COLE: Terror medicine can save lives

Leonard A. Cole
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COMMENTARY:

Critics of U.S. biosecurity policy contend that the threat of terrorism has been overblown and that too much money is going to biodefense and related programs. The $6 billion-odd now spent annually in this area will doubtless be scrutinized by the new Obama administration. But the threat remains real.

While some cuts may be justified, education and training in the new field of terror medicine warrants full support.

Terror medicine concerns not only biological agents like anthrax, but the medical management of terrorist attacks regardless of the weapon. In fact, bombs and explosives have been the weapons most commonly used by terrorists.

The emergence of terror medicine as a distinctive discipline has been prompted by the global proliferation of terrorism especially since the end of the 20th century. It involves anyone who would be called to service during or after a terror incident - from emergency responders to long-term caregivers. Yet ironically, most physicians and other health providers, let alone members of the public, are still unfamiliar with many of its features.

Efforts to prevent terrorist assaults should be among a society's highest priorities. No less important are the requirements to prepare for, respond to, and recover from such events. As such, terror medicine ranges broadly from preparedness and treatment of injuries to psychological effects.

Some aspects of this new field require preparedness that is contrary to common practice. The need for reordered thinking was evident after the bombings of the Oklahoma City federal building in 1995 and the Madrid trains in 2004. In both cases, most victims were taken to the nearest hospital, as is usual in emergencies. But the influx of hundreds soon overwhelmed the facilities and care became inefficient and delayed.

Had there been an advance plan to distribute some of the patients to more distant hospitals, fewer lives might have been lost. During the London metro bombings in July 2005, faulty preparedness bred other miscues. Confusion among rescue workers and ambulance drivers meant some victims were still awaiting transportation to a hospital four hours after the explosions. Advance planning for terrorist and disaster events is an essential element of terror medicine.

Another is the unique approach to patient care posed by terrorist attacks, especially suicide bombings. Close-quarter victims often suffer burns, crushed bones, ruptured eardrums and intestines, and penetrations from nails that were packed with the explosives. Accidents or other acts of violence rarely produce combinations of these wounds in a single individual.

Yet, in a suicide bombing, scores of people may suffer most or all of these injuries. In such a situation, trauma surgeons typically are unprepared to make informed determinations about treatment priorities.

But terror medicine provides answers based on approaches developed by doctors in societies like Israel, which have experienced many such attacks. Israeli doctors can now make rapid credible decisions about which injuries to treat first and which can wait, a skill that is essential to saving lives.

Still another area of the new discipline involves treating the emotional effects of terror incidents, which commonly are more intense than other traumatic events. After an automobile accident, for example, survivors may benefit from group therapy in which they share feelings about their stressful experience. But group interaction after a terror incident could heighten emotional turmoil. This has happened to victims who were surrounded by smoke and saw nothing. They became distraught when hearing others describe what they saw, like the dismembered head of the suicide bomber, says Israeli psychiatrist Esti Galili.

The increase in terror incidents also has raised novel ethical questions regarding medical responses: Should a critically wounded terrorist receive care ahead of victims who may be less severely injured? Is delaying a pregnant woman from reaching a hospital justifiable to search her for concealed explosives, even if she seems in acute need of medical attention? These and similar conundrums are only beginning to be explored by bioethicists.

The November terror attack in Mumbai is the most recent demonstration of the need for a broad understanding of terror medicine. An Indian journalist, Jagdish Singh, observed that the event showed many inadequacies in India's response including delayed arrivals of paramedics and other rescue personnel, and unavailability of medical supplies and equipment. These lapses all worsened the effects of the tragedy.

Since the jetliner attacks in the United States on Sept. 11, 2001, and the

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subsequent anthrax attacks via the mail, this country has become better positioned to care for victims in similar incidents. Surgical supplies, antibiotics and antidotes to chemical and radiological agents are now stockpiled in greater quantities for emergencies. Some hospitals have conducted drills in cooperation with police, fire, and other emergency personnel. But many hospitals and response personnel remain inadequately prepared.

These deficiencies should be remedied by education, rehearsals and understanding the distinctive challenges posed by terrorist attacks. The more that individuals and institutions become familiar with the issues concerning terror medicine, the greater the protection they can provide themselves and others.

Leonard A. Cole is a political scientist at Rutgers University, Newark, N.J. His recent books include "Terror: How Israel Has Coped and What America Can Learn" and "Essentials of Terror Medicine."

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