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Op-Ed

Terrorism "Preparedness": Diversion of Resources and Erosion of Trust

Two physicians argue that disaster preparedness for bioterrorist attacks diverts health care resources from other critical medical and public health needs.

Victor W Sidel, MD, and Barry S. Levy, MD, MPH

Terrorism preparedness has become an extraordinarily important topic in the United States, but the measures being taken in the name of preparedness have raised a number of deeply disturbing ethical issues. These include the magnitude of the resources being used, the diversion of these resources from other urgent public health efforts, and the risks to public health and to civil rights that certain "preparedness" measures bring with them.

The 9/11 attacks on the World Trade Center and the Pentagon and the dissemination of anthrax through the mail in the fall of 2001, despicable and worrisome as they were, caused fewer preventable deaths in the United States than did other causes. Compared to the almost 3 000 lives lost on 9/11 and the 5 people who died from the dissemination of anthrax spores, since 9/11 more than 1 million Americans have died because of tobacco, more than 250 000 from alcohol abuse, more than 75 000 by gun-related violence, and more than 30 000 due to AIDS [1,2]. Furthermore, the total amount spent on terrorism preparedness by the US government since 9/11 has been approximately $5 billion according to an April 2004 conversation with Irwin Redlener, director of the National Center for Disaster Preparedness at Columbia University. As resources for homeland security have greatly increased, resources to prevent or reduce the occurrence of a wide range of other important public health problems—such as the prevention of deaths due to tobacco, alcohol, guns, and AIDS—have markedly decreased [3].

Extraordinary attention has been given to bioterrorism, although worldwide experience thus far is that small arms, light weapons, and explosives are the most likely weapons to be used in terrorist attacks. In defense of the vast expenditures on bioterrorism preparedness, the argument has been made by its proponents that much of the resources allocated to bioterrorism preparedness may have "dual use" in health departments. It is true that some of these expenditures have supported preparedness for naturally occurring infectious diseases and have improved some selected public health capabilities, but the drastic cuts in state and local health departments' budgets caused by diminishing tax revenues and by cuts in federal public health programs have severely weakened these departments and their capabilities to respond to a wide range of existing public health threats. New resources for these departments for bioterrorism preparedness have contributed little to restoration of essential public health programs and services. In fact, the opposite effect has often occurred: the influx of bioterrorism preparedness resources has often caused public health workers to leave positions in which they are needed in order to work on smallpox immunization and other activities of bioterrorism preparedness, which are almost certainly of lower current public health priority. In Seattle, where, as in other major cities, the local health department has been forced to become the first line of defense against bioterrorism, this diversion of attention and a shrinking health department budget have contributed to Seattle's worst tuberculosis outbreak in 30 years [4].

Perhaps of even greater importance, far greater threats to the health of the public, such as the proliferation of nuclear weapons, have been permitted to worsen. The US government has done little to cut off supplies of fissile materials or

to prevent the sale of nuclear technology or of nuclear weapons to nations or to subnational groups. Furthermore, the US government has devoted much more attention and resources to waging war in Iraq, where there was no good evidence for nuclear weapons, than to addressing the proliferation of nuclear materials and nuclear technology in and from Pakistan and North Korea [5].

Certain public health preparedness measures, such as immunization against anthrax and smallpox, were based on debatable evidence of risk and had negative health consequences. Among the ethical issues was the requirement that US military personnel be immunized against anthrax and smallpox and receive experimental medications ostensibly to protect against nerve agents without the freedom to refuse and without adequate informed consent [6].

Perhaps the greatest ethical issues in terrorism preparedness lie in the conflict between freedom and security. "Security" efforts have led to constraints on civil liberties, such as those embodied in the USA PATRIOT and Homeland Security Acts [4]. The USA PATRIOT Act, adopted in October 2001, undercuts civil rights for anyone who fits a specific profile as a "terrorist" by permitting detention of immigrants, increasing governmental surveillance powers, granting the government power to be informed of every number called from a particular telephone, and establishing a new category of crime known as "domestic terrorism." In public health, one of the threats to civil liberties is the Model State Emergency Health Powers Act [4], which is being promulgated by the Centers for Disease Control and Prevention for the attention of state legislatures, since public health is viewed as a responsibility of the states rather than the federal government. If the Act is adopted by a state, the governor or health commissioner of the state would have the power to declare a state public health emergency and to impose quarantines, require immunizations, and conduct surveillance. Although some legal protections were built into the model, the Act has been widely criticized as too broad in the powers it grants, and few states have adopted any part of it [6].

Nonetheless, alliances between public health departments and law enforcement agencies, brought about by the perceived risks of bioterrorism and by the "war on terrorism" have, at times, weakened community trust in the public health system and its leaders. This weakening of trust has been particularly prevalent in communities in which there are substantial numbers of immigrants, including undocumented individuals who fear detection and deportation if they seek public health or medical services [7,8].

In sum, bioterrorism preparedness poses extremely difficult ethical dilemmas that must be confronted. A more balanced approach is clearly needed. Physicians and other health professionals need to advocate at the federal, state, and local level for a balanced approach that both strengthens our public health system and protects the health and civil liberties of our people.

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