived plans that are effectively coordinated. Current disaster preparedness programs in many communities are often insufficient in

their design, poorly practiced and lack sufficient personnel and resources.

Federal authorities must ensure coordinated ventures with the state and local communities. This requires a concerted effort to have ongoing dialogue that is timely and pertinent. Unfortunately, the multi-agency, multi-jurisdictional nature of uncoordinated strategies delivered by the federal government to the state and local community makes success against biowarfare only a remote possibility. The result is communities that are not well informed, not well financed, not well trained or drilled, and not properly integrated with the Federal response.

Communication at the State and Local Level

The interchange of thoughts and ideas is no more efficient or effective at the state and local level than with their federal counterparts. The bureaucratic structure is essentially the same; only the names and sizes of the agencies are different. Multiple agencies and departments and multiple levels of authorities make for poor communication. Even the most critical infrastructure of the health care response, the local health care professionals, the community hospitals, and the local public health system, often do not work with the state or even exchange information or ideas among themselves. In addition, the partnership of the community's private sector with the community authorities is nonexistent. Consequently, a well-conceived, fully integrated and properly rehearsed plan is not there when it is most needed. Finally, the failure to appreciate the pharmaceutical industry's important role in preparedness and response activities has resulted in a lack of prevention and treatment capabilities, surge capacity, and research and development efforts essential to our protection.

In summary, federal agencies do not effectively collaborate among themselves; they do not relate well to the state and local agencies; and the state and local agencies do not talk to each other. No one has engaged the critical health and medical sector or the business sector in these efforts. The outcome of this poor communication is inefficient and ineffective preparation for response activities at all levels.

Conclusions

Federal authorities must provide leadership, financial investment, and organizational and logistical support to develop a comprehensive national strategy with solid domestic preparedness and appropriate response plans. Inherent in that approach is a strong communication strategy. Collaboration and coordination at all levels of involvement are critical to the design and implementation of a national preparation and response plan.

Communication that allows for coordinated sharing and discussion of essential information in real-time across jurisdictional and geographic boundaries is a critical component of our national preparedness and response to biological terrorism. This also includes horizontal communication among federal agencies such as the Centers for Disease Control and Prevention, the Office of Homeland Security, the Federal Bureau of Investigation, Department of Defense and the Federal Emergency Management Agency, as well as vertical communication to and from state and local health officials and the private medical sector.

Most importantly, because an act of terrorism with a bioweapon is potentially so dreaded by the American public, crisis communications using a partnership with the

media to provide clear, concise, credible information consistently delivered by a recognized authority is an absolute requirement. We must develop principles and criteria for communication to the public that addresses the dilemma between the public's right to know versus our national security. Good communication provides knowledge that results in an informed and cooperative public. Without information, fear prevails. As President Roosevelt said: "The only thing we have to fear is fear itself."

Mr. SHAYS. I thank you all very much. I'm going to start with the questions, and just it seems to me, make an observation, it seems to me that you pretty much all agree. I mean, your message is pretty consistent, but I'd like you to tell me where you would disagree with anyone else who have spoken on the panel, and you point that you might disagree. Or Dr. Satcher. Any comments that were made today that you would just take exception to or not as strongly but just disagree? Start with you, Dr. Koop.

Dr. KOOP. In general, we seem to be of one mind. We might have little different ways of dotting I's and crossing T's, but I think the thrust has been the same from all of us.

Dr. SHINE. Dr. Satcher talked about the notion that one person can't be everywhere and that you should have multiple—there may need to be multiple spokespersons, that the media demand is very high and so forth. While he is quite correct about the media demand, the fact is that if there is a single source of information holding a daily press conference and coordinating his information or her information with other players, you can still have multiple exposures to the media. I don't see that the two are in conflict with each other. But I do believe that the notion that you can have multiple people talking is not credible.

Mr. SHAYS. I'm going to come back, because I think I disagree with you. I would love to follow through.

Dr. AKHTER. I also generally agree with what my colleagues have said, but I do believe in a single credible spokesperson and that person be the Surgeon General of the United States. We were very distressed to see the General absent in the war against terrorism at home. What kind of army you want to see—the public health community, we consider him to be our leader. The leader is not visible, then the people just got confused, looking to every direction, every which way. It was not the public who were confused but the public health people who were confused. I think, to clarify that, it ought to be the Surgeon General of the United States who should stand up and speak and be the leader.

Mr. SHAYS. Which will lead me to a question, Dr. Koop, I will ask you about, because you had the AIDS epidemic to deal with and you were pretty much the spokesperson, it seemed to me. I'll come back to you on that one.

Dr. Waeckerle.

Dr. WAECKERLE. Probably don't have a lot more intelligent remarks, but I do think that——

Mr. SHAYS. You should have——

Dr. WAECKERLE [continuing]. I could give you one example of what I think was a very effective leader who did a very good job, and that was Mayor Giuliani. In fact, throughout the crisis in New York, he demonstrated all of the characteristics and all of the behaviors that we've all discussed before you today and reassured, informed and calmed New York City.

I would also point out to you that maybe the most effective press conference I saw during this whole incident is when Governor Ridge took command and had Surgeon General Satcher and had Secretary Thompson and the Post Office Director and others involved. And while he was the main spokesperson he allowed each of those individuals to give us an update on information so that

there was one credible person leading the news conference at that time or the President briefing but that we had a cadre of informed, intelligent, responsible authorities behind him.

Mr. SHAYS. That's a good lead-in to tell you, Dr. Shine, where I get a little uneasy. I would begin to think if there was only one spokesperson for the government that the government was trying to hide something, that they weren't allowing so and so to speak or they won't allow so and so to speak. I would become very suspect and begin to question whether I was being told the full story.

Dr. SHINE. Congressman Shays, I am not suggesting that other people don't speak at all. What I'm saying is that when Secretary Thompson has a press conference, for example, the individual who is charged as the spokesperson is, just as Dr. Waeckerle described, a certain person standing next to him, and who is able to provide that information. Similarly, at a daily briefing that individual could provide those briefings.

That doesn't mean that a lot of other people will not be communicating but does mean that some—one of the things that was striking, if you looked at the media during these episodes, was that there are all kinds of experts who, when on television, if you watched them carefully there were two kinds of experts. Most of them knew the history of anthrax previously. None of them had ever had any experience with inhalation anthrax because it hadn't existed to any significant extent except in Russia. And what would happen is the media would then say, after they gave this articulate description of anthrax, but what does it mean, though they just had a case in a postal worker or whatever, and there were two responses.

The credible people said, well, I don't really know the details of that. I don't know what the organism is. The other response was—of the expert was to speculate based on what he or she——

Mr. SHAYS. I know that, but you can have experts on TV all the time, including some of you will be on TV and you'll be debating somebody else who calls himself an expert. So that will happen on TV. But I mean truly it will.

Dr. SHINE. That's why there needs to be someone who has knowledge of the actual event who is in the department, who as a consequence was being briefed by what's going on in the CDC, was briefed by the FDA, whatever the problem is, who has access to all that information for purposes of being the spokesperson.

Mr. SHAYS. Let me get to Dr. Koop.

I'm struck by trying to process what you're saying, that you want someone to help coordinate, bring people forward. But, for instance, if I want to hear from the head of CDC, I may want to hear from the NIH, I may want to hear particularly from the Surgeon General.

But just refresh me, Dr. Koop. There was and still is an AIDS epidemic, but I would guess the AIDS epidemic is more prevalent in places in Asia and Africa but still an epidemic everywhere, or am I being sensational?

Dr. KOOP. It's still an epidemic everywhere. And the African countries are being very hit very hard, and some of those are actually facing genocide. Our own problems here are specifically con-

centrated on Afro American women. So the country has its own problems.

Mr. SHAYS. I just didn't want to not call it an epidemic if it wasn't to be correct.

Dr. KOOP. An epidemic means——

Mr. SHAYS. I called anthrax a virus at one time before someone corrected me, like this person.

Dr. KOOP. Anthrax affected very few people, but it was more people that you would ever expect to have it, so that's an epidemic.

Mr. SHAYS. I recall you became the spokesperson pretty early on when we were dealing with HIV/AIDS.

Dr. KOOP. No, I wasn't. I was given specific orders that AIDS did not come under my purview.

Mr. SHAYS. No kidding.

Dr. KOOP. It wasn't until the end of Mr. Reagan's first term when the first-termers began to go back to their homes the Public Health Service was filled with innumerable vacuums. Filled as many of those as I could. That's how I became the spokesperson. I was really self-appointed.

Mr. SHAYS. But good thing. Because there began to be some real knowledge about this disease. But walk me through it. So did we have the same kind of thing we have now, a lot of different people speaking or nobody speaking?

Dr. KOOP. In those days, nobody wanted to speak; and the people surrounding President Reagan thought those who had AIDS deserved it. It was a very tough time.

Dr. SHINE. But having that spokesperson did not mean that Tony Fauci couldn't speak about HIV, that people at CDC couldn't speak about it. In other words, I don't think having a spokesperson doesn't mean you don't have—but what it does mean, as Dave Satcher described, you have a telephone conference call of key players, you review where you are, you agree on what, in fact, you know and what you're able to say so that the message is consistent and not contradictory.

Mr. SHAYS. Right. It begs another question, though. If the truth is sometimes contradictory, how——

Dr. SHINE. Then you have to acknowledge that. That's what the truth is about.

Mr. SHAYS. Mr. Tierney, have as much time as you want.

Mr. TIERNEY. Thank you. Thank all of you for your testimony.

I guess, going back to an underlying theme that the chairman was talking about also, is there any way that we can get the media to be more responsible, or are we always going to be subject to the talking heads? I noticed this in legal matters. Everybody is all of a sudden a legal constitutional expert. It takes the whole gamut. Now it seems to be medical issues. Are we going to be subjected to whoever they decide to throw on the air and people are going to get innuendo and surmise and speculation and bad information? Or is there some way through what we do that we heighten the responsibility that there will be a responsible message and voice out there? Anybody that wants to respond.

Dr. KOOP. I hinted at this in my remarks, and that is that the thing that made it possible for me to do the job that I did during AIDS I think was largely because, in the beginning, I appeared in

the press conference atmosphere and there those days the Surgeon General could get time on any network within 2 hours if he had an emergency. I don't know whether that still exists or not.

Mr. TIERNEY. Probably need to put it on a soap opera.

Dr. KOOP. But when you have all of the stations really turning health issues into entertainment on the talk shows, then you do get controversy because they don't always know how to pick the right people. And the second thing is they have very strict time constraints, and many times you can't on the Today Show or Good Morning America get out the whole message you have to get out because you only have a 90-second sound bite.

Dr. SHINE. In a free society it's going to be very difficult to manage that. On the other hand, I lived for 20-odd years in Los Angeles. Shirley Fannan was the spokesperson for the Department of Health in Los Angeles County. When a problem emerged, she was the first person who got interviewed. She gave information to health providers. She gave information to the public. She was a recognizable spokesperson. And it out balanced all of the other experts.

I would argue if you look at what happened with the American Flight 587, the crash, the woman who was the Chair of the National Transportation Board—I don't remember her name—but every day for the next 5 days she was giving very good information and she trumped—using the chairman's term, she trumped all the talking heads because she knew what was going on. She was prepared to say how long it was going to take to get the information, what they knew and so forth.

And that's I think the way you deal with the media, is make sure that you've got some way of getting information across that—where they know where to go and get it. They knew to go and get Koop.

Dr. AKHTER. Two quick things. As the health commissioner in Washington, I had to order 2 million people to boil the water for about a week or so when I was health commissioner. And the first thing you do is to make the highest level possible in your government available to the news media according to their needs, their morning news and afternoon news. So that I was available to be available for them to talk to them and provide them the information.

Once you provide that information every single day, day in and day out, then the need for the other side experts goes down.

The second thing, you need to really sit down with the media, as I said earlier, in a partnership, sit down and develop a strategy. In case of a true national emergency, how are we going to assess the information and provide the information? And that plan has not been worked out as we speak.

Mr. TIERNEY. I think we're talking about something that this current situation didn't have done, the administration didn't do, was single out somebody and put them in an authoritative position. Given what the Surgeon General said about not having any budget, his position almost being downgraded somewhat, amongst the four of you, who would that individual be in your estimation? Who should that individual be that takes the stand on health issues, public health issues in the Federal Government? Should it be the

Surgeon General or should it be the Secretary or what's your opinion?

Dr. SHINE. Well, I've made it clear in my testimony I think that the Secretary, for example, may be communicating with the public, but I think a credible medical public health expert has to be the individual to play that role. Because only under those circumstances will the public believe that it's getting effective medical public health information.

My colleagues have made reference to the Surgeon General. The Surgeon General would be an excellent choice, but I would argue that for certain kinds of problems it might be the Assistant Secretary of Health, who is a physician, if that position is filled. It could be the head of the CDC. It could be Anthony Fauci, whatever.

Mr. TIERNEY. Professional as opposed to political.

Dr. SHINE. The critical issue is, what are the attributes of that individual? What does that individual know? Can that person communicate? Can that person be credible?

As I indicated to Congressman Shays, we've got lots of data from our studies that individual can say we don't know all the answers and people will feel better that there is such an individual. But the problem is, if you don't have someone who has medical public health credentials, then there is always a doubt on the part of the public as to whether somebody who is an administrator or political appointee is the right person.

Dr. KOOP. It depends on who the person is and how careful he wants to be. I can assure you that many of the things that I said as so-called spokesperson for the government on AIDS went through Tony Fauci's mind and Jim Mason's mind at CDC before I ever said them in public. We talked about those and frequently met with the Vice President on the same issues.

Mr. TIERNEY. I just want to mention something aside on that. I first met you some years ago when you spoke at Salem State College up in Salem, MA, and you spoke on the subject of tobacco and the propensity of——

Dr. SHINE. That is unusual.

Mr. TIERNEY [continuing]. And the propensity of this government to support the export of tobacco. Even though we might be doing a better job in trying to diminish smoking in this country, we have started to export it and allow the export of it or whatever, and I just want to thank you for speaking out on that issue and continuing to do the good work that you do there.

Let me just conclude by asking one last question. You, Dr. Koop, said that we had no assurance that today's smallpox vaccine would be effective against the modern smallpox threat. Could you expand on that a little bit and tell us what we might do to counteract that problem?

Dr. KOOP. Well, the smallpox vaccine that we have was prepared against a smallpox virus that now has been frozen in Atlanta and supposedly Russia, but maybe many other places, for about 30 years, and there are two things that can happen. One is the virus can mutate, but the thing that is more likely to happen is that it can be tampered with biotechnology, so that maybe the vaccines we have would not be effective against the virus that we're going to meet.

Mr. TIERNEY. Is there anything we can do about that?

Dr. KOOP. I don't think there's a thing you can do about it until you know that is the situation, but then you've got to make new vaccine to cover that thing.

Mr. TIERNEY. So all of the vaccine that's being ordered up right now in today's papers indicate that there's enough vaccine to take care of the entire country, all of that may be ineffective?

Dr. KOOP. I don't know the details of that, but I don't know how they would get a terrorist version of a smallpox vaccine to work with.

Mr. TIERNEY. So are we wasting money?

Dr. KOOP. No. I think in the protection against terrorism of any kind, when it is all over, you're going to say we wasted a lot of money, but I think you have to waste the money, because it is the only kind of precaution and prevention that you can undertake. And when you think about the money, it is a pretty small amount of——

Mr. TIERNEY. Well, I guess I was thinking in terms of money and false sense of security for people, too.

Dr. KOOP. Yeah, well, the false sense of security might be secretly good for the panic that ensues, but I think you'd know pretty soon whether or not the vaccine worked, because if—as was explained to you today, you get one case, and you surround the patient and vaccinate the people that were in touch with them, and if they come down with it in 12 days, you know you haven't got an adequate vaccine.

Mr. SHAYS. Would the gentleman yield?

Mr. TIERNEY. Sure I'll yield.

Mr. SHAYS. Because it ties into a point. That was the old method, you kind of circle your suspects.

Dr. KOOP. It worked.

Mr. SHAYS. It worked, but it worked kind of in a rural—I don't know if it can work in Chicago.

Dr. SHINE. No. It was used in New York City in 1979 when there was a case of smallpox, and several million people were vaccinated.

Mr. SHAYS. How do you do it in an airport, that they contracted it in the Atlanta airport, and they went to 100 towns?

Dr. SHINE. Well, again, you have a—first of all, you don't become infectious until you've got the virus, that is until you've got pox, until you have the actual disease. So, I mean, somebody has to enter the country through Atlanta with a disease, and it has to be spread in some way.

Mr. SHAYS. I don't want to take the gentleman's time, but you—on record, you believe that still the best method is identify the potential candidate and encircle it——

Dr. SHINE. Because this is a key issue for the Gilmore Commission. We consulted with D.A. Henderson and Bill Fagey, both of whom were responsible for eradicating smallpox in the world. We consulted with people in public health and so forth. So it is not just my own opinion. This is opinion based on people who have very active experience with smallpox that is a feasible way to approach it.

The issue is—there are always ifs and ands about it, but the issue is balancing that against trying to immunize everyone where you know you're going to produce a certain amount of encephalitis,

and you're going to produce a certain amount of death. So you're trying to balance what is the risk/benefit.

Mr. SHAYS. Let me give the time back to——

Dr. SHINE. Could I just respond to you, Mr. Chairman? Two quick points I would make. One is in terms of the investment we make in the public health enterprise, we need a much better investment in vaccines and vaccine development that include—the anthrax vaccine is a lousy vaccine. It takes you 18 months, 6 shots at the present time to immunize somebody. You know, we can—there are reasons to believe that with a modest investment, we can genetically engineer P antigen, which is the effective antigen, and create vaccines, and then if we have the technology, if somebody comes up with an anthrax bacteria that has a different genetic makeup, which is what Dr. Koop was talking about, you've got a rapid ability to respond because you have the technology to make a new vaccine to a new antigen. And the same thing is true with smallpox.

But the other point I would emphasize, and this is again part of the Gilmore deliberations through the years, if you want—if you're a terrorist and you want to produce terrorist effects, you don't have to go to the highest technology to do it. I mean, it was box cutters on September 11th. It was envelopes with anthrax. With regard to smallpox, if you can get ahold of any of the existing stores of smallpox someplace, that is a terrible threat in and of itself. While engineering—bioengineering is important, and we need to prepare for it, we need to prepare for the greater probability, which is what if somebody gets it, it's the currently available pox, and therefore you want to be able to deal with it.

Mr. TIERNEY. I actually don't have any more questions, and that is actually intensive, because the information you all gave was thorough and helpful, and I want to thank everybody.

Dr. SHINE. Could I emphasize again, because my colleagues have brought up the law enforcement issue, the agriculture issue and so forth, when the Gilmore Commission assessed our country's preparedness, it said there had to be a place where all these came together, and you heard from Dave Satcher that he doesn't meet with people in Agriculture or the Justice Department. There has to be a place to bring those together, and that is why we think the role of health in the Office of Homeland Security is so critical to bring those various interfaces together, including communication.

Mr. TIERNEY. Well, I wish I could be more helpful with you there. I'll tell you, Chairman Shays has done a great job of bringing this to everybody's attention. We were having hearings on the need for a homeland security director and office long before others would pay any attention to this committee. The problem is that now that the President has appointed obviously a guy without a portfolio—and the real shame of this is that if you really look at what's going on, he has no direction, no legislative guidance, no portfolio at all, and a great reluctance that I still sense in this Congress to give that kind of authority and specificity and budget authority to cut across all those different agencies and be the one to draw them together with any authoritative basis. And I think we've got some work as this Congress to do and move in that direction. We've got several bills that are filed. We need to encourage this administra-

tion to stop saying that, oh, it can wait until next year or sometime down the line and move forward, and I know that Chairman Shays will keep moving on that issue.

Mr. SHAYS. Do all of you agree that office would make sense? I mean, would you recommend—I know you do, Dr. Shine, but would you, Dr. Akhter, Dr. Koop or Dr. Waeckerle?

Mr. WAECKERLE. If you remember in September 1999, we discussed this for a long period of time, and it was the consensus of all the State and local authorities who Attorney General Reno convened that was the single foremost problem in America. There was no central oversight management, and as a result——

Mr. SHAYS. As it relates to health care?

Mr. WAECKERLE. As it relates to all of the defense, to the strategy and specifically with public health and medical, as well as hospitals, because we were never able to have a coherent, collaborative plan that integrated those three important areas.

Mr. SHAYS. Dr. Koop.

Dr. AKHTER. Mr. Chairman, it is absolutely necessary that it be Homeland Security Office. Not for today, tomorrow, but for years to come this threat is going to be with us. But it does need its own budget and its own authority, and without its own budget and its own authority, we just have window dressing.

Mr. SHAYS. I'm talking more specifically about within that office, someone direct—we're trying to get the—the way they broke out the task, because I thought there was someone on—within the office——

Dr. SHINE. But it's second level, Congressman Shays. There's an associate director for prevention and so forth, and then a health person reporting to that individual, and that is never going to get the health issue to the level that I think it needs to be—deserves.

Mr. SHAYS. Dr. Koop, would you respond to this?

Dr. KOOP. I would agree with that entirely, and I think you have to—I don't like to run things by committee, but I named the most likely threats. I think there's got to be somebody representing agriculture, medicine, chemistry. We need probably eight people on a panel that—making this their own job.

Mr. SHAYS. Right. OK.

Dr. KOOP. Could I raise one other quick question?

Mr. SHAYS. Sure.

Dr. KOOP. A lot of people have said that the Surgeon General should be the person that we think about for the responsibility at hand. I would remind you that David Satcher will not be with us much longer, and the person who replaces him will be a very key person in the next administration. Having been through it myself, I can tell you that you don't walk into that job 1 day and know how to do it the next, and I would hope that somebody could influence the appointment of a person who knows something about what we've been talking about rather than be a political appointment.

Mr. SHAYS. OK. That's very important. I think the same thing applies even to the Homeland Security Office themselves. I was not eager to see Governor Ridge be a spokesperson early on, because there's such a steep learning curve, which we all knew he had to have, anyone in that position, and so I was very concerned the

press wanted to hear from him right away, forcing him to speak on health care issues, on defense issues and so on.

Lots we could talk about. We have a vote, and I'm not going to keep you. Is there anything——

Mr. TIERNEY. No. Thank you.

Mr. SHAYS. You—this has been an excellent panel, and it's—we've learned a lot, a tremendous amount. Is there anything that any of you want to say in closing before we go?

Dr. SHINE. Just to reinforce the notion that when we recommended an office in the executive branch for home security—we didn't use that term—we said that individual should be confirmed by the Senate and should have budgetary authority, because we just don't see—and I think Mohammad has emphasized this. Getting the agencies to work together, you've got to have some kind of leverage, and I don't think you can give them the budget—the budget can't be that big that it covers all of the areas. Therefore, it has got to have authority to work with the OMB and say if you're not cooperating, if you're not collaborating, if you're not—there's a stick; there's some penalty if you don't do that.

Mr. SHAYS. I think Mr. Tierney and I disagree a bit on this, and so I'd be happy to have him respond, but my view right now is the President has combined the Gilmore and the Hart-Rudman Commissions. In one sense, he has given it a Cabinet level, but he hasn't made it a department. You don't have a homeland security. But he's given Ridge the opportunity to write his job eventually, and he's already said, you know, he's going to probably suggest there be a homeland area.

And in terms of the budget, I just have to say, if anybody crosses Ridge, they're crossing the President of the United States. And so I know eventually the budget is going to matter, but right now, I mean, if you cross Ridge, it's going to get to the President right away. Their offices are next door, and you're mincemeat.

Dr. SHINE. That is absolutely true right now. The question is—Mohammad said it well—this is a long-term problem, and what is going to happen a year from now, 2 years from now.

Mr. SHAYS. And I think he's going to get his way, which is also what I'd like to see happen. I think it's going to happen.

Any other comment?

Mr. WAECKERLE. Yeah. I'd like to thank you for the opportunity to be here, and I'd like to close with the following remarks for you to consider. Biologic terrorism, in my opinion, has the potential to be the doom of mankind. Now and into the future, especially as we get into bioengineering genetically designer—designed bugs, because the State-sponsored—the State-supported, the States and the local nuts and zealots of the world, because of the technology today and the information available today, will be able to carry out terrorism against us. And I think that it requires an appropriate strategy and response, as you all know and we've discussed today.

And there's one major fault that I believe we need to focus on, and that is the critical human infrastructure and the response to biologic terrorism in this country will occur in the local community, and it's the triumvirate of health care professionals, public health and hospitals, and to date, despite numerous committee hearings and much writing and rhetoric, the local community and those key

players have not been integrated or coordinated with any national programs, and they have no input. And I hope that when we talk about communication with the public and crisis communication, we remember that many of us believe that the communication between the Federal family and the local and State partners that we have in this war has been neglectful, and it needs to be greatly improved.

Mr. SHAYS. I thank you for that. There's a minicrisis, a tiny crisis that we're going to have a vote in 4—5 minutes. So, I mean, it's in the process. We have 5 minutes left. Thank you all very much. Wonderful job. This hearing is closed.

[Whereupon, at 12:29 p.m., the subcommittee was adjourned.]