

are we prepared for the next disaster?

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AL: How did you get involved in the field of public health preparedness?

IR: The 9/11 attacks represented a dramatic turn of events in my career. It wasn't just that these horrific events changed so much about our perceptions of security and isolation. I began to learn something about the nation's ability to plan for and respond to large-scale disasters and was struck by how inadequate these measures were. This insight motivat-



ed me to learn more and try to understand what needed to be done. I was trying to focus on the issues around children, but it was impossible to do that exclusively because the whole preparedness mindset and infrastructure were so inadequate that I was really compelled to take a wider view of disaster preparedness.

AL: One issue around preparedness that makes some people uneasy is the question of national security, as it seems to extend itself into other areas of life. Given your background in medicine and public health, how has it been to interact

with people in the field of national security?

IR: I've had a long history of personal, political perspectives that generally tended to be on the progressive side. I came of age during the intense period of national anguish over the Vietnam War. And in the late 1970s and early 1980s, I was one of the leaders of Physicians for Social Responsibility, advocating an end to the highly volatile nuclear arms race. Suffice it to say, I was not an enthusiastic supporter of military involvement in anything domestically at all.

That said, I do think the military has tremendous assets that absolutely must be on the table when we are talking about big-time disaster planning. There is no other way to do it. We don't have civilian experience or mindset to handle megadisasters in the absence of substantial support from the National Guard and regular U.S. military forces. Don't forget: the military has substantial expertise in the management of major logistical operations. This is what they do, and they are generally very good at it. Plus, there is no domestic equivalent of this level of specific experience and expertise. Additionally, the military can establish medical facilities virtually overnight on a scale that simply cannot be replicated by any local or state government. Finally, the military has a significant fund of knowledge and expertise in areas such as how to train health professionals and first responders to manage victims of chemical, nuclear, and biological weapons that is not yet matched in the civilian sector.

AL: Some public health experts who aren't focused on megadisasters and the potential crises they provoke argue that a lot of resources are being spent that should be used for everyday chronic health problems, problems that local jurisdictions face on a daily basis. Do you think that there is any conflict between those two?

IR: I think that's a fabricated problem. We really don't have to choose between, say, caring for people with HIV or getting the nation prepared for major disasters. The reality is that many investments we make in preparedness measures could help strengthen the overall public health system.

Conversely, whatever we do to strengthen our health and public health systems will make us better prepared to manage catastrophic emergencies. The fact is that you actually cannot have an optimally prepared nation when the health care system is as fragile and as degraded as it has become over the years.

AL: *It strikes me that there are some areas of potential incommensurability, even if there is a lot of possibility for dual use.*

IR: Yes. The fact is—especially with smaller health departments throughout the country—that the very intense focus on preparedness has actually caused health departments to move people from TB control or STD programs to fulfilling federally mandated preparedness measures. This has been detrimental to the traditional public health agenda. Underlying the shift in priorities is another reality: funding has been—and is—inadequate for either the traditional agenda or the new agenda. So the local health department director has to make untenable trade-off decisions about what stays and what goes. Neither agenda is satisfied.

AL: *One thing that's striking about the types of "megadisasters" you write about is that most of them have never happened. So, in principle, it's hard to know what you need to do to be prepared. How do you attain knowledge about what you need to do to be ready for an event that has not yet occurred?*

IR: This is an extremely pertinent question which, more than six years after 9/11, still hasn't been properly addressed. Part of the problem is that we're depending on a body of expertise and knowledge that is generally "experiential," involving people who are mostly in disaster planning or response as a career. They are used to thinking about what has happened in the past and how we are going to respond next time. What has been blunted in this process is the ability to imagine the unforeseeable or the unprecedented, and to imagine it in a way that allows comprehensive, effective planning. My view is that we need to supplement our traditional disaster-preparedness expertise by including people from other walks of life, who may have nothing to do with the field, who can take a fresh look at disaster scenarios and imagine what might transpire, what might be needed.

For instance, if I tell you that in the event of a lethal influenza pandemic we may have to close schools for eight

to twelve weeks in a given community, but I am only speaking to officials in the local emergency management office, that is not sufficient. We would like to include teachers, parents, local retailers, community centers, and so forth. In fact, we should have some kids in on the discussions, too, to think about consequences that might not occur to parents or teachers. I want to hear what moms say about the fact that single mothers might have to stay home and watch the kids, unable to work. What happens to their ability to provide for their families? And what happens to the workplace with so much absenteeism? How will people get food and other essentials? We need to think imaginatively and expansively about megadisasters. That kind of creative process does not naturally spring from the traditional ways that we think about planning.

AL: *Your book is structured around scenarios of potential events. It strikes me that there could be some wrangling over which events are the most important. How do we decide which event to prepare for?*

IR: The politics of making those priority decisions, which end up driving where the resources go, is actually pretty complicated, because people—and agencies—seem to get fixated on a particular "disaster flavor of the day." The problem, of course, is that in this highly unpredictable business, it's always a mistake to put all your eggs in one megadisaster basket, so to speak. Pandemics are not the only major disasters that we should be working on. Who really could have predicted—and planned for—the attacks of 9/11? And no one really knows whether a terrorist organization might develop the ability to deliver a nuclear weapon to one of the country's harbors or smuggle it across a border someplace. Because of that, we have to be able to think about and plan for a range of scenarios simultaneously. It's not easy to do this, but the federal government must be able to "multi-task" when it comes to disaster threats and response planning. It just takes commitment and leadership at the top. So the secretaries of Health and Human Services and Defense, the heads of FEMA, and other critical agencies have to be able to say to their subordinates and their subagencies, "These are the fifteen scenarios that are on the table—and we have to be planning for all of them."

AL: *Can you talk about how exactly one knows whether one is prepared? What is the role of techniques like scenarios and exercises in measuring preparedness?*

IR: Right now, I think the country is stuck in process meas-

ures, where the funding agencies ask questions like “How many exercises did your team perform? How many people were involved in the exercises? Has everyone in your facility learned how to use HAZMAT suits? Do you have decontamination showers?” So people who are responding to these queries check off the boxes about things they did, [which are] not ways of measuring whether they are actually better prepared or not.

One of the points that I make in my book is that we don’t really know what “prepared” actually means. And we are into a dangerously distracting way of defining preparedness by looking at process accomplishments, rather than by saying, for instance, [that] New York City needs to be prepared to roll out, when necessary, a specific number of decontamination showers. And in order to do that, we need them to be distributed among all of the local hospitals in a particular, regionally planned distribution. When we get to that perspective in the various planning challenges, we can say we’re prepared. We have to come to grips with the fact that we need very different and specific kinds of monitoring and benchmarking to measure our true level of preparedness. Right now, we basically don’t know where we are or what more we need to do

AL: *Your center and other places have recently come out with reports showing that the public is not especially concerned about the possibility of the megadisasters—that only a small percentage of the public has plans in place. How do you explain this reticence of the public to engage in preparedness practices?*

IR: This is not a new challenge in terms of people thinking prospectively or preventively when it comes to big disasters. When you go back to the surveys conducted decades ago, the fact is that Americans have never taken preparedness very seriously. It’s true, for instance, that during World War II, there was tremendous patriotic fervor. Almost every able-bodied male signed up to go into the military, and women by the hundreds of thousands went to take over the factory jobs. But in terms of participating in civil defense preparedness measures at home, few actually did anything. During the arms race with the Soviet Union starting in the 1950s, one had the impression that there were bomb shelters sprouting up in neighborhoods and homes all over the country. While urban areas and some local governments built bomb shelters, in fact, less than 5 percent of Americans

ever built their own, even when the price was very low—in the range of several hundred dollars.

On some level the public’s willingness to get prepared is similar to attitudes about health promotion and disease prevention. Think of how difficult it is for people to stop smoking, keep their weight under control, and exercise regularly. It has to do with a mindset that is not particularly conducive to prevention no matter what the issues are. In fact, I don’t think we’d have people wearing seatbelts in cars if it weren’t for the fact that their cars are required to have them installed and people are required to use them. Absent the legislation, we’d still have people flying through windshields on a much more frequent basis than is currently the case.

AL: *In your work on Katrina and its aftermath, are you finding that people are less interested in following up and pursuing remediation measures now than they were immediately afterwards? How does one maintain focus on this agenda?*

IR: I think we should just accept the fact that the general public, and the media as well, left to their own devices, have short attention spans, whether it’s a tsunami in Indonesia or an earthquake in Pakistan or even the catastrophe in the Gulf in ‘05. So what to do about that? The answer is, in part, appropriate leadership. And right now, we don’t have that, particularly on the federal level. This is a theme I emphasize in my book, because I believe that the American public could be keenly interested in the ongoing post-Katrina recovery crisis in the Gulf. If the president of the United States regularly expressed concern and regularly went back to visit, showing that he was personally checking on progress, demonstrating compassion for the people trapped in the horrible limbo of the FEMA trailer parks, it would make an enormous difference. The public and certainly the media would be demanding action. The reality is that you have to work at keeping the American public’s attention focused on chronic, ongoing crises. We are much more involved and interested in the acute problem and the acute response—and decreasingly interested as we get farther away from the event itself.

Andrew Lakoff, author of Pharmaceutical Reason: Knowledge and Value in Global Psychiatry, is currently doing research on security experts in the United States.

hearts and minds:

85 percent of U.S. soldiers in Iraq say the war is retaliation for Saddam Hussein’s role in the attacks of 9/11