COMMENTARY

Bioterrorism: when politics make the best prevention

Michael Schull, MD

The United States dominates academic emergency medicine. In other specialties, century-old medical traditions and international leaders balance the US influence. But emergency medicine was born in the US, the number of US trainees far outnumber those of other countries combined, and our textbooks and journals are written primarily by US authors.

Emergency physicians share the same literature, but we should be cautious about adopting the same priorities and practices. American medical culture reflects the American experience. Their emphasis on penetrating trauma reflects the ubiquity of guns; their medico-legal preoccupation reflects a more litigious society, and the emphasis on medical readiness for military threats reflects the prominence of the US military.

One such threat, addressed in this issue of *CJEM*,[1] is bioterrorism. As the authors of this article note, biological weapons have been around since the First World War. It is unclear why they are now back in the spotlight. Perhaps the military, with falling budgets and waning influence, needs new enemies to combat. If so, vague and nebulous terrorist groups make an ideal target. Since the threat is ill-defined, the preparation must be all-encompassing and the budget large.

My views are coloured by my work with a medical humanitarian organization in Halabja, northern Iraq, a city whose Kurdish civilians were bombed by the Iraqi government with a mixture of nerve, mustard and VX gases. This attack in 1988 killed more than 5000 civilians, and while the horror of the attack is not in doubt, the likelihood that medical preparations could have altered its outcome certainly is. Ironically, during the Kurdish refugee crisis that followed, far more Kurds died from easily preventable diseases like diarrhea and pneumonia. Nonetheless, today the Kurds are safer from poison gas not because of medical therapies, but because of economic and political sanctions that crippled a dangerous regime.

Medical preparations for bioterrorism may not only be of questionable efficacy; they may be counterproductive. In the 1950s, Canadian children regularly scrambled under their desks at school during nuclear drills in an era when atomic bombs were accepted as just another weapon. Were children safer then, when preparations made a nuclear attack seem inevitable, or are they safer now, when talk of nuclear winters, not nuclear shelters, has led to massive reductions in nuclear weapons?

Organizations like Physicians for the Prevention of Nuclear War were at the forefront in the campaign against nuclear weapons. A simple message was repeated again and again: A nuclear attack means unimaginable horror and doctors can offer no effective treatment.

Similarly, when the Canadian Association of Emergency Physicians identified the easy availability of guns as a medical problem, it did not advocate for better gunshot wound management, but for stronger gun control legislation. If the threat of bioterrorism (or other weapons of mass destruction) is real, then physicians should adopt the same strategy.

Preparing Canadian EDs for an onslaught of anthrax may be just as effective as teaching children to crawl under their desks during a nuclear attack. Our efforts would be better directed at defining the true nature of the threat and developing political strategies to address it.

Clinical Epidemiology Unit and Emergency Department, Sunnybrook and Women's College Health Sciences Centre, University of Toronto, Toronto, Ont.

Reference

1. Grafstein E, Innes G. Bioterrorism: an emerging threat. CJEM 1999;1(3):205-9.

Correspondence to: mjs@ices.on.ca