Correspondence &

New Presidential Directive Targets Academic Approaches to Disasters

Correspondents: Nellie Bristol, BA, and David Marcozzi, MD

A White House strategic framework for enhancing disaster-related public health and medical response established a Joint Program for Disaster Medicine and Public Health at the Uniformed Services University of the Health Sciences (USU) in Bethesda, MD.

Under Homeland Security Presidential Directive No. 21, signed on October 18, 2007, the program will be housed at the National Center for Disaster Medicine and Public Health at USU. "The Program shall lead Federal efforts to develop and propagate core curricula, training, and research related to medicine and public health in disasters," the directive said. "The Center will be an academic center of excellence in disaster medicine and public health, co-locating education and research in the related specialties of domestic medical preparedness and response, international health, international disaster and humanitarian medical assistance and military medicine." The departments of Health and Human Services and Defense will carry out civilian and military activities within the program, it said.

USU President Charles Rice said the school will work on development of training sessions and courses "that would be widely available to people who would be called upon to respond to these events." Rice added that the program will be developed in collaboration with other agencies and institutions.

Rice and Robert Darling, director of the USU Center for Disaster and Humanitarian Assistance Medicine, said that disaster response is a multidisciplinary endeavor requiring a variety of skills to be successful. These skills include provision of shelter, clean water, appropriate sanitation, and food, as well as security, medicine, and psychological support. Rice said, "The array of skills that is necessary to mount an effective response to a disaster is quite large and goes well beyond a medical response."

"If we don't have all the associated support, everything we try to do in the medical response is going to fail," Darling said.

Rice said he sees leaders of disaster response as those who have had "appropriate academic preparation," perhaps under master of public health programs that would provide training in epidemiology, legal aspects of disasters, and cultural education, as well as organization and logistics—all of the necessary elements to negotiate a major crisis.

The directive also supports the establishment of a "discipline of disaster health." The provision states: "The specialty of emergency medicine evolved as a result of the recognition of the special considerations in emergency patient care, and similarly the recognition of the unique principles in disaster-related public health and medicine merits the establishment of their own formal discipline. Such a discipline will provide a foundation for doctrine, education, training, and research, and will integrate preparedness into the public health and medical communities."

A strength of the directive, according to Andrew Garrett, director for disaster planning and response at the National Center for Disaster Preparedness at Columbia University, is that it explicitly combines public health and medicine in preparedness efforts. "Think about how infrequently that happens in our country, where public health and medicine are mentioned in the same sentence," he said. He said that the disciplines have been "divorced parents at best. We're working together to meet the needs of the country, but that's a history that haunts us as we try to do this."

In addition to establishing the center, the 9-page directive outlines specific planning goals for a range of response challenges, including biosurveillance, countermeasure development and distribution, mass casualty care, and community resilience. It builds on previous executive and congressional policies, including the Pandemic and All-Hazards Preparedness Act, Biodefense for the 21st Century, the National Strategy to Combat Weapons of Mass Destruction, and the National Strategy for Homeland Security.

The directive mandates further integration of emergency preparedness efforts across federal departments including Health and Human Services (HHS), Defense, Homeland Security, Veterans Affairs, Transportation, and State. It names HHS as the lead agency for many of the actions, promoting both horizontal integration across the federal government and vertical integration with states and local jurisdictions.

HHS established a senior administrative team to rapidly develop an implementation plan, capitalizing on previous

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and ongoing work, to carry out the new guidelines. An interagency task force and workgroup, developed initially to implement the Pandemic and All-Hazards Preparedness Act, will inventory ongoing efforts stemming from the act, further refine the processes, and work toward completion of the newly required mandates.

In a deviation from a solely disaster perspective, the new directive also addresses routine emergency care—including day-to-day prehospital and hospital-based emergency care issues. This section, supported by the Institute of Medicine's Future of Emergency Care Reports released in June 2006, establishes an Office of Emergency Care within HHS. The HHS Emergency Care Coordination Center is under the direction of the assistant secretary of preparedness and response. It will become part of an Emergency Care Enterprise closely coordinating with the Federal Interagency Committee on Emergency Medical Services. The Emergency Care Enterprise's mission will be to advance the delivery of emergency care and promote effective emergency medical systems to improve triage, distribution, diagnosis, treatment, and disposition of patients requiring daily emergency care. Creating improved resiliency of day-to-day emergency care capabilities and capacity will, in turn, strengthen the nation's overall emergency preparedness.

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The directive imposes aggressive, strict deadlines for completing many of the tasks it outlines. These range from 90 days to 1 year. One concern about this new directive is that it is not immediately tied to financial resources.

Garrett said that one of the major strengths of the directive is its focus on specific benchmarks and timelines. He commented that after 9/11, the federal government made millions of dollars available to improve disaster response capacity without much accountability. "We spent a lot of money right away over the next 5 years without a strong strategy to it," he said. The directive "lays out a roadmap and then says that we're going to make funding in these specific areas contingent upon being able to show us that you're actually traveling down the right road."

Garrett said of the deadlines, "They're not wasting any time." He said the target dates are important to ensure activities progress, but "I don't know how realistic it is for us to be able to meet [all of the] goals in a substantial way" under the directive's timeframe.

Although he called the directive "extremely robust, " Dr Frederick Burkle, Jr, senior fellow at the Harvard Humanitarian Initiative at the Harvard School of Public Health, also questions the deadlines, suggesting they are "rather unrealistic." He also said he wishes the document made reference to the United States' connection to "an enduring global public health authority," that is, the World Health Organization. A global connection is especially important in the event of a situation such as pandemic influenza, he said. Community resilience provisions also could have been stronger, Burkle said, with more emphasis on local containment. "We have to ensure the communities have the resources to contain the pandemic, and it's that containment that will define resilience, rather than the response."

Burkle also called for more emphasis on behavior rather than mental health in crisis situations. He notes that during a crisis, unexposed individuals who fear that they've been contaminated frequently go to hospitals or other facilities where they then come into contact with infected individuals.

"The most important measure of effectiveness is how quickly a community can accurately implement a health information system, and that is what's going to restore mental health and behavior in disasters," Burkle said.

Rice and Darling said that effective communications and other improvements called for by the directive are a huge task that will take unprecedented collaboration among multiple federal and local stakeholders. Developing systems to enable that communication is "going to be very complex," Darling said. "But," he added, "I think if we do this right it will be really important for the country, and I think we will do it right."

Rice said the result will be a response in which everyone from "the smallest unit in the county fire department" to the president will work seamlessly, with everyone "speaking to one another in the same language, understanding terminology, [and practicing] judicious and careful use of resources."

Garrett said, "The end point is that we want to do better than we have in the past. We want to hold ourselves to higher expectations in terms of the services we can provide to the American public, and in some sense the international community, too. That's the goal of all this."

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