Preparing for the Unthinkable: NCDP’s Irwin Redlener

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Irwin Redlener, director of the Mailman’s School’s National Center for Disaster Preparedness (NCDP), which he founded last May, has seen his Share go up in the world of disasters. He’s helped with earthquake relief in Guatemala and served as medical director for USA for Africa and Hands Across America, where he treated famine victims in Sudan in the 80s. More recently the Brooklyn native has been working closer to home, having served as president of Montefiore’s Children’s Hospital before joining Columbia. He and his medical teams responded with direct assistance in the immediate aftermath of 9/11, and he’s been involved in disaster planning ever since. He also cofounded the Children’s Health Fund (CHF) with Paul Simon in 1987.

So with New York City more or less permanently on Orange Alert, Redlener certainly seems like the right man for the job. The Record recently sat down with him to talk about the NCDP’s accomplishments and role, its current and forthcoming projects, and how prepared the community and the country remains in the event of another attack. — Peter Kobel

The Record: Between federal groups such as the Centers for Disease Control and the first responders on the streets, what is the role of the NCDP?

Redlener: The national center has three general categories of work. The first consists of a multitude of services, such as training health care workers and public health officials in various aspects of disaster management, including how to deal with the victims of weapons of mass destruction. We’re also developing curricula in these areas for students in medicine, dentistry, nursing and public health. All of this is emphasized in a world very much changed by the events of 9/11. We also provide mental health services and support for people still affected psychologically by 9/11.

The second general category of our work includes a series of projects under the umbrella of “applied research.” What, for instance, do we know about the ability, or willingness, of people to come to work after a major catastrophe, or during a bioterrorism crisis? One of our senior researchers, Robyn Gershon, is learning a great deal of critical information in this area. For instance, a hospital may create an emergency response plan to a terrorist attack anticipating that, say, 80 percent of the workers will report for duty. But research may show that only a small fraction of that number will actually show up, making the emergency plan essentially inoperable.

The third area of our work has to do with the development of a dynamic “think tank” that provides policy analysis in many aspects of terrorism and disaster response planning, including how this planning and associated resource allocation impacts the larger public health agenda. There are many fundamental questions that have not yet been asked, in public health officials’ own opinion, or about our capacity to respond to terrorism in the U.S. Is it much better than it was in the fall of 2001? We really lack a national vision for what we mean by “prepared” with respect to potential terrorist attacks, especially with weapons of mass destruction. There is no directive that defines or describes what we’re aiming toward, even though more than $5 billion has been expended or appropriated to date for this purpose.

In general, we are advocating for a much more clarified, comprehensive preparedness plan for the country. To this end, we want to be a resource for the public and for government, to help frame the questions and provide some directional input on how to respond to the possibility of continuing, major terror attacks on the United States.

The Record: So, there’s no over-arch-ing plan. Safe means prepared, basically, but there’s no such thing as total safety...

Redlener: Here’s the reality: We’re dealing with a continuum here—from complete complacency at one end of the spectrum to a profound paranoia at the other extreme. We need to be somewhere in the middle, but it’s so hard to pin down exactly public confidence in how much we should spend to get there.

Preparedness benchmarks or guidelines need to be set that haven’t happened yet for hospitals, local public health departments, or the other hand, guidance for person- al and family emergency planning has been proposed by a variety of governmental and nongovernmental agencies, like the Ameri- can Red Cross and the Federal Emergency Management Agen- cy. The basic idea is that people should keep three days of food and water, a battery-operated radio and other materials in their homes, as well as supplies that can be taken with you if evacua- tion is necessary. A family com- munication plan is also essential to make sure that people can find one another in an emergency. Interestingly, there is no equiva- lent of this kind of guidance available for institutions or the whole health care infrastructure.

There is another important problem that we are quite concerned about and are attempting to study in more depth: even though individual emergency planning is available and widely discussed, there is very little uptake of the “preparedness mes- sage” by people. Actually, this is true even for many of my col- leagues. We did a survey last August, roughly two years after 9/11, and found that 76 percent of Americans are still concerned about the threat of terrorism. Yet, less than one out of four people had made any kind of personal or family emergency plan. There’s a major disconnect between the public level of awareness of the threat, on the one hand, and actually doing something about it, on the other hand. We are trying to get to the bottom of this.

The Record: You seem to have focused a lot on pediatric prep- arations. What’s different about children?

Redlener: If you’re going to have a functional community disaster plan for terrorism, there are a number of things that are extraordinarily important, including paying attention to unique needs of special popula- tions who may require focused attention in the event of a major catastrophe. Consider, for instance, a terrible situation where a thousand schoolchildren are affected—pennilessly or otherwise—by a nerve gas agent. This kind of event would require a very spe- cial approach in the response phase of disaster management. The fact is that children, physio- logically and medically, may respond very differently to a lot of these agents or “weapons of mass destruction.” For instance, small children and infants will become very sick much more rapidly than an adult might. A particular exposure to a bioterror agent might require “decontamina- tion” by immediate showering. A small infant may not tolerate this procedure in a device designed for adults. Similarly, antitoxin or antibiotic dosages have to be significantly adjusted to the age and weight of a younger victim. Indeed, our cen- ter is focusing on recommenda- tions to emergency planners on understanding the special needs of very young victims in such circumstances. In fact, we are also working on protocols for other special needs populations, including elderly or disabled vic- tims of bioterror agents.

The Record: Are there new ini- tiatives that you’re working on that deal with this specifically?

Redlener: We’ve been working continuously on the concerns of children and special populations in preparedness planning. The challenge is that the answers are not known about managing children exposed to weapons of mass destruction. So we held a national conference in Washington last year, with 65 or 70 pediatric experts, and came up with a consensus report about how, if we currently know, children should be managed under many of these cir- cumstances. This report was pub- lished last May and is currently in the hands of disaster planners in every state. We’re also look- ing into suggested standard pro- tocols for school disaster planning, as well as developing guidelines for how to establish preparedness plans for hospitals and communities.

The Record: Going forward, what would you like to see the NCDP doing?

Redlener: We are focused on continued development in all areas of the center. There is a tremendous opportunity to codify some of the critical definitions and benchmarks with respect to preparedness planning. We’ll have to a lot of offer in this area. I also see a major role for us in monitoring the implementation of preparedness planning on the core public health agenda. In other words, that as considerable con- cern that intense focus on disaster response will divert attention and funds from traditional needs like tuberculosis control, HIV/AIDS programs and getting routine immunizations for children.

In addition, we are establishing a new program called the “Emerging Public Health Crisis Working Group.” This will be a group of experts from a wide range of disciplines, who will be charged with the task of rapid- ly absorbing and analyzing infor- mation on both terrorist and public health crisis, whether it’s terrorism, SARS or anything else, and designing the kind of guidance to media, government agencies or the public.

The other large-scale project we’re developing is an initiative called “Model Prepared Commu- nities.” The plan is to select three disparate communities: urban (probably Washington Heights), rural and either a small town or suburban community where we will develop templates for getting the public and public health agencies to do preparedness planning. We want to close the gap between the pub- lic anxiety about terrorism and actually getting people to do something about their own plan- ning. We believe that the key to solving this is “ground-up” orga- nizing of emergency planning and public health agencies, along with families, schools, faith- based and community organiza- tions—all working together. It means building the confidence and resiliency of individuals and families, but not just the confidence. It doesn’t interfere with normal family life.

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Irwin Redlener, director of the Mailman’s School’s National Center for Disaster Preparedness.

PHOTO BY EILEEN BARROSO

Redlener in the South Bronx with patients from a CHF clinic.