

EXECUTIVE SUMMARY

Our American Medical Association (AMA) has demonstrated great capacity to act across a wide spectrum in response to the attacks on 9/11/01 and the subsequent bioterrorism events. Immediate activities included development of a comprehensive Web presence for clinicians and the public; outreach to and involvement of the Federation, and collaboration with both federal and private sector agencies; communications through press releases; and personal representation by AMA officers. This crisis demonstrates the need for a sustained, comprehensive medical response to disasters, both inflicted and natural. The Board of Trustees heard eloquent presentations during its last meeting about the need for the AMA to act decisively in this area, and to collaborate actively with the Federation in the process. The Subcommittee appointed to study the issue proposed a two-pronged approach: initiatives to be accomplished during 2001, including activities at the Interim Meeting; and a sustained set of initiatives over the long-term.

The long-term initiatives should focus on partnering with public and private groups to accomplish the following core functions:

- Creating a reliable and open link between the physician and the public health system, extending from national to local levels;
- Creating a truly functional emergency response system;
- Educating physicians across the continuum, including undergraduate, residency, and continuing physician professional development;
- Educating our patients and the public.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 26-I-01

Subject: AMA Leadership in the Medical Response to Terrorism and Other Disasters

Presented by: Timothy T. Flaherty, MD, Chair

Referred to: Reference Committee D
(Lila S. Kroser, MD, Chair)

1 The unprecedented tragedy of the terrorist attacks September 11, 2001 and the subsequent
2 bioterrorism events present our American Medical Association (AMA) with the obligation to
3 respond to physicians and the organizations that represent them, to our national partners in the
4 public and private sectors, and to the public—our patients.
5

6 There are truly historic responsibilities for our AMA in helping to lead the response to terrorism
7 and disaster preparedness. If national security is dependent to a significant degree on the
8 scientific, medical, and public health community's actions, then the country will be relying on the
9 entire healthcare system perhaps as much as or more than it has relied on the armed forces to
10 achieve and maintain that security in the past. This system is almost entirely within the private
11 sector. That is going to require monumental organization of all of the principal parts of the
12 healthcare system: physicians, hospitals, other health care disciplines, the public health offices,
13 medical schools and those who pay the costs of the response. Our AMA must step forward first
14 with the most responsible and effective approach to address this task.
15

16 Who is better suited to suggest the approach, enlist the other major segments of the system to
17 participate in the creation and management of the response, and lead the physician segment of the
18 system than our AMA? Compare this opportunity with the historic contributions of the AMA in
19 establishing standards for medical education, helping to found what is now the Joint Commission
20 for the Accreditation of Healthcare Organizations (JCAHO) or performing the functions of the
21 FDA before that agency was established. Due to the leadership of the Council on Scientific
22 Affairs (CSA), the editorial choices of the *Journal of the American Medical Association (JAMA)*
23 editors, and the experience of current AMA employees, the Association is well positioned to act
24 across a broad spectrum.
25

26 We must also be aware that, as President Bush said, it is time to get back to “business as usual,”
27 and that includes the practice of medicine. While our response to this disaster is vital and must be
28 addressed, other key areas of our nation’s health cannot be neglected. Access to health care,
29 ongoing issues of preventive medicine and public health, violence prevention, standards
30 development and improved quality of medical care delivery, health advocacy, communications,
31 and our involvement in medical education are but a few of the issues in which our AMA has
32 historically been engaged. The health of the public goes far beyond any single item of concern,
33 and our efforts must reflect the entire landscape of health and health care, putting the current
34 drama into appropriate context.
35

Action of the AMA House of Delegates 2001 Interim Meeting: Board of Trustees Report
26 Adopted as Amended in Lieu of Resolutions 408, 412, 413, and 418, with title change,
and Remainder of Report Filed.

1 This report will examine the issue in three sections: past activities of the Association, including
2 the immediate response to the 9/11/01 disaster and the subsequent bioterrorism events; current
3 actions under way to meet the challenges; and the need for future effort.

1 I. Past Activity

2
3 AMA policies related to terrorism and disaster preparedness have been shaped by contemporary
4 events, ranging from informing the Executive and Legislative branches of government (as well as
5 physicians and the public) on the medical consequences of nuclear war, to condemning the use of
6 chemical, nuclear, and biologic weapons: Policies H-520.997 (BOT Rep DD, I-81); H-520.992
7 (Res. 175, I-89) and H-520.999 (Sub Res. 82, A-81) (AMA Policy Database). In 1968, our AMA
8 advocated for the reinstatement of the Medical Education for National Defense (or MEND)
9 program. This program, begun in 1952 at the request of a joint committee of the AMA and the
10 AAMC, was instituted to improve the training and motivation of medical students with regard to
11 military and disaster medicine. It continued until 1967 at which time its appropriation was
12 eliminated.

13
14 Historically, our AMA has supported collaboration with the Department of Defense to explore
15 ways in which we could cooperate to assure the nation's medical preparedness in the event of a
16 national emergency (Policy H-130.994, Res. 85, I-80), and our AMA supported implementation
17 of the current National Disaster Medical System (Policy H-130.979, BOT Rep Q, I-86). As the
18 nation's attention shifted from nuclear to chemical and biologic scenarios, our AMA's attention
19 also was directed to these potential weapons.

20
21 Over the last 2 years, a variety of activities and 5 reports of the AMA's Council on Scientific
22 Affairs (CSA) have focused on ways in which organized medicine can become more intimately
23 involved in disaster preparedness for bioterrorism, and other weapons of mass destruction.

24
25 In February 1999, the CSA invited Major General John Parker, Medical Corps, United States of
26 America, the commander, US Army Medical Research and Materiel Command; Scott Lillibridge,
27 MD, of the Centers for Disease Control and Prevention, and Joseph Waeckerle, MD, a physician
28 active in the bioterrorism field within the American College of Emergency Physicians to appear
29 before the Council. Over a 3-hour period, these individuals discussed with the CSA the various
30 issues related to bioterrorism.

31
32 At the 1999 Annual Meeting, the CSA co-sponsored a forum on bioterrorism preparedness in
33 conjunction with the Section Council on Federal and Military Medicine. The CSA also submitted
34 its first policy report— Report 4 of the Council on Scientific Affairs, "Organized Medicine's
35 Role in the National Response to Terrorism." (A summary of all the CSA reports on terrorism is
36 presented in the Appendix.) Additionally, the Council formed a Bioterrorism Subcommittee to
37 help direct activities in this area. Current members are Scott D. Deitchman, MD, MPH (CSA
38 Chair-elect, and a public health service officer at CDC), Mary Anne McCaffree, MD,
39 J. Chris Hawk, MD, and Melvyn L. Sterling, MD.

40
41 In February 2000, the CSA participated in a regional meeting on Bioterrorism Preparedness
42 convened by the University of San Diego College of Medicine, San Diego County, and the Johns
43 Hopkins Center for Civilian Biodefense Studies. Council member Scott Deitchman represented
44 the AMA on a panel discussion.

45
46 At the 2000 Interim Meeting, Doctor Deitchman presented information on this topic to the
47 Medical Student Section. The CSA also submitted CSA Report 11 "Medical Preparedness for
48 Terrorism and Other Disasters."

1 In March 2001, Doctor Deitchman and James Lyznicki, MS, MPH, of the AMA staff represented
2 the CSA at the “Advisory Panel to Assess Domestic Response Capabilities for Terrorism
3 Involving Weapons of Mass Destruction” (also known as the "Gilmore Commission" for its
4 Chair, Virginia Governor James Gilmore, III). The Gilmore Commission's prominence in
5 Washington has considerable potential to promote AMA participation in disaster planning and
6 emergency response efforts. The Commission was intrigued by the concept of a public-private
7 entity (as recommended in CSA Report 11, I-00, see below) that could enhance physician and
8 community preparedness and response, and by the potential value of the Federation infrastructure
9 for dissemination, education, and advocacy efforts. The third and final report of the Commission
10 will address medical and public health response capacity, including possible recommendations for
11 AMA involvement. The report was scheduled for release in December 2001 but may be available
12 sooner. It is expected to support the AMA’s adopted recommendations from CSA report 11.
13

14 At the 2001 Annual AMA-OMSS Assembly Meeting, Brigadier General Richard Ford, US Air
15 Force, presented a 1.5 hour program, “Bioterrorism (Part 1): The Potential for Attacks and
16 Readiness Strategies.” The seminar covered the potential for and nature of the threat of
17 bioterrorism; the implications for physicians, hospitals, communities, and the public; and
18 readiness strategies. Doctor Deitchman also spoke to the Section on Medical Schools educational
19 program at the 2001 AMA Annual Meeting. He gave a description of the various forms of
20 bioterrorism and described appropriate responses to the attacks focusing on the critical role of
21 physicians and gave suggestions for medical student education.
22

23 The recommendations of CSA Report 11 (I-00) were adopted by the House of Delegates (HOD).
24 The report asks our AMA to:

- 25
- 26 1. Call for the creation of a public-private entity (including federal, military, and public health
27 content experts) that, collaborating with medical educators and medical specialty societies,
28 would:
 - 29 • develop medical education curricula on disaster medicine and the medical response to
30 terrorism
 - 31 • develop information resources for civilian physicians and other health care workers on
32 disaster medicine and the medical response to terrorism
 - 33 • develop model plans for community medical response to disasters, including terrorism
 - 34 • address community physician reporting of dangerous diseases to public health authorities
35

36 As currently envisioned, the public-private entity would be comprised of a core set of key
37 participants, including the AMA. The core group would identify specific tasks designed to
38 enhance local preparedness and response, including educational components, and then would
39 engage the necessary additional participants in order to accomplish relevant goals. Activities
40 would focus on bridging the gap between the local incident and mobilization of federal resources.
41 Creation of the Office of Homeland Security to coordinate all federal response agencies does not
42 mitigate that potential value of this concept, which ultimately would serve to more efficiently
43 integrate local response with existing federal components.
44

- 45 2. Encourage the Federation of Medicine to become involved in planning for the medical
46 component of responses to disasters, including terrorism, at levels appropriate to the
47 Federation component and by working through the Federation of Medicine develop a
48 mechanism for coordinating disaster/terrorism planning and response activities that involve
49 more than one component medical society.

- 1 3. Encourage the JCAHO and state licensing authorities to include the evaluation of hospital
2 plans for terrorism and other disasters as part of their periodic accreditation and licensure.
3

4 AMA/CSA contact with appropriate sections at the Centers for Disease Control and Prevention,
5 the Department of Defense, the Office of Emergency Preparedness (OEP) and the Federal
6 Emergency Management Agency (FEMA) has been established and continues.
7

8 Our immediate response to the events of September 11 occurred in several ways.
9

- 10 • Contact with HHS/CDC began very quickly to determine the level of response that might be
11 needed in communicating more widely to the Federation, our members, and physicians at
12 large. Similarly, contact with the Medical Society of the State of New York was established
13 very soon after the attack.
14 • Communications created a mechanism for gathering names of physician volunteers to assist
15 in the response, if needed. The call for assistance was answered by more than 3000
16 physicians and other healthcare professionals. The list of volunteers was sent to HHS along
17 with samples from our Physician Profiles, as examples of information that could be provided
18 upon request.
19 • A Web presence on terrorism/disaster response was designed to provide resource materials
20 for physicians and the public, and was first updated and maintained by Communications and
21 then transferred to Professional Standards. Your elected leadership and staff in several areas
22 have answered hundreds of calls from the media, physicians and the public.
23 • Communications handled scores of media queries. Responses were placed on a nationally
24 broadcast segment with ABC News, and the Associated Press, *Washington Post*, *Chicago*
25 *Tribune*, *Los Angeles Times*, *National Journal*, *Cleveland Plain Dealer*, *New Jersey Star*
26 *Ledger*, among others. Since the early days after 9/11/01, AMA officers and Trustees have
27 appeared on several CNN broadcasts, and have done other national and large metropolitan
28 interviews.
29 • Our advocacy team kept the Executive and Legislative branches of the federal government
30 appraised of the clinical and public health implications on an ongoing basis.
31 • Stories and updates for members and Federation executives were produced in:
32 “AMA/Federation News,” “AMA E-mail News Briefs” and the “AMA For You” page in
33 *AMNews*. The House of Delegates was informed about AMA activity through the monthly e-
34 mail letter from the AMA Board Chair.
35 • The *AMNews* President's Column and the Chairman's Column covered the AMA response to
36 terrorist attacks.
37

38 **II. Current Response to the Disaster**
39

40 Our AMA has begun several initiatives to meet the challenges of this crisis:
41

- 42 • The Board Chair met with HHS Secretary Thompson on September 28, 2001, beginning our
43 discussions with the agency about cooperation in medical disaster response. The National
44 Medical Association, the American Hospital Association and the Federation of American
45 Hospitals also participated in that meeting. The Board Chair also participated in a press
46 conference November 1, 2001, with bipartisan Senate leaders to discuss the AMA's efforts
47 to educate and prepare physicians and patients for bioterrorist attacks. Hundreds of
48 interviews and comments by members of the Board have taken place, in many venues.

- 1 • The AMA cosponsored with CDC and the American Hospital Association a satellite
2 broadcast and webcast of information for clinicians on diagnosing and treating anthrax.
3 Federation Relations ensured that physicians were quickly notified of the broadcast.
- 4 • The Speaker of the House of Delegates and AMA staff began efforts to use the 2001 Interim
5 Meeting as a platform to continue our educational efforts on these subjects. Science,
6 Communications, Federation Relations, and other units have prepared for this aspect of
7 AMA's role as the educator of physicians on bioterrorism.
- 8 • An information packet is available for all Delegates and Section representatives at I-01.
9 These include information from the Web site, educational material from several sources that
10 address the issues of general terrorism and bioterrorism, key contact information for both
11 federal and state agencies, model disaster response plans, and other resources. The goal is to
12 provide delegates with an action packet that they can take back to their states and counties
13 and encourage participation in disaster planning in their individual areas.
- 14 • Our Internet presence on this issue has been a national and international resource.
15 (www.ama-assn.org/go/DisasterPreparedness) Updated daily with pertinent AMA policy,
16 recommendations, and links to many private and federal sites, this Web presence will be a
17 great asset to both physicians and patients who are concerned about these issues. An icon on
18 the Home Page directs visitors to the disaster preparedness section. We posted recent journal
19 articles (including one entire "theme issue" on the subject) from *JAMA* along with a series of
20 CSA reports and CDC links, and as a result, the AMA has the most current clinical and public
21 health information available on the Internet.
- 22 • A memo to the Federation leadership encouraging their involvement in disaster response and
23 preparedness was sent out, followed by a survey of the Federation asking what the AMA can
24 do to assist states in responding to the disaster. The Federation was also asked to share their
25 programs and educational material so that all could benefit from those projects. A "resource
26 area" is available at this Interim meeting to view Federation material.
- 27 • Ethics Standards, in consultation with CEJA, will draft the "Declaration of Professionalism:
28 Medicine's Social Contract with Humanity" to recognize the unique legitimacy and role of
29 physicians and set forth the obligations that bind them together in fulfilling the profession's
30 social contract with humanity for review by the Board of Trustees and will coordinate a
31 national response to the ethical issues of medical triage under overwhelming conditions.
- 32 • The thousands of volunteer physicians who answered the AMA's call to action have been
33 personally contacted with our thanks. A follow-up letter to the volunteers gave them
34 information about local and state disaster efforts and urged their involvement in this arena.
- 35 • The Office of the General Counsel (OGC) and others are ready to update a preexisting (from
36 the Gulf War) summary of rights of reservist physicians called to active duty. Other
37 information for physician reservists has been placed on the Web site.
- 38 • The OGC is ready to undertake a 50-state survey of "Good Samaritan" laws (providing
39 limited immunity from legal liability for negligent medical care provided during an
40 emergency) and expedient recognition of licenses from other jurisdictions in order (i) to have
41 a ready reference tool in the case of inquiries and (ii) identify areas for possible improvement
42 (e.g., states with no such statutes and/or a possible model "uniform" state statute). Federal
43 legislation to accomplish this process is being explored.
- 44 • At the 2001 AMA-OMSS Interim Assembly Meeting, Doctor Tara O'Toole, Johns Hopkins
45 Univ. Center for Civilian Biodefense, will present "Bioterrorism (Part II): Preparing for and
46 Responding to Attack." Physicians will learn the signs and symptoms of a bioterrorist attack;
47 immediate response strategies; the role and responsibility of the medical staff and the
48 hospital; and how to develop a local readiness plan. Doctor O'Toole will also address the
49 Medical Student Section.

- 1 • Doctor Brian Johnston, At-Large Member of the AMA-OMSS Governing Council and an
2 emergency physician, has drafted a planning tool that medical staffs can use to organize their
3 hospital response for bioterrorism. OMSS plans to discuss this resource at the Interim
4 meeting, and coordinate with the CSA and other AMA units.
- 5 • The CDC is developing “fact sheets” on the disaster issue to distribute to local health
6 departments through its Health Alert system. AMA will disseminate these (and other
7 pertinent CDC releases) to Federation members.
- 8 • The AMA Division of Continuing Physician Professional Development is creating a
9 centralized site of resources for those who wish to implement continuing medical education
10 (CME) activities in this area. Topics include disaster preparedness, the physician role in
11 disaster management, the recognition and management of infectious diseases as a result of a
12 bio-terrorist attack, the physician’s obligation to the community in the event of a terrorist
13 attack, and others.

14
15 **Options for Further Action**

16
17 As the leading voice for physicians, the AMA will determine how to fashion a unified response
18 from organized medicine and the nation’s physicians. Physicians and organized medicine have a
19 distinct, crucial role to play in the nation’s response to disasters. The effort required by the
20 medical community, just like the President’s determination to bring terrorists to justice, will need
21 to be multi-faceted, broad-based, and put in place with a long-term approach. No quick fixes are
22 apparent. Our AMA and the Federation will meet its responsibilities and stand united with all
23 other sectors of our society to respond to this new challenge. One of the chief areas in which
24 planning and new activity is needed is in filling the “gap” that exists between the time of a
25 disaster, whether from natural or intentional causes, and the time that state and federal response
26 teams arrive.

27
28 **Ongoing activities**

29
30 **Partnerships**

- 31
- 32 • The AMA will continue its outreach to the Federation, providing information, linking groups
33 that have common issues, and providing checklists and references, all of which are excellent
34 resources to our colleagues, both geographic and specialty.
 - 35 • Links with the CDC and other appropriate governmental agencies will continue for
36 information gathering and sharing, and the AMA will continue its service as a conduit for
37 CDC bulletins and other resources.
 - 38 • The AMA will discuss issues of disaster preparedness and response with other private sector
39 groups such as the JCAHO, the AHA, the disaster relief organizations such as the Red Cross,
40 ensuring that we are active partners at all levels.
 - 41 • Science staff have coordinated much of the clinical and public health outreach and liaison
42 activities to date, and will continue contacts with CDC, medical specialty societies, hospitals
43 and public health departments, and related groups to obtain the most current information
44 available for physicians and patients. Model plans for disaster preparedness, information on
45 recognition, diagnosis, and treatment of biologic agents of mass destruction will continue to
46 be gathered and communicated.

1 Advocacy

- 2
- 3 • The AMA will exert its considerable influence among existing groups that define standards
4 for education, consortia for quality improvement in practice, and both public and private
5 health care organizations to raise the priority of bioterrorism and medical disaster response.
6 Properly coordinated, our representational influence can ensure that the right issues are under
7 discussion and that health care groups have the appropriate information for decision making.
 - 8 • The AMA will advocate for adequate staffing and funding for the new Office of Homeland
9 Security so that it can coordinate the needs of medical disaster response. HHS agencies, state
10 and local health departments, hospital emergency response systems, and municipal response
11 systems should be targets for increased funding, as part of our ongoing efforts to improve the
12 public health infrastructure. The AMA should also call for increased stockpiles of vaccines
13 and antibiotics, increased research, and an expanded industrial base to insure the production
14 of new antiviral and antibiotic treatments.
 - 15 • Our advocacy units and the State medical societies should explore the status of “emergency”
16 licensure, liability issues, and hospital privilege issues during emergency situations for
17 physicians who may wish to volunteer across state lines. Model legislation will be developed
18 for states that wish to pursue these options.

19

20 Education

- 21
- 22 • The CSA has been a leader for American medicine in the issue of bioterrorism, providing a
23 pathway for addressing disasters and their medical response, regardless of the origin. The
24 Council’s current strategic plan continues this effort, which should be supported.
 - 25 • The Web site on disaster medicine is an excellent resource. Besides general information on
26 disaster preparedness and many links to public and private resources, the AMA has provided
27 articles from JAMA and the work done by the CSA, making the site a superb clinical
28 reference as well. Additional material that is produced both internally and externally will be
29 incorporated into the Web site as appropriate. The appearance of the Web site will be
30 strengthened, enhanced, and the site will be made more user-friendly.
 - 31 • Our Medical Education Group will lead efforts on the medical response to disaster and
32 bioterrorism across the continuum of medical education: undergraduate, graduate, and
33 continuing education.

34

35 Communications

- 36
- 37 • An informational packet will be available for all delegates at the 2001 AMA Interim Meeting.
38 This will include information from the Web site, an updated summary of the CSA reports,
39 key information for specialty and state societies, and other resources.
 - 40 • Two video news releases containing valuable, up-to-the-minute information on relevant
41 health and medical issues will be prepared and distributed.
 - 42 • A public service announcement will be produced, featuring AMA leaders speaking calmly to
43 America’s public—our patients—to moderate the fear aroused by lack of definitive
44 information and providing highly useful medical and health perspectives on these issues.
 - 45 • Articles in *AMNews* on the subject will continue to be crafted.
 - 46 • Basic information for physicians to share with patients can be created and distributed through
47 our Federation links and other communications vehicles.
- 48

1 **Future initiatives**

2
3 Our AMA has proven that we can respond to a crisis. We can divert resources and attention in an
4 amazingly rapid fashion. For long-term policy, education, and communications development, a
5 combination of external funding through contracts and grants, and internal resource development
6 could be used. Additional capacity and dedicated personnel in several areas of the AMA would
7 be required to carry out many of these activities, should they be chosen for action.

8
9 The following initiatives are being considered, and could be implemented following further
10 discussion, assuming appropriate funding is secured.

11
12 A sustained organizational responsibility for Disaster Medicine and Emergency Response

13
14 Specific activities for the AMA to maintain and sustain the disaster preparedness response will
15 involve coordinating efforts of multiple units within the Association, including Science,
16 Federation Relations, Communications, Advocacy, Medical Education, International Medicine,
17 and the OGC. The following are examples of potential activity:

- 18
19 • Convene federal planners (OEP, FEMA, HHS/CDC) to discuss how a potential joint effort
20 could help support existing programs and build new capacity. The “public-private entity”
21 called for in CSA Report 11 (I-00) and prospectively endorsed by the Gilmore Commission is
22 a key area for development. A “memorandum of understanding” between the AMA and the
23 appropriate federal agencies is one vehicle through which such a partnership could occur.
24 While the AMA would not necessarily house this entity, we should develop and propose its
25 mission, structure, and function, and should be an integral part of its governance. Our office
26 would staff the AMA involvement in this new initiative.
- 27 • The AMA could develop a joint outreach with HHS to the Association of State and Territorial
28 Health Officials, the National Association of County and City Health Officials, the American
29 Public Health Association, state and local medical societies and public health departments to
30 develop a model, comprehensive local plan to respond to bioterrorism.
- 31 • Expanding the AMA-APHA initiatives on Medicine and Public Health could create a reliable
32 first line of defense to counter a disaster. The interface between the practicing physician and
33 the local health department is crucial in this effort. This project will be energized quickly and
34 serve as a fulcrum to improve disaster response standards and effectiveness.
- 35 • Partnering with the OMSS, the American Hospital Association, the American College of
36 Emergency Physicians, and the JCAHO would facilitate the patterns and standards for the
37 community, thereby strengthening the current hospital requirements for disaster response to
38 include bioterrorism. Parallel partnerships would be established within communities, led by
39 the medical societies and hospital boards. In this fashion, the community response to
40 disaster, with the local hospital at its hub, can be enhanced to meet the needs of the day.

41
42 Education initiatives

43
44 We should determine the level of education that physicians need and want in this area, including
45 ethical and community responsibilities, and help provide it. The entire spectrum of medical
46 education needs to address the subject of disaster preparedness and the response to bioterrorism.
47 The AMA has a unique role and influence in medical education, with particular credibility in
48 continuing medical education (more recently called continuing physician professional
49 development). The AMA can work towards including these topics in undergraduate, graduate,
50 and continuing medical education through AMA representation on the accrediting bodies in

1 collaboration with the American Osteopathic Association, the National Medical Association, the
2 American Association of Medical Colleges, the Council of Medical Specialty Societies, the
3 American Board of Medical Specialties, and the American Hospital Association.

- 4
- 5 • Graduate medical education should include specialty-specific learning to respond to natural
6 or man-made disasters. Through the 26 Residency Review Committees, our partners from
7 the specialty societies and the ACGME can do much in this area.
- 8 • Physician guidelines can be developed for prevention, diagnosis, and treatment in biological
9 and chemical attacks, distributing these on CD-ROM to the nation’s physicians.
- 10 • Our AMA could co-host a national (and perhaps annual) conference on bioterrorism with
11 HHS, seeking outside funding to establish the conference Secretariat at the AMA.
- 12 • Regional conferences offering continuing medical education for physicians could be
13 developed and produced, with outside funding. Medical specialty societies will be an
14 important resource, and could offer their own sessions at society meetings on relevant topics.
15 Experts in emergency planning, medical response, infectious disease, and other topics in
16 disaster/bioterrorism would be recruited for these seminars.
- 17 • A “speakers kit” will be developed for hospital grand rounds presentations and state medical
18 society meetings, and distributed through the Federation.
- 19 • We will provide distance learning links to Uniformed Services University of the Health
20 Sciences curriculum modules, and arrange CME credit through or the AMA for those who
21 use these modules.
- 22 • National and state-level meetings could be used as a platform for discussion of physician
23 intervention and opportunities for the medical community to enhance its responsiveness to
24 disaster situations.
- 25 • Sessions on disaster response initiatives will be included on the National Leadership
26 Conference agenda, the Presidents’ Forum and other Federation meetings.
- 27 • The AMA will explore activities in patient education with groups such as the National
28 Council for Patient Information and Education, medical specialty societies, pharmacists and
29 the pharmaceutical industry, and consumer groups. Distribution of brochures on potential
30 threats such as anthrax and other biological weapons could be distributed through
31 supermarkets and pharmacies, for example.

32
33 Partnerships

- 34
- 35 • The AMA should expand its outreach to the Federation, providing information, linking
36 groups that have common issues, and acting to convene societies that may wish to join forces.
- 37 • The AMA could partner with the American Psychiatric Association, the American Academy
38 of Child and Adolescent Psychiatry, and other appropriate groups to lead a major effort in
39 dealing with the mental health needs created by the September 11th and other disasters.
40 Other specialty-related issues may arise and present further opportunities for action.
- 41 • In 1999, the AMA began the process of developing a scientific session on bioterrorism to be
42 held in conjunction with the World Medical Association’s 54th General Assembly Meeting in
43 Washington, DC, in October 2002. The goals of the session are to raise the awareness of the
44 physicians to the urgency and complexities of bioterrorism, to educate them as to their role in
45 the preparedness and surveillance systems, and to give them concrete “take-away” products
46 and ideas that will enable them to begin to analyze and perhaps construct systems to respond
47 to potential crises. A planning committee has been meeting since June 2000 to formulate the
48 content and speakers for the session. The session will be awarded Category I Continuing
49 Medical Education credit from the AMA and that the credit hours will apply internationally.
50 The proposed document, “Responding to the Threat of Bioterrorism,” which introduced the

1 topic to the WMA at a recent meeting, was enthusiastically received, and contains several
2 recommendations for global action.
3

4 Advocacy
5

- 6 • The AMA will continue to advocate for increased federal funding for national, state, and
7 local efforts that strengthen the medical response to terrorist attacks and other disasters.
- 8 • The AMA will advocate for increased funding, both within the structure of the NIH and
9 within the Department of Defense to enhance the research, design, development, and
10 approval of diagnostic aids, antibiotics/antivirals, vaccines, antitoxins, and other antidotes
11 for potential biological and chemical warfare agents.
- 12 • Funding for disaster-related mental health services and access to these services will be needed
13 for a protracted period of time. The AMA will work with the American Psychiatric
14 Association, managed care organizations, and governmental agencies to facilitate funding
15 and availability of these services.
- 16 • The AMA also has a powerful advocacy role for ensuring adequate and appropriate care and
17 support services for victims of trauma, burns, chemical or radiological contamination or
18 infectious disease related to a terrorist attack.
- 19 • Each State medical society should contact their State emergency operations center to let them
20 know about resources that are available, and to establish links with emergency response staff.
21

22 Communication
23

- 24 • A listserv for physicians and Federation staff who are interested in exchanging information
25 on terrorism and disaster preparedness could be developed.
- 26 • AMA could stage a Science News media briefing in Washington, D.C.
- 27 • AMA officers and Trustees will have an opportunity to present these issues in speeches
28 before a wide set of audiences. Additional assistance could be given to leaders of the
29 Federation as they discuss the subject.
30

31 RECOMMENDATIONS
32

- 33 1. That our American Medical Association condemn terrorism in all its forms and provide
34 leadership in coordinating efforts to improve the medical and public health response to
35 terrorism and other disasters. (New HOD Policy)
36
- 37 2. That our AMA join in working with the Office of Homeland Security, the Department of
38 Health and Human Services, the Department of Defense, the Federal Emergency
39 Management Agency, and other appropriate federal agencies; state, local, and medical
40 specialty societies; other health care associations; and private foundations to (a) ensure
41 adequate resources, supplies, and training to enhance the medical and public health response
42 to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge
43 capacity to address mass casualty care; (c) implement communications strategies to inform
44 health care professionals and the public about a terrorist attack or other major disaster,
45 including local information on available medical and mental health services; (d) convene
46 local and regional workshops to share “best practices” and “lessons learned” from disaster
47 planning and response activities; (e) organize annual symposia to share new scientific
48 knowledge and information for enhancing the medical and public health response to terrorism
49 and other disasters; and (f) develop joint educational programs to enhance clinical

1 collaboration and increase physician knowledge of the diagnosis and treatment of depression,
2 anxiety, and post traumatic tragedy, and trauma. (New HOD Policy)

3
4 3. That our AMA recommend that a physician with public health training and experience and a
5 strong background in infectious diseases, disaster medicine, or other appropriate medical
6 specialty be appointed to serve in an official capacity to the newly created Federal Office of
7 Homeland Security. (Directive to Take Action)

8
9 4. That our AMA urge Congress to appropriate funds to support research and development (a)
10 to improve understanding of the epidemiology, pathogenesis, and treatment of potential
11 bioweapon agents and the immune response to such agents; (b) for new and more effective
12 vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for
13 enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for
14 improving biological and chemical agent detection and defense capabilities. (New HOD
15 Policy)

16
17 5. That our AMA believes all physicians should be (a) alert to the occurrence of unexplained
18 illness and death in the community; (b) knowledgeable of disease surveillance and control
19 capabilities for responding to unusual clusters of diseases, symptoms, or presentations; and
20 (c) familiar with the clinical manifestations, diagnostic techniques, isolation precautions, and
21 chemotherapy/prophylaxis of chemical and biological agents likely to be used in a terrorist
22 attach. (New HOD Policy)

23
24 6. That our AMA believes physicians and medical societies should participate directly with
25 state, local, and national public health, law enforcement, and emergency management
26 authorities in developing and implementing disaster preparedness and response protocols in
27 their communities, hospitals, and practices in preparation for terrorism and other disasters.
28 (New HOD Policy)

29
30 7. That our AMA maintain and update a comprehensive Internet-based resource on disaster
31 medicine and emergency response. (Directive to Take Action)

32 •

APPENDIX

The Appendix contains three sections: a synopsis of CSA reports on bioterrorism, a set of potential activities for the Federation in medical disaster response, and a list of the JAMA articles on biological agents used in terrorism.

1. CSA Reports on Terrorism and Disaster Preparedness

At its February 1999 meeting, the CSA held a briefing seminar to learn about national planning for responding to mass casualty events resulting from acts of nuclear, chemical and biological terrorism. The CSA concluded that significant issues confronted physicians and the United States healthcare system concerning preparedness for chemical, biological, or nuclear terrorism. In response, the Council offered **CSA Report 4 (A-99)** “Organized Medicine’s Role in the National Response to Terrorism” to the House of Delegates (HOD). The recommendations contained in this report were adopted and form the basis for current AMA Policy H-130.949 (attached). This policy directs our AMA and the Federation of Medicine to partner with relevant agencies to identify the specific needs, roles, contributions, and participation of organized medicine and individual physicians in disaster planning and emergency response to terrorist attacks, and to begin focusing on ways to improve the detection, reporting, and management of affected individuals. It also urges the development of targeted curriculum and training programs.

CSA Report 17 (I-99) updated the HOD about Council preparations for AMA-sponsorship of a series of town meetings to be held in conjunction with the Medic Weapons of Mass Destruction (WMD) 2000 conference sponsored by the Department of Defense and the National Defense Industrial Organization. These meetings were organized primarily around the themes of physician-involvement in local response planning, teaching the practicing physician about terrorism; and physician interaction with the public health infrastructure. Participants represented state, county, and national medical societies, public health organizations, military health services, and the federal health agencies. Attendance for several AMA stakeholders was made possible by a generous grant from the National Medical Veterans Society, which donated \$40,000 to help defray the travel expenses of medical society participants. More than 80 individuals participated in each town meeting.

CSA Report 10 (A-00) briefly noted and explained our AMA’s involvement in Medic WMD 2000. A more detailed follow-up report with recommendations was prepared for the 2000 Interim Meeting.

CSA Report 11 (I-00) entitled “Medical Preparedness for Terrorism and Other Disasters” summarized the medical experiences and lessons learned from recent terrorist incidents; briefly discussed physician preparedness, health care facility preparedness, and community preparedness; suggested potential roles for the Federation of Medicine; noted the importance of Academic Medicine in extending training to all levels of physician education, and summarized the role of some key federal agencies in disaster preparedness and response. This report identified the following points about preparedness and response activities as they relate to physicians and medical societies: (1) community responses to disasters, including terrorism, require participation of physicians; (2) for some disasters, including biological terrorism and other infectious disease outbreaks, the integrated public health response cannot begin until clinicians report unusual disease cases or clusters; (3) physicians will be more effective in their community response if they are prepared with appropriate education and training; (4) although various military, federal, and civilian groups have developed physician educational materials,

organized medical societies and medical educators are needed to address physician-specific issues, promote learning in this area, and promote or disseminate educational materials.

CSA Report 11 also called for the creation of a public-private entity (including federal, military, and public health content experts) that would collaborate with medical educators and medical specialty societies to develop audience-specific medical education curricula on disaster medicine and the medical response to terrorism. Additionally, it urged state and specialty societies to work with relevant agencies to develop model plans for community medical response to disasters, including terrorism, and noted that reliable, timely, and adequate reporting of dangerous diseases by community physicians to public health authorities needed to be addressed. Furthermore, the Federation of Medicine should become involved in planning for the medical responses to disasters, including terrorism, at levels appropriate to the Federation component. Finally, the report asked our AMA to encourage JCAHO and state licensing authorities to include the evaluation of hospital plans for terrorism and other disasters as part of the periodic accreditation and licensure visits by their representatives.

CSA Report 4 (A-01) informed the HOD about AMA testimony before the Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction, also known as the “Gilmore Commission” for its Chair, Virginia Governor (and Republican National Committee Chairman) James S. Gilmore, III. This Commission was intrigued by the concept of a public-private entity that could enhance physician and community preparedness and response, and the potential value of the Federation infrastructure for dissemination, education, and advocacy efforts. CSA Report 4 also recommended that our AMA work with and through the Federation of Medicine to develop a mechanism for coordinating disaster/terrorism planning and response activities that involve more than one component medical society.

2. Potential Federation Activity in this Area

Local and County Medical Societies

- Each local and county medical society could appoint a staff member or a member physician to coordinate the society’s participation in disaster preparedness. That person should make contact with the emergency coordinator in the society’s city or county, as well as the emergency coordinators of local hospitals.
- The county medical society can work with the local health department to compile and maintain a list of physicians in the community who can be contacted in case of disaster. This list should include both member and nonmember physicians, and include multiple methods of communication/contact. Beside medical specialty data for the physicians, any special skills that might be appropriate for disaster relief should be recorded. Physicians who are interested in volunteering for disaster response issues should be contacted through the medical society with information on how to become engaged in local and state disaster response efforts.
- Plans should also identify means for contacting physicians if telephone lines, cell phone links and emergency radio systems are damaged or overloaded; possible alternatives include using Internet (Web sites and e-mail), fax, broadcast radio and television.
- The medical society can also work with the local health department to ensure that physician-friendly reporting mechanisms are in place, and that a two-way flow of information exists to help provide incentives for physician collaboration.
- The medical society can be a venue for physician education as well (e.g., CME on the essential aspects of terrorism and disaster medicine in their offerings).

State Medical Societies

Most disaster responses will escalate to the state level, either because the magnitude of the event spreads across county and city lines or because state resources will be needed to augment the local response. The state medical society has a broader geographic scope than the county medical society, and is better situated to interact with state-level disaster planners. The medical society should work with the state health department in all these considerations. State medical societies should consider creating their own medical disaster response plan, in coordination with the state disaster system. In addition, state medical societies can provide assistance to county medical societies.

- The state medical society should name a liaison to the state’s emergency coordinator to explore medical needs during terrorism and natural disasters, and form a disaster planning committee to identify ways to meet those needs.
- The state medical society will also play a role in physician education by educating its members on the essential aspects of terrorism and disaster medicine through CME programs at state society meetings and by articles in state society journals and newsletters.
- The state society can also maintain a list of speakers, which local societies can use to plan their own programs.
- Most laws regulating physician licensure, practice, and liability are state laws. State medical societies should explore in advance issues of concern, including possible requirements for CME in disaster medicine topics.
- State medical societies should examine state laws governing practice and liability under these circumstances, including “Good Samaritan” laws. If necessary, the society can recommend passage of laws that will allow physicians to respond effectively during a disaster. These could include both “emergency” licensing of volunteer physicians from across state lines, and issues of liability coverage in these circumstances.
- The state medical society can also ensure that state scope of practice laws protect patients while allowing for emergency treatment in a disaster.

Medical Specialty Societies

Medical specialty societies are probably best positioned for physician education about terrorism and other disasters. Education endorsed by the specialty society is likely to have a greater impact than some other offerings. In addition, the relevant content can be targeted for physicians in that specialty. Further, specialty societies can be opinion leaders that impress on their members the importance of the topic and the materials. Specialty societies can educate their members through several means, such as:

- Offering courses at specialty society meetings;
- Publishing articles in specialty journals, including tear-out reference sheets;
- Distributing educational materials and references prepared by topic experts and organizations;
- Co-sponsoring or promoting distance learning programs or other CME opportunities offered by other organizations on responses to terrorism.

3. JAMA Articles on Biological Weapons—All Available on the Web site in Full Text Format
 - Tularemia as a Biological Weapon (6/6/01),
 - Botulinum Toxin as a Biological Weapon (2/28/01),
 - Plague as a Biological Weapon (5/3/00),
 - Anthrax as a Biological Weapon (5/12/99),
 - Smallpox as a Biological Weapon (6/9/99).