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American Society
of Internal Medicine

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Memorandum

TO: Governors
Governors-elect
BOG Guests

FROM: Cynthia S. Heller
Director, Governor Services

DATE: August 30, 2002

SUBJECT: Fall Conference in Quebec

Enclosed is your agenda book for the fall conference. As you look over the schedule, you will see that the BOG Executive Committee has planned a very exciting and interesting meeting. We will start off discussing problems in internal medicine today, and then develop suggestions as to how these problems might be resolved. We will close with small group discussions about what activities the College can engage in to revitalize internal medicine. TAB 1 is loaded with background materials to help focus the discussion. Linda Hawes Clever, past Chair of the BOG and President of RENEW, and Joel Levine, Regent, will join us for this discussion.

We will also have two reference committee hearings on Thursday, so please come prepared to represent your chapter on the 18 issues to be debated there.

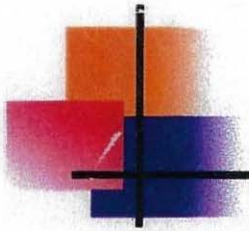
Four excellent workshops are planned for Thursday afternoon. One, Structuring Your Chapter for Success, is designed especially for Governors-elect. Sitting Governors can choose from:

- The Tools and Techniques of Effective Advocacy
- Thriving, Not Just Surviving
- Patient Safety, The Other Side of the Equation

Because of the small group discussions, each workshop will only be offered once this year. Thursday evening's reception will be held at the beautiful La Chapelle du Petit Seminaire. This old and lovely seminary chapel, featuring the largest collection of relics in Canada, Carrara marble statues and stained glass windows, will provide a taste of the history and architecture of Quebec City.

(Continue)

OVERALL HHS GOAL



ENSURE NATION IS PREPARED FOR

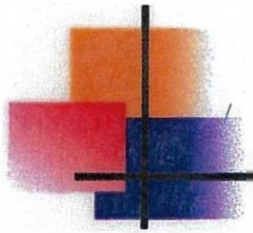
- Bioterrorism
- Other Infectious Disease Outbreaks
- Other Public Health Threats and Emergencies

MAJOR FOCUS ON STATE AND LOCAL ASSETS

All Terrorism is Local

An Effective National Response Requires an Effective Local and State Response

ONE PROGRAM; THREE WATCHWORDS



SPEED in making funds available for use

FLEXIBILITY in how funds are used

ACCOUNTABILITY for results obtained

Vaccination Immunity -- USA

- Routine vaccination in U.S. stopped in 1972
- Virtually none <30 years vaccinated
  - 45% of total population
- Of those >30 years
  - One successful vaccination, probably no immunity
  - 2+ successful vaccination, 40% immunity
- Overall susceptibility
  - 45% + 0.60 X 55% = 78%
- Problems with U.S. vaccination technique

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Vaccine Availability in the USA

- Present stock – all calf-lymph vaccines
  - Wyeth freeze-dried 150,000 vials 15-75 M doses
  - Aventis liquid 850,000 vials 85 M doses
- Sept. 30 2002 – tissue culture vaccine
  - Acambis-Baxter 1.7 M vials 170 M doses
- Dec. 21, 2002 – tissue cell culture vaccine
  - Acambis-Baxter 2.1 M vials 210 M doses
- Standby capacity – 12-15 M doses per month
- All vaccines are "Investigational New Drugs"

Critical Smallpox Vaccine Policy Issues

- Factors to consider in decision-making process:
  - Level of threat – risk of infection with smallpox
  - Vaccine supply
  - Expected adverse reactions
  - Vaccinia immune globulin supply (VIG)
  - Liability issues
  - State and local smallpox operational planning status

Smallpox Vaccine
Expected Adverse Events

- Life-threatening complications
  - Post vaccination encephalitis
  - Progressive vaccinia (vaccinees and contacts)
  - Eczema vaccinatum (vaccinees and contacts)
- Less serious
  - Generalized Vaccinia
  - Accidental inoculation (may result in blindness)
  - Rash and fever
- If 100 million vaccinated, 250-400 deaths and 1400 serious, potentially fatal complications expected

Vaccine Complications

- Number of serious, potentially fatal complications
  - 18 per million vaccinees
  - 2 to 4 deaths
- Post-vaccinial encephalitis, Vaccina necrosum, Eczema vaccinatum
- If vaccine acceptance is 50%:
  - 2500 severe complications, 280-560 deaths
- If vaccine acceptance is 67%
  - 3400 severe complications, 375-750 deaths

Who Should be Offered Vaccine?

- Options to consider:
  - Offer vaccine to all who want it without recommendations
  - Recommend that all or some be vaccinated
  - Require that all or some be vaccinated

ACIP Smallpox Vaccination New Recommendations

- Persons pre-designated to investigate smallpox cases necessitating patient contact
- Selected personnel in facilities pre-designated to serve as referral centers to provide care for the initial cases of smallpox
- Each state and territory to establish and maintain at least 1 Smallpox Response Team
  - Teams to include medical team leader, public health advisor, medical epidemiologists, disease investigators, diagnostic laboratory scientist, nurses, other personnel

Special Problems

- Administration of vaccine in 100 dose vials
  - High amounts wasted by health care providers
  - Vaccination clinics or centers?
- Equitable access to vaccine
  - Reserved for the more developed and privileged countries such as U.S. and Europe?
  - Consideration for less developed countries?
- Large scale vaccination program will raise questions about U.S. access to information
- Are Russia and the U.S. conspiring in some way?

SURVEILLANCE FOR DISEASE

Basic/first the data are here!

Morbidity Reporting – U.S.

Routine systems (passive reporting)

- **Requirements**
- **Motivation**

Data systems for bioweapons threat

- **Syndromic surveillance**
- **Data mining**
  - **Drug sales**
  - **911 calls**
  - **Emergency room visits**

Morbidity Reporting – International

Smallpox

Poliomyelitis (tetanus, measles)

Disease with prominent rash or hemorrhage

Availability of epidemiological/public health support