



Global Terrorism, Political Instability and International Crime Council September 2008

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This edition of the newsletter of the Global Terrorism, Political Instability and International Crime Council features the following articles:

- Council member Ted Cromwell discusses new regulations to safeguard chemical facilities (See below);
- Council member Dr. Robin McFee asks: “Are physicians a fifth column in the war on terror” (See below);
- Council members Britt Mallow and Doug Callen are profiled (See p. 3); and
- How to control violence on the Southwest border (See p. 4).

Raising the bar: New regulations to safeguard chemical facilities from terrorism

By Ted Cromwell

Following 9/11, thousands of chemical facilities didn't wait for government action and implemented security upgrades to protect their plants, employees and communities. But not everyone took action.

To ensure that we “raised the bar” for chemical facility security across the nation, many stakeholders in both the industry and the government worked towards passage of comprehensive security legislation. (Continued on Page 2)

Medical Terrorists, Medical Murders: Are physicians a fifth column in the war on terror?

By Dr. Robin B. McFee

“I will apply measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.” Hippocrates

Some of the worst mass murderers in the last 100 years have been physicians.

The involvement of radical Muslim physicians in the Glasgow airport and London bombing conspiracy of June 2007 leads us to ask how those trained to heal could embrace terrorism and readily kill.

In spite of recent high-profile terrorist events, the role of the scientifically trained in furthering extremist ideology is neither a new phenomenon nor unique to extremist Muslims. (Continued on Page 6)

Raising the bar: New regulations to safeguard chemical facilities from terrorism (continued from page 1)

Late in 2006, after years of debate, Congress took action and passed through an appropriations bill, the authority for the Department of Homeland Security (DHS) to implement regulations – now known as the Chemical Facility Anti-Terrorism Standards (CFATS).

Congress did exempt several categories from these requirements including: Nuclear Regulatory Commission covered facilities; Maritime Transportation Security Act (Coast Guard) regulated facilities, public water treatment facilities as defined under the Safe Drinking Water Act, public wastewater treatment works as defined by USEPA's Clean Water Act and lastly, Department of Defense and Department of Energy regulated facilities. Congress determined that these categories were sufficiently covered through existing regulation, or that other relevant agencies should take the lead for establishing the appropriate security for those sites.

That said, the DHS was given a tall order – to develop and implement regulations that could affect tens of thousands of chemical facilities within six months! DHS was up to the task, and in June 2007, they completed the “interim final rule”, and in November of that year, published “Appendix A” a list of over 300 chemicals of interest that triggered a risk-based screening process (top-screen) for facilities that possessed these chemicals above certain thresholds.

DHS selected these Appendix A chemicals after careful evaluation of their:

1. Potential offsite consequence in a surrounding plant community if terrorist attacked the plant;
2. Potential theft/diversion impacts if these chemicals were stolen for use in a subsequent attack’
3. Potential sabotage/contamination capability that could pose a significant threat if mixed or otherwise tampered with to create a poison; and
4. Potential economic impacts of certain key chemicals being deliberately removed from economic service due to a terror attack.

DHS also decided to establish four different tiers, or bins, of chemical facilities based upon their potential risk – the highest risk facilities being deemed tier 1.

For security reasons, DHS will not disclose the exact make-up of the tiers or what the risk criteria is that place a facility in one tier vs. another – yet this will create some challenges for facilities.

According to DHS, the cost of compliance for the top tiers will be substantially higher than for lower tiers and this provides a significant incentive for facilities to dramatically reduce their risk profile. Not knowing the criteria for establishing these thresholds makes that effort tougher.

According to DHS, approximately 40,000 facilities were determined to have the “Appendix A” chemicals above the regulatory threshold and these facilities had to complete the online top-screen questionnaire earlier this year. These included large and small chemical facilities, university labs, chemical distribution warehouses, bulk terminals and even food and agricultural warehouses that store or use large quantities of these chemicals. DHS spent several months reviewing the screening data and determining the tier status for selected high risk sites.

On June 23rd, 2008, DHS sent notification letters out to over 7,000 facilities that will be subject to the full CFATS requirements. Fewer than 1,000 facilities were identified as either tier 1 or tier 2 and the remaining sites were deemed tier 3 or 4.

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Council member Robin McFee asked to write article on toxin used in Litvinenko assassination

Dr. Robin McFee, a leading toxicologist and member of the ASIS Global Terrorism, Political Instability and International Crime Council, has been asked to write an article for the Journal of Emergency Medical Services on the notorious Alexander Litvinenko case. Litvinenko, a former officer of the Russian Federal Security Service, died in 2006 in London after being poisoned with the radionuclide polonium-210. This was the first time its use as a poison was documented.

Widely respected transportation security expert Doug Callen establishes private practice

When it comes to transportation security, few people are as knowledgeable – or as insightful – as Doug Callen, who recently retired as the Chief Security Officer in the U.S. Department of Homeland Security, Transportation Security Administration (TSA).

Doug, who served as a Senior Executive and founding member of TSA, is now President of his consulting firm, Douglas I Callen & Associates which helps public and private sector clients meet the ever increasing range of transportation security challenges.

A member of the ASIS Global Terrorism, Political Instability and International Crime Council, Doug managed the TSA's internal security programs, including physical, personnel and information security as well as security policy and awareness. He was responsible for liaison with federal, state and local law enforcement and security entities, as well as the international law enforcement community, transportation security officials and various associations.

Prior to joining TSA, Doug served as the Director of Intelligence at the US Department of Transportation. He was the national security advisor to the Secretary on counterterrorism issues, interagency intelligence matters and all threats to the transportation infrastructure and the traveling public.

Doug began his professional life in public service as a Special Agent with the U.S. Secret Service where he served 21 years. He has extensive experience in executive protection, criminal investigations, intelligence and interagency liaison. He served at Secret Service Headquarters in the Intelligence Division and the Office of Government Relations and Public Affairs. He also coordinated protective activities for three U.S. Presidents, and completed a 3½ year protective assignment with Secretary of State Henry Kissinger. He has traveled extensively throughout Europe, the former Communist Bloc countries and the Middle East. His other assignments included the Buffalo, New York, and Boston, Massachusetts field offices and the New Hampshire resident agency where he coordinated the Secret Service operations during the Presidential primaries.

Doug is a native of Omaha, Nebraska and graduated from the University of Nebraska. He also completed an advanced senior management program at the Harvard University Kennedy School of Government. He is an active member of numerous advisory committees, councils and associations.

Distinguished Mideast expert Britt Mallow has unique counterterrorism expertise and experience

At a time when anti-terrorism efforts are hampered by a dearth of Mideast expertise, Colonel (Retired) Brittain P. Mallow stands out. A career Middle Eastern Area Specialist and student of the region, Britt is conversant in Arabic language, culture and politics, and has served multiple tours in the Middle East.

Vice Chair of the ASIS Global Terrorism, Political Instability and International Crime Council, Britt is a Counterterrorism and Law Enforcement practitioner with over 31 years of combined public and private sector experience.

His military career spanned 28 years and included command of US Army Military Police units up to Brigade size, and multiple tours overseas. He has extensive experience managing and supporting international counterterrorism, law enforcement and security operations, coordinating with intelligence agencies, and managing felony crime investigations.

Following 9/11, his experience standing up and leading an inter-agency law enforcement and intelligence Task Force to investigate terrorists in the Global War gave him unique perspective on information-sharing, Al Qa'ida, and the paradigms of law enforcement and intelligence community cultures.

As the Commander of the Department of Defense Criminal Investigation Task Force (CITF) for over three years, Colonel Mallow supervised over 1400 complex terrorism investigations, which entailed over 10,000 interviews of detainees. He was also the Deputy Commander of the US Army Criminal Investigation Command.

Leading diverse military and civilian organizations of up to 1000 people in multiple countries, Britt managed multi-million dollar budgets and programs for law enforcement, intelligence and military organizations.

In the private sector as a Strategic Consultant he has coached and assisted national security leaders with strategy planning, change management and leadership. He was also a member of the 2007 Director of National Intelligence Summer Hard Problem (SHARP) study examining commonalities between the law enforcement and intelligence communities.

Britt holds Masters Degrees in National Resource Strategy, and Security Affairs/Middle East Studies from the National Defense University and the Naval Postgraduate School. He is also a graduate of the FBI's National Executive Institute.

Britt serves as Director of National Security Business Programs for SRA International in Alexandria, Virginia. SRA is a leading provider of technology solutions and strategic consulting services to clients in national security, civil government, and public health sectors.

Partnership: Key to fighting violent crime on Southwest border

By Tom Cramer

Mexican President Felipe Calderon and Attorney General Medina-Mora have stated that the trafficking of U.S. sourced firearms into Mexico is the number one crime problem affecting the security of that country.

The Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) is dedicated to drying up the "iron river" of weaponry flowing from the United States into Mexico, and reducing the firearms-related violence associated with this gun trafficking.

ATF's Southwest border strategy is to work in conjunction with its domestic and international law enforcement partners to deny the "tools of the trade" to the firearms trafficking infrastructure of criminal organizations operating in Mexico and along the border.

Partnership is the key. The dismantling of trafficking infrastructures can only be accomplished by joining together via cross-border partnerships in order to effectively share criminal intelligence, and through collaborative U.S./Mexican criminal investigations that eliminate the border as an obstacle to effective law enforcement.

In April 2006, ATF created Project Gunrunner as a means of focusing ATF's investigative, intelligence and training expertise to suppress firearms trafficking to Mexico. ATF works in partnership with the Government of Mexico and other U.S. agencies such as DEA, ICE

(Immigration and Customs Enforcement) and Customs & Border Protection to pursue Project Gunrunner objectives.

The cornerstone of ATF's Project Gunrunner is eTrace. eTrace provides for the electronic exchange of crime gun incident data in a secure Web-based environment. eTrace enables law enforcement representatives to electronically submit firearm trace requests, to monitor the progress of traces, to retrieve completed trace results, and to query firearm trace-related data in a real-time environment.

ATF's National Tracing Center provides information to federal, state, local and international law enforcement on the history of a firearm from manufacturer to first retail purchaser. The NTC processed approximately 288,443 crime-gun trace requests in 2006 alone.

The National Tracing Center has identified primary firearm trafficking routes into Mexico, and Project Gunrunner is focusing on these corridors.

During the last two years, ATF has experienced a significant increase in the number of trace requests from Mexico. With the deployment of eTrace to all nine U.S. consulates and the eventual implementation of Spanish eTrace, these numbers should continue to increase in the coming years. ATF's goal is to deploy eTrace software to all 31 states within the Republic of Mexico.

Another key component for stemming the illicit flow of firearms between U.S. Border States and Mexico is ATF's inspection of federal firearms licensees (FFLs) and their licensed distributors in the affected areas. These inspections detect and prevent the diversion of firearms.

In addition, ATF has established a National Gun Desk at the Drug Enforcement Administration's El Paso Information Center (EPIC). The ATF gun desk serves as a central repository for weapons-related intelligence. The ATF gun desk compiles illicit weapons information and intelligence from federal, state, and local law enforcement agencies as well as foreign governments.

The expected outcome of all these efforts is the suppression of the firearms-related violence affecting communities in both Mexico and the United States.

Tom Cramer is a Writer-Editor in the Office of Public Affairs, Bureau of Alcohol, Tobacco, Firearms and Explosives.

Raising the bar: New regulations to safeguard chemical facilities from terrorism (Continued from page 2)

The specifics about which facilities were designated under each tier are protected under the Chemical Terrorism Vulnerability Information (CVI) classification – which was developed specifically for CFATS. Generally speaking, under CVI, neither the government nor the facility can share details on which facilities are subject to the requirements, the types of security measures implemented etc. – except with others that are CVI trained and have a specific need to know the information about that site.

Each of these 7,000 facilities will need to implement the following steps in the coming months:

- Complete a detailed security vulnerability assessment (SVA) using either the DHS methodology (required for tiers 1 – 3) or using an approved alternative (tier 4). Tier 1 sites have 90 days, tier 2 have 120 days, tier 3 have 150 days and tier 4 have 180 days to complete the SVA.
- Develop a site security plan (SSP) that will be used to define security measures specifically designed to mitigate the vulnerabilities identified in the SVA process. The SSP will need to demonstrate that it meets a series of performance based standards identified in the regulation.
- Obtain DHS approval of the SSP and then implement these security upgrades at the sites.

DHS inspectors will be regularly meeting with facility personnel to review/approve the SSP and otherwise support their compliance efforts.

For facilities that fail to act, these inspectors will also take necessary enforcement action that includes \$25,000 for violations and/or facility shutdowns. DHS estimates that the implementation of these requirements at these 7,000 sites will exceed 8 billion dollars.

For additional details on the CFATS program and what the industry is doing to implement these requirements, contact Ted Cromwell, Senior Director of Security at the American Chemistry Council, (703) 741-5246.

A member of the Global Terrorism, Political Instability and International Crime Council, Ted Cromwell is the Senior Director of Security and Operations at the American Chemistry Council in Arlington, VA where he has lead responsibility for chemical facility security, chemical weapons convention implementation, drug enforcement issues and export controls. He works closely with the Department of Homeland Security on both regulatory and voluntary security initiatives that impact the chemical sector. Ted also serves on the executive committee of the Chemical Sector Coordinating Council and is assistant chair of the Council. CSCC advises DHS on numerous cross-cutting security initiatives for this critical infrastructure.

Medical Terrorists, Medical Murders: Are physicians a fifth column in the war on terror? (Continued from page 1)

BACKGROUND

Throughout the 20th Century, highly-skilled physicians have spearheaded some of the most evil and vile programs in the history of humanity.

The Nazi German Dr. Josef Mengele, (aka Auschwitz's "Angel of Death") in the name of science and his pursuit of power during World War II (WWII), subjected his patients – political prisoners, mostly Jews—to dissection without anesthesia, injections of prussic acid (cyanide) and various chemical toxicants, as well as perverse organ swapping experiments between twins.

Less well known was Japan's enthusiasm for biological weapons. In 1936 Emperor Hirohito created what would be referred to the outside world as the "Epidemic Prevention and Water Purification Department of the Kwantung Army" but in reality was Unit 731 – a secret germ warfare program under the leadership of Dr. Ishii Shiro, a physician - microbiologist. Recognizing the economy of scale, a virtual endless supply of people on which to experiment, Shiro and his willing accomplices of physicians and scientists established Unit 731 in Manchuria. Exploiting prisoners of war and Chinese civilians, the physicians of Unit 731 took biological weapons testing, vivisection, and germ warfare, especially plague, to new levels of atrocity –ultimately claiming tens, perhaps hundreds of thousands of victims.

The Cuban revolutionary Che Guevara was a physician. One of Britain's most infamous mass murderers was Harold Shipman, MD.

In the 1960's, Dr. George Habash founded the Popular Front for the Liberation of Palestine (PFLP). This pediatrician was instrumental in a rocket attack of a school bus full of children in Avivim, Israel.

The strategy of hijacking commercial airlines was the brainchild of Dr. Wadih Haddad, another physician, and second in command of PFLP. Dr. Fathi Abd Al-Aziz Shiqaqi was a founder of Islamic Jihad as well as an active member of Fatah. Another pediatrician – Dr. Abdel Aziz Al Rantisi was a leader in Hamas. The commander of the Moroccan cell that provided logistics for the 9/11 attacks was a physician (psychiatrist) – Dr. Abu Hafiza. Dr. Ayman Al Zawahiri –Al-Qaeda leader under Osama Bin Laden, another physician. As the events of 9-11 demonstrated, this trend will continue into the 21st Century. Not too long ago, Dr. Rafiq Sabir was convicted in an Al Qaeda plot; he was a Boca Raton physician.

While the topic of medical terrorism and medical murder can expand into a variety of interrelated realms important to the security professional—and will be raised in subsequent issues) including health care facility vulnerability and patient safety, the value and risk of international medical

graduates, extremist views in conflict with modern medical practice, the growing global business of counterfeit medications and the “mafia-ization” or organized crime corruption of health care here and abroad and the role physicians and other health care providers play in these criminal enterprises—clearly the radicalization of the West is a paramount concern.

Building upon the insightful piece written by Peter Probst in the June 2008 Council Newsletter, this month we’ll examine some of the dangers of this radicalization within the medical profession. It is not uniquely Muslim extremism or religious conversion or act of patriotism that drives radicalization or creation of terrorist scientists. But one must also acknowledge that the current threat to the West is one driven by radical Islamic extremists, as such sympathetic physicians pose a risk in support of Al Qaeda, Hamas and the Muslim Brotherhood. We must anticipate the threat. The challenge for security professionals, especially in an attempt to be proactive in identifying those who pose a risk to our communities is the reality that physicians and scientists are valuable to revolutionary causes.

In future issues, we will explore hospital and other critical health care infrastructure vulnerability and also the psychological aspects associated with physicians who become revolutionaries, serial killers, terrorists and security threats.

RADICAL ISLAM, MEDICINE AND JIHAD

‘The doctor has a big say and great weight in influencing his patients and in righteously guiding their orientation. Besides, he should be actively involved in propagating true Islam among Muslims and non-Muslims.’

Mahmoud Abu Saud in The Role of a Muslim Doctor in Shahid Athar’s Islamic Medicine

As the planes were crashing into the World Trade Center Towers on 9/11, radical physicians were seen crowded in front of television screens cheering in delight. What’s wrong with this image beyond the obvious that physicians should NEVER cheer human carnage? It is the reality that the Hippocratic Oath and the moral commitment we as physicians pledge – with our lives if needed – to preserve the sanctity of life has been subordinated. It is also the reality that living and working among us in the West is a group of people who support our destruction. Yet these are people we thought were our friends, colleagues we depended upon and shared our patients with – *our patients depend upon them!* It gives one pause to consider just who do some of our more radical colleagues ultimately work for, what do they believe in and how far will they go in support of those beliefs? Calls for physicians to battle inside the United States continue to be spread via Internet chat room discussions.

Historically religion and medicine were closely aligned in Islam; medical practice was viewed as a service. Verses from the Koran are often invoked as part of healing practices. Of note, some Islamic scholars suggest that Muslim leaders are often chosen for their stature in society and charisma. Medical doctors are thus among the elite in Muslim cultures; as such, they can readily influence others – even usurping religious authority from more moderate spiritual leaders. Physicians with ambitions for broad roles in society are ideally suited, especially to participate in extremist activities. Consider the 1979 Islamic Revolution; the most influential Iranian political movements originated at the medical, technical and engineering schools. In the US, physicians with extremist leanings raise funds through work at universities and in the community and/or assist in the takeover of moderate mosques to impose more radical ideologies.

The British estimate numerous doctors have adopted the radical extremism of the Muslim Brotherhood, Tablighi Jamaat and Al Muhajiroun (banned but still active in the United Kingdom), which recruit medical students. Numerous physicians remain under watch in the UK, with the British Government acknowledging it doesn’t have the resources to identify the full realm of risk.

US Health Care Facilities

Are our health care facilities (HCF) safe from terrorism? Are they low threat targets? Should they be considered as such? Consider the panic and loss of public confidence if a community hospital or venerable medical center was attacked? Beyond the immediate loss of life would be the loss of a valuable component of public preparedness and critical infrastructure. In 2005 a homeland security bulletin was sent to California hospitals stating that “U.S. Hospitals offer easy public access and would be recognized by terrorist planners as easy, accessible targets.”

Illustrating the point in the ridiculous, at a recent chemical terrorism drill, while on 'lockdown', the hospital forgot to lock the back door entrance to the Emergency Department! Video cameras are infrequently reviewed at best or are inoperable systems designed to provide a perception of increased observation/safety. Security needs are consistently balanced against hospitality. Given hospitals are sites of confidential and critical information and vulnerable people, such asset protection must be balanced against the human nature of illness and the need for support and family. The resulting ease of entry, especially with a white lab coat and a stethoscope, make HCF vulnerable to outside crazies, terrorists, criminals and 'insiders' like extremist converts. Numerous hospitals around the country are "low hanging fruit" for individuals or groups intent upon sabotage. Consider the HCF with a large propane storage tank 30 feet from the emergency room, or the hospital with a railroad track running *through it*, carrying toxic inhalation hazards virtually unguarded. Even an innocent derailment can cause severe damage with loss of life.

In spite of increased concern over the security of radioactive materials – even small quantities of medical and research isotopes – the fact remains it is relatively easy to locate and remove such materials from many hospitals, universities and labs. Several well-respected academic institutions post large signs at loading docks informing delivery services where to drop off radioactive materials. Many of those offices are well marked and unsecured! While those materials are not useful for thermonuclear weapons, they can be utilized for dirty bombs or poisoning. In either case, public concern, even panic, could result along with morbidity and mortality.

Hospital vulnerability remains a significant threat to preparedness.

Evil in the guise of good

If political warfare is an unfamiliar concept to most Americans, the thought of physicians as agents of influence, or violent terrorists is an even more unfamiliar, nay, an unacceptable concept. Patients entrust their lives, especially in times of personal crisis, to virtual strangers all because of the mantle of healer that stranger wears. It is the expectation that each doctor, each health care practitioner has taken an oath to care for the sick and adhere to that pledge.

Yet many of these very trusted caretakers may not be so benign.

Like other members of society Mr. Probst mentioned in a prior edition, those who in secret support Muslim extremists, but publicly extol the virtues of unity and coalition building, have become well integrated into society.

How much of organized medicine, like other political institutions, have been co-opted by or at least experienced a rise in activity from those who are members of Muslim Brotherhood? Imagine if entire hospital districts came under the influence of extremists? It is not difficult to imagine because it is already happening globally.

The Muslim Brotherhood has penetrated numerous medical societies in a variety of nations, including, not surprisingly, the Egyptian Medical Syndicate.

The International Medical Group section of the American Medical Association, headquartered in Chicago, has grown significantly over the last few years in both numbers and influence. The Chicago metroplex, similar to Ohio and Michigan, has large Muslim medical communities. It is well established that extremist members of these communities aggressively fundraise for radical Islamic foundations. Some of the funds no doubt end up in Iraq, Iran, Palestine and other extremist enclaves. One wonders how many physicians already practicing in the United States continue to raise or donate money to HAMAS and other extremist organizations.

Using the tools of "soft power" to mold public opinion and influence public policy, a strategy embraced by the Muslim Brotherhood, is not wasted on physicians as extremists. Articles published in the medical literature about "studies" on issues, such as "the perceived role of Islam in medical practice in the US, give the appearance of scientific pursuit when, in effect, some of these articles may be thinly-veiled propaganda efforts to enhance the image and acceptance of radical Islam. Organizations such as the Islamic Medical Association no doubt offer, like other peer group associations, positive reinforcement and mentoring. But, like other large organizations, they also wield enormous influence. The key questions for security professionals – do these organizations harbor radical extremists or provide valuable resources for extremist organizations?

One of the extremists' strategies is to influence young minds; where better than at schools and universities? Recently, the School of Medicine at Harvard University received a multimillion dollar endowment for Middle East and Islamic Studies – under the admirable objective of educating young physicians to be more culturally attuned to their patients and to promote greater collaboration between the two regions. Increasingly, Islamic Studies are being mandated in universities; and while only a handful of medical schools have such courses to date, the Harvard experience is likely only the beginning. Relating to Mr. Probst's article – can benign programs be co-opted for more radical agendas?

Reaching out to poverty stricken areas is an ideal and seemingly innocuous way to develop recruits. Radical Islamic groups responded to the 2005 earthquake in Kashmir in spite of being banned by President Musharraf. In all, at least 17 jihadist and radical Islamic organizations provided aid to refugees. These outreach programs allow money laundering, recruiting of grateful survivors, and fundraising.

An example is the Holy Land Foundation for Relief and Development which solicited funds for medical relief but, according to the US Treasury, provided millions of dollars to Hamas. HLF has operatives in the US, as does the Global Relief Foundation (of Illinois) which helped raise money for Al Qaeda. Given medical organizations often need spokespersons or a front man, recruiting physicians will remain a priority, as seen in the UK where several radical sects target scientists, engineers and doctors. In a strategy developed by Ayman al Zawahiri, provision of local health care is given in exchange for opportunities to recruit youth in extremist ideology. This strategy has been successfully employed in Egypt and Sudan, under the auspices of Osama Bin Laden. One wonders if it couldn't be employed in the US? Given prime targets have been prisons, the conversion of African Americans to radical Islam, the education system and areas where racial tensions allow for a cultural offensive, especially in seemingly abandoned, disadvantaged areas – physicians are the ideal agents of influence. Offering to provide care to prisoners allows the radical Muslim extremist to emphasize their abandonment by the 'white establishment,' demonstrate a kindred spirit, promote recruitment to the Muslim Brotherhood, and foment greater dissention.

Discussion

*"All that is required for evil to triumph is for good men to do nothing,"
Edmund Burke.*

Muslim colleagues are just as they appear – good friends, devoted family members, and skilled clinicians. Unlike the street violence and acts of rage focused upon American tourists in the Middle East, fortunately and appropriately, Muslim-Americans generally did not feel the sting of anger after 9-11, given, thankfully, most of us can (and should) distinguish between terrorists, extremists and our neighbors. But, and of concern to our Muslim friends, neighbors and colleagues, another terrorist event in the US will not likely result in such tolerance. As such, it is incumbent upon us to assist the moderate Muslims in limiting the perversion of their religion and halting the spread of extremism.

An honest dialogue among stakeholders with the objective of stemming the radicalization of the West, especially among young as well as established physicians, is critical. As suggested in Mr. Probst' cautionary article, the solution will not arise if we are so politically correct as to avoid the issue. There are exponentially more good physicians than those who intend to do harm.

But evil often hides behind good; therein rests the challenge. Although risky to do so, the good must stand up against the bad. Most of our healthcare system in The United States, like the United Kingdom, is increasingly reliant upon international medical graduates and foreign educated nurses – FEN, especially in overcrowded urban hospitals, underserved (prisons, inner cities, projects), public health clinics in disarray, or disadvantaged regions (rural). According to the AMA 2005 Member Fact Book, the number of physicians in the U.S is 794,893, of which there are 185,234 international medical graduates (IMG) from 127 countries. The number of IMG is expected to increase. Among the top 20 countries of origin or education for IMG physicians, 7 of these nations (India, Philippines, Pakistan, Egypt, Syria, Iran, Lebanon) are known terrorist havens; in total representing over 40%. In 2001- 2002, there were 100,958 graduates in ACGME accredited residency training programs; 26% were from non-U.S. schools.

IMG play a vital role in providing care to underserved regions. Potentially hiding within the kind and devoted IMG majority is the dangerous minority – a group well versed in using every means at their

disposal – the law, intimidation, money or political influence – to achieve their objectives. The opportunity for IMG with extremist loyalties to overtake public health departments and their systems – which, in the aftermath of 9/11 and October 2001 (anthrax) were designated as the “go to” players for bioterrorism and emerging pathogens – poses a grave risk to our infrastructure. The British National Health Service is a cautionary example of such vulnerability.

One advantage that preparedness experts have is the reality that physicians not only occupy high positions in their own countries, but in their newly-transplanted communities in the US. Physicians are thus readily visible members of what might otherwise be difficult communities to locate or identify.

It is worth noting, even in a post 9-11 environment, special visas for foreign alien MDs and other health care personnel, as well as gravely-ill individuals from abroad (the veracity of their illness often is suspect) putatively scheduled to receive advanced treatments, remain relatively easy to obtain, especially if rural and other disadvantaged areas need clinicians. And as more individuals rely upon public care, the likelihood that restrictions to IMG will diminish to fill gaps emerges. Taking advantage of this opportunity, proponents of IMG extol the values of easing immigration restrictions. Where security and health care collaborate or collide is predicated upon how we address this issue.

Hospitals are dangerous places without the aid of malefactors. But for those with intent to do harm – on an individual basis or system wide destruction – there is plenty of opportunity especially for well-organized, well-funded, determined adversaries.

CONCLUSION

“Decisions are complex, and there are always competing factors. To look for simple explanations is the bias of the human brain, but it doesn’t correspond to reality. Nothing is ever as straightforward as it appears.” Richard Stengel

The 2007 London and Glasgow bombings conducted by health care professionals, mostly physicians, demonstrate the ‘no boundaries of decency’ the terrorists are willing to exploit in pursuit of their objectives. But the problem of physicians as terrorists is far more insidious and widespread than that handful of extremists using vehicles as weapons. The potential threats extremist physicians and other health care professionals pose to the United States range from direct risks to patients and our health care system, to economic, political and technical support of terrorist violence as well as fronting illegal enterprises, performing as ‘agents of influence’ or direct architects or participants in violent events. At the very least, extremist physicians and scientists represent a formidable information gathering network and funding enterprise operating inside the United States. To be sure, given the number of physicians sympathetic to or supportive of Islamic extremism residing in the United States, there is little time left to ignore this fifth column.

The idea of doctors turning to terrorism remains unsettling. In the face of great evil, it is tempting to seek logical answers, such as identifying the convergence point between ideology, theology and terror. In essence, what would make someone do such evil? It is tempting to attribute the conduct of Muslim extremist physicians as a protest against the “depravity” or “excesses” of the West or a reaction to some perceived injustice to Palestine or Iraq. There are little data to support this as the overarching catalyst. Radical Islam clearly was not a driver for Mengele, Shiro or Shipman. To understand the ‘conversion’ from healer to murderer, one must understand the social context. Physicians, engineers and men of science occupy positions of power within their society, not unlike the importance the shaman or medicine man enjoys in tribal cultures. Because of their importance, skills and often wealth, radical ideologues target physicians and scientists. This, along with insights into how physicians become terrorists, will be discussed in depth in a later issue.

As in Western cultures, physicians typically transcend political rivalries. Similarly, physicians often transcend factions among Islamic extremists. A physician can also travel about freely with significantly less scrutiny than the average citizen. Physicians, especially academics, are expected to present research internationally; with bona fides, ease of cross border movement is all but assured. The same is true in the US. Extremist health care workers can position themselves innocently into vulnerable, i.e. recruitable populations, as well as infiltrating the more ‘diplomatic’ and ‘sophisticated’ arenas– raising funds, creating foundations, and interacting with the media and politicians.

It is important to remember not all physician murderers are terrorists. Some are just plain evil, such as the British physician Harold Shipman who killed over 250 patients.

Solutions to a fifth column that the public increasingly is called to rely upon for health care will be challenging as security, legal, moral and practical considerations collide. Increasing the number of domestic medical graduates is a longer-term solution, along with incentives for US graduates to care for the underserved. Such policies, however, come into conflict with an inherent hospitality toward and value of IMG. Introducing safeguards to prevent subversion of health care by potential extremist physicians is worth exploring. Moreover, more comprehensive background checks for physicians who are considered for positions critical to the preparedness infrastructure are necessary. A coordinated effort across homeland security, medical and other government agencies is needed.

It has been said that the most committed usually win. Our resolve can be no less than that of our adversaries. Mr. Probst so aptly described the reality that a highly-trained radical Islamic cadre is operating successfully in the US; it is indeed the “third rail” of political discourse. Within this cadre are highly-skilled scientists and physicians. We must address this significant challenge to the long term security of our nation. Awareness of the threat is but the first step. It will be a formidable task requiring courage from our leaders and the cooperation of all the key stakeholders, including the public.

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