THE CHRONICLE OF HIGHER EDUCATION

Research & Publishing

From the issue dated March 14, 2003

Panic Button

Social scientists say the government's preparation for bioterrorism attacks gives too little credit to the public

By DAVID GLENN

In late May, fire departments, hospitals, and political leaders in Seattle and Chicago will take part in a terrorism exercise with the faintly Strangelovian name TOP-OFF II. (The term is military shorthand for "top officials.") The exercise will simulate the release of biological or chemical weapons -- the exact agents will be a surprise to the participants -- in a test of the cities' ability to cope with the crimes of the next Mohammed Atta or Timothy McVeigh.

ALSO SEE:

Who Lives?

The original TOPOFF exercise, conducted in the carefree spring of 2000, revealed serious flaws in the public-health infrastructure. Various federal and state agencies failed to coordinate their responses. The emergency room at the Medical Center of Aurora, Colo., was overwhelmed by 800 "patients," and the governor was forced to declare a "state of emergency" in order to stanch civil unrest. In a companion East Coast scenario, National Guard troops "shot" desperate citizens in confrontations at antidote-distribution centers.

In the intervening three years, of course, bioterrorism has become a reality, and the federal government has invested a great deal of effort in preparedness. Most observers expect this spring's exercises to run much more smoothly. That's in part because governments, both state and federal, have been working with academics to model scenarios, and, indeed, to create laws designed to guide agencies in the aftermath of a bioterrorist attack. "I've had to put my life on hold for a year," says Lawrence O. Gostin, a professor of law at Georgetown University and of public health at the Johns Hopkins University, who was invited to lead an effort to revise state public-health laws. "But I wanted to make

Related Materials

SERVICES:

About The Chronicle

How to Contact Us

How to Register

How to Subscribe

Subscriber Services

Change Your User Name

Change Your Password

Forgot Your Password?

How to Advertise

Press Inquiries

Corrections

Privacy Policy

The Mobile Chronicle

Help

sure that this went forward in a way that respected individual rights."

Mr. Gostin is satisfied that government is trying to strike the right balance. Other scholars aren't so sure. Many professors of public health and sociologists of disaster say that post-September 11 bioterror-preparedness projects have been slow, awkward, underfinanced -- and, in some cases, actively destructive. Public authorities are wedded to a command-and-control model based on misplaced fears of public panic, these scholars argue. They also complain that government is speaking to citizens strictly as individuals, imagining us as a nation of duct-tape-wielding Robinson Crusoes while ignoring the social networks -- churches, offices, schools -- that will play a profound role in responding to any actual attack.

Some scholars, for instance, believe that the "riots" in the original exercises were the product of faulty assumptions by the simulations' designers. People are not really so likely to panic, these scholars say. Others concede that such riots are plausible enough, but they worry that the unrest was caused (as, perhaps, it might someday be in real life) primarily by the ham-handed, authoritarian decisions of public officials. It is important "to dismantle the myth of the hysterical, prone-to-violence public, which gets reproduced in professional discourse and practical exercises," says Monica Schoch-Spana, a medical anthropologist who is a senior fellow at Johns Hopkins's Center for Civilian Biodefense Strategies. "The general public should be approached as true allies in managing bioterrorism, and not as the problem to be managed."

There has not been a "mass quarantine here for 100 years," says George J. Annas, a professor of health law, human rights, and bioethics at Boston University who has been one of the most visible civil-libertarian critics of government plans. "I think it's fair to say that you want to keep that possibility available as one of maybe 50 different ways to respond to something. What I don't want to see is governors thinking that that's the first thing they're going to do -- exercise all of their power and authority to the maximum immediately."

Shields Up

But if they don't blockade the roadways, how can state governments minimize the odds that a disease will spread from city A to city B? Most scholars answer: Far in advance of an actual attack, the government should prepare the public to stay in place voluntarily, to resist the impulse to flee to family and friends outside the initial danger zone. An interdisciplinary team of researchers at the University of Virginia has recently begun to elaborate a noncoercive model of mass

quarantine -- a voluntary plan that they call "shielding" -- and they believe that public officials are paying attention.

The notion of shielding emerged at an April 2002 conference sponsored by those researchers, who are part of the UVa-based Critical Incident Analysis Group. The basic idea is that people will be much less prone to panic -- and, consequently, less likely to spread an infectious agent -- if they voluntarily go home and stay there. By "stay there," the Virginia scholars have in mind weeks or even months -- long enough for a local epidemic to burn itself out. "Stable, familiar environments offer security because they have an existing infrastructure of support," writes the group's executive director, Gregory Saathoff, a professor of psychiatry at Virginia, in a new monograph published by the group, *What Is to Be Done? Emerging Perspectives on Public Responses to Bioterrorism.*

"Our modern society is geared toward the fantasy of evacuation," says Dr. Saathoff. "There's a belief in the automobile as the savior that will lead you to some kind of security -- when, in fact, that might actually be doing the bidding of the terrorists, because you're of course going to be spreading the epidemic. ... Staying home is a bit counterintuitive -- "

" -- unless you've ever been involved in overseas evacuations, where they never quite work," inserts his colleague, W. Nathaniel Howell, a retired Foreign Service officer who now chairs the critical-incident group. He was U.S. ambassador to Kuwait at the time of the Iraqi invasion in August 1990, and stayed, along with staff members, within the confines of the embassy for five months, until the onset of the Persian Gulf war. Mr. Howell says the idea of shielding derives in part from his own experience with long-term sheltering-in-place -- "what we call overseas 'standing fast.'"

The shielding concept has another unusual personal source. Another participant in the April 2002 conference was Stephen D. Prior, research director of the National Security Health Policy Center of the Potomac Institute for Policy Studies, in Arlington, Va. In a late-evening conversation at the conference, he told Dr. Saathoff about the history of his hometown, the English village of Whiteparish, which successfully enacted self-isolation during a medieval plague. "That was the kernel of the idea that we then pursued," says Mr. Prior.

Government Support

Serious technical challenges surround the notion of shielding. Would public or private agencies be able to deliver food, medicine, and other necessities door-to-door without spreading disease? If not, then

shielding would work only if families routinely stockpiled two or three weeks' worth of essentials -- far more than the three days' worth recommended by the Department of Homeland Security. Some observers are skeptical. "There's no chance" of door-to-door service, says Mr. Annas. "It's hard to even think of a scenario where they'd say, Stay in your homes and we'll come to you. We don't have those kinds of numbers out there, even today, when there's no bioterrorism. Do *you* get house visits from medical personnel?"

"Why does he think that's impossible?" asks Richard L. Bonnie, a professor of law at Virginia and a contributor to the Virginia group's report on shielding. "We deliver the mail every day -- even during snowstorms. We deliver the newspaper. I don't see why we couldn't distribute medicines and food."

But others agree with Mr. Annas and question the country's capacity to sustain long-term shielding. "It's one thing for the Foreign Service," says Jonathan D. Moreno, a professor of biomedical ethics at Virginia who is editor of the forthcoming book *In the Wake of Terror: Medicine and Morality in a Time of Crisis* (MIT Press, April). "What are you going to do with my 16-year-old son, and my lawyer neighbors up the street? I guess I'd be much happier if I knew of a cross-section population where something like this had been done for even a week. I'm a great admirer of Greg [Saathoff], but I wouldn't want to put too much in the bank with that model."

Mr. Prior, however, emphasizes that shielding can be useful even if only a relatively small percentage of the population takes part. In new epidemiological models, which have not yet been peer-reviewed, he and his colleagues have found that at a threshold of roughly 25-percent shielding (depending on population density and the type of infectious agent), the progress of a disease can be sharply slowed.

And elected officials appear to have bought in to the notion of shielding. The Virginia team has held discussions with local legislators and leaders of the state's health department. There have also been briefings "at the highest levels of the federal government," says Dr. Saathoff.

"We've been told that shielding has changed the way that government looks at these things," says Mr. Howell. "Now, that's a big order, because it's a big government. I'm not saying that there's not still somebody in a back room somewhere" planning military-style quarantines. "But we know that a number of the agencies, from the [Centers for Disease Control and Prevention] on down, see this as the best solution. They were worried about what they were going to run

into if they tried to railroad people -- or if the troops would even obey them. They're not going to shoot people who are trying to evacuate." (A spokesperson for the Department of Health and Human Services confirms that the agency has had extensive conversations with the Virginia scholars, and that those discussions are continuing.)

There Ought to Be a Law?

Regardless of what approach government takes in a bioterror emergency -- evacuation, coercive quarantine, voluntary shielding, or some combination of the three -- it will need to exercise extraordinary powers. Even in the least coercive model, the government might want to commandeer, say, dormitories at private colleges in order to add hospital-bed space. The state would probably order private-sector health-care workers to report to specific locations, and it might also conceivably seize and distribute private businesses' stocks of food, water, and medicine. All of those proposals are controversial (Would businesses be reimbursed? Would doctors' autonomy be violated?), and they have given new urgency to a national effort, which predates the September 11 attacks, to reform and streamline states' public-health statutes.

"One of the main ideas is to require planning," says Mr. Gostin, principal author of the Model State Emergency Health Powers Act, which was drafted in late 2001 in the midst of the anthrax scare. He is also director of the Center for Law and the Public's Health, a joint project of Georgetown and Johns Hopkins.

Twenty states have incorporated parts of the model act -- which has been widely criticized by civil libertarians and business lobbies -- into their own public-health laws. "The act requires all the key players in a state to come together around the table," Mr. Gostin says. "The act provides guidelines about what to plan, how to plan, and with whom."

No one objects to planning -- but critics charge that other elements of the model act rely too heavily on police powers. In an essay in *In the Wake of Terror,* Mr. Annas argues that the model act allows public-health authorities (many of whom are not M.D.'s) to override doctors' judgments about such questions as mandatory vaccinations. Mr. Gostin's model, he writes, "is a classic good-versus-evil view of the world, but fantastically treats only public-health officials as the good, and Americans and their physicians (instead of terrorists) as the evil enemy."

Mr. Gostin, who once served as general secretary of the British Civil Liberties Union, and who has been known as a libertarian in debates

about HIV policy, is unaccustomed to such criticisms, and says they are not valid. He emphasizes that the model law gives people placed under quarantine or isolation affirmative rights to food and medical care -- rights that are absent in many states' public-health laws. Replying to Mr. Annas's comments, he says, "It's oversimplifying to say that personal autonomy is some kind of trump card. ... It simply defies common-sense ethics and any understanding of law to say that an infected person who refuses treatment and then wants to move to their family or some other congregant setting -- that the government would be powerless to prevent that, either by requiring vaccination, requiring treatment, or, if necessary, placing the person in isolation. That's never been the case in American history, that's never been the case in constitutional law, and that's never been the case in medical ethics."

Mr. Gostin's hypothetical is misplaced, replies Mr. Annas. It grants an absurdly disproportionate weight, he says, to the problem of controlling the very few people who would refuse treatment in an emergency. "There are some antivaccination types out there," he concedes. But the real concern is "people trying to break into the hospitals and clinics to get to the vaccines. That's what I worry about." And the correct way to prevent such riots, he asserts, is not to expand states' police powers, but to design efficient public-health systems that people can trust.

Building Trust

How to achieve such trust? The government's efforts to ease anxiety and encourage preparedness have been "atrocious," says Lee Clarke, a professor of sociology at Rutgers University at New Brunswick and author of the forthcoming *Worst Cases* (University of Chicago Press, 2004). Like some other scholars, he particularly faults the performance of federal officials during the anthrax attacks of late 2001. Among other gaffes, they repeatedly announced that anthrax spores could not pass through sealed envelopes -- which, of course, turned out to be untrue. "You should never overpromise safety," says Mr. Clarke, "because, number one, Americans are among the most highly educated people in the world, and number two, Americans are among the most skeptical people in the world. You can lose trust so easily. And when people think they're being talked down to, it just dissipates."

Mr. Clarke contrasts the feds' anthrax performance with the news conferences given by New York City's mayor, Rudolph Giuliani, that fall. "I'm no fan of Rudy Giuliani," he says. "But I'm a big fan of the way he conducted himself after September 11. He was willing to say, I don't know but I'll find out. He was willing to show his vulnerability, and he was willing to show his ignorance. I'm sure, if you're in a

position of leadership, that it's a pain to be honest like that. But it's the only way to go, because Americans are just too skeptical."

When asked about the recent duct-tape advice and the government's associated preparedness Web sites, Mr. Clarke replies with a verbal shrug: "Most of those kinds of advice are perfectly fine, but they're pretty much like telling people to buckle their seat belts." What he would prefer to see is risk communication geared not toward individuals and families, but toward entire neighborhoods and social networks. "If I live in a one-room apartment with four kids, and most other apartments in my building are the same way, then that's a completely different disease vector" than the bucolic suburbs, he says. "I don't see that the government is giving any thought to that. What's their plan for the people who are most vulnerable?"

Governments are making appropriate plans for densely-populated urban neighborhoods, insists Joseph M. Henderson, the associate director for terrorism preparedness and emergency response at the Centers for Disease Control and Prevention. "As public health officials, our modus operandi is always to attack the weakest link in the chain first."

Similar concerns are raised by Johns Hopkins's Ms. Schoch-Spana, who worked as a consultant on the federal government's latest preparedness campaign. "I had some hesitancies going in to consult, ... but I've been clamoring for more attention to the public's needs, and I decided it was time to put my money where my mouth was."

Like Mr. Clarke, however, Ms. Schoch-Spana says, "I think we still have a long way to go in readying civic organizations, as opposed to individuals stocking things in their basements." She emphasizes that in actual disasters, people rarely panic, but instead tend to behave in extremely prosocial ways. That cooperative impulse could be put to much greater use if offices, religious bodies, and civic groups were trained in advance in emergency-response techniques, she argues.

Exercises like this spring's TOPOFF II are useful for building social relationships among diverse public health and law-enforcement agencies, Ms. Schoch-Spana says. But such simulations, often constructed on the myth of a public "prone to hysteria and violence," might "cement [the panic stereotype] as a planning principle." She is also concerned that government simulations fail "to test the capacity of various publics to help in response to an emergency" -- again, failing to take note of the spontaneous constructive behavior that is likely to emerge in a disaster.

Other scholars say the most important variable in an emergency will not

be citizens' "preparedness," whether as individuals or in groups, but the government's own ability to bring separate agencies into harmony. "There seems to be a subtle struggle between law-enforcement, coercive philosophies and public-health, trust-building approaches," says Ruth Gaare Bernheim, an assistant professor of public health at Virginia who contributed to the shielding report. "Those two groups need to come together and create relationships and a philosophy that somehow mesh, and communicate to the public that they're working together to protect, not to coerce, and that they can be trusted. But it's not yet clear that that relationship has been built sufficiently, that it *deserves* trust from the public."

---

http://chronicle.com
Section: Research & Publishing
Volume 49, Issue 27, Page A14
