Bio Terror Bible

EXPOSING THE COMING BIO-TERROR PANDEMIC

BIOTERRORBIBLE.COM: The following whitepapers were published by think-tanks, universities, NGO's and various governmental agencies and have at the very minimum set the stage psychologically for the impending bio-terror induced pandemic. The simple fact that these whitepapers exists in mass confirms that an upcoming bio-terror attack is in the cards and may be played in a last ditch effort to regain political, economic and militarial control of society.

WHITEPAPERS: Army War College , ASM (American Society for Microbiology), CATO Institute, Center for a New American Security, Center for Biosecurity of UPMC, Center for Counterproliferation Research, Chemical and Biological Arms Control Institute, CRS (Report for Congress), GAO (General Accounting Office), Institute for National Strategic Studies, Institute for Science and Public Policy, Johns Hopkins University, National Academy Of Engineering, National Defence University, PERI (Public Entity Risk Institute), RIS (Research & Information System), Terrorism Intelligence Centre, The Federalist Society, UNESCO (United Nations), University of Laussane, and the WMD Center.

Title: After An Attack: Preparing Citizens For Bioterrorism
Date: June 2007
Source: Center for a New American Security (PDF)

Abstract: Responses to a catastrophic bioterror attack are likely to greatly amplify or substantially mitigate the attack's consequences. No less significant, if our post-attack responses fail, we are likely to encourage future attacks by demonstrating their efficacy in spreading terror.

Citizen preparedness is a key variable in our response, but while the United States has made substantial investments in professional preparation, only rhetorical attention has been paid to preparing the broader public. Using aerosol anthrax and smallpox attacks as primary examples, this paper demonstrates that our present preparations are likely to fail when measured against the six most fundamental citizen expectations. It advocates five research and development investments that would enhance citizen preparation.

The Likely Failure to Meet the Most Fundamental Citizen Expectations
We anticipate that if a substantial aerosol anthrax or smallpox attack were to occur in an American city, most members of the public would reasonably expect six fundamental kinds of support from the government. However, at present we believe local, state, and federal officials would fail to provide this support. Phrased as expectations from individual citizens, the requested support and likely responses would be:

1. Instruct and equip me to protect myself as much as possible immediately and in the event of future attacks. Advice about modes of protection (the value of masks, modes of decontamination, means of infection control, etc.) is for the most part designed for professionals in hospitals rather than laypeople in everyday environments. It is remarkably rudimentary, without a sound scientific basis, and without consensus. After a bioterrorist attack, citizens would receive little or no advice, and the advice they receive will likely be conflicting, often incorrect, and would probably amplify their anger at the government's failure to prepare.

2. An aggressive program to develop advice and support systems that would facilitate home care and

protection of home caregivers from infection in the event of broad-scale aerosol biological attack. Because we anticipate that the demand for hospital care will greatly outstrip its supply, home care will play a vital role. Moreover, home care can be effective, particularly since for many of those exposed to biological agents the care required will be palliative. Home care can be enormously enhanced if systems are developed in advance to provide caregivers with information that allows them to minimize risks of transmission of infectious agents and maximize quality of care.

3. Determine ways to supply individuals with the medical goods and basic supplies of daily life that they will need for self-care at home, or for ongoing sequestration in the case of a contagious disease. Neither price nor a first come, first served system will be an appropriate rationing mechanism. The vulnerability, logistical difficulties, and psychological resistance to central distribution points suggest that alternate mechanisms are required, including outreach systems that support people in their homes and efforts to flood the system so that supplies can be obtained in multiple ways from multiple places.

4. Create means for rapid diagnosis outside of hospitals to reduce demands from the worried well and enable hospitals to focus on treatment. Effective diagnosis outside the hospital setting is enormously difficult, but also enormously important to targeting treatment for those who require it, reducing the burden of the "worried well" on hospitals, and improving the psychological wellbeing of the population after an attack.

5. Supplement traditional "hub-and-spoke" communication from centralized government with complementary social network systems. The research program suggested here will be of practical use only if its findings can be credibly disseminated to the public at a time of great stress. Traditional hub-and-spoke communication from government authorities to citizens has a vital role to play, but sole reliance on it ignores the deeply ingrained human tendency to double-check information with trusted members of social networks. Social and peer-to-peer networks and trusted points of contact can complement existing information distribution capabilities. For example, peer-to-peer users could identify in advance those authorized to receive notice in the event of an injury, illness, or emergency. Experience of past catastrophes suggests that local and personal contacts can dramatically reinforce or undermine centralized government communication.

II. Six Requireremenents, Six Failuresresres

We anticipate six predictable and reasonable public expectations from our authorities following a major aerosol anthrax or smallpox attack:

1. Instruct and equip me to protect myself as much as possible, immediately and in the event of future attacks.
2. Tell me whether I and those I love have been or could be infected by this attack.
3. If I cannot reasonably be assured that my loved ones and I are not infected, provide us with whatever drugs or vaccines will protect us and do so quickly, fairly, and safely.
4. Provide health care for me or others who become ill as a result of attacks.46
5. Prevent more attacks of this kind.
6. Speedily establish conditions and provide information that will permit me and my family to return safely to ordinary daily activities.

Three things are noteworthy about this list. First, establishing a baseline for public expectations should be among the first steps in developing both a "Culture of Preparedness" and a strategy for consequence management after a bioterror attack. To our knowledge, however, this is the first time any such list has been compiled.

True, each of these concepts is encompassed by Department of Homeland Security statements about the need to "prepare, prevent, protect, respond, restore, and mitigate" and the military mantra of "sense, shape, shield, and sustain." But the abstraction of this vocabulary and scope of the task list that results

obscures a practical sense of what is required, a sound grasp of priorities, and recognition that these are not merely technical requirements but rather critical variables in a struggle for the hearts and minds of our population. We hope others will adopt, or improve and adopt, our short list. If this leads to a consensus, we will have made progress towards establishing an agreed set of essential goals for public preparedness and consequence management programs.

Second, there is rich reward in harmonizing lay public and professional priorities. In our view, a present comparison of the two repeatedly reveals contrasts rather than similarities. While some citizen demands appear to be implied in analyses of professional requirements, in reality the professional paradigm focuses almost exclusively on what existing professional constituencies ordinarily supply—not on what will be demanded by the lay population. For example, the professional paradigm places great priority on trying to expand professional health care, but even in the face of an unbridgeable gap between supply and demand very little attention is given to non-professional care. As discussed below, when professional and layperson plans and expectations are forced to the surface and laid alongside one another, a large and troubling disconnect becomes apparent. To improve America's resiliency, either professional priorities should expand or citizen expectations need to be lowered.

Finally, there is not just a failure of focus but also a likely failure of achievement. If a catastrophic bioterror attack occurred today, our governmental authorities would not be able to meet any of the public's key demands. Such a failure would have grave repercussions in both lives and livelihoods lost. Worst of all, it would undermine public solidarity and confidence in the government following a terrorist attack. America had a taste of this in the wake of the 2005 Hurricane Katrina, but a catastrophic terrorism incident would make the problems of Katrina seem miniscule.

Conclusion

There are substantial reasons why public perspectives are slighted in the development of federal programs to prepare for bioterrorism. Interaction with the general public is commonly seen as predominantly a city or perhaps a state responsibility, but not a federal one. Even if perceived as needed, federal efforts are seen as difficult when preparations, responsibilities, and opportunities for dealing with laypeople are fragmented across thousands of jurisdictions with culturally, psychologically, and physically diverse populations. Moreover, it is hard to capture the public's attention before a crisis, to communicate with them during a crisis, and to secure their trust and effective action in the face of fear, rumor, family fragmentation, and suffering from potential or actual injury. As one of us has written elsewhere:

"The neglect of laymen is understandable. We live in a society that idealizes and relies upon professional competence. We employ licenses (predicated on training), rewards (dollars and prestige), and punishments (e.g. by a ban on unauthorized practice of medicine) to reinforce the division of labor. By these means, also, we seek to assure consistency and quality in professional services. Conversely, we distrust laymen. Their ethics, skills, knowledge and judgment vary widely. One well-designed survey of laymen flatly concluded: 'The majority of respondents have a number of beliefs about smallpox and smallpox vaccination that are false.' Deficiencies run deeper than this. In an urban area beset by biological crisis we can anticipate that a third of all citizens are likely to be depressed, alcoholic, addicted, paranoid, psychotic, incarcerated, elderly, infirm, disabled, infants and children, immature adolescents, or some combination of these. Moreover, a quarter of the populations of New York or Los Angeles, for example, describe themselves as not speaking English 'very well.'"

However discouraging this situation may be, readers should bear in mind that professional and bureaucratic perspectives have repeatedly demonstrated their own limitations. Bureaucracies and professional groups are notoriously fragmented as each looks at a problem parochially, asserts the

privilege of its own procedures, employs its own vocabulary, and fights for its own status and resources. Professionals and bureaucrats are trained to focus on previously defined problems, follow routinized procedures, and meet consensus standards. It is therefore hardly surprising that they are institutionally conservative and tend to react to new problems with old procedures. They have strong predilections to divert energy and resources, even if intended for future contingencies, to meet pressing present-day priorities. They are self-referential, even self-reverential: The FBI tends to ask about a proposal, “Is it good for the FBI?” An Admiral demands, “Is it good for the Navy?” And a hospital administrator asks, “Is it good for my hospital?”

At the same time, an empowered citizenry is more likely to be mentally, as well as practically, resilient during a crisis. Accounts from London during the Blitz and Israel under threat of Iraqi Scud missiles during the first Gulf War illuminate how a citizenry that has been prepared for worst-case scenarios can withstand attacks beyond expectation. People can also learn to protect themselves physically. Returning to the fire analogy made earlier, deaths by fire have decreased steadily since 1974 when Congress mandated a range of fire safety measures, including educating citizens on how to protect themselves, and fatalities are now less than a third of what they were prior to these measures.

It is important to recognize that in an emergency like that which would be caused by a bioterror attack, the public is often going to be thrown upon its own resources. If this reality is ignored, we risk facing a Katrina-like disaster raised an order of magnitude by its malevolence, its immediacy, its potential for recurrence, and its scale. If, on the other hand, citizens are empowered, they will be able to take measures that will improve their protection, reduce demands on our health care system, and enable our country to return to normalcy more quickly.

Above and beyond these practical considerations stands an overriding psychological need. Terror will be an intensifier. It will make the United States stronger or it will make us weaker. The critical battle is in our citizens’ minds. Catastrophe can bring us together as a nation, as occurred in the aftermath of 9/11. Or it can shatter our national myths and diminish national cohesion. Our greatest concern about a future terrorist attack, and a biological attack in particular, is that it may corrode public faith in our government, and thus in our democratic system itself. We think this risk demands attention and action (Center for a New American Security, 2007).