Bio Terror Bible

EXPOSING THE COMING BIO-TERROR PANDEMIC

BIOTERRORBIBLE.COM: In the aftermath of a bio-terror attack and subsequent pandemic, a great many people will die as a result of the actions and inactions of hospitals throughout America. Based on recent bio-terror drills, hospitals will likely open temporary clinics whereby people will be vaccinated in mass. Whether or not the vaccines kill or save the patient is yet to be determined.

Title: Some Hospitals To Rebuff Victims Of Bioterrorism
Date: April 16, 2003
Source: UCLA

Abstract: St. Vincent's Hospital, a 758-bed acute-care facility in Manhattan, recently held a drill to prepare for a nuclear, biological or chemical terrorist attack. The first step: Lock down the hospital so that no new patients could come in.

"If we can't protect the people who are here, we can't do our job," says Richard Westfal, assistant director of emergency medicine at St. Vincent's.

Doctors in the nation's emergency rooms have long sought to treat everyone. But as U.S. hospitals confront the possibility of terrorism -- especially acts resulting in victims who might contaminate others or spread infectious diseases -- a few health-care providers envision a significant, and highly controversial, change in mission.

In the case of an attack with nerve gas such as sarin or a radioactive "dirty bomb," Dr. Westfal says, St. Vincent's wouldn't admit patients until its staff was fully outfitted in protective gear. Even then, he says, it would open just one of its eight doors to the outside and take only two victims at a time, after each has had a decontamination shower. St. Vincent's has coordinated its plan with local police, who could be called on short notice to guard the outside of the building.

In Houston, St. Luke's Episcopal Hospital is vaccinating up to 75 of its staffers against the smallpox virus. But since smallpox doesn't have a cure and kills about 30% of its victims, hospital officials say they would lock down the moment conditions were deemed unsafe for those within.

Such a policy "may not have the needs of the [smallpox] victims in mind," says Herbert DuPont, chief of internal medicine at St. Luke's, but he says St. Luke's first priority should be to its patients, staff and their families.

Last year, as part of push for smallpox preparedness, the Centers for Disease Control and Prevention urged state planners to identify facilities that might house patients in the event of an outbreak. But health-care facilities proved reluctant participants. Some feared losing revenue; others worried about a lingering stigma.

Still, in the matter of turning away victims of contagious diseases, or nuclear or chemical attack, many hospitals either haven't tackled the issue or rather have tackled it in such a way that they are hoping to meet the needs of the community with the resources they have. Some have no specific policy to lock down but won't rule it out as a last resort. For now, however, St. Luke's and St. Vincent's are not in the mainstream.

"Most [hospitals] have said it's not our job to shut people out," says Jim Bentley, senior vice president for strategic policy planning for the American Hospital Association in Washington, D.C.

David Hooper, chief of the infection-control unit at Massachusetts General Hospital, says, "Our goal is to take care of people who need medical help. Some may be on our doorstep, others may be in our hospital. But we're not closing our doors."

But health-care officials say that hospitals are generally ill equipped to deal with bioterrorism. A just-released report by the U.S. General Accounting Office found U.S. hospitals would need capital improvements and additional equipment to deal with an extraordinary bioterrorism attack -- from medical stockpiles to decontamination facilities.

"Bioterrorism preparedness is expensive and hospitals are reluctant to create capacity that is not needed on a routine basis and may never be utilized," the report concluded.

Since hospital accreditation requires disaster planning, many hospitals are ready to take emergency steps, such as following an American Hospital Association preparedness checklist, which includes a three-day supply of specified pharmaceuticals, emergency power, a loudspeaker and outdoor decontamination showers.

A group of Rhode Island hospitals are backing a state plan to use a mothballed mental-health facility in Pawtucket as a place to treat potential smallpox victims so that local facilities aren't overwhelmed, their staff and patients contaminated or infected.

Providence's Rhode Island Hospital has acquired two inflatable decontamination tents, raising its decontamination capacity to 150 from 30 in the case of a chemical attack and allowing the process to take place outside its regular facility. "We're just taking what we do on an everyday basis and extending it," says Thomas Magliocchetti, who heads emergency preparedness for the hospital.

Washington Hospital Center, Washington, D.C.'s largest trauma center, is using a $2.2 million grant from the Department of Health and Human Services to draw up plans for what it calls "EROne." Hospital officials are scheduled to unveil the design next month and they say construction will follow.

Among the features: ambulance access to the emergency room modeled after automobile drop-off and pickup at airports and rooms equipped with negative pressure, where air is vented outdoors, rather than recirculated through the hospital. "The objective is to handle three to four times the normal load with graceful degradation as opposed to catastrophic failure," says Mark Smith, chairman of emergency medicine at Washington Hospital Center.

At Washington Hospital Center, overflow in the event of a terror attack would likely be in the parking lot. "To try to isolate ourselves from the community would be hard," says Christopher Wuerker, medical director, MedSTAR transport at Washington Hospital Center.

The center has vaccinated 24 of its staff against smallpox , and intends to vaccinate all employees should the hospital treat a single case. But Dr. Wuerker says a full-fledged epidemic could possibly force the hospital to discharge some of those infected for lack of space. And, he says, locking down the hospital in the midst of such a crisis isn't out of the question. "It's sad to think that's what might be needed," he says. "But that's the reality" (UCLA, 2003).

Title: Utah Implements Harsh Triage Guidelines For Bioterror, Epidemic Emergencies
Date: May 19, 2010
Source: Homeland Security News Wire

Abstract: Utah's new triage health emergency guidelines would see some children and some seniors turned away from hospitals during a bioterror or epidemic emergency; those who are severely burned, have incurable and spreading cancer, fatal genetic diseases, end-stage multiple sclerosis, or severe dementia will be turned away; people older than 85 also would not be admitted in the worst pandemic; those who have signed "do not resuscitate" orders could be denied a bed

When a killer flu strikes, with several thousand sick or injured and no room to spare in understaffed hospitals, care will be denied to the sickest adults and children. Those who are severely burned, have

incurable and spreading cancer, fatal genetic diseases, end-stage multiple sclerosis, or severe dementia will be turned away. They can be sent elsewhere for comfort care, such as painkillers, but they will not be treated for the flu, according to controversial Utah triage guidelines being modeled across the country.

People older than 85 also would not be admitted in the worst pandemic. Those who have signed "do not resuscitate" orders could be denied a bed. Doctors could remove ventilators from patients deemed unlikely to recover, to give them to other patients.

The *Salt Lake Tribune*'s Heather May writes that these triage guidelines envision an outbreak — or another public health emergency — so severe that the health care system is unrecognizable. They apply to disasters from bioterrorism to an earthquake.

Developed by the Utah Hospitals and Health Systems Association for the Utah Department of Health, they aren't mandatory and rely on physician judgment. "The choice is: When you don't have enough, who do you do it for?" said state epidemiologist Robert Rolfs, who joined hospital medical officers, nurses, emergency doctors and an ethicist who wrote the recommendations. Their answer: Provide the greatest good for the greatest number. Priority will be given to patients who will most likely recover with treatment. People likely to die even with treatment, or likely to survive without it, will not get care.

Largely finalized in January, the guidelines were required as part of the Governor's Taskforce for Pandemic Influenza Preparedness, created by then-Governor Jon Huntsman Jr. in 2006.

May writes that a group convened by the hospital association spent years studying how others allocated scarce resources, including during a severe acute respiratory syndrome outbreak in Toronto in 2003, said Deb Wynkoop, its director of health policy. She said more than a dozen states have adopted some or all of Utah's guidelines.

The state could have decided to provide care on a first-come, first-serve basis or use a lottery, said medical ethicist Jay Jacobson, a workgroup member. Instead, it used a wartime triage model. "It was difficult grappling with the idea we would say no for any reason," he said.

The recommendations would have been implemented if the H1N1 outbreak in Utah had escalated, Wynkoop said. In the year since the outbreak started in April 2009, the flu has hospitalized 1,334 Utahns and killed 49.

May notes that by comparison, the triage guidelines anticipate thousands being hospitalized at once: Every emergency department would be overwhelmed, the state is 5,300 hospital beds would be full, along with another 1,100 beds placed in offices, conference rooms and exam space. Hospitals would be operating with 60 percent to 80 percent of their staff. Ventilators would be in high demand and short supply, without enough respiratory therapists to oversee their use.

Once the governor declared a public health emergency, the guidelines would apply in hospitals but also to physician offices, clinics, long-term care facilities and paramedics, so they do not transfer patients who would not be admitted.

Providers could not be sued for denying care in an emergency, except in cases of gross negligence or criminal conduct, under a 2007 state law.

The guidelines show eleven ways an adult can be excluded from care, ranging from a "severe neurologic event" with minimal chance of recovery, such as a stroke, to certain stages of cystic fibrosis. They do not address how to treat pregnant women, a matter to be decided in the fall.

Children 13 and younger would be turned away for six reasons, including underlying conditions that are often terminal by age 2, including Trisomy 13 or 18 and spinal muscular atrophy. Premature babies with an 80 percent or greater chance of dying would not be resuscitated.

Peter DeWeerd, a family medicine doctor who works in the emergency room of St. Mark's Hospital, participated last summer in a mock drill to test the guidelines. "It's going to be pandemonium," DeWeerd predicted, noting that denying life-sustaining care runs counter to what doctors and nurses are trained to do. He recalled a mock mother fighting to get treatment for her 7-year-old daughter, who was in a wheelchair and had severe chronic respiratory illness. "She was doing everything she could to break through security," he said recently. "There's a point we say, 'We're sorry, we don't have the ability to treat your child.'"

He emphasized the need for prevention through vaccinations and having emergency storages of food, water, medicine and blankets. "Those are the things that are going to keep me and my colleagues from having to make as many of those gut-wrenching, once-in-a-lifetime decisions."

Guideline authors said they tried to avoid judging the quality of someone's life. They acknowledge, though, that they did so when it comes to dementia, based in part on surveys asking whether people would want life-sustaining treatment if they had it, said ethicist Jacobson. "There is a judgment [that] even if they did survive, the duration of survival and quality of that survival is poor in terms of the value to society," said Rolfs, the epidemiologist.

Physician Norman Foster agrees it is reasonable to allocate scarce care based on a person's underlying cognitive abilities. He worries, though, about the guidelines' vague language. He is unaware of anyone with expertise in geriatrics or neurological diseases being consulted on the guidelines.

Foster, director for the Center for Alzheimer's Care, Imaging and Research at the University of Utah, said most Utah dementia patients are not properly evaluated. That means medical staff in a triage situation would not know if the condition was severe, he said. He fears staff could deny care to more people than intended, including people with mild forms of dementia, those with reversible delirium, those with speech problems or the elderly in general.

"Dementia care is not a priority in our health system or among health professionals," he wrote in an e-mail. "There is a significantly greater risk of abuse of these patients in a triage system of any kind."

Other language excludes those with end-stage multiple sclerosis "requiring assistance with activities of daily living."

That language should be eliminated, since "there are many healthy, high-functioning people who require such assistance," the National MS Society said in a statement.

May writes that Utah has also been criticized for using DNR status as a reason to deny care. "Do not resuscitate" refers to not wanting life-sustaining measures if a person's heart or breathing stops. People who sign them likely would not anticipate they would be denied a ventilator for the flu.

The orders "reflect individual preferences" more than "an accurate estimate of survival," said a report by the Institutes of Medicine, which evaluated crisis guidelines from Utah and other states.

Helen Rollins, a retired nurse who helped develop end-of-life care programs in Utah hospitals, said patients typically sign DNRs when they are critically ill. If they get better, it would be "unfair" to use that status to refuse treatment during a separate emergency, she said.

Excluding patients based on DNR status "is one that continues to worry me a little bit," said Rolfs, the epidemiologist. "Judgment [by a physician] is needed."

Besides excluding certain patients, the recommendations prioritize patients for admission and use of a ventilator based on the Modified Sequential Organ Failure Assessment — a tool that predicts mortality.

One point could make the difference between being sent home or getting a bed — or being removed from a ventilator. The scale “was not designed as a prospective predictor of survival,” the IOM report said, noting it is unknown whether the difference of a single point means a patient is more likely to recover.

Wynkoop said Utah doctors evaluated the scale by examining the records of past intensive care patients. Those who would be denied care under the guidelines died even after the most aggressive treatment, she said. “We’ve got to start from somewhere,” she said. “Just saying we’re not going to have any [evaluation tool] doesn’t appear to be humane.”

Patients denied care would be sent home or to another facility and provided with sedatives and painkillers to keep them comfortable until they die. “Many of us have a family member or a friend who is on that exclusion list,” Rolfs said. “You look at it and you think about it. ‘These are not going to be easy times.’” (Homeland Security News Wire, 2010).