The Public as an Asset, Not a Problem
A Summit on Leadership during Bioterrorism

Transcripts

Welcome, Monica Schoch-Spana, PhD
Leadership's Role in Helping New Yorkers Prevail after 9/11, Neal Cohen, MD
Opening Remarks, Monica Schoch-Spana, PhD
Rethinking Preconceptions about Mass Response to a Crisis: Introduction, Robert J. Ursano, MD
Anticipated Psychological Impact of Bioterrorism, Ann Norwood, MD, COL, MC, USA
The Problem of Panic in Disaster Response, Lee Clarke, PhD
Public Resistance or Cooperation? Historical Experiences with Smallpox, Judith W. Leavitt, PhD
The Health and Safety of Actual People, Not a Theoretical Public, Monica Schoch-Spana, PhD
The Frail and the Hardy Seniors of 9/11: The Needs of Older Americans, Myra I. Lewis, PhD
The Value of Culture and Social Capital in National Defense and Bioterrorism Preparedness, Kathleen Rand Reed, MAA
The Role of Schools in Meeting Communities' Needs During Bioterrorism, Bradley D. Stein, MD, PhD
The People Talk Back: Anthrax 2001 Public Communication Lessons, Monica Schoch-Spana, PhD
How Leaders Can Confidently Step Up to a Reporter's Mic?, John Burke, JD
Introduction to Civil Society as an Asset during a Public Health Emergency, Kathleen J. Tierney, PhD
Community Organizations Acting During Crisis: 9/11 and Neighborhood Associations, Diane S. Lapson
Mobilizing a Community Around the Desire to Protect Children, Ernie Allen
They Will be There: Managing and Protecting Volunteers, John Clizbe, PhD
Panel Discussion: How to Lead a Community During Times of Trouble

Monica Schoch-Spana, PhD

Welcome
DR. SCHOCH-SPANA: I want to extend a warm welcome to all of you. I am Monica Schoch-Spana. I am the Senior Fellow with the Johns Hopkins Center for Civilian Biodefense Strategies.

This is one of those moments where it feels like I'm throwing a dinner party and every person who I want to be there has said yes, I'm going to come. So I want to say thank you.

This is going to be our kick-off event to a very important conference on a critical issue that has not yet received the attention that it deserves, and that is the need to both recognize and to support a positive, active role for the general population in responding to a bioterrorist attack.

Now I'm going to save my more formal remarks for tomorrow, but our speaker line-up and our attendee list has exceeded our expectations, so I wanted to give warm thanks to all of you for the high level of interest that has been expressed regarding the substance of this conference, and also, the swiftness with which you made time in your very busy schedules, all of you, to take part in this conference and bring it into being.

The goal of this meeting is to synthesize for government and public health authorities essential principles of leadership that encourage the public's constructive collaboration in the context of bioterrorism.

This is an issue that people often put in the "too hard" category as Tara O'Toole mentioned earlier today, but I think the level of interest expressed by your participation suggests that it is a complex issue that we have to pay attention to.

There has been a necessary maturing of concepts in the emerging field of biodefense such that we are going to wrestle more thoughtfully with the issue of how it is that we help populations help themselves during a public health emergency.

So my thanks to all of you for joining this public dialogue on how we can move beyond this prevailing image of a panic-prone public, how we can mobilize a coordinated, collective response among diverse publics and how we can capitalize on everyday institutions such as schools and workplaces and neighborhood associations to help people cope with the public health emergency.

I'd like to extend a warm thanks to my colleagues Drs. Tara O'Toole and Tom Inglesby for the intellectual and moral support that they extended during the development of this program and of course beyond that as well.

Our Events Coordinator extraordinaire Andrea Lapp, who I think everyone in this room had a relationship with.

(Applause)

Dr. SCHOCH-SPANA: A key Research Assistant to the issue of the people's role in biodefense, Ms. Onora Lien. Our webcasting crew and then everyone back at the
Biodefense Center who's holding down the fort while the rest of us are here at a party in Washington, D.C.

It really has taken the entire staff plus to pull off a conference of this scale and quality. So my thanks to my colleagues. Also, a hearty thanks to our generous funders the Alfred P. Sloan Foundation and the Memorial Institute for the Prevention of Terrorism. Without their support, this critical event couldn't happen, and so my thanks to Paula Olsiewski and Brian Houghton on behalf of their respective institutions for their support.

I'd like to turn the podium over to my colleague Tara O'Toole who'll be introducing our keynote speaker, Dr. Neal Cohen.

(Applause)

Neal Cohen, MD

Leadership's Role in Helping New Yorkers Prevail after 9/11

DR. O'TOOLE: Good evening. Let me add my welcome to Monica's. Neal Cohen, our speaker for this evening, is a lifelong New Yorker. He is a physician who was appointed by Mayor Giuliani to serve as the Commissioner of Health for New York City from 1998 to 2002, a period which encompassed a number of what can only be called amazing public health crises, which included the outbreak of West Nile Virus, a disease that had never previously been seen in the western hemisphere.

He was called upon to deal with the consequences of the attack on the World Trade Center in September, 2001, and then, in short order, with the outbreaks of anthrax that occurred as a result of bioterrorist attacks in New York City.

During the same period, as though that weren't enough, Dr. Cohen also served as New York City's Commissioner of the Department of Mental Health, Mental Retardation and Alcoholism Services.

I can't even say it, much less imagine doing it all at the same time. He advocated successfully to merge both of these departments into a unified Department of Public Health, a plan which was endorsed by New York City voters last November.

Following the events of September 11, Dr. Cohen oversaw the establishment of Project Liberty, an initiative in New York to ensure that all New Yorkers received the support services, counseling and treatments they needed to address the consequences of the 9/11 attacks.
He has been a strong advocate of integrating mental health professionals into community settings and is a long-time advocate of destigmatizing the acceptance of mental health care throughout the nation.

In February of 2002, Dr. Cohen became the Executive Director of the newly created Center on Bioterrorism, which was formed by a consortium of 39 of New York's schools of public health, medicine and academic and research institutions.

The goals of this new center are to lead a partnership with industry, academia, government agencies and the public to improve the understanding of the threats posed by bioweapons and to improve and augment the planning and research required to mitigate those threats.

So without further ado, it’s a great pleasure to introduce our dinner speaker, Dr. Cohen.

(Applause)

DR. COHEN: Thank you. I was very pleased to receive this invitation. I had two conversations in the reception time that bear on what I'm going to say tonight.

One is one colleague, who didn't know I was a psychiatrist and was really very surprised, and I have to confess for a number of years I didn't really sort of speak about that very much as I was trying to gain some credibility as the public health leader, although I had a very strong personal commitment to an integrated public health model.

So that really didn't last that long, but I was pleased that the newspapers, the media didn't refer to Dr. Cohen the psychiatrist as the health commissioner.

They more or less accepted that I was. Another colleague told me it's an opportunity for me to be very blunt and candid, and it must be different now that you're outside of government.

So it is. So I certainly hope that I was fairly candid before, but there is a difference being in government and being outside government with respect to when you wake up the next day and who might have heard what you said and what opinion they may have had about what you said.

So I did have a very unique perspective, opportunity and challenge to address both the public mental health and the public health issues that would emerge from 9/11.

I was a psychiatrist who shared a vision that Surgeon General David Satcher had in his Surgeon General reports on mental health and suicidality where he really advocated for the integration of mental health into the mainstream of a public health agenda, something that there was a good case, a great argument for, but certainly, I think, the events of 9/11 and bioterrorism really lend themselves to that vision in a very easy, clearly demonstrable way.
Long before 9/11 I had become very keenly aware of some of the cultural differences in the public health communities and the public mental health communities concerning community and consumer participation and input into agenda-setting.

I regarded myself as a community psychiatrist in community mental health. I was trained in the principles of deinstitutionalization and the era in which the NIMBY syndrome, which stands for Not In My Back Yard, would be the death knell for really excellent community programs that never had the community support, buy-in or participation that it would need to be successful.

From a perspective in public health practice, I think that limited resources and an ongoing erosion of public health infrastructure has brought about probably more recently somewhat wider acceptance of the need to engage with communities and find partners to establish priorities and develop strategies for intervention.

So for me the take-home lesson, looking at the way public health and public mental health has moved along with regard to community engagement, is that so many programs working so good on paper have failed so miserably in their implementation because of a lack of community acceptance and participation, and ultimate success has not occurred.

So for me, looking at the title of the conference, I would paraphrase it and say the public as an asset, or there will be a problem. That has been my experience and I believe that perhaps at the end of the day tomorrow we'll come to appreciate what that might look like going forward for the asset that needs to be derived from bioterrorism preparedness.

I was asked to direct my remarks to leadership and certainly to do that I have to consider those clearly demonstrated leadership qualities of the person who now literally wrote the book on leadership, Mayor Rudolph Giuliani.

In his book, I noticed that he wrote that, "leadership does not simply happen, it can be taught, learned and developed." So the Mayor goes on to describe leadership skills that he practices, writing that he hopes they'll be useful to anyone who has to run something.

So undoubtedly there are lessons to be learned about leadership style and how you can be successful in leadership roles. I think it probably would take us back to the nature versus nurture argument and my assumption is that there are certain individuals who are constitutionally better prepared to assume the role of leader in the moment of crisis, such as 9/11, and that there were qualities about the man, Rudolph Giuliani, that made it possible for him to emerge so naturally, so clearly as a significant leader.

No doubt history will judge him very differently than if his tenure had run out on September 10 than September 11, because he had that moment of opportunity for that leadership to be appreciated and recognized.
I think that an examination of leadership response in New York City to the events of 9/11 would reveal the benefits to the city of having created an Office of Emergency Management, which occurred in the mid-1990s.

For a number of years, there was a lot of media attention that was focused on "the bunker" as they call it, this very complex, multi-million dollar telecommunications facility that was located at the 7 World Trade Center with opportunities for city, state and federal agencies to come together for emergency management planning and response.

We at the Health Department had participated in a number of practices and drills, including biological and chemical attacks and terrorist bombings under an incident command structure that I think was instrumental in making the events of 9/11 and the weeks that followed sort of unfold in a way that would allow me to speak to the successes of the management of 9/11 in New York City.

Interestingly, we were scheduled on September 12 to hold a POD drill, or a point of distribution drill on Pier 92 on the Hudson River, and in that drill there were about 1,000 police and fire recruits who were going to act as civilians who had been exposed to a bioterrorism release event and they were going to be lining up to receive antibiotic prophylaxis.

Four days after, on the Saturday following the Tuesday of 9/11, the city moved its new emergency operations center to that very same pier, which had some preparation in relation to the drill that was going to be carried out the next day.

On the morning of 9/11 -- I'll just sort of quickly walk through this with you -- I actually got the message on my Nextel phone of the first plane hitting the World Trade Center.

I raced down to the towers and I met up with Mayor Giuliani on the street with a number of his senior cabinet officials and we weren't able to -- My expectation of going down there was I wanted to know what was going on, but I expected that we would be going into 7 World Trade Center into the emergency operations center.

I had my expectation of working from the Health Department desk, then, and telephone that would be available to me. But we couldn't get into the building because there were concerns about the structural integrity of the building, and in fact, later that afternoon the entire building collapsed on its own.

So the Mayor needed to find a place to call Washington. He was going to try to find out what was going on. He was going to be asking for air cover, as it turned out, and he needed some opportunity to communicate.

We went into a building on Barclay Street, which is just a block away from the North Tower, and he was able to reach the White House, learned that the Pentagon had also come under attack and secure air cover for the city.
We were positioned there when the first tower collapsed and despite some locked doors and some significant uncertainty about our safety, we were eventually led out through a smoke-filled basement maze out onto the other side of the building, which is facing Church Street, and we moved north away from the towers.

As we moved up Church Street, we started with a people caravan of about 25 of us who were city officials, and the caravan was growing block by block and I remember vividly the Mayor urging very ghostly and ash-caked survivors to go north.

I remember there was sort of a rowdy teenager who obviously was distressed, but he needed to be calmed and the Mayor gave him a very fatherly shushing along the way.

We almost reached Murray Street, which is four blocks north of the World Trade Center, when the second tower collapsed at about 10:30. As we were doing all this and we eventually got to a firehouse, later to a police academy, which are two miles north of the towers, I’ll confess that as a physician and as the only physician who was with the Mayor in his senior cabinet, I kept my eyes on him.

I did that both because he was my boss and also because I felt a responsibility to keep an eye on the leader in this moment of crisis. As a physician, to encourage him to keep on his air filter mask, which some of us had been given when we left the building on Barkley Street, to suggest that he stay hydrated as much as possible with bottled water. I was also feeling a lot of frustration because phone lines were down in lower Manhattan and I wasn’t able to get into contact with my health department staff about the mobilization of our emergency response teams, but in fact that was taking place without me because my deputy knew exactly what to do and that proceeded.

The immediate focus that I was going to address was the public health impact and the potential medical emergency that derived from the tragedy. Witnessing the crash, one had high expectations there would be very large numbers of casualties that would have to be treated in the emergency departments, whether we would have enough beds, and whether there would be a surge capacity in the hospital system in New York to be able to absolve all the wounded that we expected we might see, but regrettably, that surge capacity was never really tested.

But interestingly, actually about 10,000 people were seen in emergency departments in the greater metropolitan area: New York, New Jersey and Connecticut, and there were about 450 hospital admissions.

But there were only nine deaths that occurred after September 11 in the next several weeks that were a consequence of the 9/11 events. So there were a lot of walking wounded, but relatively minor injuries that were addressed.

I think one of the lessons learned -- this is just an example of how people were fleeing the scene. But I think a lesson learned here underscores that terrorism will create health impacts that will go well beyond the immediate boundaries of the disastrous event.
People, whenever they can, are going to try to get home and try to return to their home base and then seek care as they need to. So planning for the management of a terrorist event must always be regional in approach, not local, because it's just never going to stay local.

So we went on that day to set up a makeshift emergency operations center at the police academy and later in that week we were at Pier 92 as I mentioned before.

Johnathan Alter wrote in Newsweek of Mayor Giuliani that he inhabited the role of wartime leader with a fine mixture of brisk compassion and a gritty command presence.

My own observation from the critical early hours of the first day was that he really embraced that role of being a leader with confidence, but not with arrogance.

His credibility for that role was strengthened by the fact that he was everywhere. He was seen, he was very visible. He had presence at Ground Zero again and again and again and later at funerals and memorials.

Here's where I'm out of government and my candor -- this is in contrast to some of the leaders, government leaders, who were criticized later for not being so visible and available to the public at a time when that was sorely needed, or some whom were reported to be in unknown locations.

Another element of his leadership was the credibility of his public statements. No doubt there is a great temptation for government leaders to put out reassuring and comforting statements to the public, but those very same reassuring statements can badly damage credibility with a loss of trust when the statements are found to be inaccurate or less than an honest assessment of their safety.

The post-9/11 events, remember, did not give us any opportunity to really assure the public of safety from further harm. We continued to receive messages of potential further attacks by Tom Ridge and by Secretary Rumsfeld, news of Al Qaeda planning to launch its further attacks, the war in Afghanistan, mid-East strife and terrorism.

It sort of worked like this for us, right? One story after another. So it didn't take a rocket scientist or a psychiatrist posing as a Health Commissioner to figure out that we could anticipate the potential for a looming mental health crisis in New York City.

I just want to make one comment about the Mayor's statements. He didn't promise safety. What he actually did was he talked about the steps that had been taken to make the city safer on 9/12 than it had been on 9/10.

So then he talked about the air defense and he spoke about the heightened alert and vigilance for any further act of terror, but he didn't promise us that we would be free from any further risk.
So we had in New York City, with regard to this looming mental health crisis, I had been there since 1996 and in the `90s we had a number of experiences with the management of the psychological sequellae of mass violence and terrorism.

It first started for us in the creation of crisis intervention services when we had what was called the Happyland fire, and this was arson in the South Bronx in 1990 which killed dozens of people, and from that point on we created, within our public mental health program, a crisis intervention network and an ability to respond with a team of staff who were experts in disaster management and trauma.

Then in 1993 we had the World Trade Center bombing, and then later in the `90s we had several airline crashes, TWA Flight 800 and a Swissair crash. In each instance, what we did was to create a site for family members of the victims to come together, to get information, to receive concrete services as they needed it and to receive crisis counseling and support for their bereavement.

The Mayor, familiar with this model, asked that we set up a family assistance center, which was carried out at the New York State Armory, which is 26th Street, which is also about two miles north of the towers.

In those situations, the American Red Cross assumes authority to manage services at a disaster site and the local health department and mental health agency assume authority to mobilize the clinical staff.

We knew the crisis intervention teams and the mobile outreach programs, so we were able to kind of pull together the professional staff that we needed to man and support these family assistance centers.

So in this instance, the acceptance of the finality of the family members' loss was progressing very slowly, because many family members were clinging to the hope that -- offered by reports, that survival under optimal conditions can last up to two weeks.

So that the movement from a rescue to a recovery operation really moved slowly and unevenly. Almost immediately, we saw the proliferation, if you will, of these posters of missing persons which appeared on lampposts and hospital walls and outside the Family Assistance Center with a picture of the family member who was described as lost or missing, and asking for information about them.

It was on the third day that the Mayor asked me to bring in experts on bereavement and trauma to meet with him, because he also became keenly aware, and he was concerned with how best to speak publicly of the tragedy and how to respect the families’ process of bereavement with words that might at the same time help the healing of the city.

So from the very beginning, I think what the Mayor did extraordinarily well was to provide a trauma narrative for the city that actually incorporated a vision of recovery.
So he didn't speak in a more narrow, limited way about the attack and about the losses. From the beginning, he introduced the concept of recovery as a part of the narrative in the experience that we were all going through.

So he described in detail, of course, what the city was doing at Ground Zero. He told families that they could assist by bringing in toothbrushes or hairbrushes that would be collected by the Chief Medical Examiner for DNA identification.

He kept clarifying on a daily basis, he had press conferences a couple of times a day, with new information as it came along, but always in the context of looking forward to the next steps in the recovery.

One of the measures he took was to offer families to waive the usual period before a death certificate can be applied for, because in the absence of a legally identified body, it normally would be several years before you could be eligible for a death certificate, and he recognized that the death certificate would allow certain benefits and entitlements to be paid.

Teams of volunteer lawyers were organized and they were at the Family Assistance Center and there was an annex to the Chief Medical Examiner and his staff could waive the waiting period for the certificate.

But we saw in the first three months that -- I can't put a number on it right now, but there was a very, very small number of families who took advantage and applied for the death certificate.

I've heard Mayor Giuliani say more recently that it underscored for him the need to move slowly with his language and with his actions with respect to addressing the finality of the loss that family members were experiencing.

So we also, you know, I know that I had my staff get me the reprints of the articles on the Oklahoma City federal building bombing, and I was trying to get a quick brush-up on what I might be able to expect in New York City with the belief that we should see comparable rates, if not higher rates of PTSD and depression and other health impacts as well.

We began to prioritize by recognizing there's higher risk, medium and perhaps low-risk individuals for these sequellae, so the higher risk people would include the rescue workers and the evacuees from the towers and family members as well as those people living in the immediate area near Ground Zero and children who were going to school in the neighborhood of Ground Zero and nearby.

There were some unique challenges in thinking about how to mobilize the social support networks of families of victims and surviving coworkers.
For example, there were 343 fire fighters who were lost and we sat down with the Fire Department leadership and it was impressed upon just how insular, if you will, the uniformed services are.

They don't quickly trust or welcome outsiders and historically the Fire Department has looked out for its own. So we attempted to adapt a model by which we paired a peer counselor, someone who was a fire fighter, retired fire fighter, someone who had training in counseling services, they had a small team of people like that, with a licensed mental health professional who was well credentialed and trained in disaster mental health and bereavement in order to have this sort of way of gaining more acceptance with the fire fighters.

Some of you may recall that some of the earlier surveys that were done. The New York Academy of Medicine researchers did a telephone survey five to seven weeks after 9/11 and they looked at 1,000 adults living in Manhattan south of 110th Street, and the finding was that about 7.5 percent had symptoms that were compatible with PTSD, including prolonged occurrence of nightmares and difficulty concentrating and sleeplessness.

Another 9.7 percent had symptoms of depression and consistent with the earlier literature, and literature from Oklahoma City, the rates were much higher for people who lived and worked closer to Ground Zero.

So we had rates of 20 percent PTSD and 17 percent with depression. So we recognize that -- and combining the two was about 13, 14 percent. Well, the population of Manhattan being about 900,000 people, that's a lot of folks who now have significant distress symptoms that were going to impact on them very profoundly.

While it's logical to focus on PTSD, and those values are about twice what you would expect at the baseline for an urban population. PTSD, obviously, is most clearly related to the traumatic event and has been associated in the literature with lots of different types of disability, work impairment and health issues and lower quality of life and suicidality and other dysfunction.

But, you know, the reliance on a categorical model of psychiatric disorder means that relatively little attention gets paid to people whose disability and impairment doesn't reach the threshold to give them this diagnosis.

One of the New York researchers at Columbia, Randall Marshall and his group had just published in September, I think in the American Journal of Psychiatry, an article where they did a survey of 9,000 people who were screened on National Anxiety Disorders Screening Day, and they found that what were called sub-threshold PTSD has very significant disability associated with it as well.

As you go on incrementally to one symptom, two symptoms, three, and then the threshold is reached at four symptoms, you get -- from one to three, you have twice as
many people who are going to meet the threshold at four, and that these people were found to have much higher levels of suicidality, even when the presence of major depressive disorder was controlled for.

So you have more suicidality, you have impaired work performance among a population that potentially is twice to three times greater than even the PTSD population.

So the impact is like looking at the tip of the iceberg. There's a much larger chunk of the population that has significant distress as well. For the larger population of New Yorkers, we launched a public education campaign.

In large measure, Sandy Mullin, who worked with me, who headed our Public Affairs Bureau, helped to craft that campaign, and we called it the New York Needs Us Strong Project Liberty campaign.

This campaign appears on bus shelters and subways and there are public service announcements. The intention was to normalize the experiences that New Yorkers had to trauma, and to destigmatize the acceptance of professional mental health care if, in fact, that's what they would need.

Interestingly, I think over the course of months, the numbers of calls -- there was a hotline associated with this, a 24-hour, seven-day-a-week hotline -- and the number of calls to the hotline has increased over the course of the first year.

So it really also corresponds to a finding in the Oklahoma City at there were more people in the second year after the bombing who presented themselves for mental health treatment as a consequence of their reactions to the trauma than in the first year.

We've seen more people call and after the one year, 200,000 people have availed themselves of some level of services related to this Project Liberty campaign, from the very least intensive education and outreach to more intensive crisis counseling services.

At the same time, and I spoke with the Academy of Medicine researchers recently, those surveys have been repeated at seven-month interval and then one-year interval, and we're seeing a significant decline in the PTSD-like symptomology.

I believe that at one year it was 1.3 percent, and it's been declined by about 80 percent. So I'd like to think that the data suggests that we're reaching a population that was significantly impacted by the 9/11 tragedy, many of whom delayed seeking professional care for many months, assuming that, you know, it's something that will get worked out, that they'll be able to get beyond, but over time they've become increasingly receptive with the help of a public health campaign such as this to presenting for professional care.
Actually, again, the premise is that rather than this being a clinical program as a public health model, we saw it as an opportunity to normalize and to help reconnect people with the social supports that they had prior to the 9/11 experience.

So this is an example of one of the posters in which the individual, Tony from Queens writes that, "I guess what I'm going to do is to play ball in the neighborhood park, cook for my girlfriend, attend more 12 step meetings so I don't relapse, find other support and check in with my friends more often."

So, you know, these are posters that appear on subways and if you're riding the subway in New York City, you know, we've got your attention for a little bit of time.

So you read that and you're able to digest the opportunity to sort of normalize and think about what you might do to feel better. It also is a great challenge because we're dealing with a public mental health system, at least the one in New York City, that historically, for the past 40 decades, had seen itself as a safety net for public mental health care that would be rendered originally to the deinstitutionalized population and then to the population of the severely mentally ill.

So it's really a sea change for this public mental health department that has now, as of this past year, become integrated into the Department of Health and is now, the agency's called the Department of Health and Mental Hygiene Services, and that vision that Dr. Satcher advocated for hopefully will be launched in New York City.

The danger, the risks that people felt in those communities where you had the mental health community who was fearful that they would be swallowed up by the big fish, in this case the public health community, and the public health community who sort of questioned what they were doing with a mental health agency, what, you know, just where would it fit in.

So that's going to be a lot of work and a great challenge. But the data suggests to me that there is a lesson learned here, and that mental health promotion, whether it's through education or messaging or by mobilizing social networks and the availability of mental health services that are carried out outside of the usual clinic walls, because FEMA required that the services be done in the community as part of an outreach, and they not be done as business as usual in the licensed mental health clinics; that type of initiative may have had a major role to play in New York City's recovery.

Difficult to say, you know, how much and how far, but the data suggests that the goals of this campaign are being met. I want to speak now, just specifically to our bioterrorism experience.

It was on October 12 that we got the phone call from the CDC, actually it was about 4:00 a.m. when our Assistant Commissioner for Communicable Disease, Marcie Layton, got the call from Atlanta confirming that the diagnosis of anthrax in the skin biopsy that was done on the person who was the assistant to Tom Brokaw at NBC.
Obviously, it set into motion the perception now that we had a new threat and that this could be a national crisis, despite the focus, as it turned out, in the northeast corridor, in Washington and New Jersey and New York.

It’s very vivid in my memory, talking again about leadership, that I called Mayor Giuliani shortly after getting that call and I met him in his office at City Hall at 6:00 a.m.

We got the CDC Director, Dr. Jeffrey Copeland, on the telephone and I recall that Dr. Copeland told the Mayor that the tests were compatible with a diagnosis of anthrax.

You know where I’m going with this. So the Mayor sort of intuitively knew that this was a way that a scientist might speak about a diagnosis, but he also might be hedging a bet a little bit, whether it’s absolutely what he’d just heard that it was.

I remember that the Mayor shot back at Dr. Copeland, "Doctor, is it anthrax or isn't it?" and, in fact, Jeff Copeland said, "Yes it is, Mr. Mayor." So we were off to the races right at that point.

So he needed to know, and he needed to know in terms that the public would be able to comprehend. It was only a matter of the next several days that we got several reports of cutaneous cases that needed to come under investigation at CBS, at ABC and also at the New York Post.

The Mayor actually went to each of those networks with myself and with other staff and he brought the people in the newsroom together, because these were sent to, you know, it was Dan Rather.

We don’t know the exact source, but the expectation with ABC, because there was no letter found, but we brought together the staff in the newsroom to explain what would be done next in terms of the investigation, both from the public health and the criminal justice perspective; that for the epidemiological investigation we would be interviewing and we might be doing nasal swabbing as part of that investigation; that there would be environmental testing and there would be a clinical component as well; that we would be offering antibiotic prophylaxis for those people who were at risk.

Then, you know, we needed to ascertain what that meant and what level of risk was going to lead to our recommendation that people take prophylaxis. In fact, NBC, there were more than 1,000 people who were prophylaxed in the next 24 hours, but as we went along, those numbers came way down and we had just a handful of people at ABC and CBS.

So as we gained a little more experience and a little more confidence in the risk assessment, we were able to target and raise the level of concern only to those individuals whom we thought were in direct contact and at highest risk.
I should add that given my interest in the integrated public health model, I was never prouder of the performance of my public health agencies than I was in managing those crises at the media outlets, because we set up clinics in each of those buildings, and we had medical epidemiologists, nurses and physicians working side-by-side with mental health professionals.

So they were doing swabbing and they were explaining the risks and at the same time we had counseling going on in a very destigmatized environment that made people feel rather comfortable.

People could talk about their anxieties and their concerns without worrying about being labeled. As you know, when the hoax letters started coming in, as well as when America became white powder-phobic, so all the public health laboratories in the months that followed were overwhelmed by the many calls that were made that required hazmat teams to come in and take envelopes, secure them and bring them to the local public health laboratory, we were overwhelmed.

We were overwhelmed by the need for the public to have their fears addressed in as rapid a timeframe as possible. We could sit back and say high priority, low priority, but it seemed like there was no such thing as a low priority specimen for anyone who was concerned about powder that a hazmat team came in and brought to our laboratory.

So that wouldn't fly with them. But we also learned that our public health laboratory infrastructure was very inadequate, and Surgeon General Satcher, to give us an example of leadership, speaking, though, in the last weeks of his tenure, which also speaks to what I said earlier about being outside of government allows candor, he publicly commented on how antiquated, inadequate and that the CDC laboratories constituted a national disgrace.

So obviously the truth needed to be acknowledged by a public health leader of Dr. Satcher's stature, and in this past year we've all seen a great infusion in new federal funding for public health infrastructure, including laboratory expansion and enhancements at CDC as well as at state laboratories.

But we also remain challenged by the reality that there is a historical schism that exists between public health and clinical medicine. One evidence of that is that historically there has been widespread under-reporting of diseases that public health departments are expected to hear about from hospitals and from community physicians.

With West Nile Virus, in the summer of 1999, when we learned about West Nile Virus, that was fortuitously a phone call from a community physician in Queens who had two patients with atypical presentations in their encephalitis, that turned out to be the West Nile Virus.
So that reporting was critical, but in retrospect, we also found out that there were 17 individuals who were sitting in hospital beds at that time who were later understood to have West Nile Virus.

So we weren’t hearing about these presentations and new clusters of symptoms that should have raised a red flag for community physicians until we heard from that one community physician.

I think there is a window of opportunity now with the focus and concern with bioterrorism for much greater cooperation between clinical medicine and public health communities, but there’s going to be a requirement, even with all the new funding and the new infrastructure that’s being created, there’s going to have be a buy-in, acceptance and partnership take place between the clinical medicine and the public health communities that just hasn’t existed here.

For that to happen, again to the subject of leadership, we’re going to have to find leaders in the clinical medicine world as well as the public health world who are going to be willing to step up and advocate for changes in the medical school curriculum and ways to influence the thinking and the practice of the next generation of physicians and other health care professionals for this partnership really to be meaningful.

Lastly, I wanted to comment on one of the strengths, I think, of the response in New York was that we did make a great effort on communication, both to the public and to the clinical medicine community.

Our Assistant Commissioner Marcie Layton was responsible for providing public health alerts. You know, when you look at the top of those e-mails that are submitted electronically and you see 3:00 a.m. and 4:00 a.m. and 5:00 a.m., you know you have a very remarkable person, very dedicated and that’s what Dr. Layton is.

She disseminated these e-mails on a huge list that was regional and national, and we continue always to hear that it had a huge value to the public health and the clinical medicine community who was receiving these alerts.

We know that on the national scene, there was inconsistency and the lack of authoritative and reliable voices to communicate the real nature of the threat.

This is a Times piece in which the reporter writes that, "People in the grip of fear want information that holds up, not spin control. Again and again in recent weeks administration officials tried to reassure the public. Again and again the situation proved more serious than the officials had suggested. As a result, public trust has evaporated."

I think that the Mayor in putting information out there as early as possible. I can tell you that he had a strong belief that we needed to get this information out because if we sat back and held information until we had absolute confirmation as to a specific diagnosis,
we probably as we were waiting for this substantiation, this confirmation to occur, that the press would hear about it.

That's been the experience, and then we would be getting phone calls and government would then be put into a reactive position and articles would start appearing, and whatever then we said, there would be this decreased credibility in the public's eye.

So there was no textbook experience that we could fall back on as a guide to how to respond. As you know, a number of assumptions that were made about the pathogenicity of the anthrax spores turned out to be wrong.

So nobody thought that the postal workers who were dealing only with sealed envelopes would be at risk and the expectation was that it would take from 8,000 to 10,000 spores of exposure before you might likely lead to inhalational anthrax.

So we were learning the science as we were going along. So the public, I think, is much more likely to be tolerant and accepting of the kinds of errors that can occur in the management of these crises if they feel that you are engaged in really timely communication; giving out the best information that's available to you at any given time.

If they don't get the information in a timely fashion, the public will perceive the government as not protecting them, and then they are more likely to go and find a way to get Cipro and to buy gas masks and in an adaptive way to protect themselves and their own families, which may not be the best public health advice, but it's something that people have a need to do in order to feel that they gain more control and ability to kind of withstand the threat that we're facing.

We, I think in summary, see that it was very valuable to put emphasis on reconnecting individual loss and tragedy to a larger community. Tara said that I am a native New Yorker, and I never experienced New York this way as a small town, you know, where people actually on elevators, usually we don't look at each other and we kind of look up and we wait to be alone, but we actually spoke to each other on elevators, in a very friendly and supportive way.

The spirit of resiliency and rebound was taking place with the influence of a government leader such as the Mayor. So I think one nice example of how we sort of wove our way through this crisis actually appears in a New York Post headline, which -- this is actually a young woman who was the victim of the anthrax letter at the New York Post, so in their style we're giving anthrax back, we're giving the finger to the terrorists.

So, you know, it's a message about the will and courage and the sense that we don't want to be defeated by this. There is a growing body of literature that suggests that social cohesion and social capital can go a long way toward fortifying people against the terrorist's fundamental goal of inflicting psychological trauma and protect people from overall morbidity and mortality.
I'm grateful to the Mayor for embodying the voice of the city and the nation in a period of mourning, and inspiring, with his sense of control and his optimism for our recovery.

I thank you for the opportunity to share those experiences with you. I think this summit on leadership is really an important opportunity for us to really get our hands around and digest what are the priorities going forward that we're going to need to address in order to ensure that we'll have rebound and resiliency when we face and prepare for future threats.

Thank you.

(Appause)

Monica Schoch-Spana, PhD

Opening Remarks

DR. SCHOCH-SPANA: Good morning. I'm Monica Schoch-Spana. I'm a Senior Fellow with the Johns Hopkins Center for Civilian Biodefense Strategies. I want to extend a warm welcome to you to this Summit On Leadership During Bioterrorism, our theme being "The Public As An Asset, Not A Problem." And I wish we had time to go around the room to allow for personal introductions, because there is incredible talent captive in this room to address this very critical issue. And in lieu of taking that much time, I wanted to go through and describe the type of audience that we've pulled together today with your cooperation, because I think it speaks to your influence in the field, and a sense that when you walk out of the room today, you can go out and effect change around this issue. And we are quite grateful that you made time in your very hectic schedules to join us today.

We have about 170 people who include thought leaders in the fields of medicine, public health, nursing, hospital administration, disaster relief, and national security. We have people who have senior operational decision-making authority in the realms of public health and public safety.

For instance, we have over 35 local and state health agencies represented here from the southeast of Florida and Georgia, through the mid-Atlantic, up the coast to Maine, over to Wyoming and Idaho, and even thank you for the individual coming all the way from Hawaii in the middle of February to Washington, D.C. to help with our regional diversity here in the audience.

We have wonderful representation from the family of federal health agencies, Department of Health and Human Services, Centers for Disease Control and Prevention,
the FDA, SAMHSA and the Center for Mental Health Services, thank you very much for
taking time out of your busy schedule today.

We have other federal agencies represented in the audience, Defense, Education,
Veteran's Affairs, and also the Corporation for National and Community Services. We
have international colleagues here, as well, someone from Health Canada, so welcome to
Washington, D.C. today. We have eight professional public health groups represented,
six nursing professional groups represented, five hospital and medical groups
represented. We have nine think tanks in the realms of national and international
security, and also health represented in the audience today. Over ten universities, we
have inter-governmental groups represented, including folks from mayors, to police
chiefs, to county executives. We have disaster relief service organizations represented, as
well as community service organizations, experts in public affairs and risk and crisis
communications, and also journalists from prime news media outlets, including the

We've gathered you in particular today to address this issue which we feel still needs
more work, more focus and more inclusion in bioterrorism policy planning, and we're
hoping that you can be the agents of change in this particular realm.

So why are we here today? Our goal is to try and synthesize for government and public
health authorities, those essential principles of leadership that encourage the public's
constructive collaboration in confronting a bioterrorist attack. And we have the
unfortunate opportunity to learn from recent front line experiences with terrorizing
events.

The program is organized around the concept of the public's capacity to respond
effectively to an infectious disease emergency, maintaining steadfastness in the context
of uncertainty, helping practically to contain an outbreak, and rendering assistance to
others when possible. And we believe that it's decisions, actions and messages of the
people in charge of bioterrorism response that will have a dramatic impact on the
likelihood of the public's positive reactions to crisis.

Now it was four years ago in the month of February that the Biodefense Center
convened the first National Symposium on Medical and Public Health Response to
Bioterrorism, and that program was organized around this core lesson; that the
potential consequence of a biological weapons attack is an epidemic. The corollary
principle or lesson of that program was we needed to open up the circle of first
responders to include health professionals, such as emergency room docs, nurses,
infectious and control practitioners, epidemiologists, public health administrators and
so on. And we, at that point, were charging that particular audience with going out into
the world to make sure that bioterrorism preparedness and response policy making and
planning circles were opened up to include health professionals. So today we're asking
in a comparable public venue for a further widening of that circle of stakeholders. And
the stakeholders who need further influence and responsibility in the realm of
biodefense are members of the general public.
So we invite you today to share in three collective tasks, to revisit our assumptions about mass responses to crisis. Should we continue to accept in an unquestioning fashion the dominant image of an emotionally vulnerable public prone to panic and social disorder as the primary organizing principle for bioterrorism response systems?

Secondly, we invite you to explore ways to meet the public health and public safety requirements of diverse publics during a bioterrorist crisis. For instance, how do we meet the needs of both the old and the young during a moment of emergency, the able-bodied and the disabled, the insured and the uninsured, and also to meet the needs of our multi-lingual/multi-ethnic community in the United States?

And thirdly, we ask you to explore ways to equip every day institutions, such as workplaces, schools and civic groups to help people cope with a crisis. And so these three topics are going to comprise the focus of our first three panels today.

We will have a working lunch between the second and the third panel, and we will close with a wonderfully distinguished panel of seasoned political and public health leaders and their constituents who have had to confront a recent terrorizing event. We're going to draw from their collective wisdom, and then also your collective wisdom, as well, to try and pull out those essential principles of leadership that foster a capable, confident public during a crisis.

There is incredible experience and expertise in this room, and as a member of the Program Planning Committee, it was a matter of robbing Peter to pay Paul, so we've asked our speakers to limit their remarks to 10 to 15 minutes. It was a strategy to try and rest enough time so that we could get input from you, so we heartily encourage you to share your criticisms, your comments, and most importantly your cheers. And the substance of the program is meant to spark conversation and interest, continued interest in this issue, but this meeting is also intended for you to foster new relationships, so please take advantage of conversations with everyone that you meet for the rest of the day.

Robert J. Ursano, MD

Rethinking Preconceptions about Mass Response to a Crisis: Introduction

DR. SCHOCH-SPAN: It is a great pleasure to turn the floor over to Dr. Robert Ursano. I was mentioning to Robert that it was a pleasure to read his formal bio, because it's through personal interaction that I feel a sense of his leadership qualities, but it was nice to see the types of accomplishments that he has achieved in his career. He is a professor of psychiatry and neuroscience, and also the Chairman of the Department of Psychiatry at the Uniformed Services University of the Health Sciences. He was the first Chairman
of the American Psychiatric Association’s Committee on Psychiatric Dimensions of Disaster, and he is a member of many, many distinguished panels that are focused upon the mental health aspects of terrorism. And you're welcome to read his bio when you have an opportunity. And I would welcome you to the microphone. Thanks, Robert.

DR. URSANO: Thank you, Monica. It's a pleasure to be here. Just to set the stage for our speakers to remind all of us that bioterrorism is one particular type of terrorism. Terrorism is actually one particular type of human-made disaster. In thinking of that nosology it can aid us in understanding both what are the types of problems that we face, and what are the problems that leaders face, what information can we draw on that may be helpful.

What is different about terrorism is the way in which it has become a national agenda, and in the way in which we recognize it as a threat to our national security. Where in the past it has been well-known that military power, economic power and information are, in fact, the cornerstones for national security, this conference is raising the level of our awareness of our communities and our social capital, as a critical element of our nation's security. Since that is a primary target of terrorist events, and in particular bioterrorist events, the importance of leaders understanding how to protect, how to ensure the resiliency, the reliability, the redundancy of our social capital, that it can survive a potential bioterrorist event. The role of leaders in such settings span from naming the problem, to deciding when to make changes.

I had the opportunity to chat with Mayor Giuliani, and asked him one particular question; which was, how did he know when to change from talk about rescuing people at the World Trade Center to recovering bodies? That change in language mobilizes a community in a particular direction, and the subtleness of that decision assures either accurate and helpful responses of large groups, or potentially creates roadblocks for communities in such settings.

Following 9/11 I was doing a live web broadcast with Sam Donaldson, and at one point he turned and asked me about so, how do you think Mr. Bush is doing? As a federal employee, I felt my career pass in front of my eyes, and realized the opportunity to do bad here was high. Reaching back into my memory banks, I responded that I thought Mr. Bush was expressing the fear and anger of the nation. Number one, I thought it wasn't a bad answer. Number two, it saved my career, but it represents how leaders approach a community and try to assure that communities are an asset, rather than become a problem. How they make time decisions, and what they choose to say. So this morning we're going to spend time thinking more about how communities can be assets, how leaders will relate to those communities, and how the mass response to a crisis in fact requires and demands that our communities be an asset to us.
Ann Norwood, MD, COL, MC, USA

Anticipated Psychological Impact of Bioterrorism

DR. URSANO: Our first speaker is Dr. Ann Norwood, and is a wonderful friend and colleague. She's a member of my faculty at the university. She's also the Associate Chair of the Department of Psychiatry. Ann is one of the leading speakers in the area of bioterrorism at almost any meeting that you go to. She is presently the Chair of the American Psychiatric Association’s Committee on Disaster Psychiatry, and she's going to speak this morning on anticipated psychological impact of bioterrorism.

DR. NORWOOD: Good morning. First, as Monica said, Dr. Ursano is a stellar thinker in this area, but I also want to just underscore this part, and the Associate Chair part. He's also the smartest man I know, so moving on, I first want to thank Monica Schoch-Spana for her scholarship and leadership in this area, and also to commend the Center for Civilian Biodefense Strategies for their good sense in hiring her very early on.

This morning again the emphasis is why do we care about psychological impact? I just want to focus for a moment on this word, "terror" embedded in bioterrorism, and that's really the reason we're speaking this morning. Today, I'll be discussing factors that make bioterrorism so frightening. I'll also discuss psychological responses, and I'll present a couple of examples of outbreaks.

The one take-home point I really want to make is that our goal as leaders, as health care providers and so forth, is to prevent ideally or convert terror to a realistic fear in the wake of these sorts of events. First, I want to also acknowledge my collaborators, Dr. Ursano, and also in the audience Dr. DeMartino.

There are a number of reasons that I think psychological responses are important to our understanding. In the first place, they affect our physiological responses, and that can directly impact health care seeking behaviors, which I'll allude to later on this talk. Also, overwhelming emotions can disrupt realistic problem solving, and we're going to hear more about panic. I rather liked yesterday's definition that was offered at lunch time; is that, panic really is when people do what we don't want them to do, and don't do what we want them to do.

The last, and I think this really is the cornerstone. As a psychiatrist, of course, I'm interested in how people do long term as well as acutely. But in the immediate aftermath of a bioterrorist attack, we're really focused on behaviors, whether people do things that are adaptive or mal-adaptive, and that's at both an individual and a group level.

Why is bioterrorism so scary? Well, first of all, the agents are invisible and odorless. They tap into very deep rooted fears of being invaded and destroyed by an invisible
force. There’s a delayed onset between exposure and illness, which produces tremendous anxiety and uncertainty in those fearing they may have been infected.

Because most biological weapons produce diseases that are rarely seen in American medical practice, there is limited medical knowledge about diagnosis, treatment and outcome. And as you saw with the Anthrax, these agents may behave differently than we anticipated based on prior experience in terms of their ability to infectivity, and ability to be aerosolized and so forth.

Because of this uncertainty, physicians and patients really are in the same boat. And another thing to emphasize is this will be relatively new. We did have the Anthrax experience, but as we’ve see over a variety of things; for example, the introduction of machine guns in war, the use of gas for the first time, the novel use of something is terror-producing. The idea of taking something familiar like an airplane and crashing it into the World Trade Center and the Pentagon causing so much destruction, again is novel and, therefore, more frightening.

The other thing is grotesqueness. The agents like Smallpox are very disfiguring, and you just show a picture of someone with Smallpox, that does a pretty good job right there of establishing fear and terror.

Other aspects that are important to our understanding, is there is a potential for a high number of casualties, although again as we saw with Anthrax, even with relatively few fatalities, as awful as those were, the amount of disruption, and economic and psychological toll that they took was very remarkable, so that they may or may not be weapons of mass destruction, but they certainly can be weapons of mass disruption.

Again, there may be limited availability of treatments. You can recall as we started to worry about Smallpox, the amount of vaccine that was available. That was a topic very much on our minds. Uncertainty about the effectiveness of treatment. Again, we have new medicines, new procedures since we've dealt with these infectious diseases in the past, so it's kind of a new ball game. Also, the wild card of potentially genetically altering things.

If there's contagion involved in something like Smallpox then that ups the fear ante quite a bit. And again, biological casualties could be widely dispersed in this era of rapid transportation.

Again, biological agents generally are poorly understood outside of limited professional groups, and there can be uncertainty there, as well. And the way that scientists tend to like to learn the truth, if you will, is to argue with one another, and that tends not to be terribly reassuring in the event of a bioterrorist attack, as you saw with the Anthrax. And again, I've added the scientific uncertainty. It's hard to give advice when you really don't know what's going to happen.
Okay. And this is to point out the real dilemmas for those of us who will be dealing with risk communication, and especially with the media since they'll be our primary mode of getting information out to that public. Events will be viewed as uncontrollable, dreaded, catastrophic. Again, with something like Smallpox, it may produce a third casualties and deaths. These are things we found out in other sort of events similar to bioterrorism.

Additional stressors. First of all, you have to look at the context. Is this going to be an isolated event or is it in the case of a metropolitan area like Washington and New York, in a set of ongoing threat, and the expectation of the other shoe dropping, which makes a big difference in psychological stressors.

Other things that happen, again depending on the scope of that disruption of your natural support system, loss of job, relocation, the hassle of working with insurance and government agencies, as wonderful as they may be, it takes a fair amount of energy to navigate that.

The other point I wanted to make is that in a bioterrorist attack, even if it's one attack, there are a series of events that you have to anticipate. There is, first of all, discovering that it happened and figuring out where the exposure took place. There is also then the issue of evacuating buildings, the issue of treatment. You recall all the psychological ramifications of introducing an investigational drug like a vaccine, or the discrepancy between one group, the postal workers get one set of antibiotics, and those on the Hill getting another. And then the decision to go back into buildings, how safe is safe? So there's a whole -- even within one attack, there are a series of events embedded in that that will have psychological consequences.

This is just to show us that the psychological toll, this was from a national poll, that in the aftermath of 9/11, 71 percent of the representative sample of the nation felt depressed, difficulty concentrating, trouble sleeping. I suspect the recent tragedy with the shuttle you'll also see a fair amount of sadness, if that's being studied.

Psychological responses. This is just a partial list, and again, there's that sense of horror, fear, anger and paranoia. And I want to point these out because that can lead to rumors and scapegoating. Rumors can be very -- have powerful consequences of their own. For example, in the Surat Plague outbreak there was a rumor that Pakistan had deliberately introduced the agent from the Soviet Union as a weapon of bioterror. And again, with two nuclear armed countries, that creates a bit of heartburn.

Sadness, grief. Again, we tend to overlook the positive outcomes of responding to a tragedy. Altruism. Again, I had mentioned uncertainty, terror. Again we do see resilience. Numbing and withdrawal is a problem, as is a feeling of helplessness, so that anything that helps empower people with a sense of there's something they can do is generally helpful.

Okay. To speak a little bit about the Surat Plague outbreak again, this was not bioterrorism. It was a natural outbreak. It resulted in 58 deaths. It was antibiotics susceptible, so in other words if you caught it, it was effectively treated. But I just want
to -- again we'll hear more about panic and behavior, but the doctors took off too in this event, so we are not immune from fear and terror. And this points to the fact that I think again that panic is sort of in the eye of the beholder, and it may not be so silly to stock up on a treatment if you think that you might need it and there might be a shortage. Maybe not desirable from a management point of view.

And again, there are social and economic consequences, a ban on flights from India. Of course, a lot of people didn't feel like traveling over there. And just to show the international, things aren't local any more. The CDC Plague Hotline received over 2,500 calls during that time period.

Another thing that our concern is, is that there'll be a tremendous health care seeking behaviors that again could be distributed throughout the country, or indeed the world, for people fearing they've been exposed to something. If we look at best case scenarios, there's an identifiable event like the Tokyo sarin attack where the scud missiles, where they thought there might be something going on during the first Gulf War. It produced immediate symptoms so there is not that uncertainty. You know something has happened. The agent is identified rapidly so you know what you're dealing with. Ideally, there's some warnings so you're kind of primed and ready to go, and it's a small event. And under those best circumstances, I've chosen to call these behavioral rather than psychological casualties.

What I mean by this is that people take themselves to a health care provider or a hospital to get checked out because they're worried that they might have whatever it is. Now why do people do that? Well, some of the signs of physiological arousal when we're exposed to fear are quite ubiquitous and quite, you know, wide-ranging. And you can imagine if you start to feel these kinds of things that that might just reinforce your concern and fear that you have been infected with something, so that there is a real true physiological response that can play into this health seeking behavior and fear. So again, this misattribution of the normal symptoms of, if you will, fight, flight or freeze, to be something of a serious illness. And if there are rumors and false information, again to underscore points that have been made, it's important to be honest and fast in getting the information out. And also, to monitor for rumors and address them. And there's a certain amount of hypersuggestibility right after something that kind of stuns us. And again, the take home point is that risk communication will be a critical factor in determining outcome to one of these events.

Just wanted to show another national sample by London. Again, I think people were relatively -- put things into pretty good context overall following -- in the immediate aftermath of the Anthrax. I have a few more slides on that, but you can see like most people thought it was more likely they'd get the flu.

Moving to things that are behaviors, again, which I think is really where the money lies. Thirty-seven percent used precautions opening the mail, about a quarter of people had stocked up on emergency supplies, looked for information. And this again is what I want to show, is really less than 5 percent purchased something or started taking -- I think it
was less than 1 percent that actually took antibiotics, even though some had purchased it.

And this is just to show that other things around here, again in a climate of expected continuous threat, the terrorists, sniper incidents really generated more terror in this particular region than the Anthrax did. And I think understanding the reasons for that would be important as we try to predict and manage responses to. And again, looking at behaviors, almost 44 percent changed their outdoor activities in this region. Thirty-six percent use a different gas station. And again, I think rather than seeing this as necessarily panic, you might also see that this is reasonable strategy perhaps to avoid being shot, even though there was a very small risk of doing so.

And with that, I think I will close with the final remarks, that I think it's very important that we understand the psychological and social consequences of these attacks so that we can mitigate against them. And that risk communication and honesty, and trusting in the public will be the cornerstone of those activities. Thank you.

DR. URSANO: Thank you, Ann. You know the last time I had the opportunity to introduce Ann, my wife was in the audience, and Ann also made that comment about being the smartest man she'd ever met. I went home that night and I said to Diane, my wife, who's a social worker, isn't that wonderful what she said? And Diane said, "Bob", she said you're the smartest man." Just to make sure you all are out there and staying with us.

---

Lee Clarke, PhD

The Problem of Panic in Disaster Response

DR. URSANO: It's a marvelous chance now for us to move on, and to hear some additional comments. Dr. Lee Clarke is a Professor of Sociology at Rutger's University. His early worked concerned how decision-makers chose among the various risks in uncertain environments. He is one of the few people who has published not only in the American Journal of Sociology, but also in the Atlantic Monthly. He's also served as consultant to the Department of Energy. This morning we look forward to hearing his comments on the problem of panic in disaster response. Lee.

DR. CLARKE: Thank you for that. That's wonderful. Can I ask that the lights be brought back up, unless there's some great compelling reason to keep other folks in the dark. Thank you for having me here. I'm going to keep that short because I need all my 15 minutes, all of them. If there's a silver lining, it's a cloud with a silver lining, the silver lining in 9/11 is that our imaginations have been stretched, and prodded, and doubted, and it is important, I think, because if we're going to be valuable in this war on terror, we have to imagine in new ways, because they say, everything has changed. We're only
now starting to discern how it is that our society changed as a response to 9/11, and
government response to it.

One thing we know for sure, before 9/11 experts on terrorism thought that it was against
the terrorists’ interests to kill large numbers of people. That was the conventional
wisdom, so now there is no conventional wisdom on terrorism, so our imaginations have
to change. Now it used to be that we advised people not to imagine the worst cases. We
would tell them that it was against their interest, and against good reason to concentrate
on the risk, as opposed to the outcomes. We would tell them it was unreasonable, that
perhaps we would even be prone to panic if we focused on worst case possibilities,
rather than the likelihood of occurrence. But, of course, we live in a worst case world
now, and I think our imaginations are not going back.

Now I’m going to make two broad points today and fill these in. One is that we know a
lot about preparation and response to disaster from social science. And the second is
that planning processes can be way too top heavy. The first point, of course, first.

We know a great deal about how people prepare and respond to disasters in social
science, but we have failed, those of us in disaster studies, we have failed to properly
communicate this knowledge to officials, and even to some emergency planners. And
the result has been the perpetuation of a number of myths. One is that people
automatically follow their leaders. Another is that
we need only one spokesperson with a
single consistent strong message. Not true. Another is that people become inured to
warnings that there's some sort of cry wolf issue, that if we tell them that they're in
danger multiple times, after a while they won't believe us. And the last two I'll
concentrate on, that people panic in disasters. At least in the United States, panic is
quite rare in disasters, although it does happen occasionally. And that people can't
handle bad news.

Now I want a quick sort of academic footnote here. We need to be careful. We need to
look wherever we can for new ways to imagine about terrorist attacks, and especially
bioterrorist attacks, but we have to be careful about this, because nobody has really
thought through, or I haven't seen it, thought through the implications of making direct
comparisons between bioterrorist attacks and other kinds of normal disasters.

One obvious difference is that a bioterrorist attack will not be geographically
concentrated. For theoretical reasons, I'm not going to -- I won't spend time on that
today. That could matter enormously. Nonetheless, we look at other instances for
lessons. We look at the World Trade Center, of course, and there we see very little panic.
People were scared out of their minds, but that’s a perfectly rational thing to do.

One of the reasons there wasn't a higher death toll in New York is indeed that people are
generally -- generally responded well, but this is not surprising to those of us in disaster
research. All right? They did not rush, pushing people out of the way to get out of the
building. They helped each other. They helped complete strangers. This is not unusual.
We look at other bio events, the Yellow Fever outbreak in 1793, the Spanish Flu outbreak is probably one of the most important examples we can draw on, the Rajneeshe cult attack on a small town in Oregon in 1984, the important lessons there is that at least 1000 people sought treatment. People overflowed the hospital. Everybody was overwhelmed in the area, very little evidence of panic. By panic, we understand people taking actions that end up harming themselves and harming other people, and engaging in anti-social behavior. That's the sort of panic that's quite rare, at least in the United States.

Between 1932 and 1945 the Japanese attacked the Chinese with all kinds of agents, Bubonic Plague, Cholera, Anthrax and all, but if you read those cases carefully you see very little evidence of the kind of panic that we see in disaster movies, so such cases suggest that panic will not be more likely.

Let me move into a couple of other issues. For miscommunication research, we know that if people trust the messenger, they generally respond -- this is a nice picture, isn't it? They generally respond quite well to alarming news. I've been calling this somewhat reluctantly for the past year and a half the Giuliani Phenomenon. And Dr. Cohen referred to -- talked at great length about the qualities of Giuliani right after the terrorist attack.

It's interesting, what he said differs very dramatically from what other members of Giuliani's staff have said at other conferences, what they have concentrated on in contrast to Dr. Cohen are Giuliani's John Wayne proclivities, take charge kind of guy, take no prisoners, we're in charge, everybody is okay, but that in fact -- and I think that was -- he was a strong leader, and that is important for any leader, and will be in any kind of terrorist attack. But I think in addition to the John Wayne proclivities there are Giuliani's Alan Alda proclivities, where he's hugging somebody. That is to say, as Dr. Cohen said last night, he didn't get up there and say everything is fine. We're all in control. He wasn't like Alexander Haig after Regan got shot.

This is important because it made him trustworthy. He showed his vulnerability. He didn't over-promise. When we over-promise it's a problem. We know some things about how to engender trust under difficult conditions. We also know some things about how to engender distrust. I'm not going to read all these quotes. They're wonderful quotes. These are quotes that happened after the first Anthrax fatality of Bob Stephens down in Florida. These are ways not to engender trust. I'll just read the last two because I love them. I think they're so telling.

Florida's Lieutenant Governor says, "No reason to think this incident is anything other than what we've seen in the United States over recent years." It took journalists five seconds to discover it was the first pulmonary case of Anthrax in 25 years. Health and Human Services Secretary says, "People should not go out of their way and do anything other than what they've been doing, what they're doing." This is a time when we're on high alert. That's what we're doing, we're being concerned. We're going out of our way to
other people tried to imply that poor Bob Stephens contracted Anthrax by digging in a garden or in a stream in North Carolina.

These are not calming. Such statements do not engender trust, and they are easily dismissed for all the foolish things that Americans do. We smoke, we drink, we overeat. We drive cars. Of all the foolish things that we do, we are among the most educated and the most skeptical people on the planet. Soothing homilies don't work.

Let me move to my last point, having to do with planning being too top heavy. Let me -- a little caveat here quickly because I've sometimes been misinterpreted, which it's all my fault for failing to -- been misinterpreted as being anti-organization or anti-planning. I am not. I like organizations. I like what they do. I like planning. I like what it does. Grade school fire drills and hurricane evacuation plans are excellent examples of tight command and control planning. We need that under certain conditions.

The problem is that, especially at the federal level, there's too much emphasis I think on issues of command and control. I put this slide together before Saturday, but I just couldn't take it out. It's a NASA slide. The command and control approach sees managers as generals in charge, and people in the street as children. This seems to be especially true, as I say, at the federal level.

There are two big problems with command and control. One is that command and control works best when all the tasks to be accomplished are contained within the system. Controlling the nuclear arsenal, operating theater in a hospital, an aircraft control carrier, all some evidence that even on an aircraft control - that's not right - aircraft carrier, a nuclear aircraft carrier that responsibility devolves. But in those cases, all the things that you have to do are contained within the system.

In the case of a terrorist attack, especially a bioterrorist attack, not everybody is in the organization. You can't just assume that you can order people around. You can't just assume you can order all Americans around. We're too diverse. We're too skeptical.

Another point is, contingency plans are often written by organizationally based planners for other organizations. The problem is that our world, especially a world under bioterrorist attack may not conform to command and control assumptions. I put together my own little planning scenario. Let's call this Clarke's unrealistic scenario. It goes like this, I'll be quick.

Several hundred people develop flu-like symptoms. It's noticed in some places, but not in others, very unrealistic, providing lots of opportunities for misinterpreted signals. Some insiders suspect widespread contamination, but others aren't so sure. We don't want to panic everybody, so the information -- so people sit on it.

The Department of Homeland Security has been worrying about al-Qaida and so it's caught off-guard when the Arian nations mount an attack against African Americans. Congress, movie stars somehow gain access to the media and become players. There are
confusions and turf wars. Experts contradict each other. They're shifting blame and pointing fingers. At some agencies, amazingly, bosses tell their public health officers not to talk to reporters. Meanwhile, people evacuate at their own pace, at times of their own choosing, and at the end of the crisis the body count is lower than initially expected, but mainly because of luck and the incompetence of the terrorists. There are hearings, investigations and new rules, and then we have conferences on lessons learned. Who is thinking about this kind of unrealistic scenario? I'm not sure.

I looked long and hard at the Department of Homeland Security’s documents on prevention response and countermeasures, and I'm looking for some mention of the public in there, my little organization chart. I think that the budgetary figure is actually $5 billion too high. But anyway, this is a rudimentary organization chart of the new DHS.

I find instead of mention of the public, what I find is references to fear and panic and the first responders. The first responders here are always officials and organizations. The problem is the person in the street is the first responder. It's the passenger on the airplane. It's the teacher in the local school system. It's your neighbors. Those are the first responders. It matters. It matters. I saw -- we know the disaster response is largely a local affair, so I looked also in those documents for some reference to that. You see some words about coordination at the local level. You look in vain for the actual people. It matters. Our models of how people respond in disasters, it matters if those models are wrong. Okay.

How to involve the public. We need to find ways to not just think about educating the public, but actually involving them in more active ways. I have no solutions. If I had the solutions, well, I guess I’d be boss of everything. I have no solutions, but just as imagination provokers we need, of course, massive upgrading of the Public Health Service. We might engage in something like the operation alerts during civil defense days, but in ways that involve people more directly.

We might think about disaster response as organized the way that normal social life is organized. We are a people organized by race, we're organized by age, by occupation, by families, by churches, by non-profit organizations, all at the very local level. We need to push the effort, the resources and the imagination. We need to push the imagination down.

Effective preparation, detection and response will always depend on formal organizations. This is a good thing. Organizations are very effective, but organizations are built to do some things well, and to neglect other things, and there’s no one best way. Complex organizations tend for good reason not to be fleet of foot and nimble of mind, but it may be exactly flexibility and speed that we need most in a bioterrorist attack. Thank you.

DR. URSANO: Thank you, Lee. I'm always impressed when we have discussions about panic that we are focusing on what are the behaviors which, in fact, interfere with
adaptive response. What we're hoping to do is to foster those and to recognize that the most probable response of any community is, in fact, adaptive behaviors.

Judith W. Leavitt, PhD

Public Resistance or Cooperation? Historical Experiences with Smallpox

DR. URSANO: Another area for us to turn, we've looked at the individual. We're looked now at the study of groups, is to look at previous experience, which draws us to the question of history, history in our past, far past, history perhaps in our present. It's important to remember that there are communities in the United States in which terrorism is endemic as we speak, long before 9/11. In Baltimore, Angela Dawson's house was fire bombed. She died, and her five children. The intent of the fire bomb which was thrown by a drug dealer was to discourage what she had done, which was to tell the police about the marketing of drugs going on in her community. Terrorism has been around for quite some time, and biological events have been around for quite some time.

Dr. Judith Leavitt is presently the Ruth Bleier WARF professor of medical history. She focuses on the issues of 19th and 20th Century public health and women's health. She's recently published the book Typhoid Mary: Captive to the Public's Health. She's the past president of the American Association for the History of Medicine, and this morning she's going to talk to us about "Public resistance or cooperation? Historical perspectives from Smallpox." Judith.

DR. LEAVITT: Thanks very much. I'm really so pleased to be here, and honored to be here. Let's see if I can get this going. And you see, I changed the title a little bit. I'm really going to talk about only two outbreaks of Smallpox in two different cities, so I call it a "Tale of Two Cities". And the images that I want to begin with are images of the two cities. One is Milwaukee, Wisconsin, which experienced a Smallpox outbreak in 1894 of fairly major proportions, and caused urban rioting for about a month in the city streets. And here you see Leslie's illustrated rendition of that rioting in 1894. And the second one I'm going to talk about is New York City during the last Smallpox outbreak in this country in 1947. And the lines here are illustrative of something very different from the Milwaukee riots, and that is total order. These people stayed in line, in these kinds of lines for hours, full days, came back the next day in some cases, and there was no sign of the kind of riot that we saw in Milwaukee. So let me start first with Milwaukee in 1894.

This was an outbreak that came to the City of Milwaukee hitting every ward in the city by June of 1894, at the same time as a brand new health commissioner, Walter Kempster, had taken office. Now Kempster was someone who did not believe in political patronage for the health department, and refused to give jobs to the people in his own
political party, so he started off immediately on the wrong political foot. Everybody was mad at him, and then on top of that, Smallpox comes. Well, he treated it in the same way as previous health officers had. He started a vaccination campaign. He used the isolation hospital, and he used home quarantines.

Now it happened that he used home quarantines for the most part in the middle or upper class parts of the city because he felt that people could be isolated in home there more effectively; whereas, in the poor immigrant sections of the city, he used forcible removal to the isolation hospital. And you can imagine that discrimination there was not helping, so the Smallpox, as I said, spread city-wide. It began concentrating in the immigrant wards, and health department activity concentrated there also. This is just to show you what home placarding looked like in a case of Mumps, but take a look at the uniforms. The uniforms of the health officers became an issue also. So there was enormous resistance, and it focused mostly in the immigrant wards where the Smallpox itself focused.

Part of the resistance to health department activities in 1894 were specific to Kempster; that is, he was a very unpopular man right from the start. We’re in the middle of an economic depression in 1894, and he was not giving people jobs who thought they deserved them politically.

Another big part of the resistance came from the anti-vaccinationists. This was an organized movement at the end of the 19th Century to prevent people from getting vaccinated. Now these are people who thought vaccination was a dangerous procedure. It was centered in immigrant wards, but it was certainly not exclusive to immigrant wards. And the physicians in the city were split probably one-third/two-thirds. One-third against vaccination, two-thirds for it. There was significant, as that tells you, significant medical disagreement, so anyone who turned to a medical authority would have gotten various and mixed messages.

There was great immigrant fear of government authority, in general. Government authority that came knocking on your door in a uniform in specific, especially when it was trying to take your child to the isolation hospital against your will, and so that was a big focus for the problem.

There was a perception, I think there was also a fact of injustice in the way that government policy was handled; that is, the rich were allowed to stay home and be quarantined, the poor were taken to the hospital. There was this phrase, "The scum of Milwaukee" in the newspapers quite a bit, and the people who lived on the southside of Milwaukee felt that that’s the way the rest of the city viewed them, as the "scum of Milwaukee" and, therefore, it didn't matter what you did to them, so there was definite unequal application of the policy. And the immigrants responded by not reporting cases of Smallpox, by hiding them when people came to the door. And ultimately, by rioting against forcible removal, and against vaccination.
The riots in Milwaukee were characterized this way, women played a large role in them. Mobs of Pomeranian and Polish women armed with baseball bats, potato mashers, clubs, bet slats, salt and pepper and butcher knives lay in wait all day for the isolation hospital van. The van was, of course, drawn by horses in 1894, and they also had some scolding water to throw on the horses. The riots lasted about a month, and were depicted nationally, as you saw in this case. And the Health Department responded in a very dismissive, inflexible and incentive way, and these are quotations from the Health Commissioner, from Walter Kempster. "But for politics and bad beer, the matter would never have been heard of." He dismissed the whole thing.

"I am here to enforce the laws, and I shall enforce them, if I have to break heads to do it." And, of course, it's the break heads that people heard. "The question of the inhumanity of the laws I have nothing to do with."

Well, I don't have time to tell you the whole story, but Kempster goes on to get impeached, thrown out of office, and ultimately after a year reinstated, but in the process of that impeachment, the Health Department lost a lot of the authority it had gained over the whole of the 19th Century, including the authority to remove anybody to an isolation hospital. And Milwaukee took at least the next 25, 30 years to recover some of those powers.

The story was very different in New York City in 1947, and some of you may know this story because Burton Rushay has told it so nicely, and the man from Mexico.

Eugene Le Bar was a citizen of Maine who had gone with his wife to Mexico on vacation, and had taken a bus back on his way back from Mexico to Maine. He was not feeling well when he got to New York, and so he got off the bus, checked into a midtown hotel and wandered around the city for five days, before finally his rash erupted. He was feeling so badly he couldn't get out of bed, he said, and he was finally taken first to Bellevue Hospital to the dermatology ward. New York had not seen a case of Smallpox in a generation and a half, and nobody thought of it when he came in.

He was ultimately switched to the isolation ward at Willard Parker Hospital, and he died before a definite diagnosis was made of Smallpox, so he had a chance to expose people in the streets of New York, in Bellevue Hospital, and the nursing and medical staff at Willard Parker Hospital before he died. This led to the largest mass vaccination campaign in U.S. history. Here is a case of somebody who was exposed to Eugene LeBar who got Smallpox, and another one from that same outbreak.

Now the Health Department activities in 1947 differed greatly from the Health Department activities in Milwaukee 50 years earlier. They relied on case tracing, voluntary mass vaccination, daily press conferences. We've heard already, and I'm sure we're going to hear more how important it is for information to keep flowing, and New York did that so well. Israel Weinstein was the health commissioner and Mayor O'Dwyer was also very active in this.
There were signs and buttons around everywhere, "Be safe. Be sure. Get vaccinated." There was multiple daily press conferences and radio shows about the diagnosis when it finally came, the spread of it, every case was announced, and there was a perception, and I would argue also a reality of honesty and justice from the Health Department and from the city government at this time, because people felt they were being informed as things were unfolding. Here you see the case tracing tree from Eugene LeBar here, and the one other person who died in the outbreak. There were 12 cases all together.

The vaccination campaign, as I say, started and ended really with free and voluntary vaccinations. Now this was despite the fact that the Health Department had the authority to do forcible vaccinations, or at least to bring people in for vaccinations against their will, but they didn't do that, and they didn't need to do it.

Vaccinations were given in 13 hospitals, 84 police precincts, and every school around the city of New York, and daily press, as I said, and radio reports. In two weeks, five million New Yorkers were vaccinated, and in four weeks, six million three hundred and fifty thousand New Yorkers were vaccinated. And in the next week, another few, they always said it was six and a half million, although these are the documented ones.

President Truman came to visit New York after being very publicly vaccinated. There was a lot of federal and local cooperation in this outbreak, and especially around vaccine production. New York could rely on the federal laboratories to bring in -- to produce and to bring in vaccine. And laboratories public and private around the city were pushed into service and cooperated. The drug companies were a little less cooperative until Mayor O'Dwyer locked them into City Hall, and said you are going to produce more vaccine, and you're going to do it very quickly, or you're not leaving this building, and they surprisingly agreed.

There were a lot of volunteer workers helping this effort from the Red Cross, to teachers' groups, to women's clubs around the city. And remember, it was a voluntary vaccination program so those people standing in line were there in a voluntary fashion. Public compliance was incredibly high. Now I don't have to remind you that this is immediately post World War II, and that did have something to do also with the level of organization in the city and the cooperative effort.

Here you see another photograph of people lined up. This is in Brooklyn, lined up waiting for their vaccine. And this one you've seen already. This is really my favorite picture. There was one day when vaccine ran out and everyone had to come back, and apparently they did so without a peep. This is inside one of the vaccination centers where you can see the people lining up for vaccine. So it was a successful program, I think, partly because of federal and state, and local communication, voluntary vaccinations, public information blitz, that it was seen as, and was non-discriminatory. That is, every part of the city and every population group was targeted, that there were networks of citizen activity which were coordinated through the Health Department, and there was a very strong Health Department infrastructure. And so, instead of the four thousand some cases and nine hundred some deaths that they would have
anticipated based on the previous New York outbreak of Smallpox, they reported 12 cases and 2 deaths, so it was quite convincing.

Now here I just did a little matrix to show you. Milwaukee had a strong Health Department also when it started out, some state Health Department help, strong-arm tactics for everybody, not just drug companies, very discriminatory in its policies, limited information, mixed messages, no citizen activity, and consequently a raging epidemic. Whereas, New York City had also a strong Health Department, state and federal cooperation, information and respect for people shown at every stage, even-handed in its policy, a media blitz with a clear message despite what Lee just said. It wasn't just one person, but it was a clear message. Use of citizen groups and confined, very confined outbreak.

So the implications for today, I think, of all of this, and obviously, I've raced through it and not given you the full historical context that I would have liked to, is that the response of the public historically has covered the spectrum from strong resistance and rioting to strong cooperation. There is, obviously historically shown a need for well-supported integrated public health structure, and by that I mean integrated not just locally, but local, state and federal integration. That coercion where it has been tried has not worked historically, and has led to more problems; whereas, cooperation with a strong education component has been much more successful.

Public support, I think is based on frequent and honest information and communication. Media has played an enormously important role in giving the message. The media during the Milwaukee outbreak was very partisan, pro or anti-Kempster down the line; whereas, the media in the New York outbreak was an outlet for information. And the information given always demonstrated respect for the public's need to know, which I think is an important part of leaders' roles, is that to respect that, and to give them the knowledge they need, because then they know how to respond. Without that knowledge, they don't. And a perception of justice and equity. Actually, the reality of justice and equity would be what we would aim for. So just in case you want to do any further reading, you can see that I've published on both of these outbreaks, and can lead you to a lot of other sources, as well. Thanks very much.

DR. URSANO: Thank you, Judith. Marvelous reminder of both the importance of history to inform us around modern problems, such as vaccination programs, as well as the importance of terror as an element which can make present the faults that are always lurking within our society, frequently around issues of social justice, which we tend to fall down on way too often.

---

**Monica Schoch-Spana, PhD**

**The Health and Safety of Actual People, Not a Theoretical Public**
DR. SCHOCH-SPANNA: Our second panel is focused on the "Health and safety of actual people, not a theoretical public." And what we meant by that title is the need to get to the complex reality that stands behind the placeholder phrase the general public. I mean, we use the phrase general public and the population, and the people as if it’s all clear who we mean. And I hesitate to add another layer of complexity, such as the diverse community that constitutes the United States, to take that complex reality and then heap it onto the complex threat that is bioterrorism. But there is grave peril if we continue to perpetuate some homogenous notion of a general public, if what we’re trying to do is to shut down an outbreak and involve people who are directly affected, or indirectly affected, or tuning in from Spokane about what's happening on the east coast, if we fail to involve everyone. So we want to move away from notions of a statistical population or a faceless mass, and pay attention to the actual people who are affected by an actual event, paying attention to differences of life cycle. Are we tending to the needs of children, tending to the needs of adults in the prime of their life, and also aging Americans in the United States? Are we paying attention to ethnic and cultural diversity within our United States? And remarks by the earlier panels brought home the message that there are pre-existing social fault lines in the United States that either can be exacerbated during a crisis, or hopefully help mended during a crisis, and hopefully mended ever before crisis, and we need to work on that, as Bob pointed out.

There is a varying sense that the interest and perspectives of some groups are included in public policy, apart from the differences that exist, socio and economic differences in the United States. There are also historic senses of does my voice matter when public policies are made? Are my people included in the discussions of the American population?

Myra I. Lewis, PhD

The Frail and the Hardy Seniors of 9/11: The Needs of Older Americans

DR. SCHOCH-SPANNA: So I want to turn the floor over to Myrna Lewis who is an accomplished scholar and practitioner in gerontology. She's an Assistant Clinical Professor in the Department of Community and Preventive Medicine at Mount Sinai School of Medicine. She's a member of the United Nations Committee on Aging, and is going to speak to us today about both the needs and the contributions of older Americans in emergencies. Thanks, Myrna.

DR. LEWIS: Good morning. It's an honor to be here with all of you. And it occurred to me that what I'm going to be talking about applies not just to older people, some of whom may be disabled, but it also applies to the disabled population of all ages, so if you will keep that in mind as we go along.
I'm going to be talking about the World Trade Center and its impact on the older population in that immediate area. There were two distinct impressions from those of us working during the World Trade Center period, that the majority of older New Yorkers held up extremely well in the chaos of September 11th and its aftermath. However, having said that, a significant group of frailer older people faced unique situations that compromised their ability to manage, and this was especially true for those living within that so-called frozen zone or red zone that surrounded the Trade Center area. And I should explain that this area was blocked off by police barricades for a number of weeks. And initially, only residents or people who could prove that they worked in the area, or people involved in rescue, recovery and cleanup were allowed access.

A little bit about the volunteer experience of many of us. Many New Yorkers, like myself, volunteered our services even though we had no formal training in disaster work. I came to it as a mental health professional, a gerontologist, a teacher, but not a trauma specialist. My experiences following 9/11 occurred first on the Missing Persons Hotline, then in the red zone surrounding Ground Zero, and the eventually work within Ground Zero itself. And finally, something that none of us I don't think have mentioned so far, and that was the air crash that we had about a month later, Flight 587 going to the Dominican Republic. There were also numbers of us involved in both the family work with that, and the neighboring community where the crash occurred.

I'll limit my remarks today to observations about older people as we encountered them in the red zone around Ground Zero, and the pertinent background information. The pertinent background information is that federal estimate was that about 6,300 people aged 65 and older were living in that area within a few blocks of Ground Zero, and maybe 18,000 older people in the effected areas below Canal Street, which is the location of the initial red zone barricade.

The communication breakdowns were the most immediate problem. Older people were very affected by this. The telephone and television cables were destroyed as the towers fell. Disruption of regular phone service was virtually universal. Very few older people had cell phones. Those who did found them unreliable the first few weeks. The phone lines were jammed, the electricity was out, the phone recharging was impossible. Events like the reopening of the Stock Market and Wall Street on day five began even further to overwhelm cell phone capacity. TVs, plug-in radios, computers were inoperable. Mail and newspaper delivery were discontinued for most of the red zone in the aftermath of the attacks, so the result was that many older people had enormous difficulty just finding out what was happening, and equal difficulty in calling their friends, their family, their health care providers.

And one example I'll give you is an older woman who I found clutching another older woman who was sobbing. She had run out of her prescription medication. All the local pharmacies had closed down. The women had no phone, no way to reach their doctor or the pharmacist, and so on impulse we took them a couple of blocks through police barricades, rescue vehicles, piles of relief supplies to an Army medical unit that was bivouacked in a tent. And there a very kindly Canadian male nurse gave the woman an
emergency supply of medicine. And she gone in sobbing, and she came out smiling two minutes later, so that simple intervention put her back on track. And we heard her later regaling the rest of the people in her housing unit about where they could go and get their prescriptions refilled.

This was a week after the attack, I might add. Eventually, the Visiting Nurse Service and Red Cross nurses and others began providing emergency prescription service, but it took some time for all of this to be established.

Isolation was another issue. The majority of older people lived alone or with an older spouse, significant number of these, especially the emotionally and the mentally frail remained hidden behind the doors of their apartments and houses. They were located only after relief workers and volunteers began going door to door checking on every resident. This occurred, interestingly enough, only in the second week after the attacks. There was some initial work done, but solidly going through these buildings didn't really take place until the beginning of the second week.

Disaster relief organizations that ordinarily would have been immediate responders were overwhelmed. Bridges, tunnels, airports were closed, so the logistical problems of setting up service was unprecedented. The Manhattan agencies that typically provide services to the frail and the disabled elderly were caught unaware. Many had no disaster plans for their staff or their clientele. And furthermore, personnel could not get through the police barricades, nor could they phone their clients.

The separation from home health aides, homemakers and home-bound services like Meals on Wheels was universal at first. Permits, special IDs and proof of residence or work in the red zone was necessary, so that it took a couple of weeks for many workers to begin acquiring these necessary documents, a very important point.

In addition, numbers of elder care workers were hesitant to enter what was possibly a contaminated area, and some were simply afraid to go anywhere near the Ground Zero zone. The results were that a number of older persons were found in deteriorated conditions with dwindling food, water, medical supplies. Some required immediate medical care, emergency medical care. The Visiting Nurse Service reported incidents of heart attacks and strokes that appeared to be directly related to 9/11. Some older people were emotionally traumatized by fear of not knowing what was happening. They had no access to information, or what would happen to them in the next days and weeks. Those who suffered from prior anxiety and depression were especially vulnerable to the exacerbation of the psychiatric symptoms.

Evacuation issues. A number of older people were evacuated because of suspected structural damage to their apartments or their homes, or dangerous breakdowns in the utilities. Some of their experiences were striking examples of survival. I met two women, for example, in their 80s who had been part of the larger exodus fleeing the Trade Center area on the first day. They described how they ran north to midtown in their slippers and their nightgowns, and a week later they were proudly telling us their stories.
of their ingenuity of how they stopped to buy shoes and clothing along the way. They borrowed cell phones to call their relatives, and they checked into a midtown hotel where they could have access to television and see what the mayor was saying.

There were also less inspiring stories. The New York Times reported instances of younger able-bodied folks commandeering the evacuation buses, leaving older people with canes and wheelchairs behind. Evacuated elders worried about their pets, their plants, their treasured possessions. It was some time before volunteers were able to respond to requests to feed or move stranded animals, but there’s an interesting reversal here too, that some lucky animals were rescued within 24 hours, far before many of the frail elderly by volunteer animal lovers moving in very quickly.

We also located elders who had declined evacuation. One man refused to move his wife who had Alzheimer's Disease. He thought it was too big a stress for her. Another couple in their 80s chose the security of their apartment over the chaos in the streets outside, even when they had a full view of the smoking towers.

There were special problems for the hearing impaired. A number were evacuated without their hearing aide. Those around them were too preoccupied, too involved to notice that they had hearing difficulties, so they missed the emergency information usually relayed verbally. They had to rely on their own wits as they told us. Those with hearing impairments who were still in their homes reported that closed news captioning disappeared for a period of time on those few televisions that were still working. Once electricity was restored, a few of the fortunate elderly with computers were able to use e-mail and the Internet to find out what was happening. And that was one of the most reliable sources, as long as they had access.

Air and water quality was an issue. The alkaline air pollution from the explosions and the fires were a continuing concern, especially for older people with Emphysema or any other breathing difficulties. The New York physicians have reported an immediate marked increase in lung problems. A year later now, however the New York Academy of Medicine reports a surprisingly few long term problems for the general population. However, in my own institution, Mount Sinai, the clinic for Ground Zero workers themselves are finding some major and long-lasting serious consequences.

For a time, the drinking water was also worrisome down in the red zone with concern that water was backing up from the sewers to some apartment buildings. Many elderly went for weeks with no hot water in certain apartment complexes.

Those older people who witnessed people jumping off of the Trade Center towers were especially traumatized, obviously. Some saw these incidents from the street, while other viewed the Trade Center from their apartment windows or balconies just a couple of blocks away. Sleep disturbances, anxiety, grief were especially common among this particular group.
The search for ongoing mental health services for these and other elderly affected by the attack revealed the scarcity of such services in New York City. The exception, of course, was the emergency counseling directly connected to the Trade Center attacks. However, these were often hastily put together services that were not designed with the special needs of the population in mind.

Now I come to what I consider to be the sturdy majority, and I'll give you a few vignettes. I want to emphasize again, the majority of older New Yorkers whom I met showed remarkable resilience in the face of overwhelming circumstances. There was the older woman in the Red Cross in the red zone who put on her gold star mother pin. Some of you from World War II remember that. That's the pin that was given to mothers who lost a son in World War II. She walked with this pin on into the local fire station to hug the firefighters and to reassure them that she understood their losses, and she told them, "You'll survive."

There was also humor and humorous situations. There were three older friends we found sitting in a park in the midst of dump trucks, cranes, rescue vehicles, and they were busy planning their weekly bus trip to gamble in Atlantic City. And we said what are you guys doing, and they said, "Boy, do we need a break."

There was a 65 year old with a bad hip and a full-time job teaching school in Harlem. On the day the schools reopened I saw her limping her way to find an undamaged subway stop far from her house, and she was on time for school.

The older woman with eight cats and two dogs who lived alone, she had managed to make friends with the veterinarians who were taking care of the Ground Zero rescue dogs. These vets were inundated with dog food from all over the country, piles and piles of dog food, so she charmed them and she managed to connive and commandeer enough surplus dog food to take care of her animals for a year or more.

There was the Italian born widow who had been a little girl during the Nazi invasion of Italy. She hung a huge American flag from her balcony on the 30th floor facing Ground Zero. She said to me, "This isn't so bad. I've seen worse than this before". And finally, the 95 year old very tiny fragile looking African American women out on the street with her shopping cart after returning from a nine day evacuation, smoke was still pouring out of the buildings behind her. Meanwhile, she was busy buying her groceries for supper. When I asked how she was doing, she gave me a big smile and she said, "I'm just fine. Glad to be home again."

So what have we learned from these sturdy and frail elderly and does this apply to the threat of bioterrorism? Communication is critical. Older people need to know what is happening, and how to respond. Battery radios and cell phones work the best in New York. It's unclear that that will always be the case, particularly with cell phones if cell phone use continues to explode and increase. People need guidance on where to call for immediate information, or where to tune their battery radios for emergency instructions.
A recommended list of emergency supplies for the home would be useful. For example, battery radios, three day supplies of water, flashlights, a list of older people's prescriptions and their doctors, and a list of their relatives and their health care providers.

Organizations like FEMA, the Red Cross, the Salvation Army and local health and aging service organizations need to develop specific coordinated plans to locate and assist the older people and the disabled, rather than relying as we had to in New York on ad hoc systems. And when we interviewed some of the representatives of these organizations, we learned they had really no formal plans before 9/11 to reach these populations.

The coordination of volunteers, you've heard other speakers mention this, responding to the disaster is very necessary. Some community organizations for older people were flooded with surplus helpers. Others were begging and crying for more.

There's a need to find some way to identify the frail and the disabled, and the isolated elderly who are not connected to any service organizations and, therefore, especially vulnerable in an emergency. Prescription drugs are a special concern, since most people have at most a 30 day supply or less, many have less.

And finally, I want to emphasize once again that sturdy older population, particularly in view of our discussions of bioterrorism. They could be enlisted and trained as volunteers to serve as a resource in helping not only the frail and disabled, but other populations, as well.

There was an interesting article just yesterday in the Wall Street Journal that was talking about the granny patrol, the Florida cops recruiting elderly volunteers. One man had been volunteering for 15 years as a volunteer cop, cruising around in his cruiser looking for trouble. And now at 95 years of age, his police chief called him in and said he needed to have him another 10 years.

There's a senior corps, a federal service program that is now indicating that hundreds of police organizations around the country are beginning to enlist the elderly, and I think it's a long overlooked group of citizens who are well experienced, and very eager to serve and have the time to serve, so something that we should be seriously considering in looking at extra resources for bioterrorism protection.

Finally, I want to bring to your attention a brief which has been prepared out of our experiences with 9/11, some beginning thoughts on emergency preparedness for older people. I happen to have about 20 copies here if anybody is interested, but Monica told me they would be up on the website, so thank you very much.

DR. SCHOCH-SPANA: In this business sometimes I think the planets align and allow me to meet someone like a Myrna Lewis, who can speak to this type of issue. I met her at a wonderful conference at the International Longevity Center in New York, and she
shared some of these anecdotes, and I thought we need to bring this type of information to this audience, so thank you, Myrna. That was wonderful.

Kathleen Rand Reed, MAA

The Value of Culture and Social Capital in National Defense and Bioterrorism Preparedness

DR. SCHOCH-SPAN: It's my pleasure to introduce our second speaker, Kathleen Rand Reed. It was another moment of planets aligning. There are very few anthropologists who work on biodefense issues, so when we bump into each other, we cling together, such as the old ladies in Myrna's talk. And—I shouldn't have—I think I made an age-ist remark. Excuse me.

You'll note in Kathleen's biography that she has interdisciplinary training in biology, behavioral science and broadcast electronic arts. And I think it's the merging of those three fields, which will bring us many answers to how to deal with the complex problem like bioterrorism. She has numerous research accomplishments that touch on the social and ethical dimensions of clinical trials.

She's more than an educator who reaches out to diverse public, teaching them how to plug into medical and public health assets in the United States, she's an educator of genetic scientists, clinicians, and public health officials of the value of reaching out to all sectors of our society. Thank you very much. Kathleen.

MS. REED: Good morning. I'd like to say that there's a certain point in your life as a woman when—I'm sure you've all heard about the book that said, you know, Women Who Run With Wolves. And I always like to say there's a time in our lives when women are wolves.

First of all, let me say thank you to Monica, to Tara O'Toole, especially to Andrea Lapp because I know how rough it is to do this kind of work. And more importantly, to the young ladies that are out "manning" the desk outside, or "personing" the desk outside who don't get a chance to be in here, but who have done a lot of the work that allows us to be here today.

The second bit of housekeeping for me is a moment of silence for the seven souls that were lost on the Columbia, and a moment of joy for the 90th birthday of Rosa Parks today, so this is a wonderful time.

Let me explain a little bit about segmented targeted marketing. Monica mentioned ethnomarketing. That goes back to say the late 60s or early 70s. I always laugh and say it's during that time when people discovered that people of color had money, and
decided that they wanted some of it. And, of course, that's when ethnomarketing was born. Because, again the joke is that there was an argument between Billy Bob and Bubba, and Bubba said in the Trent Lott way, you know, get them out of here. And Billy Bob said, "Oh no, that's market share! So it's in that spirit that I say to you that I've been able to take an ethnomarketing background, add radio/TV, and then I got interested in health care. In health care policy, especially in the early 1990s in transplantation, people were talking about not enough minority donors, but they were couching it in the aspect of, "If you give, then you get."

And, of course, now we know that that's a little bit different when you start talking about, the human genome project, genes, haplotypes, et cetera. So we've moved forward.

Lately, I'd say the last few years, I've been very much involved with genetic education and the public, and a dear colleague, Michelle Puryear, who is the Genetic Services Branch Chief at HRSA (Health Resources and Services Administration); we're beginning to see a lot of good moves in terms of some of the programs where the public is, you know, being involved. What I am thrilled about is the opportunity to be on the cutting edge and sort of leapfrog ahead. That is, take the lessons learned, as people say, and come to this arena of biodefense, terrorism, and emergency preparedness, and actually take some of these issues and move forward. I might also say that I spent 26 years in Silicon Valley, and I go back and forth between the two coasts.

Let me just say one thing. I said it to Jack Simms the other night; and that is, Silicon Valley thinking is different thinking. Some people say "out of the box". People in Silicon Valley say "out of the sphere", "out of the cylinder". Sometimes it isn't even the box; it's just different thinking all together. And one of the things that we learned, I was reminded of it with Neil Cohen when he was talking about "in government" and "out of government"; and that is, that it's very interesting for me to see out of private industry governmental thinking of CYA. And what that turns out to be is, in Silicon Valley people think of failing early, getting failure out of the way, because it's cheaper on the front-end, and you fall on your face as many times as you can, so you can get to the right answer, because the feeling is that failure is the predecessor to success.

That is what comes with an innovative creative spirit, and so I would say to people who are moving in this new direction, "think out of the cylinder", you know, "think out of the sphere". Don't always put it in a box. That's a very Cartesian way of doing it sometimes, you know, and sometimes you can get stuck on the corners too. But at any rate, the title: "The Value Of Culture And Social Capital In National Defense And Bioterrorism Preparedness". I came here with a sense of the practical, because I talked to a colleague in public health not too long ago, who said at one of the academic meetings—he said, "This is wonderful. This is great stuff." He said, "but you know when I go back home, I've got to deal with local diseases, poverty, drug abuse, infant mortality, and real world issues. I mean this is great.
But I don't have the time to be able to talk about the esoteric and the studies.” So I came here to give some information that I think is practical, and a model for the cultural context for social change in bioterrorism and national defense.

I also came bearing in mind that there are budget cuts in public health. There's a recession and state and local budgets are slashed, if at all. There are demographic changes in terms of immigrant populations and their customs and needs.

And just as a short aside to that, you know there was a time when you could talk about Black people, and people pretty much knew what you meant by that, when you said Black people or African-descended.

Now we're in a situation after the Immigration Act of 1965, where when you talk about African-descended or Black people, you could be talking about Dominicans. There are places in Oaxaca and Guerrero and Vera Cruz, Mexico where people look like they're from Cleveland, you know. There's the Sudan, Ghana, Nigeria, as well as U.S. African Americans. So you know, we're talking about diversity within diversity now. And so I know that most of the people in public health are dealing with these issues, so bear in mind when I talk about African Americans or Black people, I'm bearing in mind that there are these variations on a theme. And the other part is immediacy in use. In other words, you need things that can hit the ground and—where you can hit the ground running.

The two models that I'd like to talk about briefly is STEWARTTM, and that means Segmented Targeted Environmental Web Articulated Relative Territories, that's a mouthful. And at another time, in another life perhaps we'll get a chance to talk about that. But what it takes into consideration is the idea that there are a lot of different disciplines that overlap, but it's been my experience that many people have their narrow niched fields. And remember, I'm talking about segmented marketing and niches. People go into their fields, and sometimes they put these blinders on, and they don't look to the left, and they don't look to the right. But in many cases in public health, and especially in medicine and public health now that genomics is coming aboard, ethnohistory is just as important as understanding contagious disease. Understanding pre-migration families of origin, may be just as instrumental in how you plan a program, or in this particular case, approach biodefense. So the idea is to use segmented targeted marketing, in other words, if you have a zip code you need to know what you've got in it. That means to profile communities, not just profile them where product development was years ago, but actually profile based on what you've got in your zip code as to ethnicity, demographics, lifestyle analysis, how people do things, what they do, et cetera.

There's a reason that's important, and I'll get to that in just a second. There are five sources that actually are the best sources to begin to do this. Number one, the Dictionary of Occupational Titles. Second, what used to be the old SIC, Standard Industrial Classification Code. Now it's called NAICS, (nākes) the North American Industrial Classification System. Gales Encyclopedia of Associations is a mainstay. The Library of Congress system and getting very facile and very comfortable with that. And
Lastly, a tool that we use as anthropologists called the Human Relations Area Files. And what that does is: HRAF is where all of the various and sundry aspects of life and living is catalogued. As a way of looking, let’s say, how do people look at adornment? How do people look at creation of identity, and the list goes on. But it’s an anthropological tool. Those five sources become very important and will help quite a bit.

The reason I bring all of that up is that if you profile your populations and do what we call a culture audit, you will find that epidemiology is interesting, and that’s a part of it, but you really need to get down to the beliefs and customs. It’s the both/ands. It’s the beliefs, and customs, and systems of the populations that you’re serving. Let me give you an example of how important that is.

I was once giving a talk before the National Medical Association, and I asked some of the doctors that were there, "How many of you are from Mississippi; how many are from Tennessee; how many are from Illinois, especially East St. Louis; how many are from Missouri and Chicago? And, you know, various hands went up in the audience. I said, "Do you talk to one another? They said, "Yeah, every now and then, you know. We get together maybe for a drink or something, you know, at a conference." I asked, "But are you talking to one another constantly? Do you have a setup, a loop, if you will? And they said no.

Well, that’s interesting because anyone who really knows ethnohistory and migration in the country, knows that the people in Yazoo in Holmes County, Mississippi are the same people that are in Memphis, Tennessee, are the same people that are in East St. Louis, St. Louis and Chicago on a certain side of town.

That has aspects of not only getting the message out, but also in this particular case we were talking about what’s called geophagy or clay eating. And in Chicago, if a Black woman,- I don’t know about some of the other groups, but certainly African-descended people-if she’s pregnant she’s either eating clay or she’s got an Argo box of starch that she’s working with, because it’s a West African practice of geophagy that is going on at that time, and you need to know that in terms of fetal development, et cetera. I point that out because in cases like in the District of Columbia, I’ve got a principal investigator that’s got a sarcoidosis trial, and he’s having a dickens of a time finding people for that trial. What we began to talk about was the fact that most of the people that he wants in that particular trial, their families are in North and South Carolina, because that’s the pre-migration locale for many of the people in Wards 7 and 8. So it’s that linkage that begins to become important as to how you deal with—in terms of biodefense—how you deal with your population.

Let me move forward quickly. Let me just say this too. We are now beginning to forge new relationships. As I say, I lived on the West Coast, and I would say to someone in some instances leave the church alone. Some people want to go to church on Sunday and just go to church on Sunday and pray. The Black church has been overworked. People are having church fatigue.
I always say that it's a comfort zone because it's where people don't have to worry about whether African Americans are going to be violent because, of course, they're in their Sunday-go-to-meeting best clothes, and it's a comfort zone for people to go and meet, but there are new places. The hip-hop generation is really, as the brothers say, "got it going on." And there needs to be forays into that generation because of the aspect of popular culture, and getting messages out in particular ways.

The other thing is, African American women and outreach means that we need to talk to the Vietnamese community. Many of the African American women are a captured audience for 45 minutes as they get a "cut down and a fill" in the nail salon. And the linkage between the Asian community and the Vietnamese and African American women's community, these are sites.

And I just—you know, I'm bringing this up, and I know I'm throwing a lot out, but I'm bringing it up because these are sites that are often overlooked unless you understand how to profile your community and where they come together.

Now here's probably the most important thing that I would say for me, you can write this down, and that is Ashby's Law of Requisite Variety. Ashby's Law of Requisite Variety comes out of W. Ross Ashby who is a cybernetician, He dealt with feedback loops and systems analysis. And what he gives us, and I think it's, to this particular audience, is a rule.

And that rule is that, "In order to control a system, the governor of a system has to match or exceed its variety." And this goes to what Lee was talking about, command and control, or what I call the "mommy mode" of biodefense. Do what I tell you to do or else.

And, you know, the idea is that we can no longer match the variety of any system. It's just too much. In fact, variability and variety is profitable. So the idea of matching a system: you have to get inside those populations and those critical social networks, and that social capital and allow that social capital to come out. That means that you've got to disempower yourself as officials and policymakers so that that little old lady at the church with that big hat, she's got credentials behind her name too, and that is MVP, most valuable player in the community.

I know physicians and public health officials that have enough degrees to bake a cake, but the bottom line is when it comes to going in those communities and disempowering, and taking the white coat off, and really understanding that they really don't know what they're doing, and it's okay, those are sorely lacking.

Let me cut right to the chase. Let me move on. You know, how you always over-write. You know, this is wonderful, but let me give you just a laundry list of what I saw at Brentwood, because I think that's one of the things that we came up.

Number one, legal issues aside. That'll be adjudicated in a courtroom, but what I saw at a community meeting was this. Five or six white middle-aged guys sitting on a stage-
talking heads-telling everyone what they were supposed to know about what they were doing. Dana Briscoe, who happened to be the president of Brentwood Exposed, was in the audience with a lot of other postal workers, and basically there was no representation on that stage of the postal workers. Their agency was stolen. There was no voice in terms of the postal workers at that meeting except, you know, outside the official realm.

The antagonism is usually framed that it's the postal workers union versus the postal management. But a lot of people rarely review the antagonism between the labor management and the rank and file, and that's an internal struggle. So while a lot of people thought that their union was representing the postal workers, they didn't understand the antagonism between the labor management and the rank and file, and that's a real issue.

Lastly, the postal workers were aggregated as "the postal workers". And all throughout this entire thing, that's against human research protections. I sit on an IRB (institutional review board), and I can tell you that it's each individual postal worker. Now, if they aggregate, they aggregate out of their own agency, but they do not aggregate because they are "the postal workers". That has some stigmatization issues surrounding it.

Last thing. A young man approached the microphone to ask about sending an animal into the facility. That was his own indigenous scientific knowledge. That was all he knew to ask to do. "If you send something else that's living in there and it survives, you know, and it comes out and a week later it's still alive, maybe that might work for us."

The gentleman that was on the stage who will remain nameless said, "Oh, we don't do that any more", and he dismissed him. "We have scientific instruments." Well, I must tell you, it is that very scientific community that many African Americans are afraid of, because they've watched those kinds of things be used on them. So as regards his other ideas he felt dejected and he walked away. And I said to some of the officials, and I will say it here openly, and no offense, and no disparagement meant in terms of culture and people. But I said, "You know, before it's over, you may have to bring the Shaka-Shaka man in to send the spirits out. You don't know what you're going to have to do to get people to come back in there and work. But the bottom line is you've got to be open to allow people to be where they are, and to let you know what they need, as opposed to you telling them what you're going to tell them."

I've been told to stop, and I thank you very much for the opportunity to allow me to give you some information. Thank you.

Bradley D. Stein, MD, PhD

The Role of Schools in Meeting Communities' Needs During Bioterrorism
DR. SCHOCH-SPAN: We’re next going to hear from Dr. Bradley Stein, who’s a natural scientist with Rand. Also, an Assistant Professor of child psychiatry at the University of Southern California. His current research activities include the development of mental health recovery guidelines and technical assistance materials for schools nationwide for use in response to a school-related violent event. Thank you very much for coming out to the east coast.

DR. STEIN: Well, thank you very much. I look forward to having the opportunity to talk with you this morning a little bit about the role of schools in meeting some of the challenges and responding to bioterrorism. I’d like to start off by thanking Monica for bringing this wonderful summit together, and allowing me the opportunity to share some of our ideas with you. I’ve really enjoyed this morning, and I feel I’m following a very thoughtful group of speakers and those in the audience. Of course, by doing so what you may find is some of the ideas I’m going to share with you may reflect themes that you’ve already heard discussed this morning.

In the next ten minutes, what I’d like to do is really discuss why schools are a natural place to support children and families in the community. I’m going to argue, however, that there are some important differences between bioterrorism and the other types of disasters that schools may be prepared for, and discuss the implications of some of these differences.

Based on these differences, I’d like to take a little time to talk a bit about how we may want to go about improving the tools that schools have available to meet the psychological challenges that may arise related to a biological event. And finally, I’d like to argue that for this to really work, that schools must be a full and active partner in a community-wide public health response to any event involving a biological weapon.

Many of the ideas I’m going to share with you today draw on work that we've been doing under the umbrella of the Rand Center for Domestic and International Health Security, projects such as Monica mentioned, including a review of mental health issues and school safety plans, working very closely with the Los Angeles Unified School System to develop and evaluate a school-based mental health intervention for traumatized students, and the writing of a white paper based on a series of expert interviews, outlining some of the behavioral health issues and strategies related to bioterrorism preparedness and response. For those of you who want more information about the center, there are packets available outside by the registration desk that give information about the broad range of activities going on in this multi-disciplinary center.

Schools are a natural place to think about supporting children and families in a bioterror event. On any given day across America, over one out of every five Americans is an K-12 school as a student, as a teacher, as some other type of staff member or volunteer, but schools have an immediate and direct effect on a much larger group of people in a disaster. After disasters when parents are asked what was important to them, time and again they answer where were my children, and are they safe? And parents are going to look to schools to answer that question.
Finally, if you want to know about the role the schools are likely to play in any future event, one of the best places to look is the past. You see the local school districts responding to events in their community. The Oklahoma City Public Schools which screened thousands of students and provided support services following the bombing of the Federal Building. The New York City schools where there’s evidence that over half of the kids who received some sort of counseling in the months after September 11th, received it through the schools. And the schools in the Washington, D.C. area, which during and after the sniper attacks played a very important role in supporting the children and families of the communities in this area. But the role of schools really goes beyond responding to a traumatic event in their own back yard.

I’d like to share with you some data from the national surveys we conducted at Rand after September 11th. The first, which was conducted just three to five days after the attacks, was one of the first studies to really document the wide-spread psychological impact of the attacks across the country.

We went back to many of the same parents in November, and among other things, asked what their children’s schools had been doing to support children and families in response to terrorism. As you can see on this slide, nearly two-thirds of the almost 400 parents we talked with across the country in November told us that their child’s school had been active in supporting children and families after the attacks. Schools had held special assemblies and classroom programs in response to terrorism. They had provided counseling to their students and children. And they had provided materials and information to assist parents in helping their children cope. So schools are important, and their role really isn’t limited to an event which happens right down the road. But a bioterror event may be quite different than many of the other crisis events that schools and other community planners commonly think about and prepare for; such as, natural disasters, earthquakes, tornadoes and other disasters that schools at least give some thought to, such as shootings on campuses and explosions.

When we compare these other types of crises with bioterrorism, as people have already mentioned this morning, we note there are very important differences, including the speed at which the event results in an effect on an affected population. The ability to identify the site of the event, the public’s knowledge of the event’s boundaries and scope, and who is really likely to be at risk, the familiarity with the type of the event. Dr. Norwood spoke this morning that biological events raise some very primitive fears in all of us about being attacked by something unseen and unknown. And the distribution of affected people, and where they might be geographically. So we see that bioterrorism differs on some very important dimensions from other crises that schools are accustomed to dealing with.

These differences have led many people to suggest that the behavioral and psychological issues are likely to be somewhat more complicated and more widespread in a bioterror event than in many of the other crises that schools and communities commonly face and plan for.
So what do these differences imply? What do these differences between bioterrorism and other crises imply for schools? Well, there are a number of things, but I’d really like to take the time I have available to focus on two that I think are critically important to think about.

First of all, we all need to think very hard about whether the tools now available to schools, the materials they send home, the counseling or debriefing services that they commonly provide, which are really two of the things that schools are most likely to do, to whether these interventions are appropriate and effective for helping children and families cope with the psychological challenges of bioterrorism.

And second, to the point I made earlier, that schools must really take an active role in ensuring that they’re an integral part of a community-wide public health effort related to bioterrorism, not an after-thought.

To the first point. An obvious place to begin developing and refining the tools to help children and families in the face of bioterrorism is to build on the tools that schools already use, that the question is how do we tailor them for bioterrorism and evaluate their usefulness, not just take what we know now and send it out there and say well, you know, we’ve been doing this for a long time, so let’s continue to do it.

Some might argue that this can’t be done, but I’d like to suggest that we can make a good start by examining and evaluating the impact of these tools in situations that may serve as analogs to an event involving a biological agent. Analogs include some of the things that we’ve heard about already, and that we’re going to hear about this afternoon.

Infectious disease outbreaks. Meningitis is one example. It certainly is something that schools are very alert to, but there are other examples of acute outbreaks both in this country and abroad that we may be able to learn from.

The schools' role in the sniper attacks in the D.C. area is certainly another example. And unfortunately, some areas of our country are terrorized by acts of random violence on an ongoing basis. These areas may also serve as a very good analog for some of the things we need to learn about. In all of these situations, the questions we need to ask include what are the schools doing, and when in the course of the event did they do it? What impact have these actions had? And by learning this, can we improve the tools available to schools?

And finally, do parents, children and others in the community perceive the school's action as helpful, or is there something that the experts feel needs to be done, and the community wants something else?

I’m not suggesting answering these questions is going to be easy. And the answers we get won’t be perfectly applicable to bioterror events, but the answers will allow us to begin building an evidence base where currently almost none exists for strategies that schools can use to meet the psychological challenges of bioterrorism.
The last issue I want to address is the importance of schools as an active partner in an integrated community-wide response to bioterrorism. As we all know, the vast majority of children in this country are in school, so any plans to ensure our children's safety in the event of something that involves a biological agent must begin with schools. School safety plans, which are mandated in most states, and really form the architecture of a school's response to any crisis, really need to include strategies for keeping children safe in the event of an attack with biological weapons. I think you're starting to see that now. One great example just last week is the announcement by the Fairfax County schools of plans to shelter in place in the event of a biological or chemical event.

It's likely that in the next several months the Department of Education is going to recommend the strategy for schools across the country, but this is more complicated than it sounds. Implementing such strategies will require substantial planning by the schools, and it's also going to require substantial resources for the schools to be able to implement.

Remember as my slides earlier suggested, in the case of a biological weapon, it may not be obvious when an attack has occurred, who is at most risk, or when the danger is passed. As a result, schools and the rest of us really need to consider what it means to discuss and ensure children's safety on an ongoing basis in the situation where there's great amount of uncertainty about the level of risk.

The second major role of schools is likely going to be communicating with parents, both in advance of an event, as well as after an event. Since September 11th, not only do parents want to know their children are safe, parents want to know how schools are planning to keep their children safe. And schools really need to make sure parents are aware of any plans. And optimally, parents should be participating in the discussions of such plans as they are made, and as they are implemented. As part of these activities, schools may also play a very important role in educating much of the public about things community members can do to protect themselves in the case of bioterrorism.

Finally, and again I'm going back to a point you've heard before. Because of the ongoing nature of any event involving a biological weapon, schools need to think about and plan for an ongoing dialogue with parents about children's safety. The best way so to begin and sustain this dialogue will probably vary from school to school, and district to district. The challenge is going to be to balance consistency across communities or districts with flexibility.

Now for those of you who are familiar with schools or have worked with them before, you've probably already recognized that many of these tasks are going to be quite new for schools. They create an entire new set of demands on teachers and on school staff, in addition to what we're already asking them to do.

We need to be sure that they're provided with the support they need to meet these new demands. But in addition to those resources, in many cases the things I'm discussing are
things that schools are not going to be able to do in isolation, which really brings me to my last point.

Schools cannot and should not make decisions about the safety of children and what should be communicated with parents in a vacuum. Instead, schools will need to be part of a joint community decision-making process. In any event with a biological weapon, there's going to be a substantial amount of uncertainty. And for a period of time, the level of risk may actually be unknowable. Schools aren't going to be able to ensure children are safe and effectively communicate with parents unless they're a full partner in the overall community response, because schools are going to be critically dependent upon these other organizations in their community for receiving the information, and receiving it in a timely manner. So for schools to be successful in this critical new role, they really must become full partners in the overall community response to bioterrorism.

I'd like to now get to the point that Kathleen said, is what does this mean, and how do you operationalize it? I mean, these are very wonderful sentiments. How does that happen? Well, I think three things that are very concrete things that I hope all of you can take back to your communities include, one, schools should be part of emergency management agency planning to allow input from community partners into the school's crisis plans, and at the same time to allow other plans in the community to be informed by what schools know about children and families. Also, as I said, schools may provide one of the best ways to communicate with much of the public about these plans.

Second, schools should actively participate in emergency management community drills and tabletop exercises. That's the only way you're really going to refine the school's role in the community's response to bioterrorism, and really find out where the gaps are, and how to make this system work.

Finally and optimally, have a seat at the table in the community's incident command structure so that in the event of a crisis where these decisions are going to have to be made in the face of changing information, schools can participate as these decisions change over time.

I've discussed many of the issues faced by schools in preparing for and responding to any event involving a biological weapon. Bioterrorism presents schools with unique challenges in an environment that will be characterized by uncertainty and lack of information. But schools have a history of rising to meet the needs of children and family during crises. I think it's imperative that we now work together to provide schools with the support they need, the information they need, and the tools they need to be better prepared to face the new challenges posed by bioterrorism as part of community-wide public health response. Thank you.
Monica Schoch-Spana, PhD

The People Talk Back: Anthrax 2001 Public Communication Lessons

DR. SCHOCH-SPANA: I wanted to, I guess, follow-up these wonderful presentations by bringing in additional voices. I want to talk to you about some preliminary findings that we are receiving from a set of facilitated small group discussions that we've been holding throughout the United States, that is the Biodefense Center. And it's those voices out of our small group discussions that I want to channel today, so that although we have a small group, we can allow some other constituents to sit at the table if it is in fact just their quotes that are shared with you today.

I wanted to thank the Memorial Institute for the Prevention of Terrorism for their generous funding of our project, which is entitled, "Epidemic Communications Advice For Decision Makers During Bioterrorism Response". And the Biodefense Center is looking forward to sharing with you the findings from this conversation or these conversations we've been holding around the United States.

There's emerging expert advice about how to interact, or how decision-makers can interact better with the public during a bioterrorist crisis, but there have been few attempts to find out what citizens themselves consider the elements of successful communication in such a scenario, in their own words, and that's what I wanted to share with you today.

I did want to thank members of my research team who are present here in the conference, Ms. Onora Lein and Ms. Sylvia Cohn. They worked very hard to help with this project.

So what are we doing? Well, we're going around the United States to six cities, which were selected based on their proximity or distance to the terror events of 2001. And we're talking to three groups of people, we're talking to the official responders, people such as yourselves. We're talking to public health officials, senior executives in the mayor's office. We were talking to public safety executives, members of the press, physicians and nurses, and also the Red Cross typically. But apart from that, and I don't want to bore you with that. I'm going to focus in on the other groups that we're talking to, which are two proxy groups for the general public.

We're convening groups of 8 to 10 people who worked in occupations that were potentially at risk of Anthrax exposure last fall, so we're talking to Congressional staffers, people who work in media outlets. We talked to mailroom workers of all variations, from the U.S. Postal Service, to people who populate the mailrooms of large universities, government agencies and businesses, and talking to them about their experience with the Anthrax attack, and what they think went well, and what went poorly in terms of communication from the people in charge of the response to them.
We're also talking to civic and community leaders who are selected from various parts of the city. And we're just trying to get a different perspective on what the larger community was experiencing during the Anthrax attacks. So we're going -- we're almost completed. We're talking to folks in New York City, Baltimore, Washington, D.C., San Antonio and Seattle, and we've almost completed all of our focus group among the members of the general public. We just have 2 of 17 to finish up.

And what is it that we're asking them to talk to us about? Well, of course, we spend about an hour or so talking to them about the Anthrax attacks, and then, you know, we give them a break and then, of course, you know, we push them on to talk to us about a hypothesized Smallpox attack. And we serve a meal, and I want to say as a take-home point, that when we recruit for these small group discussions, people are delighted to participate. They are delighted that someone is willing to take the time to listen to them about what they experienced last fall, and what they think might work if unfortunately we have to face a future bioterrorist attack.

I want to emphasize the absolute critical importance of pre-event public education. What was interesting was that these focus groups, we were there to gather data in that sort of gorilla colonialist way. Right? Tell me what you know. But what people were taking -- what people seemed to be -- what was striking to us as the parachuter-type of researchers, is people were so grateful for an intimate gathering in which they could talk about esoteric things, such as Smallpox vaccine, what are the adverse effects? Anthrax, you know, what's the difference between cutaneous and inhalational? And people were just hungry for information, and so I feel that there was an indirect benefit of convening these groups throughout the United States, because we trained the trainer, basically. And we had friends and relatives of our participants calling to say, you know, we're glad you did that. And, you know, I'm a nurse and I want to get involved, and so there was feedback to us in a very positive way. And this is one small research project that was marked by extreme gratitude at the level of local community about experts parachuting in to learn what they had to say, and they were graciously accepted whatever, you know, expert facts we had about these diseases, so just to bring that to your attention. So we've talked to about 130 people, and we've logged almost 40 hours of conversations about Anthrax, and Smallpox among members of the public.

I want to bring in some direct quotes from these conversations, and underscore some of the larger themes that were raised in the conversation. I want to mention that I'm going to just focus on core matters of consensus. There's an extreme variation of opinion on the value of marshal law in terms of, you know, maintaining quarantine. The folks, just FYI, folks in San Antonio were okay with that. Folks in Washington, D.C., we're not okay with that. Kansas City seems to be pretty much okay with that, so there were big variations of opinions on some issues. The role of force was one of them, but there are, I think five military bases in San Antonio, so the military is not a faceless entity to San Antonions, and so we need to pay attention to those kinds of issues, as well.

And some of this has been, you know, reiterated by my colleagues in the first panel and here, but people are indeed capable of handling uncertain and unsettling news, provided
its given candidly. And this is a manager of mailroom services in San Antonio. "I think the government tends to treat us more like children, the mommy mode of command and control. It tends to feel like they know what's best for us and they don't tell us enough."

Another critical point that's been expressed over and over by our participants, is that information flow is an antidote to panic, not its cause. And hopefully, they are shrinking in number, but government officials who feel that withholding information is going to prevent hysteria, panic and violence and the social chaos. We need to let go. WE need to let go of that assumption.

This is from a Congressional staffer in Washington, D.C. "I think if you give less information, then there's more uncertainty. And then you might inspire some more panic. At least if you give all the information possible, people know what they're dealing with. All the cards are on the table."

Now this was a corollary finding related to the first two. There seems to be a common assumption that government experts must have the answer somewhere. The scientists must know the answer to this. I mean they're smart, right? They're scientists. And the government should know, well because it's in power. It's in control. And there needs to be some readjustment or some sharing in the burden of uncertainty, of the uncertainty that characterizes a biological attack on both sides. I mean, the people in charge of a response need to speak to the limits of their knowledge about what's going on. And members of the public need to understand with our assistance that it may take some time to get a clear picture of what we're dealing with, and what potential solutions are.

This is from a Congressional staffer in Washington, D.C. "I guess I have a natural assumption that it's the government. Everyone is going to do the most rational thing, and we're going to be top of things and everything. But I really lost some confidence because I just got the sense that they were kind of making it up on the fly."

So along with that common assumption that the experts in the government must have the answer, was a brutal realization by members of the occupationally affected group that the folks in charge, you know, they were making it up on the fly in many cases, and that was unsettling to people. And on the issue of what Lee Clarke had brought up about the value of speaking in one voice, from the point of view of people who are in positions, or the occupationally potentially affected group, they were -- it was not an issue of one voice. It was an issue of agencies, and you'll pardon the French, "Getting their shit together", basically, and that was their message. And this is someone speaking to that topic. "It would have been good if they had chosen somebody, one person to deliver a streamlined version. This is what it is. We've all talked about it now. We concur that this is what's to be done."

And of course, as Brad has underscored, it is absolutely critical to members of the U.S. public that they are given meaningful and practical advice on how to protect themselves and their families, and that this was always at the top of the list in our conversations. And it was spoken very well by this health and safety officer at a New York City Hospital.
"I wanted to see an actual exposure plan smacked in front of the television. This is what you do in case you come across Anthrax, and this is how it should be handled, as opposed to bits and pieces."

And my last point, in a media crisis - excuse me - in a crisis, and it can be a media crisis too, the media is an essential source of information, though fragmented and dizzying. People really were tuned to their media outlets to get information. There was an incredibly poignant exchange between an employee of the mail contractor to the Department of State. They had a co-worker who had a case of inhalational Anthrax. An exchange between that person and a Congressional staffer, both talking to the role of CNN in revealing how risky their respective jobs were, that they found out information on CNN quicker about what was going on in their own work places. Both a Congressional staffer and the postal employee, and it was a moment where sort of bridging the divide between well, maybe you guys on Capitol Hill, you got your own version of the shaft. And there was this wonderful sharing of the experience of what it felt like not to have one's public health and safety needs met.

And on the issue of while the media is absolutely critical in moving information to people, there was a common feeling that there is a noise of information during an emergency that they had a very difficult time finding the signal, what the critical public health and safety information, bits of information that they needed to know, that there wasn't a template or a filter in place. And they spoke to the need for some type of truly public broadcast system of a non-commercial and non-competitive nature that moved critical information. And people also underscored the importance of involving civic and community leaders. I'll give you anecdote, and I'd like to open up the floor for remarks.

We do need to enlist the mass media in getting out critical public health and public safety information during a bioterrorist attack, but that modality will not reach everyone. Our bilingual -- I should note that we conducted five groups in Spanish among Latinos and Hispanics, and both in San Antonio, Texas and New York City, which have wonderfully well-developed Spanish speaking news media, that the bilingual viewers could tell that they were getting information faster on the English speaking channels, that there was almost as much of a 24 hour delay in the information that was being streamed through the Spanish speaking channels, mostly because of the translation time that is involved. And also, the poor translation that was happening. And there's a sense of perhaps not being served well by mass media. And we really do need to tap our civic and community leaders. And I'll close on this with this note, because I think it brings in a lot of the things that have been raised by others. This is from a Latino community organizer up in New York City.

"We could do training through community leaders. I feel capable of going to the parks, the streets, wherever I can meet people because in my community, I don't believe much in papers. I strongly believe in look, let's go that place tonight, a meeting, and we can gather 500 without any problem." And it's those people who we really do need to tap in terms of building up our capacity to deal with the effects of bioterrorism. Thank you very much.
John Burke, JD

How Leaders Can Confidently Step Up to a Reporter's Mic?

DR. INGLESBY: John Burke is smart, funny, provocative, and very constructive in his comments, so I'm sure you will greatly enjoy John Burke and your lunch time presentation. John.

MR. BURKE: I broke one of my golden rules by coming here. I really try to talk only to audiences that are not in a position to judge the truth or accuracy of what I say, and this is probably the most experienced and sophisticated audience I've ever presented to, so this is going to be a new experience for me. And I'm not using my computer, so this should be a new experience for me too.

Everybody is a media critic, and everyone you speak to on any public health issue at any public forum, actually is judging you against a very high standard, the anchors, television anchors, and they can tell right away when you're screwing up. We've already talked about body language. We do a lot of teaching on presentation techniques, and the fact is that the intuitive aspect of being an audience member carries much more weight than the intellectual aspect. And people can tell your voracity and your attitude, and the degree of your conviction intuitively better than they can by what you say. People are reluctant to believe what you say. They believe their sixth sense.

When I'm talking to smart people, these are always people that read, and have read a lot, and they worry about adjectives and conjunctions, and the average person out there doesn't. In fact, I find that most people don't read much at all. They buy papers but they self-select what they read, so the traditional concept of the media, this old newsboy inside the kiosk isn't accurate, because that's not where most people get their information today. Most people get their information instantly from digital and telecommunications. And the fact is that your story, whatever it is, whether it's West Nile, or Anthrax, or plague, is going to run with or without you. And it's imperative for everybody in a position of authority, particularly your bosses and their bosses to understand that you need to have your material in advance, because when you develop it on the fly as so many of our speakers have alluded to today, it comes off as on the fly, and you jeopardize yourself.

And as scientists, and engineers and medical people, you carry the burden of this debate about accuracy versus speed. And it's an academic debate, because the audience is actually pretty indulgent. They know that you won't have all the information. The trauma is in your head, not their's, so it's much more important today to be fast than to be accurate.
The ideal objective for everything I'm saying today would be that all the Fox news channels and the local news channels, and the 24 hour CNN, and the talk radio shows would actually select spokespeople from this informed group rather than go out and find those jackasses that they find, who are apparently waiting in limos outside. So we should make one of our objectives identifying informed people and sensitive people as sound sources, and putting a list together maybe by geography. The same way we put URLs together for information, we should identify people that are competent to do this, and have the courage to put their careers at jeopardy.

The fact is that today, and most of the clients I deal with don't have the luxury that you have. When you're subject to a bioterrorism attack, you're guiltless. You don't have the mental agony of having to deal with dirty hands, and shame, and guilt and doubt because you're the cause of it. Most of the clients I deal with have that aspect to deal with. And the fact is that when you're dealing with a crisis event like an attack, the audience comes to you. They're waiting for you to talk. They're already assembled. Usually, it's the other way around, we have to go out and find the audience, but today everything is instant, and it's global. And the amazing thing is it works both ways, so if you're the health commissioner of Des Moines, Iowa, your day will be upset because of something that happens in Bogota, or in Florida. If somebody -- I mean, whatever happens will be on the news, and local people will be asking you questions about it, so you can't think that you have any protection by geography. You don't. You have to be prepared, as prepared for all of these crazy things, whether or not they happen in your zone of impact, if I can coin the phrase.

And you have to think in terms of pictures. I like to show pictures because I found pictures make presentations much more memorable. And pictures are a very important part of understanding the media, because you have to think in terms of pictures. And you have to think in terms of T.V.

Rodney King. You know, I live in New Jersey and for years I noticed that there was a good chance on the Parkway if somebody was pulled over it would be a black person and not a white person. And at that time in my hometown, I noticed that youngsters who were pulled over more often than not would be people of color. And I said that's going to come back to haunt us, and I know activists complained about it, but it got nowhere until there was video tape. And the video tape changed everything.

The President of the United States within two days charged the FBI with doing something because there was video tape, because TV is powerful and emotional, and it sets the tone for media coverage. And it has been for 15 or 20 years, so I'm not telling you anything that you don't know.

The important thing to take away from this presentation is that it alters reality, that little things that in this room that might be insignificant, suddenly become enormous when you put them on the big screen. So, I mean, Trent Lott knows this. We all know this, because we've seen it time and time again. And you have to appreciate that. And I'm going to say something that it may be provocative, especially to people who hold
themselves to a high scientific standard, but any time you're presenting to the public, you have to think of it in terms of a performance. You want it to sound like a conversation, but it's not a conversation, it's a performance.

Roger Ailes wrote a book about 20 years ago called You Are The Message. It was most breast-beating about how he created Ronald Regan, but there's a great amount of information in that book that gets you to think about the importance that you, the person, plays in communicating the message, because we're not judging what you say. In fact, what you say is less than 7 percent of what people take away from the exchange. What you are, and how you appear, and how you sound is 93 percent of communication. And those of you who have studied body language know that this is well documented by a guy with the interesting name of Birdwhistle, and I remember that.

T.V. alters reality. In a room this size, well there's the White House briefing room and there's three little guys babbling into what looks like a pencil from far away, muttering, and they might just as well be those people who push the shopping carts full of clothes the way they're off there muttering. But at 6 and 11:00, they're shaping public perception, and they're interpreting what you say. And your job is to make it impossible for them to misinterpret what you say. And T.V. is your avenue to do that.

And I want to make this point. I know there are journalists, respected journalists in the room who I have to be careful what I say about what I really think, because they'll sit in judgment and think I'm cynical. But when the media misinterprets what you say, it's because you haven't done your job, and you have to turn your perception upside down because your job is to make it impossible for them to interpret.

There's no way to prevent them from deliberately misinterpreting, and occasionally that happens, particularly on the news magazines, but in the case of an emergency situation, the burden is on you to make the message understandable, and to make it impossible to misinterpret, and I'm going to show you some examples of that. And you face something that your predecessors never faced, and it gets worse every day now.

Everything is potentially news because video is ubiquitous. I mean, who -- I can't even shoplift any more in any of the -- it's terrible, but you know what I mean. Any time you're making a public appearance, there's a good chance that you're being recorded, so -- and I'll tell you what, as a videographer, I can follow anybody. I can follow Mother Theresa around and guarantee you that I have an expose if I take enough tape, because eventually we all do dumb things. We all violate basic rules. Anybody can be made to look foolish.

In the face of a public crisis, that's not what the media's job is, but people will be judging you. And your performance is judged against a very high standard, so your responsibility is to do a good job, and to remember that it's a performance. And I will repeat myself several times on that issue.
Now I talk about T.V. because in our classes we use T.V. We make people get up, because nobody learns to improve any better than somebody that you videotape and show them their own performance, because we're all horrified by our own performance, but the second time you videotape them, there's 100 percent improvement. But T.V. has impacted the print media, so that's why you see -- I mean, I had to put this in because I noticed it at the airport. It's the swimsuit edition of National Geographic.

The reason is, there's a finite number of dollars to be spent on the media, and everybody is competing for that same dollar. And because T.V. is so powerful and impactful, the print media, even National Geographic has to be provocative, so that's why you get stories, and these are real headlines. "Is your toaster killing you?" It was a big expose, and I'm going to show you a tape, "Are your muffins killing you?" That's a piece of tape that I'm going to show you. Major stories, because they have to compete with the emotionalism of T.V.

It gets personal too. There's high personal risk. Several speakers said that today, and if you go through it, you know, especially if they're going to talk to your former classmates or former co-workers, or those two people you just fired last week, there's a good chance that you'll become a story. And I'll tell you from personal experience, I always find out the guy we just put on CBS Evening News didn't really graduate from Harvard even though, you know, he's the director of quality control, or the director of personnel. You have to make sure whoever you choose to be the spokesperson you vet internally. And it's like being a presidential appointment, you really have to be careful because mistakes are interpreted as conspiracy, not only by the media, but by the public. We suspect you, especially those postal workers.

I want to tell you what goes on inside a reporter's head. It really isn't personal. There is such pressure on them to file or to get something or, you know, the 24 hour news shows, they -- if you've been watching the coverage of the Columbia disaster, you see how they're repeating the same thing. They're dying for one scrap of additional information or to find another guy who operates a garage who found a piece of trash, who can tell them how exciting it was that the trash fell in front of his -- you know, this is brought to you live and exclusively by XYZ. But the fact is, all they want from you is a thousand words or 30 seconds, or 15 seconds, and your job is to make it so compelling that they'll use it. And it has the message, you know, be prepared, be smart, or whatever the message is.

They need updates, so your job is to update them. Now that doesn't mean I'm going to tell you where the investigation is. An update could mean let me show you the equipment we use to analyze this. It's just something that I can write about, that informs the public, that shows I'm doing my job, that makes me look smart. It gets down to very interpersonal and venial information sometimes, and you don't -- that's what they want, they want updates. And they want pictures.

I say this all the time. For a lot of people out there, are you familiar with the Charlie Brown cartoons? The adults in Charlie Brown all sound the same because kids can't
understand what the adults are saying, so that wah, wah, wah, wah, that's what most people sound like from the scientific community to reporters, honest to goodness. And you leave them to their own devices if you get too scientific. That's when they're going to ask you, have you ever considered suicide, or whatever the miscellaneous left-field questions are. You cause the problem. You're going to say they didn't ask the right questions. You don't wait for the questions. You have messages. You try to control the situation, and give them information that they find so compelling they won't interrupt you with those crazy questions.

They prefer drama. That means is this the biggest, is this the worst? Who are your enemies? What will your critics say? That's part of the nature of the game. You may not consider it fair, but that's what sells papers, and that's the reality, so when you're walking across the stream, you've got to deal with the current. And they prefer a top dog. They would like to talk to their chairman or the president, or the commissioner, so they're going to -- if you're not the commissioner, they're going to treat you as if you're a second-class citizen. You have to be confident enough to do the job, and the burden is on you to do it.

Now unfortunately, there's a history of investigative journalism. When I went through Columbia, it was during the Watergate era, and people -- young students who were younger than me. I came out of the service and went to graduate school. Their objective in life was to bring down a president. That was the new goal, or bring down a department. That's expected. Now they may miss the savings and loan crisis, but they're going to find out about that nanny. But that's the nature of the game, so you have to expect it. It's really not personal. It's not personal, it's part of the job. And you've got to stick to the science and don't get drawn into those issues, and take all the stupid questions seriously.

They don't understand you. I use this picture all the time because it's a metaphor for the media. Ted Kopple I think is one of the brightest of all broadcast journalists. He can actually conduct a conversation without cue cards. It must be that Canadian education. I don't want the school people to get upset, but he really is a smart guy. And he's a thoughtful guy, but we always assume that because they're nodding, they know what we're talking about. That's a theatrical device, that nodding. Most of the time reporters have a difficult time understanding what the hell you're talking about, so don't think when they're nodding and you know, thoughtfully stroking their chin they understand. The burden is on you to make it simple, to create analogies.

When the Stock Market crashed in `87, he was the News Director of Nightline, and I guess it was the ABC Evening News then before it was called Nightline They had to figure out a way to describe the Stock Market, because 75 percent of the American public wasn't invested, and most reporters didn't really understand what happened, except that their portfolio was down, so they were looking for ways to talk to the public, because they believe the public has about a ninth grade comprehension level. And somebody came up with the -- I think it was Ted, he took credit for it. Let's have Kermit explain the
Stock Market, so Kermit came on. Well, Ted, and he simplified it, and it wasn’t offensive because it’s Kermit, so who’s going to -- you know, if we talk down to them -- so I want this image burned in your mind. One of the best broadcast journalists in history interviewed a sock. Okay. Just keep that in mind.

I want you to think in terms of pictures, and by pictures I don’t just mean photographs or video images. I also mean word images. What were the most compelling things we heard this morning, anecdotes about old people, stories that were flesh and blood, and concrete. That’s what draws you in, and that’s the way to control an interview, by giving people real flesh and blood. And it sounds so easy, and people nod like crazy and say I got you, John, and then they go out and talk about health care delivery. And my neighbors in western New Jersey think it’s a UPS truck. You have to try to put yourself in the audience’s mind.

Now this was one of the most watched events in history, the World Trade Center attack. And there must have been a billion pictures taken, and videos taken of that event. But what the media looked for is what they call a moment. They want something that captures a very complex situation, and boils it down into something that we can all understand in an emotional way, like remember the National Geographic swimsuit edition. We want an emotional response.

Well, Time Magazine picked this photo of all those photos, and editors and T.V. producers all over the world have to decide what image do I need to represent this? How can I best communicate that? They think about this. They have photo editors to think about it, and this was a spread that I got off the internet of British publications. Look at the unanimity. These were all different editors who had to decide. They know what they want. They’re looking for something that simplifies things.

Your job, and your staff’s job is when I’m trying to communicate a public issue, what image can I provide them that is emotional and compelling, but communicates the importance of whatever action I’m advocating, whether it’s quarantine or we saw some images yesterday from New York about insecticides being used in New York against West Nile disease.

You have to paint the picture, you have to provide the picture. And I'll tell you what, in an interview, if you can provide a picture or slide, you're dominating the interview, because you're controlling what they focus on. And it’s a great way to dominate for your -- now it has to be a good image. Like we'll be hearing from Sheriff Moose tomorrow. They showed images of trucks and things, and they gave an 800 number, and it was the wrong number, and there was no truck so, you know, there is an accuracy requirement.

This I just took the day after the Columbia. Same thing, everybody had to decide how do we capture the emotion? How do we capture the moment? What can I put on there that screams buy me. Read what I say about this event, and it's amazing the unanimity. You have to think like a photo editor. You have to think -- in your presentations you have to think what image can I provide? I'm not just talking about pictures.
Ronald Regan, I remember one of the most compelling speeches was when he went to Normandy for an anniversary, and he was talking about Omaha Beach and the invasion of Normandy. And they were at the graveyard of all the Allied soldiers that died, and all these gravestones behind him. And he wanted to make a memorable dramatic speech, and how did he deal with it? He chose a single person, a human being, flesh and blood that they focus the camera on, who lost her dad. Never met her dad. She wrote a letter to this dad that she never met who died on Omaha Beach saying, "Dad, I thank you for what you did", and it went on in that vein. And Ronald Regan with that masterful presentation read the letter. And really, it's hard to keep a dry eye when you hear something like that.

It's the same, that the best newspaper in America does, The Wall Street Journal. We think that the public can't deal with complex issues, but they start by talking about a guy with a mule in the mountains of Peru, and how the mule needs new shoes, and how he drags these coffee beans. And you're in there and you say oh, my God, poor Pedro. And by the fourth paragraph, we're talking about the price of coffee, the price of gold, international trade, and you're there without even realizing it, because they know that it's concrete and graphic information, and human stories that draw us in.

I've got to show you these, because we remember -- we don't remember any speech by Lyndon Johnson. We remember the Vietnam War in terms of Pulitzer Prize winning photos. I say Vietnam War to classes, even young kids who weren't even alive and they have images of the Vietnam War. This is one of them. The Tet offensive assassination. You all know what the other one is. What is it? Exactly, the napom girl. And nobody knows what the -- we all think Americans did that. It was actually South Vietnamese pilots that dropped the napom in error, but we just remember the picture. It's because it's a metaphor. It captures the complex insanity of war, and the violence and brings it into -- Tieneman Square, this picture appeared on the cover of every publication the world over, because it capsulized. And I -- see those two girls up there, the New York Times had a hundred year publication, the best photos in a hundred years, and they used that in their ad to publicize the photo exhibit, because it's the best of the concept that I'm talking about.

The title of that is, "Miss Teenage America 1972. Who do you think won?" It captures a moment. It tells a story, and that's what you have to do. You have to simplify things down with your words and pictures.

When issues go public. As I said, you know, disaster is on your side because you're guiltless, so the credibility and the momentum is yours to lose. We're not holding you guilty until after. Then we'll hold you all guilty like they are now with the NASA is on trial.

I wanted to make a point that Monica made, that ignorance is the ally of panic. And the enemy in dealing with a disaster, and controlling a disaster, is information. But it's useful information, not abundant information, but useful information, and understandable information.
You need to -- well, here I guess I could sum up this part of the presentation by I agree. Everything that everybody's talked about, I agree with. In a real crisis situation your systems are overloaded. You lack coordination. No matter how much time you put into it, and what I've always found is when you deal with people who have beautifully written crisis plans and statements, they're written by staff, and in the actual emergency, senior management takes over, and never invite the staff in to -- they never look at the plan actually. It may be different among enlightened groups like yours, and the media here starts before you do.

You wind up -- the worst thing to be caught without in a crisis is a radio or a T.V. Even the Pentagon is watching CNN to find out how they're doing because -- well, they were anyway. You have to be able to monitor the media and react to it. And there needs to be some infrastructure for sharing information, current information so you know the status of things.

The public can overreact if we're not prepared. And in today's environment, my key message is you have to be prepared in advance. You have to have the statements in advance, not merely answers to questions, but statements of policy in advance. We call them contingency statements. They're pre-approved. Everybody signs off on them. It's something to say.

The issue came up that it's okay to say I don't know. It is okay to say I don't know, but it doesn't inspire confidence. And we deal with plant managers who have explosions or fatalities, and the media wants to know instantly what happened. And the honest to God nice guy plant manager says I don't know, and the neighbors say get that jerk out of here. Put somebody so we try to teach what we call affirmative language. And it's that thousand word concept.

"Well, we haven't identified the source of the problem, but let me tell you what we're doing", so you take the advantage, you take the momentum. And you're telling them stuff you know, you have the information. It's just that you can't respond to the question literally, because if you do, you're going to kill yourself. The longer you've been around, the more garbage you have in your head, the more dead skeletons you know in every closet, so if somebody asks you an open-ended question and you take them literally, you're not only going to assassinate your own career, but you'll probably drag the whole institution down. And that's why I say there are two rules for crisis management, crisis communication. One is, never lie. And the second rule is, it depends, because it always depends on the personality, on the situation and you really have to be flexible and fluid.

Common mistakes, you know about them because you've all experienced them. The finger pointing is what I hate. And the one thing I want to warn you against is this organizational self-absorption. Don't get up and tell me how hard a night you had, or how difficult, how hard everybody is working. Talk in terms of -- you know, you can say that to your staff, but that's not -- that's valuable time on T.V. there. We don't want to hear it. That's your job. We don't want to hear that.
Everybody has seen this, but the point I wanted to make there is we're very judgmental. And if you seem not -- to be working on the fly, we're going to -- you're history. Spokesperson is credible, is critical rather. Remember only 7 percent of your total communications is the words you're saying, even when people want to know what they should do, because they're judging you. And at first in a case of new impression, first impression, they're skeptical. They're skeptical because of their history with our government.

I remember. I lived in Trenton when we had the Legionnaire's Disease. I remember that. I remember the crazy stories the first day about Legionnaire's Disease. Now Legionnaire's -- we had a client that had Legionnaire's Disease, and they were terrified that all their employees would sue and run away, and we brought an epidemiologist in and we said please describe it as Legionella Pneumonia. And he did, and they said oh, okay. It was as simple as that. But credibility involves likability.

I know it sounds crazy, but if we had to choose the best spokesperson on any issue it would be Bill Cosby, because all the research indicates that Bill Cosby has the highest Q rating in T.V. And a Q rating is likability and credibility. And these concepts don't come from me in my experience. I'm going to the master. This is Dale Carnegie, and he's right. The man was a genius. You have to be knowledgeable, but you can't be an egg head, and you have to be consistent or it doesn't matter, but you have to be likeable. And we always say smile and show enthusiasm. Well, it's hard to smile when you're talking about the World Trade Center, but be genuine. Show people, and be sympathetic and be understandable. I mean, it's so obvious but it's hard to do. It's like pole vaulting. We all understand the concept, but it's hard to do.

Likability, that's -- I usually have Bill Cosby, but we're in Washington so I put the Chief over here. Be genuine. Talk in terms of the audiences' interest. Don't talk about what's important to you. Show enough common sense to talk about what's important to them. And if they ask you dumb questions, respect them and treat them straight.

And this is very important because, you know, body language is very critical. Each of us, and if you're a Type A, and you're an A student and you have this little monster in your head. And you stand up here, and as you're talking it's telling you they know that. They're smarter than you. Who the hell do you think you are? Do you have a lisp? Is your -- and that, you know, it might be from mother, it might be from sister you carry it, but the important thing is, be so familiar with your subject matter that you don't think about yourself. Think about the messages, and I talk about messages, and messages are important. And it's important to have them in advance. Like I said, the more you know, the more trouble you can get into.

You're the guest, and recognize the risk and take charge. Don't let the microphone rule you. You've got to stand your ground and take charge. And there are exercises that you could do to improve that. The questions, CDC put a book together for communications guide. It has great -- ten million questions that you can anticipate being asked on Anthrax, but this is the basic questions. And the other one is a horrible question, could
you have prevented this? Well, of course. But then you open the liability issue. Prepare with your staff before you go public with these questions, and this will be on the website, so I'm going to move forward.

Be brilliant in shaping your message. Johnny Cochran beat the pants off millions of dollars worth of scientists by saying if the glove don't fit, you've got to acquit, because it was the right message for that audience. It gave them the information they needed to vote the way they were predisposed, and DNA evidence be damned. And I'm writing a book about communicating complex information. And if I can, the title is going to be, "If The Glove Don't Fit", because that's the perfect example of the perfect message.

Be concrete and human. Tell the story, tell how you felt, tell what you said to your mother about this, because it humanizes you, and it creates a link with the audience. And don't talk about health care delivery, talk about the nine year old baby named Tonya who's in the emergency room crying, because that's what people understand. It's familiar.

Take charge. Never go out there unless you have somebody with you who will tell you your zipper is open, your tie is crooked or whatever. And there's a big debate about telling everything and telling it immediately. I say you don't have to tell everything. Just make sure everything you do tell is true. And you don't have to know everything, but don't say I don't know. Say well, here's what I can tell you, and here's what I'll do to get that information for you, so that you sound like you're in charge.

Remember that reporters are walking cameras, so if they turn their recorder off, it doesn't mean they stop thinking. If the camera lights go off, it doesn't mean you're home free. Everything a reporter sees or hears is fair game. There was a big story in the Times about Pat Rousseau who's running Lucent, and in the middle of it they said she took the extraordinary step of conducting this interview in a room with only one picture rather than her office. Well, what does that have to do with anything? But that was the reporter's perception, so it becomes part of the story. Reporters, and don't relax. It's not a conversation. It's never a conversation. You sit down with Larry King and you think he's really interested in you and your background. It's not. It's a performance. And from the time the reporter comes in the door to the time the reporter leaves, it's a performance, and that's your job. And it may be your job, if it's not your job.

And I say use for example. Force yourself to say for example, let me give you an example, let me tell you what happened in Wisconsin or Milwaukee. Great story, repeat your key points, and use boomerangs and setup phrases. It sounds stupid, but all you need sometimes when you're asked a question is four seconds to get your mind in order. And that four seconds can save your career. Rather than going this way with it, you go this way with it. So we say embed these setup phrases because they also tell the reporter what's important. And 15 minutes later when he or she is writing the story, you say well the most important thing I can tell you is, and they put a little star in the margin. And later on when they're trying to figure out what was important, there it is just like you said. And you speak in whole sentences, so you don't say as I told you earlier, and then
blah, blah, blah, blah, because I'm not going to use that as a sound byte. You want a total sound byte.

Great sound byte. Bob Dole, his wife was being named the Cabinet Secretary, and he was there. I think it was either Regan or George Bush, I, and he said, "I regret I have but one wife to give for my country", great sound byte, you know, but he thought about it. It all boils down to this. Our first priority is this, they say people can only pay attention for about 17 seconds. Then you have to rewind their tape. These phrases rewind the tape, and they put framework, and they force you to summarize. That's important, because we can ramble on. Five nevers, never lie, never repeat negatives, never say anything you don't want to see in print, never get angry, and you wouldn't think you'd have to say it, but I have people running away all the time, and it's a great shot, you going down the hall.

The key is preparation. I'm going to show you two pieces of tape. This is -- you need media contingency plans that people are aware of, that they'll use. So it should be like flip cards rather than documents. You need contingency statements, statements that you thought through and worked through, and video taped yourself saying so they're on the tip of your tongue, so you can say well, I'm glad you asked that question, Ted. Here's the way we approach a problem like that, and suddenly, you know, this guy is on top of things. He's not doing it on the fly. It's because you've practiced.

Designate and train spokespeople, and evaluate them carefully. Don't put anybody out there, and then leave them hanging, because everybody knows what you should have said Monday morning. Why didn't you tell Mike Wallace that? And simulation exercises, you know, the phones have to ring. It can't be -- we prepare material for people and they say oh, yeah, I got it. I got it. Well, let's do it in front of the video. I got it. I got it. And they get out there and you hear this loud sucking sound. Okay.

Can I play the video? Okay. I want to show you, it's going to happen, you know, there's no way around it. And thank God you people are here, and you've made it a priority to try and pull our public health structure together to respond to it. But I want to show you a guy who made some mistakes, because this is an example of what I want you to implant in your mind. He's an epidemiologist just like you, and this was the day when the big story in America, because nothing else was happening, was "Your Muffins Are Killing You." Now maybe 15, 17 years ago, some place, some competitor of a big muffin company did an analysis of the ingredients, and found parts per billion of methylene dibromide, so as a competitive strike they said you better check into this. I think those muffins are going to make your head explode or whatever. And it was a big story. In fact, it was on Nightline because Princess Di was healthy that night, so the company that made the muffin mix did not want to go and defend their poisonous muffins. They said, you know, I got these Washington think tanks, like the Food Manufacturer's Association, and you've got all these experts who, you know -- have one of your guys go out and defend us generically, so that we don't associate. So this guy's called, the epidemiologist is brought up from the basement. They give him a suit, and he calls everybody he knows on earth and says I'm going to be on Nightline. And everybody
gives him advice, make sure you do this, use analogies. And you only have 30 seconds, but what they didn't tell him was that means -- the recipe for a good 30 second spot is add shortening. They didn't tell him that, so he tries to say everything in 30 seconds. And I want you to listen to this like an informed viewer. Ted Kopple has no idea what he's talking about. You will, but in the background you can hear Ted Kopple cough because he's waiting for this guy to take a breath so he can interrupt him. And Ted Kopple has an earphone, and the producer is saying get this guy off. They're turning to Johnny Carson. He's deadly, and he's going on and on. And suddenly that little monster, he realizes this is going on a little long. I may be adding too many -- and you can see his face start to -- he has this dissonance occurring his body language. And finally, Ted Kopple says what the hell are you talking about? And Ted Kopple, the guy who spoke to the sock, is one of the brightest people on T.V. Please roll tape one, go the video tape.

(Video Tape Played.)

MR. BURKE: I've carried that tape for 17 years for exactly this purpose. God knew what he was doing. I have another tape here. It's a tape of somebody who did the job well. It's Rudy Giuliani at that press conference when they're talking about the exposure of the little girl, and it's hastily called. Now I want to say something about Giuliani. He's been doing -- he has a radio show at this point, every Friday on WOR in New York. Every week he deals with the toughest news media in the world who are out to kill him because they hate him, so this is an experienced spokesperson. So when we glorify him, it doesn't mean that everybody should aspire to a performance of this nature, but we can learn from it. But it's like tennis, you have to practice, or golf which is even worse. You have to practice. You have to develop the right muscles before you can perform this way. But the key point I want you to take away is something that I think Neil Cohen put into his head when the mayor said, "Tell me, doctor, is it or is it ain't Anthrax?" The doctor said, "We're using an abundance of caution. We're taking an abundance -- in an abundance of caution we're doing this." And he's a politician. He picked that up, and he used that phrase repeatedly to reassure people. And he just tells them -- he's not telling them anything that's awe inspiring. He's just explaining things in simple language what's being done, and this prevented hysteria in Manhattan, no matter how you define hysteria. After people saw this, said oh, good, they're taking care of it. You know, where's Archie Bunker, or whoever the prevailing Archie Bunker is. Please play the tape.

(Video Tape played.)

MR. BURKE: You can stop the tape. It goes on and it comes across the ticker excessive caution, taking excessive caution. We feel comforted. He does a good job, and part of it is he's built such a reservoir of credibility from the 9/11, and we don't always have that.

So to summarize, I agree with everything everybody has said today. I think that this audience understands what needs to be done. We understand that like pole vaulting though. It's very important to actually rehearse and prepare the material in advance, and don't assume -- don't look in a narrow sphere of what might happen in your facility or your location, because with instant technology, anything that happens anywhere will -
- you'll receive questions locally. And you have to prepare those good messages, and come out strong and take control.

I hope I've been helpful.

---

**Kathleen J. Tierney, PhD**

**Introduction to Civil Society as an Asset during a Public Health Emergency**

DR. SCHOCH-SPANA: It is my extreme pleasure to introduce Dr. Kathleen Tierney, who's a Professor of Sociology, and Director of the Disaster Research Center at the University of Disaster. Well, then you must be a very important person right now, and I hope the funding is flowing to your University of Disaster. University of Delaware.

I should note that for those of you who aren't disaster chasers, that the Disaster Research Center at the University of Delaware is the premiere center, and Kathleen brings leadership to that center based on over 20 years of experience in the disaster field, studying social aspects of hazards, disasters and risk, and her publications are multiple. But leading texts include Disasters, Collective Behavior and Social Organization, and Facing the Unexpected - Disaster Preparedness and Response in the United States. Thanks very much, Kathleen.

DR. TIERNEY: Thank you very much, Monica. Well here I am representing the University of Disaster. The title of our panel this afternoon is "Civil society as an asset during a public health emergency", and the panelists that you'll be hearing from after me are Diane Lapson, Ernie Allen and John Clizbe.

We've been asked to deal with questions like these. How can leaders make use of existing networks? Does bioterrorism pose special challenges? And if so, what are they? How can schools, workplaces and other institutions, and I see a typo on there, and other institution be mobilized?

I'm going to start off by talking just a little bit about findings from research on individual group and organizational behavior in major natural and technological disasters. There is a field of social science disaster research that has been in existence for more than 50 years. It is a multi-disciplinary and international group of researchers who look at issues around disaster response and the public involvement in disasters. And based on these findings, I'd like to just talk very briefly and in very general terms about what we know, and what the challenges are then in terms of harnessing the capacity and the social capital of civil society in disasters.
First of all, one thing that we do know is that ordinary community residents play an extremely important role in disasters of all kinds. Whether you’re talking about groups of people who come together to sandbag along the Mississippi River in the 1993 midwest floods, whether you’re talking about search and rescue following disaster impact in areas of impact and collapsed buildings. The majority of people who are led to safety, who are rescued and pulled out of rubble in disasters, major disasters, are pulled out and rescued by ordinary community residents. And as Lee Clarke said in his presentation this morning, the real first responders are the neighbors, the friends and the co-workers of disaster victims.

We have seen this pattern in disasters worldwide. It has been widely documented, so the first line of defense is the local community resident, followed by emergency workers and followed distantly by outside search and rescue teams that come in to communities. These search and rescue teams perform a very important function of finding in 99 percent of the cases dead bodies rather than living people. They perform a very important function, but the true first responders in search and rescue personnel are local community residents.

Similarly, when disaster victims need to be transported to hospitals and other health care facilities, they don’t go in ambulances. They are transported there by local community residents. And people are involved extensively in disaster response, even in the pre-impact period, in the impact period, and in the response and recovery period through volunteer activity, through donations and in other ways.

Secondly, we know from research that altruistic norms and pro social behavior prevail and dominate the social response in disaster situations. People are more caring, more giving, have more of a community spirit, and generally counter-intuitively higher morale in disaster situations than they do during normal times. Anti-social and maladaptive behavior, here we’re talking about things like panic, extreme demoralization, helplessness, looting, civil unrest, these kinds of behaviors are vanishingly rare following disasters. This is particularly true of disasters in the U.S.

Another point that we know from extensive research is that ordinary people are very willing to assume risk in disasters in order to help others. People are not risk adverse. Let me give you an example. In 1989, a magnitude 7.0 earthquake, October 17th, 1989, magnitude 7.0 earthquake occurred, epicentered near Santa Cruz, California. That earthquake caused widespread damage throughout the San Francisco Bay area. The largest loss of life took place when a double-decker highway structure pancaked and collapsed. This was in the East Bay in Oakland, in fact, in West Oakland. This was a cyprus structure. This is where most of the people were killed in the earthquake. Workers from nearby work places came out and climbed onto those pancaked structures in order to bring people to safety. It was workers in the immediate area, African Americans in West Oakland who did the rescuing from that collapsed cyprus structure, knowing that there could be further collapses and after-shocks at any time, so people are not risk averse.
We saw this very dramatically in the World Trade Center disaster, where people risked their lives again, and again for their fellow workers. And the most touching example that I found was the man who stayed with his disabled best friend and fellow worker in a wheelchair, and died by the side of that person. People take risks to help others in disasters.

We also know that the roles that are undertaken when people do mobilize following disasters tend to be related to their pre-disaster roles. This includes gender roles, work-related roles, and leadership roles. Contractors, people who work with heavy equipment, these sorts of folks are going to volunteer for search and rescue and debris removal. It's related to their pre-disaster roles.

We know that there's a gender division of labor in terms of how people help, and how people mobilize in disaster situations. Prior leadership roles also carry-over, and we're going to see a good example of that when Diane talks. She was a leader in her apartment complex. She had a leadership position, and that carried over, so we know in some senses that people are going to show up offering expertise that they have.

The desire to provide disaster aid is extremely strong. This is an incredibly robust finding in disaster research. Community residents will respond and they will do so in very large numbers. They may do so in larger numbers than are needed, wanted or requested. Volunteers will converge, donations will converge whether requested, or needed, or wanted. There will be large scale convergence.

The challenge then is for us to be able to plan in ways that enable us to develop the organizational and institutional capacity to incorporate the volunteer sector appropriately and effectively in safety, because they will come. They will not be prevented from coming. They will not be kept out. They will not go away.

How do we meet the challenge? Well, I'm just going to suggest a few ways that we working together need to consider. And I'm going to focus on pre-event planning, what we can do beforehand. And certainly, one of the major things that we're going to want to do is, if I'll borrow a word from Kathleen's presentation this morning, an audit. That is, it's very important in terms of planning to identify roles for volunteers and community groups. What is it that volunteers can do? Recognizing that within our civil society, we have large numbers of people with unique skills that are going to be needed, be they the interpreters, be they the translators, be they the students at the local community college who are taking courses in geographic information science, be they students in a college or a university who are training in the health care professions.

The challenge here then is to identify existing groups, identify networks and professions out there in the community. Are there retired public safety people? Are there retired medical people? What about the medical academy in the community? In other words, identify the needs, the places where volunteers can be used, and link with those groups before the event happens.
Again, many speakers have talked to the importance of making community groups a part of the planning process, and for developing structures to incorporate volunteers into response efforts. There need to be linkages. In other words, there need to be volunteer coordinators identified. There need to be structures in place when people begin to mobilize for utilizing them.

Now I want to -- you know, everybody here has talked about the importance of a collaborative community planning process, and involving the local community. I want to call your attention to something that disturbs me and probably disturbs others of you in this room, and that is that with terrorism and bioterrorism planning, there is beginning to be a tendency towards stovepiping, and toward viewing this as a law enforcement problem, as a command and control problem, and there has been a trend toward greater and greater secrecy in terms of the nature of planning that’s going on.

This is a problem if we want to look comprehensively in terms of comprehensive outreach to community-based organizations, and to a wide variety of sectors within the community. This secrecy and this stovepiping is going to be a source of risk for us, is going to compromise our ability to respond.

I think that there is also a need to go on a concerted search, a systematic search to identify best practices with respect to how we work with civil society organizations and institutions. Looking at community-based programs that have been shown to be effective, and one example that I can give here is the concept of the community emergency response teams, which were originally developed in Los Angeles, California by the L.A. Fire Department, community emergency response teams that receive training so that community residents would be able to be on their own, be self sufficient and help one another in the event of a major earthquake.

What local officials out in California had been telling people is be ready in a near catastrophic or a catastrophic earthquake to be on your own for up to 72 hours, and so this community emergency response team concept was developed, and was shown to be effective when an earthquake struck the Los Angeles area in January of 1994, so we need to learn. We don’t reinvent the wheel. We go out and we look for things that already work, good models of incorporating the community into planning and response efforts.

And I will just leave you with a couple of parting thoughts. First of all, that these findings are very robust. They have been shown to be consistent across a variety of different societies in many different types of disaster situations. And despite the fact that bioterrorism is different sort of hazard agent, and has its own unique qualities, we should expect more similarities than differences in terms of the way that members of the public will respond to an event threat of that nature. Thank you.
Diane S. Lapson

Community Organizations Acting During Crisis: 9/11 and Neighborhood Associations

DR. TIERNEY: It's my pleasure now to introduce our next speaker, Diane Lapson. Diane is the Vice President of the Independence Plaza North Tenant Association, and was prior to 9/11. She was one of those community leaders. Independence Plaza is a building complex housing approximately 4,000 people that is located three city blocks from Ground Zero. Diane is a co-founder of the 9/11 Environmental Action Group, and a member of the World Trade Center Residents Coalition, a 30 year community activist in lower Manhattan, exactly the kind of person that should be at a meeting like this. Diane continues to deal with Tribeca's issues as a result of September 11th, 2001.

MS. LAPSON: This is Glen, who miraculously put my photos together within like three seconds, so I didn't think I'd show you any photos until he said he could do it, so thank you.

Well, the fact that I'm standing here in front of you is proof that this conference has validity, because if someone would have told me a few years ago that I'd be speaking at this kind of function, I would have just simply ignored them. It wouldn't have had any reality to me.

There are three sayings in Buddhism that inspire me daily. One is, the muddier the swamp, the more beautiful the lotus flower that grows from it. Another is, with strong faith poison can surely be turned into medicine. And the third is that winter will never fail to turn into spring.

September 11th, 2001 was a primary election day. Greenwich Street was full of activity. Our city council member, Katharine Freed, who is a friend and neighbor, was running for a higher position. Three blocks away was our familiar backdrop, the Twin Towers. Suddenly above our head came the loud roaring and the huge plane speeding downtown exploded into Tower Number 2. The next hour was horrific.

After rushing to evacuate the schools, Katherine and I ran to the 1st Precinct for assistance with the multitude of people pouring onto the streets. Someone then shouted the Pentagon was hit, and it seemed like it was the end of the world, yet my instinct was to keep helping and we'd lived through this. We is the key word. Evidently, this thought is not unique to me.

It was suddenly apparent that humanity's instinct for compassion is stronger than its instinct for personal survival. The one officer that was left at the police station said, "We can't help you. You have to do what you have to do." No police. We returned and tried to move the crowd uptown. Smoke poured through the streets, and people were jumping from the towers. The towers were crumbling. Later number 7 fell, number 5 had split in
half. The tangled steel piled high over a raging fire became our new backdrop. I have a picture of that, of what we saw at the end of our street.

Independence Plaza North or IPN is a large middle-income housing complex in Ground Zero in Tribeca. There are 1,345 apartments in three towers and lower townhouses. The three towers are referred to as Building 1, Building 3 and Building 9. As you heard, there are approximately 4,000 people of all ages, races and denominations, with a large senior group.

Columbia University once said that we are a microcosm of New York. Most of us moved in during the early 70s, and we’re the pioneers of Tribeca. Having no amenities, we proceeded to build the streets, schools, parks, commercial businesses, gentrifying an area that consisted of nothing but factories and a few loft buildings. We did get used to working together.

Three years ago faced with some serious tenant issues, a group of tenants decided to revamp our tenant association, the IPNTA. We really didn’t know that we were also laying the foundation for surviving a terrorist attack.

The IPNTA has one president, six vice presidents, so I’m not that special, and a secretary and a treasurer. I’m the vice president of Building 3, but most important and maybe unique to our tenant association is our army of floor captains. We have a goal of one captain per every floor, and we know have 90 floor captains. Our goal is 115.

After the attack, a researcher from Johns Hopkins Biodefense Department wanted to know how our community organized so quickly. I explained that we were already organized before. No one questions my taking over the complex because they had worked with me, and they knew me already. I questioned my taking over the complex, but that’s another story. I still question it.

Immediately following the attack, our tenant association structure took over, and we realized that we were facing many serious problems. Building 9, closest to the Trade Center, lost all power and had been hardest hit by the debris dust. Many people had no choice but to evacuate. The other buildings had electricity but no hot water. All phone service was out. Cell phones worked sporadically. We didn't know if our buildings were structurally safe, or if they would fall down, as well. All businesses were closed, including our supermarket and drug store. And actually, Dr. Lewis talked about this before, when she was talking about what the seniors had to face. This is a slightly different story, because the seniors were not abandoned in our complex.

Anyone who left Ground Zero was not allowed back into the neighborhood. Some tenants had been in the Twin Towers when it happened, some had been below. Some tenants died, some lost relatives and friends, all had witnessed the terrible after-math, including very young children. People were getting sick, traumatized, confused, depressed and very frightened, and for better or worse, I was in charge with no experience in this kind of -- with no disaster experience at all.
Sean, the vice president of Building 9, was forced to take his family to safety, so the other vice president, Dorothy, she was vice president of Building 1, and I set up our posts in our respective lobbies. I think I have a picture of that. There we go. This is actually not me, but this is where I stood. I stood next to that black phone for about -- between that and the street for about 16 hours a day. That's how we ran the complex, and we used this very antiquated intercom system which miraculously worked for the first time in 20 years.

Seeing the vice presidents at the security desk, they knew that -- the floor captains came down to the lobby, and when they saw us they knew that we were part of the -- they were part of the team. Management gave us a list of seniors and disabled for each building, and this was our A list, people to check-in on first. Everyone talked to their neighbors, made sure the elderly were okay. We made mental notes of who returned home safe, consoled the frightened, watched the news hoping they would find believe alive and prayed the attacks were over.

Although rescue services and armed forces were all around us, it was as if we were invisible. The reporters used our building for video. All eyes were understandably on the rescue site, and we were on our own. We didn’t know it would be for 10 days.

The next morning Elizabeth, a psychologist trained and experienced with Red Cross, organized a trauma drop-in center. People dropped in immediately, and we identified which tenants were blind, paraplegic, partially paralyzed, suffering from Alzheimer's, immobile, et cetera. Their home attendants, as Dr. Lewis said before, were not allowed passed Canal Street, so they were alone in their apartments.

By afternoon, Red Cross volunteers appeared in the lobby, and they said that all of Building 9 must be evacuated. They would also help by going door-to-door to other buildings, starting with our A list. I explained that there was a paralyzed woman who had stopped eating and drinking. A neighbor had obtained her key, and they also gave us a few volunteers for our drop-in center.

There was a lot of food set up in the streets. We needed 60 meals for our A list, but we were told it was only for the rescue workers. It took days to negotiate with the Salvation Army. A rescue worker from IPN heard the problem, and he quietly showed up with 60 meals twice a day for all of our seniors and disabled.

A few days later there was so much food being donated that our constant begging resulted in food being designated directly to our building, and we sent teams of people to pick the food up and bring it back. This is what our street looked like. I’m just showing you some tenants. You notice people are smiling because they were smiling. They were working in hell and they were smiling.

During the second day some bigger problems cropped up. A resident announced that she had just taken her last heart pill. We discovered that many people expected prescriptions in the mail, but there was no mail. We turned to Katherine to see if she...
could help. She arranged for a doctor to come from Chinatown the next day, and we posted signs for all who needed medical supplies to go to our community room in the morning.

Another problem involved the paralyzed woman. Unfortunately, the Red Cross volunteer maybe was a little inexperienced, and she brought a reporter up to her apartment without asking the woman, and when the woman found out, she had been convinced to go the hospital, but when she discovered there was a reporter there, she threw everyone out of her apartment and didn't go to the hospital, and it was a very serious situation taking care of her for the next few days.

When Building 9 was evacuated, some tenants moved into other buildings and the rest went to shelters. Some people waited for hours with their elderly neighbors in the streets so the neighbors would get picked up before they themselves evacuated.

By day three no doctor came. However, Katherine had somehow managed to find the owner of the drug store and convinced the authorities to let him in. Tenants volunteered to run the cash register and manage the store as he honored all prescriptions. And knowing the guy who runs the drug store, you know that's a miracle, anyone behind his cash register.

Having our city council rep living there was a great advantage, but she also was helping the rest of the area. Without her it would have been worse. Con Edison told us that Building 9 wouldn't be back for two or three weeks, and she managed to get it running in five days.

No response from the Office of Emergency Management the entire time, I'm sorry to say. Oddly, my cell phone number was distributed as a Tribeca emergency number, and for all of those other groups that did not have any tenant association, suddenly I had a $400 bill for helping my neighbors figure out what they should do in their situations.

Minister Diane Dunne arrived asking if she could set up a soup kitchen which, of course, we really wanted because we didn't have any hot meals until then, and so we set up the soup kitchen, and all of the tenants served -- this is an Egyptian family that was particularly traumatized. You can imagine how the kids felt, and we put them to work too.

Four days without hot water, we all smelled like smoke, the air was terribly polluted. It was hard to breathe. Paper masks were distributed, but they only helped with the smell. We were trying to be good citizens, but it would have been very good if we got assistance from somebody. No assistance came. After voicing some of our complaints, we were told that people with proper I.D. could now leave and return to the neighborhood, and so the home attendants were finally allowed back in. That took a big load off of us, and other tenants starting making trips with shopping carts to bring staples back for their neighbors.
Much to our shock, the Red Cross volunteers told us they were leaving our trauma center. Somebody thought that they didn't need our help. We had to move on and replace them with a few tenant social workers. And I think we, all of us who are leaders should have been at that drop-out center, I wish, drop-in center because we were traumatized and we didn't even know it.

That Friday night, we had a general tenants meeting, and a few religious leaders came to give some encouragement to the tenants who needed it. Recently, a neighbor told me that I saved her husband's life, and thanked me for it. I had no idea, but evidently during that chaos she said her husband wasn't feeling well, and I called the Red Cross, and they rushed him to the hospital. Never heard about it again.

Based on our experience, I have a few messages to get out. To the citizens, organize your neighborhood now. Start a small group, a large group, we pray no more attacks come, but do it anyway. It's good to be prepared. Elect officers, enlist volunteers and give them assignments. Meet regularly and create bylaws. If needed, charge a reasonable fee and you could always use it to buy batteries and flashlights, and first aid kits, and invite groups in to train. If nothing else, once a year have a great party to celebrate each other. It's a great way to bring back a sense of community to the United States.

To the government and the relief agencies, knowing people will volunteer and want to help during an emergency, accept their invitation. There may be fear that volunteers will not do the job correctly, but they're going to volunteer anyway, so training is important. At least one person in each community should have Red Cross training. Start more outreach programs to communicate groups.

The police departments, and fire departments, and even the armed forces can give us some instruction. It may not seem so important -- it may not have seemed so important before, but now it's really important to us.

I've only hinted at our survival, and we're still struggling with a lot of issues. The rest of the country may think we're back to normal but we're not. But because we have a strong community, we continue to overcome each obstacle.

I know I'm running out of time. I have one more thing to say. One late night during the difficult week of September 11th, I stood in the street looking at where the World Trade Center once stood. I remembered something I once said when asked how can you live in the middle of a city? There's no landscape, no hills and no forest, just concrete and glass. That's true, I responded, but in New York City the people are the landscape. On September 11th, 2001 and during the ten days that followed, we let go of our personal issues and focused on the common good. The statement became ever more precious to me. The people are the sunrises, and the sunsets, and the mountains, and the rivers, and flowers and valleys. The community is what fills my heart with inspiration and hope. Thank you very much.
Ernie Allen

Mobilizing a Community Around the Desire to Protect Children

DR. TIERNEY: Thank you very much, Diana, for that incredible first person account. Our next speaker is Ernie Allen, the President and Chief Executive Officer of the National Center for Missing and Exploited Children, an agency that he co-founded. Ernie came to the center following public service in Kentucky, where he was the Chief Administrative Officer of Jefferson County, Kentucky, Director of Public Health and Safety for the City of Louisville, and Director of the Louisville Jefferson County Crime Commission. He's an attorney, and a member of the Kentucky bar, and he has held faculty positions at the University of Louisville, the University of Kentucky and Indiana University.

MR. ALLEN: Thank you. I was saying to Diane, I can't help but think about the power of people, the power of individuals to make a difference. I was a little bit curious about why I was invited to be here. I don't claim knowledge or expertise in bioterrorism, but when Hopkins asks I respond, and Monica made the point that she thought there was relevance in terms of the way that we have built our networks and mobilized the public as a real asset.

I know that there's kind of a stereotype, and that stereotype is that if you tell the public the truth in times of crisis, people will over-react or resort to violence, they'll panic. And I submit to you, and I recognize that the underlying premise of this conference is that that's wrong, so what I would like to do today is try to make the case as it relates to one particular effort, one particular initiative, that the public not only should be communicated with, but that the public is a vital ally in times of emergency. And that average citizens can do amazing things, as you've just heard.

My premise today is that if we tell people the truth, if we identify roles and are specific about what they could do, and if we mobilize them to work with existing public agencies and private efforts, we magnify the value and the impact of the whole. And to illustrate that point, let me talk a little bit about the history 20 years ago when we began an effort to try to mobilize the nation and attack the problem of missing and exploited children.

For those of you who can remember 20 years ago, it was a time very much like last year when the media called in the Year of the Missing Child. It was a time of Adam Walsh and the missing and murdered children in Atlanta. And enormous recognition of the fact that this was a nation that didn't have a plan and didn't respond very well to these crises, these disasters that occurred to communities one child at a time. And as a result, what we learned, and I think what we came to understand is that this is a nation of 50 states that often act like 50 separate countries, and 18,000 different police departments, that by and large didn't communicate with each other.
Monica mentioned to me before the panel that there are 3,000 public health agencies in the United States, and I want you to know how jealous I am of your small numbers. But I suspect that the communication and information sharing challenges are very much the same as we faced in law enforcement. So what have we tried to do about it?

Twenty years ago you couldn't enter missing child information into the FBI's national crime computer, put information about stolen cars, stolen guns, but not stolen children. And the federal government opposed a law that would allow you to do that, and the quote was, "It would interfere with the management prerogatives of the FBI", like getting in the way of doing really important stuff, like working bank robberies and tracking down car thieves. Well, that changed.

In 1982, Congress passed what was called the Missing Children's Act, made it possible to put that information in into NCIC, so at least there was the ability to exchange and spread information around the country. When Adam Walsh was abducted and murdered in 1981, arguably the most high profiled child abduction case since the Lindbergh kidnapping, the Walsh family mobilized their friends, created their own posters, and called every police department in their home state of Florida two weeks into the investigation, just to make sure they had posters, they had the little boy's picture, they knew what to do.

What they found was 80 percent of those police departments didn't know who Adam Walsh was. Eighty percent of them didn't know their little boy was missing, so that no matter how good a job that local community did in putting up pictures in the front windows of 7-11s, the reality is that if your child disappeared, you were on your own. There was no network, there was no system. And so that's what we sought to do. We sought to build a network where there was none. We sought to create a mechanism for rapidly disseminating images and information across America and around the world.

To millions of Americans, our organization is probably still the milk carton organization, because that was our first aggressive effort to take pictures of missing kids into homes across the country. We stopped doing that because Dr. Spock and others said we were scaring America’s children to death, so we sought more generic ways of getting that information out there.

We had a nation of 18,000 police departments. How do we communicate with 18,000 agencies when NCIC even today, though it’s changing, is still text only. How do we provide a picture real time to a police officer in Osceola, Iowa? Well, what we tried to do was work with private sector partners to build a network. CompuServe gave us a hundred free accounts, so we created state clearinghouses in 50 states, replicating the airline hub and spoke system, feeling that it would be easier to communicate with 50 than 18,000, and maybe those 50 could then get the information to all the agencies in their state.

We developed public/private partnerships. The center works closely with the United States Department of Justice, but we also work with photo partners who are actively
distributing missing child information, companies like ADVO whose direct mail card, the "Have you seen me?" fliers going to 85 million homes a week. One out of every six of those children is recovered as a direct result of that photograph.

Walmart whose bulletin boards in 3,000 stores have already led in the last three years to the recovery of 75 children, just because Walmart shoppers walk in, look at the picture and say I know where that child is, just recovered an infant abducted from New York in a laundromat in Aida, Oklahoma, because a grandmother who had gone into town to use the laundromat saw the child, then went to Walmart and she walked in the front door, saw the poster of that child on the bulletin board. Mobilizing the eyes and ears of the public.

We created a central mechanism for people to report that information, a national toll-free hotline, and today a cyber tip line, a 911 for the internet. So what we sought to do were several very basic things. One is to go to the public and say this is a serious problem. This is a disaster problem happening to one family, but 800,000 families a year are experiencing it, and you can help. Here's what you can do, at its most basic, look at the pictures.

Secondly, if you have information, here's a mechanism to provide it. Thirdly, through these clearinghouses, and through law enforcement and a variety of other means, we're mobilizing volunteers to help educate families and kids about how to stay safe. And we're mobilizing businesses to provide the kinds of tools that parents need should their child become missing, photo IDs, free pictures of their kids.

Is it working? Well, the recovery rate has climbed from 60%10 years ago to 94% today. 3.2 million hits every day on our internet website which has absolutely revolutionized the way we get information to the public. The scariest information is that we know from data from research, that in the most serious child abduction cases, in abduction homicides, in 74% of those cases, the child is dead within the first three hours, so we can't wait until tomorrow. We have to move now, and so mobilizing public and private sector resources and really using the public as an asset, going to the public to help is bringing children home as never before.

Let me cite two very specific examples of simple ways that we think you can mobilize the public, and that have not resulted in vigilante violence or outrageous acts on the part of the public. One is the so-called Amber alert. Born 1996, a local grass roots effort following the abduction and murder of a nine year old in Arlington, Texas, a little girl named Amber Hagerman. The community was outraged and in these kinds of cases, you see all of the same dynamics that happen in disaster cases. The community mobilizes, people help law enforcement search. There are command centers created. There's fear that goes into thousands of homes and parents who say there but for the grace of God go my family and my child.

Well, Texas authorities, broadcasters and law enforcement said what if we use the old emergency broadcast system, the EAS system today, to provide breaking information in
the most serious cases via radio, and all of us experts said you can't find a missing child through the use of radio. Well, we were wrong. Today there are 84 Amber plans across the nation, 34 statewide, and 44 children have already been saved as a direct result of Amber broadcast using radio or crawls across T.V. screens, including those two teenaged girls last summer in Lancaster, California who were recovered literally within minutes of their execution, simply through the power of communication. Giving the public information in a timely manner and telling them here's what you do with it. Call somebody and tell us about it. Forty-four lives saved and at no cost.

The second one I want to talk about is a little more controversial, and that is Megan's Law. The whole notion of taking public information that the public heretofore has not been able to access. Criminal history, criminal conviction record is public record. But as any of you from New Jersey know, when a convicted sex offender was paroled and lived across the street from a family, the family didn't know about it. The child basically befriended by the guy, ultimately murdered, so the question is can we in a reasonable way provide information to the public, just knowledge, and the critics said this will create blood in the streets. There will be massive vigilante violence.

Well, there are now Megan's Laws in all 50 states. The State of Washington has done extensive research, and what they have found is that in less than 3 percent of the cases were there reported acts of harassment directed towards the offenders. Now there have been some outrageous acts, and I don't tolerate harassment at all. I think that's got to be dealt with, but the reality is that the doomsayers said there'd be 80 percent, or 60 percent. And the message of Megan's Law, the success of Megan's Law has been based in two basic facts. One is tell people the truth. Where there had been the most dramatic reactions to offenders coming back into the community, has been when neighbors have found out about it without there being a public communication, without public meetings. Then people feel they're being betrayed, and that this guy is being slipped in under cover of darkness.

When you tell people the truth, when you go to the public with information, they can handle it. So my recommendations today, and this is certainly not rocket science or something you've never heard before is one, tell people the truth. Two, ask for their help, empower people to help, prepare, organize, just as was done in New York, and be specific. Give people tasks that they understand, and our lesson from the network that we have built is that people will help, and it will make a difference. Thank you very much.

---

**John Clizbe, PhD**

**They Will be There: Managing and Protecting Volunteers**
DR. TIERNEY: Thank you very much, Ernie. Our last formal presentation is by Dr. John Clizbe. For many years, John was the Vice President of Disaster Services for the American Red Cross. He left the Red Cross, but is now back with the Red Cross as CEO of Red Cross Triangle Area Chapter in Raleigh.

During his time with Disaster Services at the Red Cross, his responsibilities included planning for disaster, disaster response and recovery, training including volunteer training, both with respect to disasters and with respect to terrorism and weapons of mass destruction.

John is a psychologist by training. He received his Ph.D. in psychology from Washington University at St. Louis, specializing in organizational and clinical psychology. Welcome, John.

DR. CLIZBE: There is a story told in the Red Cross that is both apocryphal and prophetic, I think, but it's a story that's applicable probably to every single organization that's represented here. It seems that a few years ago a group of our people were checking into a hotel right along the eastern seaboard just before a hurricane was due to strike. And as they were checking in, the hotel clerk said gee, it's nice to have Red Cross people here. And they looked around, didn't see any identification. They said how did you know who we were? And she said well, everybody else is checking out and you're checking in.

Well, I think there are some important messages in that story about how to manage and protect our volunteers. And as a psychologist who got my start in disaster working on the disaster mental health side, I think it became increasingly clear to me that the issue of dealing with volunteers was as much an emotional issue as it was a logistics issue.

Let's start with a person who's volunteering. There are a number of distinguishing features about that person. One of them is that they're there because they want to be there, and only because they want to be there. They don't have to be there. They're not paid to be there. They're not even expected to be there. They are there because they want to be there.

Now they can want to be there for a lot of different reasons. One of them might be a genuine desire to serve other people. That might be the motivation. Somebody else might be motivated by the excitement of it all, what some of us affectionately refer to as the cowboys. Some people may be motivated to be there out of some social kinds of needs that maybe a group of neighbors come together to help respond, similar to what Diane was describing. Or it could be the motivation as my wife I hope professionally says could be my rescue fantasy. You know, I want to go in there somehow and rescue a bunch of people. But the point is that as we manage volunteers, we have to manage them differently, depending on where they're coming from, what their motives are.

I can give you one very concrete example. Let's take our cowboys. I can tell you the one thing we don't want to do to protect our cowboy is to give them a mask and some gloves,
because if we do, they're going to feel safe to deal with every imaginable kind of biological or chemical outbreak. We have to manage them differently because of the way they're approaching the situation.

There are some other distinguishing features about our volunteer. It is, for example, their belief, and it is entirely their call what they will do. Now for those of us in emergency management, we're accustomed to thinking that we assign people based on what we believe needs to be done. The volunteer who is arriving is thinking in terms of what they want to do.

Now there are some important implications for that. One of them from my point of view is that we must, absolutely must adhere to the standards of performance and expectations that we would have regardless of who the person is that shows up. As a volunteer, and then ultimately as someone attempting to manage and lead volunteers, I became convinced that the issue is to have the right person in the right place, doing the right things at the right time, in the right way, and it didn't matter if they were a volunteer or a paid employee. But we needed to have consistent solid standards and expectations that remained in place, whether it was a volunteer or an employee.

Now there's another implication, I believe, and that is, and we don't like to talk about it a whole lot, the issue of selection. From my point of view, some volunteers who want to volunteer shouldn't volunteer. And we have a responsibility to select in and select out the people who can fulfill the expectations and the standards that we've established. Another distinguishing feature of our volunteer is that they believe it's at their discretion when they're going to work. We like to think in terms of 16, 17 hour days, seven days a week. A volunteer plans to volunteer on Tuesdays for three hours. That raises havoc with our typical way of thinking about continuity and consistency, but there is an implication to that also. It's called job sharing.

In fact, many of the things that we do, many of the tasks we perform on a disaster operation can, in fact, be shared by numbers of people, instead of following our traditional model of believing that one person has to do one thing all the time. There's another distinguishing feature of our volunteers, although I'm increasingly convinced it doesn't distinguish them from paid staff, and that is that their training and experience can range from zero to a lot.

Now there are some important implications of that also. One of them, obviously, is training, and not just training in advance, but being prepared to run an honest to goodness training operation when the operation is occurring. Many of our organizations are not set up when a disaster happens to conduct on the job training right then and there. But there's another implication of that range of training and experience, and that is that some volunteers, in fact, have more training and more experience than some of our paid people. And we need to recognize the strengths and the assets that the volunteers are bringing to us. More about that in just a minute.
Now let's take this person and plop them into the situation. And we know first and foremost about that situation that it's a disaster. Often a disaster in more ways then we intend. And a number of dimensions arise because it's a disaster. One of those dimensions is that it's a very intense climate. The last thing we think we have is time to deal with the complications of all these volunteers who are showing up, and we get very impatient with them.

They, in turn, get very impatient with us because they came ready to do some work, and we start running them through all kinds of structural and bureaucratic rigmarole from their point of view. Now the implication from my point of view is very straightforward. We absolutely must have a full time person or team devoted exclusively to managing the volunteers. I know of no other way to deal with the dimension of intensity, and that full time person responsible for volunteers needs to be an integral part of the incident command system and structure. They need to be right there where it's all happening, and know what’s happening so they know when and how to put volunteers to use.

Now the other dimension of this disaster is it's very complex. And we talk about having multiple balls in the air, those kinds of things. The interesting news is given all I've said about volunteers, the good part is they can diminish the complexity for us in a number of ways, many of which have already been discussed. They can, for example, take on a myriad of those tasks that we don't quite ever get around to assigning to the full time paid people who are there. They can take enormous items off our plate.

On the other hand, they can bring enormous insights that diminish the complexity. They know the neighborhoods. They know the people. They know the vendors. They know the transportation system. All those things that are giving us fits in attempting to manage that disaster situation, the volunteers know and have the answers to, so the volunteer actually can diminish the complexity if we take advantage of the knowledge and skills that they bring to us.

Now that gets to the final dimension that's involved in this disaster situation, and it's something those of us in the disaster business preach all the time, and that is that all disasters are local. Well, Oklahoma City and September 11th certainly drove home the localities that become involved, particularly in acts of terrorism. We know it was a local disaster in New York City, and in New Jersey, and in Connecticut, and in Washington, D.C., and in the surrounding communities, and in Pennsylvania, but it was also a local disaster within New York City.

There was a neighborhood here that Diane describes. There was another neighborhood there that someone else may talk about. All of those were local disasters, but on September 11th it was a disaster in Des Moines for the mother who had the six year old being bombarded on television and who couldn't sleep. It was a disaster in Minnesota for the tourists who were stranded, foreign tourists who were stranded and couldn't get prescriptions. It was a disaster in Los Angeles for the man who had a friend working in the World Trade Center. It was a nationwide series of localities, and the implication is that we can take these volunteers, and in fact probably use them best in their locality,
whether it's Des Moines or Los Angeles, or the neighborhood in New York City, or the neighborhood outside the Pentagon area.

One clear implication is the opportunity to use volunteers within the locality that they reside and that they know. So really what I'm saying is that everything we've been taught about managing people is exactly what we have to do to manage and protect volunteers. We have to have standards and expectations well articulated in advance.

We need to recruit a large pool of people that could potentially be available to us in advance. We need to make good selection decisions. We need to place people well, and we need to train them. That's how we manage and protect volunteers.

Now the good news is a whole lot of that is already in place. Speaking from my own experiences in the Red Cross for decades, we've been establishing standards of performance for volunteers, we've been recruiting them, have been selecting them, have been training them, have been placing them. And that's true of the voluntary organizations active in disaster around the country. Those skills already exist in practically every community represented here today. We just need to take advantage of those skills that already exist. And certainly the civilian corps and a number of the government programs that are emerging are ideal opportunities to exploit and take advantage of those skills that already exist in our communities.

Volunteers will, as Kathleen said, show up. We don't know for sure in bioterrorism exactly how the proportions are going to work out, but they will be there, and we need them to be there. The real issue is are we ready? Thank you.

Panel Discussion: How to Lead a Community During Times of Trouble

DR. O'TOOLE: So what we're going to do today is ask our panel members, as I said all of whom have been leaders in different contexts and in different crises, to share with us their recollections, their insights, and their lessons from their own experiences, and from observations of other leaders through the course of challenging crisis.
The way we're going to do this is as follows. I'm going to introduce each of the panelists very briefly so that you get an idea of who they are and where they come from. And I'm going to start by asking some questions, but mostly I want this to be a conversation. The panelists are free to query each other, or to comment on questions that I ask, even if I don't direct it to that particular individual. And at the end, as usual, we will stop for comments from the audience.

So first of all, let me thank all of you for being willing to share your experiences in a forum like this. It takes some courage to do this, which is even more testimony that you are, indeed, leaders. I'd like to introduce first of all to my left. Dr. Georges Benjamin. Dr. Benjamin has a long career. He was trained as an emergency medicine physician. He has been Commissioner of Health for the District of Columbia. He was also Commissioner of Health for the State of Maryland from 1995 through December of 2002, and he is now the Executive Director of the American Public Health Association. Georges, welcome.

Next in line is Ed Clarke. Mr. Clarke has a distinguished career in law enforcement, which included extensive experience in community policing. He is credited with saving at least one life during a hostage crisis, and he has a very impressive conviction record, though he never once fired his weapon in the line of duty. He is here today because he is also the Director of School Safety and Security for the Montgomery County Public Schools, and was of course in the midst of managing the sniper attacks of this fall.

To his left is Tom Day. Tom is the Vice President of Engineering for the United States Postal Service, which employs over 750,000 people, second in size as an employer only to Walmart I just learned. During the fall of 2001, of course, Tom and his staff were in the midst of managing the response within the postal system to the Anthrax attacks.

Next to him is Dr. Margaret Hamburg. Peggy is currently the Vice President for the Nuclear Threat Initiative Program in biological weapons and bioterrorism. Before that, she served as Assistant Secretary for Health and Human Services under the Clinton administration. In which capacity she set up the CDC's bioterrorism program in an age when public health was not very keen on accepting such a mission. She's also been Commissioner of Health in New York City, and was in that position during the first World Trade Center bombing in 1993.

Next to her is Mayor Ron Norick, who is a three-term mayor of Oklahoma City. He was mayor of that city during the 1995 bombing of the Murrah Federal Building, and among other things, convened a 350 person committee. I can't even bear to think about a 350 person committee, to create the Oklahoma City National Memorial. He's now a prominent social and business leader in Oklahoma City.

Next to the mayor is Sally Quinn. Sally Quinn is a well-known figure in Washington, D.C. She is an author and reporter for the Washington Post. She is here, in part, because during the Anthrax crisis, Ms. Quinn wrote a very provocative article about the need for officials to provide the public with better information about how they should protect themselves from the Anthrax threat. Thank you for being here, Ms. Quinn.
Next to Sally is Dr. Ivan Walks. Dr. Walks is a physician. He is a former Chief Health Officer for the District of Columbia, and he led the Public Health response in D.C. during the Anthrax attacks of 2001. He is now CEO of Ivan Walks and Associates, which is a consulting firm dedicated to proactive health security, with a focus on the specific opportunities and challenges facing urban communities.

And on the end we have Peter Sandman, who is one of the world's preeminent risk communicators. He has helped public officials and others negotiate a wide range of controversial crises in the course of his career. He is now advising the New York Department of Health on bioterrorism preparedness and communication. He is also the founder of one of the earliest University departments dedicated to risk communication, and he is still a Professor of Environmental and Community Medicine at Rutger's University. Peter, thank you for being here.

So I'm sorry, I think I am making all of these hisses and bumps. I will try to sit still, which is usually not easy for me, but we'll see. Dr. Walks, I want to ask you as someone who is in the very confusing firestorm of the immediate aftermath of the Anthrax attacks, how you managed to maintain your credibility in the course of ever-shifting information? At one point, for example, we believed that postal workers who hadn't been exposed to open envelopes were safe from Anthrax, and found that that was wrong only in the tragic aftermath of two postal workers from Brentwood dying. How do you go with the flow with facts changing as quickly as they were during the Anthrax, and still be a leader?

DR. WALKS: Well, you start by remembering who you are, and where you come from. My mother always told me, if you honestly tell people what you don't know, they'll believe you when you come back to tell them what you do know. And that one pearl stayed with me throughout all of the shifting facts.

The other thing that again goes back to my own community and my own neighborhood, is that it's very difficult to come to someone and say trust me. Trust is something that is garnered through experience with consistent behavior, so if you behave the same way, people begin to trust that that is how you will behave. And you can build credibility that way.

I think that with respect to what happened during the Anthrax attacks, people were very concerned, felt they were being treated unfairly, felt that some groups had certain kinds of things going on, and people were just flat out lying. And I find that during a time like that, if you can use examples, like Dr. Walks, how do you know that the post office people didn't know that there was -- well, the Post Master General had a press conference in the back Brentwood work area. Do you think that if he knew it was dangerous, he would have gone back there? And that kind of actual anecdote that people can go oh yeah, helps to break through -- because no matter how technical you try to talk to people, people want to know about real life experiences. They want a real story, and then they want someone who will come and stand in front of them when they know everything, and when they don't know everything, but always be honest.
DR. O’TOOLE: Ed Clarke, you were also in the midst of a very complicated and scary set of events with the sniper attacks of last fall. And you had to balance a lot of different stakeholder groups, and maintain their trust, including the parents of all of Montgomery’s school kids, many of whom were anxious about the decision to reopen the schools two days after the first attack. What do you have to say about maintaining trust in stakeholder communities?

MR. CLARKE: Well, I think like Dr. Walks had mentioned, it’s about getting out accurate timely and factual information. And not being afraid to stand up and say we don’t have all the facts at this time, but we’re working very, very hard to get you the most accurate information, to provide the senior level decision-makers, the superintendent of the schools for Montgomery County Public School, Dr. Weiss, with good recommendations. What should we do? Should we open on time? Should we delay our openings? What information do we share? How do we coordinate that information with really the lead agency who’s charged with investigating these homicides in Montgomery County and outside Montgomery County was the Chief of Police, Chief Moose. So it’s important to have those relationships and be able to get information back and forth so the senior decision-makers can give good information to a variety of stakeholders.

DR. O’TOOLE: Did the fact that you had been a cop play an important role in your ability to be a player in that decision?

MR. CLARKE: Absolutely. I think that was a critical role for me to play, having come from the County Police Department that was leading the investigation, just removed two years from retirement. In my role, we were now a consumer of public safety services, so it’s important to have those relationships.

I was dispatched to the police command post. Ironically, the day of the first shooting in Montgomery County, the very first homicide, the police department was also burying one of their own officers who had died unexpectedly. I was at the service and the chief called me directly on the cell phone, and there was a rumor circulating that the superintendent may be considering school early dismissal. And the chief said, "Ed, here’s what I need you to do. Please get with the superintendent, inform him that everything is okay, and we’ll share information", so that relationship and the confidence that the chief had in me to go directly to the superintendent as sort of a broker, the information was so valuable and important.

DR. O’TOOLE: Tom Day, you also were in a very difficult position during the Anthrax attacks. You had many different stakeholders that you had to answer to. Your bosses in the postal service, CDC, and Dr. Watts’ department were also giving you information. You had to deal with the union leadership, as well as the rank and file. What was that like?

MR. DAY: The leadership really came right from the top. Post Master General Jack Potter, importantly came up through the ranks of the postal service. He’s a career employee, and understood that, and spent much of his career working to improve labor
relations. And from the very onset of the problem, we had daily meetings with our unions and management associations so that they had the latest information. But obviously, a daunting task. We have 750,000 employees to communicate with. Getting a clear, consistent message out to them, and they’re spread out amongst 38,000 locations, so that’s not an easy logistics task in and of itself. And then we service the entire U.S. population, so 280 million plus consumers who see us six days a week, so it’s not an easy thing to do. But clearly, communicating to them, getting them accurate information was essential.

DR. O’TOOLE: So I’m hearing communication, communication, communication here.

MR. DAY: I think the key, it’s not just talking, but you’ve heard it also, it’s letting people know what you know, but also being honest with what you don’t know. I think defining moment for Jack Potter was a meeting I was involved in. As it progressed from the original event on October 15th, and then Mr. Kersey and Mr. Moore died on the weekend of the 20th and the 21st, obviously, the whole situation progressed rapidly. The question arose is the mail safe? And we discussed that in a meeting, and there were those pushing to say we ought to say it’s safe because there’s huge financial problems there. The postal service, in general, represents, and that’s the whole mailing industry, represents 8 percent of the gross domestic product. It’s a huge industry and employs nine million people. But the reality was we couldn’t really say the mail was safe. In a defining moment, he very publicly admitted that no, we cannot say that at this time, so you’ve got to be honest with them.

DR. O’TOOLE: Georges, you and Ivan have an interesting story about the difficulty leaders sometimes have getting good information during a crisis. Can you tell us about your late night tryst with Dr. Walks, beginning with the Anthrax event?

DR. BENJAMIN: Well, you know, it was a very interesting dynamic in that the world was centered around Washington, D.C., and Maryland and Virginia were pretty much considered outliers, which what basically meant was we were not in the information flow initially at all. So I don’t know, it was about 11:00 one night, Ivan, I think it was, I decided to insert myself into the information flow and met him on the corner outside his house. We sat in his kitchen all night, and we talked about communication and ways in which we could improve communications. And ultimately, one of the things that happened was we went to -- basically came down, met with the CDC, got liaisons in place between Virginia and Maryland, did lots of things.

A lot of communication was going on at the lower levels between staff, but not a lot of communication at the upper levels. And when you have a governor, or mayor or the White House on the phone wanting to get answers from you, they understood we were part of the process, but the infrastructure did not, and so we had to really create that on the fly.

DR. O’TOOLE: So what’s the sound byte there to leaders in the midst of a crisis where it’s murky what’s going on?
DR. BENJAMIN: I think is don't just sit there and accept it. You know, go find the information that you need, and create the opportunities to solve your problems. You know, work the problem.

DR. O'TOOLE: Dr. Hamburg, you've had many interesting crisis experiences in your life, one of which was mentioned earlier today. It involved the outbreak of plague in Surat, India. And you got a call at one point, as I understand it, when you were New York City Commissioner of Health, that there was an airliner about to land at Kennedy Airport that might have had a plague infested passenger or two, or three on board. Could you tell us a little bit about what went through your mind, and what you did, and how you dealt with all of the uncertainties and the implications of decisions in that kind of crisis?

DR. HAMBURG: Well, I think actually the true story was a little bit different, and I think, you know, perhaps represents a different aspect of leadership.

DR. O'TOOLE: Okay.

DR. HAMBURG: WE didn't get the call that there was a plane that might have individuals with plague on it, but we did get a call about the seriousness of this plague outbreak in India, and the fact that we needed to be aware that there was going to be a lot of travel potentially between the Indian community, which is quite large in New York City and India because there was a major Indian festival going on in New York City, and that when we looked into it, there were 36 I think it was flights a day that either came directly into Kennedy Airport, or had a brief stopover. So we began thinking about how you would deal with imported cases of plague, and proactively actually set up a program to try to address how we would screen patients, screen potential --

DR. O'TOOLE: How much warning did you get? I mean, what kind of preparatory time was involved to set up the programs?

DR. HAMBURG: There was not -- this wasn't an acute crisis. There was an outbreak going on in India. It was actually poorly defined, but seemed quite worse. I mean, this clearly causing major disruptions. And the most striking part of that, actually, for me was when I, you know, realized that this was something we didn't really seriously think about, and that we didn't necessarily have the capacity to deal with proper isolation and management of a lot of cases of importing plague, I thought it might be good to brief the mayor. This was Mayor Giuliani at this point, about the preparations that we're putting in place. We identified triage hospitals and worked with CDC to develop a screening approach at Kennedy Airport for individuals coming off of airplanes that might be symptomatic, and put out bulletins to all front line health care providers about what to look for, and who to call if you saw a certain set of symptoms.

Initially, I got a very brusk response that the mayor really didn't need to be briefed about plague in India. He could read it in the New York Times. He didn't say the Washington Post, but then I called back and left a message, was he aware that there
were 36 flights per day that came directly into New York City, or with a brief stopover. And then he personally got on the phone and said, "Should we close Kennedy Airport?"

DR. O'TOOLE: Well, you know, how to get colleagues' and bosses attention is definitely one of the key skills of leadership. And I noticed that in the conversations earlier today, and even now there's the sense that information kind of flows well, quickly, naturally. That's not usually the case in my experience. Does anybody have a really good worse nightmare story of having to deal with a boss who didn't get it, or a colleague who was fighting turf battles when the ship was going down, and what you do in that situation?

DR. WALKS: I can tell one. The person who didn't get it was me, and the person who -- it happens. And the person who actually came up and told me I didn't get it was Bob Nelson. Because, you know, when you're in the government, you --

DR. O'TOOLE: He's the head of the, we should say D.C. Hospital Association.

DR. WALKS: They all know him. Bob Nelson is the head of the D.C. Hospital Association, and also a very good friend, though not as good a friend of mine as he is of her's, but that's okay. And when you're in the government you think what you're doing is very important, and you've got your colleagues, and you're moving right ahead. And Bob called and said, "Ivan, I don't know what the hell you're doing because I don't know", and there's no communication set up with the outside community. And it was one of the critical junctures of what happened that helped all of us during the Anthrax attacks, was that with Bob's leadership, we set up a routine every day 10 a.m. conference call that got all of the folks from Maryland, Virginia, the military health system, the hospitals here in town, primary care folks, the Health Department all on one call to share information, so I think that it was one of those times when, you know, those are the stories that didn't make it to the Post, that I was the one who didn't get it, but that I had good friends who were able to call and say you're not getting it. You need to do this this way.

DR. O'TOOLE: Georges, you were in a position at one point in the Anthrax response, there was a moment when the District of Columbia, and Virginia and Maryland were about to issue contradictory prophylactic guidelines, prophylaxis - excuse me - guidelines. And it was nipped in the bud, as it were, and things were coordinated. But can you say a little bit about how that happened, and how it got fixed, and what you did afterwards?

DR. BENJAMIN: Yeah. I think the fundamental issue was when do you stop antibiotics? And we had different recommendations between the federal government and the local jurisdictions. And it all revolved around the debate around whether or not you could -- what trace Anthrax was. And as some of you know, the testing was qualitative and not quantitative, and so nobody knew what trace meant.

DR. O'TOOLE: I still don't know what it means, actually.
MR. BENJAMIN: Well, we were very uncomfortable. I think Ivan and I were very much uncomfortable taking people off on antibiotics whom we had already put on antibiotics until that facility had been cleared. And there was a federal recommendation, there was a discussion of doing so, taking people off the antibiotics. And ultimately we came to some near agreement, because there was still a disagreement. I mean, we still had varying recommendations out there, but they were much more narrow when we were all done. And I think actually our recommendation was very much similar to what New Jersey ultimately did on that, but it was on this recommendation that - and this belief that you still couldn't get sick unless you had 8,000 spores. And we all know ultimately that turned out not to be true.

I think that the take-home message was, and we still haven't really resolved this, that it is okay to disagree as long as -- because what we ultimately decided on was that we would disagree on the narrow clinical question, but that we would explain it away so that we all understood the rationale for doing it differently. And that was a very, very tricky communications message. It sure was, and people still talk about the difference in recommendations. I happen to believe that we were right in the end, and we saw that certainly in Connecticut and other places where people apparently got sick from very, very low doses of Anthrax.

DR. O'TOOLE: Sally Quinn. Peter, go right ahead. Peter, go right ahead.

DR. SANDMAN: I just wanted to reinforce that, because it's a point that hasn't come all day, and I think it's an enormously important point, that disagreeing, you know, when mommy and daddy disagree the kids really can take it. And what the kids can't take is if mommy and daddy hate each other. That's another story, but two authorities like CDC and the Health Department that are respectful of each other's opinions, each of which is capable of explaining their own opinion and the other's opinion, and why they reached a somewhat different conclusion does not leave the public in the lurch. It leaves the public understanding that there is a dilemma here. That the answer isn't obvious, and that honorable people who are working well together reached somewhat different conclusions. And I know my clients are terrified that if they don't speak with one voice, the kids will go crazy. And I think it's a false fear, and the kids can take it.

DR. HAMBURG: Well, can I just comment on that? I basically agree with you that open discussions are -- but I think it puts an additional burden on leaders to really speak to the public and explain the issues so that they don't come away with only the sense of confusion that even the experts can't tell me what to do. And I think that in the Anthrax incident, there was an unfortunate episode in my view around the use of the vaccine that I think didn't reflect well ultimately on Public Health leadership, in terms of the data was inadequate, and it was confusing about whether or not vaccine should be used in the context of people who had been exposed, and/or potentially exposed and had gone on antibiotics. There were several standing recommendations that said yes, they should be, but it hadn't really been broached until the very end of the treatment period, the 60 days of antibiotic therapy. And then there was a lot of discussion about the pros and the
cons, and the inadequacy of the data, and the problems with the monkey models that had been used, et cetera.

And finally, the recommendation that sort of formally came out was the data is too confusing, so discuss it with your personal physician, and make your own decision. And, you know, I think was very unhelpful. And actually, I had been struck by it at the time, and I was on a panel a few weeks ago with Leroy Richmond, the postal worker who had inhalation Anthrax and did pull through. And he said, you know, I was really looking for leadership, and I really felt let down. You know, the data may be confusing, but don't tell me to talk about it with someone who knows even less.

DR. SANDMAN: Well, I mean, people do feel let down when they're not told precisely what the answer is. But leadership means letting them down gently, if you don't know precisely what the answer is.

DR. HAMBURG: But giving them as many tools as you can, is my point.

DR. SANDMAN: I agree with that.

DR. HAMBURG: In order to make a good decision, and I think it's right that if there isn't an answer that's clear, you don't give it. But I think you have to realize then you have an additional burden of responsibility to really take the time to educate the public, and explain the information, and make sure that there are resources in their community that are as well educated about it, as well, that they can turn to.

DR. SANDMAN: I agree. And they should -- they understand that you're not saying we hate each other. We can't agree. You know, what you're saying is, we agree it's a difficult decision, and one of us came down on one side of that difficult decision, and another of us came down on the other side.

There's a spectacular example right now with Smallpox vaccination, you know, where lots of people think ACIP was right, and many fewer people should be vaccinated than the president decided, and lots of people think that Vice President Cheney was right, and we should vaccinate humongously more people. And that difference of opinion depends mostly not on what you think are the side effects of the vaccine, but on what you think of the probability of a Smallpox attack. And the task now as we reach out to healthcare workers and give them pretty much exactly the same situation, you can get the vaccine if you want it. You don't have to take it if you don't want it. It's voluntary. It's up to you. The task is, I think, to explain to them why some people think it's a good idea, and some people think it's a bad idea.

DR. WALKS: Let me just say this. I don't like that, and I don't like that because what typically winds up happening is that you have people making individual decisions that fall out along resource lines. We saw this with Anthrax. We see it with health literacy differences, primarily folks who understand what you're talking about when you're trying to explain it. And we saw things move out along racial lines, and it's very, very
dangerous during a public health crisis to have behavior fall out along racial, religious, ethnic or age lines. Public health is really very simple during a time of crisis. Let me demonstrate.

Everyone get up and move this way. That's public health during a time of crisis. It's shelter in place, it's line up for the vaccine. It can't be you decide what you want to do. With Anthrax maybe, okay. If you don't take it, you die. But with something contagious, you don't take it, many others may die. So I think that leadership is going through all of those gyrations about who's right. But then there needs to be a clear leadership recommendation, not an order, but a clear recommendation that fits everybody in this risk group. That's one person's opinion.

DR. O'TOOLE: Sally Quinn, you wrote a very widely noted article in the midst of the Anthrax response, saying in effect that you weren't hearing coherent advice from public officials, and you called many of them personally to ask what you should do to protect yourself and your family. What do you think about this exchange?

MS. QUINN: Well, actually there are two pieces. One of them was for the opp-ed page which was extremely provocative. I had watched Tommy Thompson on 60 Minutes where he had said, "We're prepared", and it just drove me crazy because I knew that we were not prepared. And we weren't getting any kind of advice from the government at all, what to do. I mean, should people has gas masks? There were all these stories going around. Should people have Cipro? You know, should you go out -- I called my doctor. The gas mask stores were sold out, that kind of -- so I did a piece about that. And then I did a follow-up piece for Outlook on whether the government actually was prepared, and I called everybody, Homeland Security, and the White House, and the Pentagon, and FEMA, and Bob Nelson is the only one gave me any decent information. He actually had figured out how to at least create some sort of communication in the city among the health care facilities, and the police and all of that. And that's unusual.

He in Children's Hospital, he and I were both on the board of Children's Hospital, so I was very proud to see that. We were the only ones who I felt had any coherent answer, any coherent plan at all. But I think the thing that's important for all of us to realize today is that what we're all talking about here on this panel are things that happened that we were not expecting. And now one of the reasons that we're all here today is that we are expecting the unthinkable. That it's not unthinkable any more. It's possible, it might even be probable, particularly if we go to war in Iraq.

And now I think, I feel even more strongly that the government should inform us, just give people the basic idea of how to protect themselves. And there is this view, and it was reiterated over, and over and over on the panel today, information, information, information. We can take it, and the whole idea that people are less likely to panic, the more information they have. And what I found was that nobody wanted to give out information because they were afraid if they said well, you should have a mask, an N-95. I carry it with me at all times, it cost a dollar, or if you want to put bottle water in your house, or have extra money, or flashlights or batteries, it seems to me that that's basic.

Johns Hopkins Center for Health Security
centerforhealthsecurity.org • Office: 443-573-3304 • Fax: 443-573-3305
I mean, even in California when they have hurricanes, I mean, earthquakes, or in the midwest when they have hurricanes, they give you that basic information. And people sort of say oh well, it's on the website, you can look it up. But I think we need to have somebody, particularly in places which are target cities like Washington, D.C., there should be guidelines. There should be neighborhood organizations. I mean, the government should come out and say look, you know, this is unlikely but we're going to be in a war. I mean, we had air raid shelters during World War II. We need to be prepared. The citizens need to be prepared.

After I did my last piece, Senator Bill Frist called me up and said, you know, I was so horrified to see what you had written. All these people in the government not having any answers at all, and I might even write a book about it. He did, and one of the things he did was just put a list that everybody should have in their house. And it was a radio with batteries and extra water and cash, medicine and that kind of thing. I just don't see why, particularly now, we can't be given guidelines by the government as to what to do in case there's some sort of attack.

DR. O'TOOLE: Mayor Norick, you actually lived through the unthinkable, in a city that was not a target city. And most of the commentaries on -- in fact, all of the commentaries I read on the Murrah Federal Building bombing noted with great admiration how forthcoming spokespersons were in the immediate aftermath of the bombing about what was going on, and what to do, and so on and so forth.

What in your mind was valuable in terms of preparedness for that catastrophe? Or what would you do differently now if you were told, God forbid, that such a thing were about to happen in a city? What would you advise other mayors about preparedness?

MAYOR NORICK: Well, it wasn't in my operations manual to begin with, so as I don't think anybody obviously expected it. We probably in the, what I'm going to call the Heartland, which includes probably everybody that doesn't live on the coast, figure anything that's going to happen, is probably going to happen on the coast and it's not going to happen to us. So I think that is probably what, if I can use the word shook the nation up more than anything, was that it happened right flat in the middle of the country. And our city was very fortunate in that the bombing was April 19th, `95. In the summer of `94, our city staff came to Washington, part of FEMA, EMI Institute, Emergency Management Institute, to really learn about how to deal with disasters. And, of course, at the time that our people were in the Washington area, they're thinking of disasters like tornadoes or maybe even an airplane crash at the airport or something like that. But mainly, you know, acts of Mother Nature really is what it amounted to. And then when the actual Murrah Building bombing occurred, the police officers and the fire department that was on the scene really knew very, very quickly that it was a bombing, and not a natural disaster, like a natural gas line or something else just by the crater and what was going on.

But I've heard today over and over about communication, which is absolutely true. And I heard what everybody said, and I think Kathleen was the first one that said it, was if you
don't know, tell them you don't know. I mean, that -- you just can't believe how well that sits with the public.

I had probably some advantage in that I’d been in office for eight years, and I’d been through three elections, and without sounding braggadocios was very popular, and was very well respected by not only the people of Oklahoma City, but by the press. I had always shot very straight with the press, and very straight with the people, so they felt like whatever I told them at this particular incident was no different than I’d be telling them for eight years previous.

Governor Keating, who a lot of people I think probably know, he’d been in office three months so, you know, he was at quite a bit of a disadvantage compared to me at that time. And so we worked very well together, but I’ll have to admit, he was -- he looked a little bit like, you know, the deer in the headlights. I mean, the eyes were pretty big like a lot of us were at the time, but it all got down to really communication. And we didn't know really, you know, who was the cause or what was the cause. We knew really what it was pretty quickly, and we relayed that that day. It came out that day. We didn't hide it. I came out though in a very organized fashion, and we had set up press -- we had done a number of things that day that, I mean, I could stand up here and talk probably for an hour exactly what we did that day. But really, I'd have to go back and say we were fortunate that we had had planning on disasters a year before that obviously had to have a great impact on the way our community reacted.

DR. O’TOOLE: You know, there's been lot of mention today, and again here amongst yourselves about the public being very different than an undifferentiated mass. Ivan talked about different levels of health literacy in the population. We’ve also heard a lot about children being a special population. And Ed, you had to deal with a lot of very anxious parents in the course of the sniper shootings. Is there anything you or others would like to say about what leaders should consider when particularly vulnerable populations, particularly children are imperiled?

MR. CLARKE: I think it's critical in a couple of areas. You cannot wait to the day of an emergency or crisis to develop relationships and partnerships, nor can you wait to the day of to be trained up. That has to be done in advance. And I think you have to have an established relationship as a building principal, or a teacher. You need to know your parent groups, and you need to know that in the event of an emergency or crisis, they're coming to your schools.

As we saw certainly on September 11th, and in even some of the sniper days, parents were coming to retrieve their school children, their loved ones, and that was a natural reaction. But I think it's how we plan for that event, how we communicate it, and the superintendent needed to reassure parents that children were safe during that horrific ordeal, 22 plus days.

Also, to have good preparedness drills and training employees. In Montgomery County Public Schools we have what we call a Code Blue Status, which is an enhanced level of
safety and security. We may, depending on the situation, secure the exterior doors. Well, when we developed that concept, we never envisioned that we would be in a prolonged state of Code Blue for 22 days, so it's getting that information out, being supportive of parents, and also the teachers that are in that building, because they are parents too. So it's how you reach out to the parents, and how they have confidence in that you have a safe facility for children. And attendance was up very high, very high, except for the last shooting when they came back around, the snipers came back around when tragically the Ride On bus driver was the victim of a homicide. It couldn't have happened at a worse time. It was right during the start of school. And we saw a little dip, especially in the impact area, but people could not get to the school building. But we saw tremendous signs of leadership by teachers that were able to get to their building, and building services worker that filled the void of the administrator. And they did what they needed to do.

DR. O'TOOLE: Let's talk about the end and the aftermath of crises for a minute here. Tom, you recently were on television because of scares that there were trace Anthrax contamination found in the, I can't remember, was it the Federal Reserve Building? Would you make a few comments about you handled that, and what it means to have these kinds of scares following in the wake of a real crisis, such as we had last fall?

MR. DAY: In the case of Anthrax, and really any biological threat that might come through the mail, the reality is we faced the attack in September/October of 2001, but we've had incidents throughout, and some very public ones like the one at the Federal Reserve. It's just as important that you communicate that even as this one ultimately turned out to be negative. It was not an Anthrax event, but the level of anxiety quickly rises. Our employees are very concerned, and quite honestly, we learned a great deal from the attack of 2001, so based upon that knowledge, it just prompts you to respond that much more quickly. We did some precautionary testing to assure ourselves that we didn't have a risk.

It was interesting to watch the media. It was a slow news day, and we got a lot of coverage over about a 24 to 36 hour period. And the media kind of went both ways on me. I had to handle all the interviews, and there were some as it ultimately turned out to be negative to say well, why did you essentially put us through this? And on the other hand, the other question on the other extreme was, why were you so slow to react? So you kind of get questions from both ends.

But we understood there was a reason to be concerned, and we wanted to get the information out there quickly. Again, it's the common theme here, and we went the extra step of personally briefing our employees at the facility that potentially was at risk, but ultimately was not.

As we found, it's not something that goes away. There's still a very heightened sense of awareness, particularly in our workforce, and just to give you the statistics, and this is probably a little bit dated, but in the year that followed the Anthrax attack, the actual attack, we had 17,000 incidents that closed facilities for four hours or longer, so there is
a real heightened sense of awareness. And that was, the overwhelming majority of that was in the first three to four months after the initial attack. But you’ve to treat it like it’s real. You’ve got to deal with it. You’ve got people getting anxious just from the fact that they went through what ultimately turns out to be a negative event. It wasn't real.

DR. O’TOOLE: Ron, you're stealing with the aftermath of the ‘95 bombing. Is that right?

MAYOR NORICK: Yes, I was telling somebody at one of the breaks that we are still having cases of mental health problems, and it's been eight years. There are still police officers, there are still firemen, rescue workers, individuals, you know, the human mind is a funny thing. It doesn't know exactly when it's going to break, but it'll break. And one of the speakers this morning talked about New York, that they had had more problems in mental health the year after. Well, I’m here to tell you it'll be a lot longer than just the year after, it'll be years after.

We are still rebuilding the area, and even though the cameras focused on the Murrah Building, we had 300 buildings damaged in Oklahoma City, and we had over 100 buildings that were completely torn down. They were not the size of the World Trade Center, obviously, but they were buildings nevertheless. And we’re in the process now of -- and I guess maybe the final part, at least as far as the rebuilding is the federal campus that's now being built about two blocks north of the Murrah Building, which will rehouse a number of those agencies, are going to come back into the downtown area, and that's been eight years, so it is still probably another year off from finishing.

DR. O’TOOLE: Sally.

MS. QUINN: When he was talking about the mental health reaction, I just think that the sort of anticipation -- I think people are not talking as much about the kind of -- well, we were talking about it earlier during the break, of the kind of anxiety that people have every day, particularly in Washington and New York about the possibility of an attack. And there was an article written by Bart Gellman in the Washington Post right before Christmas where he was talking about the possibility of attack, and basically saying, you know, the terrorists are going to finish off what they didn't accomplish the first time, and the plane that crashed in Pennsylvania was headed toward the White House, and they're going to kill the White House next time. And this said, who was a terrorism expert, who works right next to the White House said I'm scared to go to work everyday. I don't want to be on that street.

It shows itself in every way. It's like it's one level below the conversation. I had a friend the other -- these are high power journalists, and they woke up one morning. There was this horrible explosion and they were terrified. They grabbed the baby. They went down to the basement. They were just absolutely panicked, and they thought that there had been a terrorist attack. It was thunder.
You know, I have friends who carry Iodine with them every day, friends who carry Atropine with them every day to give themselves a shot in case there’s some kind of attack. People who have gotten motorbikes so that they can get out of town quickly, and they don’t talk about it, particularly the women. Women will talk about it but the men won’t. The men sort of seem to be in denial but the women will talk about it. But it’s there all the time.

I was talking on the phone with a friend the other day, and I live in Georgetown and my house shook, and she said, "Oh, my God, what was that?" She’d heard it too, and her house had shaken. And my first response was to look out the window to see if the Washington Monument was still there, and it was. But this is the kind of thing that we’re dealing with. I mean, everybody has stockpiled Cipro, and Doxycycline. And it just seems to me that instead of having this kind of underlying sense of anxiety and terror, that people would feel a lot safer if there were some guidelines, any guidelines so that there wouldn’t be this sort of psychological atmosphere.

DR. O’TOOLE: On that note, and given that everyone in this room is faced with trying to lead during very powerless and uncertain times, let me offer the panel parting shots or pearls of wisdom that you might want to offer before we ask for questions from the audience. Does anybody have any? Let me just open it up.

MAYOR NORICK: To somewhat agree and disagree, what my colleague said to my left, if we as a country are going to crawl under a rock, then in essence the terrorists have won. And I know that we need to protect ourselves and we need to do everything that we can. And I told the people in my community eight years ago, we didn't know who had done it, why or anything else. And like Mayor Giuliani, I wasn't in a bomb shelter somewhere. I was out there on the street. That's where I needed to be. If I was in harm's way, so be it, you know. That was just the way it was going to have to be and, you know, I understand what you're saying, but I think we can get to the point that we can overreact. We do need some guidance. I won't disagree with that at all, but to go around and put fear either into our hearts or the fear of the hearts of our children, I just think means that we've, you know, waved the white flag and given up, and I'm just not ready to do that.

DR. O’TOOLE: Peter.

DR. SANDMAN: Somebody commented in an earlier panel that fear is appropriate. Terror isn't, apathy isn't, denial, which is not the same as apathy isn't, but fear is. And in terms of our task, which is to think about leadership, it seems to me one of the things leaders need to do is model being fearful and bearing it. A fearless leader is no help at all, because I’m fearful, and if the leader is fearless, I can't follow there. I can't go there, but a leader who is fearful and bears it, and makes decisions nonetheless, and is not freaking out, and there's sort of routinization of that fear, that's where we need to go as a society, and that's where our leaders have to take us.
MS. QUINN: Well, that's exactly what I'm talking about, is that we should -- I just think it's important to be realistic, and to be realistic you have to be truthful, and you have to be prepared. And that makes people feel less panicked and less fearful.

DR. WALKS: I think one of the other things that helps people to feel less panicked and less afraid is routine. It's like Tom was talking about, you know, 17,000 things you respond to, and you close the building each time. There's something about routine that helps you to build trust, and helps people to feel a little bit more secure, particularly - and I don't know how much this was covered earlier today, but we live in a very, very diverse America, and we keep hearing these messages like if all of America looks the same way, has the same education level, and most importantly, has the same history of dealing with leaders. We've had in many communities some very bad experiences about the person that shows up and says hi, I'm from the government and I'm here to help.

And if you don't keep that in mind, and you don't treat every scare like if you're going to do the same thing, the same suits come on, same folks show up, close the building for hours, do the whole thing, then the trust that you need during a crisis when people will trust you to tell them what the real risk is, that will be lost.

I think we've had some recent examples of that not happening, and we've seen the fallout break out across communities, across neighborhoods, across racial lines. And my biggest concern is that during a time of crisis, we'll see that again. And we'll have an unnecessary loss of life, because when we're there giving that real good advice, using all the great risk communication skills, the history of the people we're talking to will prevent them from doing what they should do, and we'll have an unneeded loss of life. That's the thing that I spend my time concerned about.

DR. O'TOOLE: Anybody else? Tom.

MR. DAY: Just a little bit, and I'll go to my engineering side. Some of it is technology, and there are moves afoot to do things, because if our warning system remains when the person shows up in the emergency room with the advanced symptoms, be it Anthrax or any other biopathogen, we're well into the crisis, and the mask isn't going to help then. It's already happened. So the investment in technology that gives us some warning that an event has taken place is critical, because then we can spend a lot of time warning the public about if there's an Anthrax attack you can wear this mask, or gloves, or anything else. But the reality is, we're not going to know it until people start getting sick and die. And again, at that point, the mask and the gloves, and all the rest of it are just a placebo. They're not going to do a thing for you.

So there is a technology side to this that we need to advance, that if we really have this threat that is going to be with us for the foreseeable future, we need to have systems that let us know as early as possible.

DR. O'TOOLE: Thank you. All right. Well, it remains to thank our panelists for your generosity with your time and your insights. I know everyone is extremely busy. We very much appreciate all that you did to be here today. Thanks to all of our speakers for that
matter. I think it was an extraordinary conference. It gives us a lot to think about in the days ahead.

I’d also like to thank the amazing Andrea Lapp. Where is she? She is never in the room when we thank her for all her choreography, and of course, Monica Schoch-Spana, who was the heart and engine of this. It is as always, Monica, an honor to be your colleague. And thanks to all of you. This has been an amazing audience. Thank you for your attention and your courtesy, and all that we will do together starting now. May you have a safe journey home. Goodbye. Thank you.