president of the D.C. Hospital Association, recently asked, "Does it make sense not to have D.C. General's trauma center at a locale 19 blocks from the U.S. Capitol?"

LaRouche himself said recently, that those who opposed the efforts to keep D.C. General open have now been "proven terribly, terribly wrong."

"The point is, now the Control Board is ended, the issue of D.C. General Hospital is back in the lap of Congress," LaRouche said, referring to the termination of the Financial Control Board whose charter ended on Sept. 30. Its five-year dictatorship over the District of Columbia, included shutting down D.C. General in violation of its Congressional mandate. "We have a national emergency, which includes a national medical emergency, which includes the D.C. area. The only sane thing to do now, is to totally reconstitute D.C. General Hospital."

But that was not the approach taken by District of Columbia officials at an oversight hearing on emergency preparedness held by the D.C. Council on Oct. 5. The issue of D.C. General was only raised by D.C. Hospital Association president Malson (representing private hospitals), who presented it in the following terms, including citing the role of the HMO system:

"Our nation's hospitals no longer have the 'surge capacity' required for large-scale casualties, mainly due to the advent of managed care and a major shortage of health-care workers—particularly nurses, radiology and laboratory technicians, and pharmacists," Malson testified. "In the meantime, one of the city's leading trauma centers, D.C. General Hospital, located 19 blocks from the U.S. Capitol, was closed earlier this year, seriously crippling our trauma and decontamination capacity. I urge the Council, the Mayor, and the Federal government to review the feasibility of reinstating a wider range of emergency services available to those who live and work near the U.S. Capitol and the Supreme Court."

That night, on the ABC-TV "Nightline" town meeting, host Ted Koppel asked D.C. Mayor Anthony Williams about the closing of D.C. General. "Mr. Mayor, people outside the District of Columbia do not know, but D.C. General, one of your biggest hospitals, just closed down," Koppel said. "So you have fewer beds now than you did a year ago."

Williams sidestepped the question, instead saying that the District has a good system for monitoring the utilization of hospitals, in which the D.C. Hospital Association has taken the lead. And, despite all the warnings that were made about the danger of shutting down D.C. General in case of any public health emergency, Williams glibly continued: "But this is a good story of where you are building your system for normal times, you're not building your systems for spikes and emergencies, and that's where we have, as I said earlier, a lot of work to do in terms of investment. One of the things we're looking at is what role D.C. General can play in terms of providing backup space."

Of course, without restoring D.C. General, it can't provide much more than beds and empty space, since its surgery, laboratory facilities, and other essential back-up components have been dismantled.

'A Reckless And Callous Act'

The folly of closing D.C. General is shown in the letter to the D.C. Council (see box), from the former head of the Department of Surgery at D.C. General, Dr. Bernard Anderson. Dr. Anderson notes that D.C. General was a "vibrant Level I trauma center" and that it was one of only three centers in Washington, D.C. with the capability and equipment to function as a mass-casualty and decontamination center in the event of a nuclear, chemical, or biological attack.

"Surely the decision to close DCGH without providing for the services it rendered faithfully to its natural service community, and was capable of rendering to the wider community, was a reckless and callous act that considerably increased the exposure and vulnerability of all persons in the city," Dr. Anderson wrote.

Meanwhile, the death toll arising from the dismantling of D.C. General Hospital has reached at least 47, according to LaRouche activist Lynne Speed, a leader of the Coalition To Save/Restore D.C. General Hospital. Most of the cases involved victims of gunshot wounds or other trauma, who had to be transported to more distant hospitals because D.C. General was no longer accepting ambulance arrivals. Since Aug. 26, ambulances have been permitted to bring some patients to the stripped-down emergency room (actually just a clinic) on the site of D.C. General, but a number of these have died because there are no surgical, laboratory, and other essential services necessary to quickly treat emergently injured or ill patients.

Senate Is Warned That Public Health Is Unready

by Linda Everett

Two recent Senate hearings, focussed on the country's capability to respond to a biological or chemical terrorist incident, uniformly presented a chilling warning—that the United States is, on every level of its public health infrastructure, woefully unprepared for such a terrorist event. On the Federal level—states and localities are in worse shape—a newly released study by the General Accounting Office (GAO, the Congressional research body) found that the government's plan for responding to the public health and medical consequences of a bioterrorist attack is a collection of poorly coordi-

nated, underfunded projects that involves 20 departments and agencies.

Despite Health and Human Services Secretary Tommy Thompson's assertion on Sept. 30, that the U.S. is safer "than we'd been led to believe" with regards to preparedness for a biological or chemical terrorist attack, experts at two Senate hearings—the Oct. 3 hearing before the Committee on Appropriations Subcommittee on Labor, Health and Human Services and the Oct. 9 hearing before the Committee on Health, Education, Labor and Pensions Subcommittee on Public Health—had one theme: A paradigm shift must take place in the country, the nation must make considerable investments, resources, and effort to rebuild every aspect of our deteriorating public health system on an emergency basis.

Dr. Jonathan Tucker, PhD, Director, Chemical and Biological Weapons Non-Proliferation Program Center, Monterey Institute of International Studies, in Washington, D.C., testified on Oct. 4, that threats of emerging diseases and intentional release of biologics, such as plague, anthrax, or smallpox, are best addressed by strengthening the nation's public health systems, which have been allowed to deteriorate: "Back in the 1950s and '60s, publicly supported community hospitals and public health laboratories supported an effective early-warning network for detecting and containing epidemics."

Disease surveillance is a fundamental function of public health at local, state, and Federal levels. But, as experts testified repeatedly, today the medical professionals on the front lines of an attack are seldom trained to diagnose unusual diseases or to report an undiagnosed cluster of suspicious symptoms to county health departments. In any case, 94% of county health departments do not have staff fully trained in bioterrorism preparedness, according to the National Association of County and City Health Officials (NACCHO).

After the shift to the post-industrial policies of health maintenance organizations (HMOs), and privatization and deregulation of health care, labs today conduct only the tests that health insurance companies will pay for. The profit-driven policies of managed care forced hospitals to slash staff and beds. Congress, too, significantly undercut direct funding for public health, replacing them with block grants to the states, whose legislators used the funds for more politically popular projects.

Indeed, Dr. Stephen Cantrill, Associate Director of Emergency Medicine at Denver Health Medical Center, in his Oct. 4 testimony, ridiculed the illusion that the U.S. health care system could adequately deal with a significant weapons of mass destruction incident. "Our hospitals today have no 'surge capacity.' They could not adjust to a sudden increase in patient load without degenerating into chaos," he said.

EIR was told that some hosiptals are so flooded with patients, so limited in the number of their intensive care unit beds, that they are on permanent "bypass," meaning they routinely tell ambulances to deliver emergency patients to other hospitals. Hospitals are at overcapacity all through the year: they are on "red alert" during a typical flu season. The testimony of Dr. Donald Henderson, MD, Director of the Johns Hopkins Center For Civilian Biodefense Studies, says it all: Research found that "no hospital, or geographically contiguous group of hospitals, could effectively manage even 500 patients demanding sophisticated medical care such as would be required in an outbreak of anthrax."

Iowa Case-Study In Unpreparedness

Patricia Quinlisk, Medical Director and State Epidemiologist of the Iowa Department of Public Health, also represented the Council of State and Territorial Epidemiologists at the Oct. 4 hearing, where she methodically compared Iowa's level of preparedness to the recommendations laid out by the U.S. Centers for Disease Control in its "Biological and Chemical Terrorism: Strategic Plan for Preparedness and Response." Dr. Quinlisk told *EIR* that Iowa's shortcomings in preparedness would hold true for nearly all states.

She told the committee of Iowa's shortages of staff and lack of capabilities for detection, diagnosis, response and communication, necessary for preparedness against biochemical terrorism. Iowa's health care providers don't have the training, diagnostic tools, or communications system for rapid reporting of suspicious illnesses. If an anthrax attack were to hit Iowa right now, the state has only one laboratory with the reagents to rapidly and correctly diagnose this disease, and those supplies would be depleted within hours. In event of an emergency, there is no communications system to alert health officials across the state. Only 10 out of 99 local health departments in Iowa have someone on call 24 hours a day, 7 days a week.

Iowa has no one to undertake systematic surveillance to monitor community health data for indicators or aberrations (unusual syndromes) from emergency rooms. There is no one to collect, analyze, and report the data or coordinate communications and investigations. The state has only one veterinarian assigned to the health department to conduct active surveillance on animal diseases, which give advance notice for human diseases.

It is estimated that it takes 6-12 hours for Federal stockpiles of vaccines or drugs to reach states needing them. Millions will need to have antibiotics within 48 hours if exposed to pneumonic plague, or within 24-36 hours after onset of anthrax symptoms. In an exercise of simulated attack of pneumonic plague, medical workers were to dispense prophylactic antibiotics to 1 million people within 48 hours. But, it took 60 workers 24 hours to dispense antibiotics to only 3,360 patients! Dr. Henderson called for resources to undertake the staggering logistical problem of large-scale, rapid distribution of medications.

State and local health departments rely heavily on the expertise of the U.S. Centers for Disease Control and Prevention (CDC). Janet Heinrich, Director of Health Care-Public

Health for the GAO, testified Oct. 9 that, when the small West Nile virus outbreak occurred in 1999, it taxed Federal, state and local laboratory resources. The CDC laboratories handled the bulk of testing. At the time, officials said the CDC labs could not have handled another outbreak, had one occurred at the same time.

Government's Key Role: Vaccine Production

Michael T. Osterholm, Director of the Center for Infectious Disease Research and Policy at the University of Minnesota, called for building enough medication in our Federal pharmaceutical stockpiles to provide treatment or prophylaxis for to up to 40 million people. Osterholm cited the need for accelerated development of smallpox vaccine, and research on development and production of other vaccines for the civilian population.

As was recently reported, the national anthrax vaccine stockpile is insufficient and likely uneffective. Worse, there are considerable inadequacies of the vaccine's sole producer, the Michigan-based Bioport, which is repeatedly cited by the Food and Drug Administration for manufacturing violations and suspiciously doctored test results.

Arkansas Sen. Tim Hutchinson (R), a hard-line "free trade," small-government devotee, surprised the Oct. 9 hearings with a call for sanity. We need a government-owned and -operated vaccine producer, said Hutchinson. "We can't rely on the commercial sector alone. It is not necessarily commercially feasible. There are some things the government has to take responsibility for."

Sen. Edward Kennedy (D-Mass.) and Sen. Bill Frist (R-Tenn.), both of whom sponsored the Public Health Threat and Emergency Act of 2000, have proposed a fivefold increase in current Federal funding to deal with a possible bioterrorist attack. The Oct. 9 hearing, Kennedy said, presented further evidence that their proposed $1.4 billion plan is fully justified. Sens. John Edwards (D-N.C.) and Charles Hagel (R-Neb.) have introduced S. 1486 to provide $1.6 billion to increase the ability of the "first responders" at the state and local level to prepare for biochemical terrorism.

It took horrible mass killings to make many legislators and experts recognize the need for fundamental changes in medical policies to protect the general welfare, of the sort which Lyndon LaRouche has mandated since the 1970s, and particularly since the AIDS epidemic began in the early 1980s. Providing the basic public health daily needs for the nation and preparing it for disease outbreaks, such as the West Nile virus or the predicted pandemic influenza, simply mirrors what is needed to prepare the country in the event of a possible biochemical attack. As Dr. Rex Archer, Director of Kansas City Health Department in Missouri and chair of the Bioterrorism and Emergency Preparedness Commmittee of the National Association of County and City Health Officials, testified, "Every dollar we spend on bioterrorism preparedness will pay off in countless other ways."

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