Statement Before The Senate Committee On Governmental Affairs And The Subcommittee On International Security, Proliferation, And Federal Services

"Terrorism Through The Mail: Protecting Postal Workers And The Public."

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Mr. Chairman, and distinguished Members of this Joint Committee, it is an honor and a privilege to come before you this morning for the purpose of shedding light on the events of the last week and a half. I am Doctor Dan Hanfling, a board certified emergency physician practicing in the Department of Emergency Medicine at Inova Fairfax Hospital. I am Co-chairman of the Inova Health Systems Emergency Management and Disaster Preparedness Task Force, and have had extensive experience in the delivery of out-of-hospital emergency medical care, including disaster scene response, most recently at the Pentagon with the FEMA National Urban Search and Rescue Response System.

In the post-September 11th world, it is clearer than ever that many elements of our

'newest' war will be fought in ways never previously imagined. Many of the battles will be waged, quite literally, right here at home. The eruption of a public health crisis from anthrax-contaminated mail has demonstrated beyond a doubt that the front line in this war is our hospitals and their emergency departments. With hardly a moment to collectively catch our breath in the wake of the events of the second week of September, the medical community has been thrust front and center in the response to multiple cases of cutaneous and inhalation anthrax during the month of October. What we all hoped was a case of natural outbreak of disease was quickly proven to be the deliberate work of terrorists. And what we hoped would be limited to one work site quickly spread to multiple targets across three metropolitan regions.

Actions Taken by Federal, State and Local Public Health Agencies

On the afternoon of October 20, 2001 I was called with the information that a United States Postal Service employee who works at the Brentwood Postal Facility in the mail-handling room was admitted to Inova Fairfax Hospital following a comprehensive emergency department diagnostic evaluation. Although confirmation of the inhaled form of anthrax was still pending, and the Centers for Disease Control and Prevention (CDC) had already dispatched a superbly capable epidemiologist to interrogate and evaluate this patient, there was no question in anyone's mind just what this gentleman had come in with. In the words of Doctor Thom Mayer, the Chairman of the Department of Emergency Medicine, and Doctor Cecele Murphy, who made the diagnosis, this man's blood was "crawling with anthrax." With a sense of urgency appropriate to the gravity of the situation, hospital administrators and key clinical decision-makers conferred by way of hourly conference calls. This was primarily meant to keep abreast of the fluid situation and craft a plan of action, especially a medical plan of action. Those new to the field of crisis management naively assumed that all would be made clear by "soon-to-be-released" guidelines coming from the CDC. But such information was not readily forthcoming. In fact, as the crisis unfolded, the stream of information continuously appeared to be moving in a unidirectional flow. The CDC was requesting and receiving clinical and epidemiologic data. But the return of information to the people who needed it the most in order to take care of this patient -- and then his colleagues, and the many thousands of postal employees at risk for contracting this disease -- simply did not happen in a timely fashion. I am aware of daily conference calls occurring between representatives in the State of Virginia Department of Health and their counterparts in the CDC, but the results and conclusions of such discussions did not filter down quickly enough to the hospital and medical communities. From some very frank discussions that I had with my counterparts in the District of Columbia and within the State of Virginia Department of Health, it was clear from the very beginning that

the CDC was perceived to be in charge of the unfolding situation. In addition, the local health department took some time to find its position and voice in this developing story. What is so ironic is that if this were a major snowstorm barreling up the East Coast, we would get so much more information than we did this past week, and in large part because a mechanism for conveying that information would have been utilized.

Coordination of Federal, State and Local agencies with the medical community

It became readily apparent that a lack of coordinated communication and inconsistent leadership from the top was hindering the ability of the medical community to respond in a coordinated fashion to this crisis. This was further exacerbated by the geographic and jurisdictional boundaries that separate the National Capitol Region into its constituent parts – the District of Columbia, the State of Maryland and the Commonwealth of Virginia. The conference call mechanism initiated by Inova Health Systems on October 20th soon expanded to include participants from hospitals all across northern Virginia. Along with a handful of my colleagues, we created an operational entity that was designated the Northern Virginia Emergency Response Coalition, comprised of key decision makers from the hospitals and including representation from the local and State public health departments. In doing so, we attempted to create a clinical consensus with respect to the evaluation, treatment and management of patients presenting to hospital emergency departments with the concern of anthrax exposure. In support of this effort, Inova Fairfax Hospital stood up its Disaster Support Center, which served as a real-time communication link for the northern Virginia hospitals. Simultaneous with these efforts, much the same was being done in the District of Columbia through the excellent leadership provided by the District of Columbia Hospitals Association (DCHA). In fact, hospital and public health representatives from both the States of Maryland and Virginia increasingly populated the DCHA conference calls. These calls were as close as we came to approaching a semblance of coordinated communication. But even these shared telephone calls were no substitute for a professionally managed Emergency Operations Center (EOC) that has the capacity for providing sophisticated communications support and timely information management. Politics got in the way of effective consequence management, as evidenced by the fact that the five patients from Brentwood showed up for treatment at hospitals across the region – in the District, in Maryland and in Virginia – yet the Mayor and the State Governors never once discussed this crisis together in public. In fact, I do not believe the Director of the District of Columbia Department of Health spoke to anyone from Inova Fairfax Hospital until Thursday night when we sat together to do a television interview, five nights after the first patient had been

admitted to my hospital. By no means was this an omission of purpose. It most likely occurred because no formalized mechanism was solidly in place to facilitate such a discussion.

Training for Bioterrorism Response by Emergency Department Staff

Some of these failures may be due to a lack of understanding of the expectations and roles of public health officials in such an emergency. Some of these shortcomings can be offset by proper preparation. As an example, training emergency department staff and other members of the medical community in the recognition of the use of bioterror agents must now be given the highest priority. Previous training efforts have been very limited in scope and reach. The American College of Emergency Physicians, supported by a grant from the Department of Health and Human Services, evaluated the barriers to effective training in the medical response to nuclear, biological and chemical incidents. These were primarily found to be a lack of adequate funding and time constraints due in part to personnel shortages. Yet, what this last week has taught us more than anything else, as did the outbreak of West Nile Virus before, is that clinical determination of biological terrorism will be recognized first by a cautious, astute clinician, well-versed in the possibilities of bioweapons use. In fact, while we have discussed certain failings in the public health system, it should now be quite clear that the front lines in this war are our emergency departments, even more so than the public health agencies. Federal efforts to address such existing deficiencies should take this matter seriously into consideration.

Recommendations and Lessons Learned

There is a lot of work yet to be done with respect to 'all-hazards' disaster planning and preparedness. I cannot emphasize enough the fact that such preparation must take a systems approach in order to be able to address whatever the next threat may be. And financial support for these efforts must be focused on emergency departments and the hospitals that will diagnose and treat the next victims. Surveillance systems, for example, while they have their role, will not replace the doctors and nurses in the trenches who make the diagnoses and treat the patients. What follows are the absolute needs that hospitals require in order to effectively face these new threats.

An enhanced communication mechanism and protocol that allows for coordinated sharing and discussion of essential information in real time across jurisdictional and geographic boundaries.

Improved integration of federal experts into the local organizational structure, and delivery of their message in a consistent and timely manner.

Development of local stockpiles of essential medical supplies and equipment in the event that the next outbreak occurs simultaneously on multiple fronts, thereby delaying the delivery of federal assets, or diluting the amount available to be distributed.

Funding for fixed cost items such as decontamination capabilities and personnel protective equipment that may be required by hospitals in order to meet the threat of unconventional terrorism.

Financial support for training and education of healthcare providers in the evaluation, diagnosis and management of the new threats that threaten the well being of our nation's public.

The accepted means of declaring an escalating situation a 'disaster' are straightforward. This occurs when local resources are outstripped such that Federal assistance is required. Implementation of the Federal Response Plan, in turn, clearly designates the appropriate lead federal agency to handle the crisis. With that in mind then, it is hard to understand how it came to pass this week that the CDC took the lead in responding to this crisis. As we attempted to do in Northern Virginia, the healthcare community, including the local county health department, became increasingly coordinated in developing and executing a response to the unfolding situation. Ideally, the CDC, and the United States Postal Service (USPS), with its ability to contact its employees, should have served more in a consulting role, giving back information to the public and to the medical community. However, this communication was slow in coming and often lacking in definite authority. In order to be truly effective, these efforts must instill confidence, and the message must be consistent and clear.