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Commentary

Handcuffing the Flu

CAN A LAW ENFORCEMENT/NATIONAL SECURITY APPROACH TO PANDEMIC PREPAREDNESS PROTECT THE AMERICAN PEOPLE?

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Remarks delivered by Monica Schoch-Spana, PhD, on January 14, 2008, to mark the release of the ACLU's report: Pandemic Preparedness: The Need for a Public Health—Not a Law Enforcement/National Security–Approach, *by George J. Annas, Wendy K. Mariner and Wendy E. Parmet. Dr. Schoch-Spana was one of three panelists who spoke at this event.*

By Monica Schoch-Spana, PhD

My thanks to the ACLU for its close attention to public health preparedness matters, to the report authors for their insightful analysis, and to the health authorities who work tirelessly behind the scenes to protect against pandemic flu.

At the outset, let me say that my colleagues at the Center for Biosecurity and I concur wholeheartedly with the report’s principal argument that effective policies for pandemic influenza and other public health emergencies cannot be “built around a vision of sick people as the enemy” (p. 5). The authors rightly contend that disease control methods that compromise democratic ideals of self-determination and equality of persons can inadvertently spread an epidemic further.

Several threads are worth extending out from the ACLU's argument that a “gates and guards” approach to epidemic management threatens the health and liberty of the American public.

First, a fortress mentality distills public health into the singular goal of stopping flu from making its way from an infected person over “there” to an uninfected community over “here.” This linear idea is mentally satisfying, but falsely reassuring. Second, the priority focus within U.S. pandemic plans on controlling contagion has unwittingly diverted attention from caring for the sick—an equally compelling population health problem in a pandemic. Lastly, members of the public—rather than a blank slate onto which containment policies are written—are capable partners alongside health authorities in minimizing the effects of a pandemic flu. I’d like to address each of these points in turn.

The first point: Thinking of pandemic preparedness in defense terms as “securing the perimeter” leads to poor health policy and a false sense of safety. The reason has to do with how both the flu virus and people actually behave in today’s interconnected world.

Official doctrine, as well as the popular imagination, erroneously embraces the idea of U.S. communities somehow escaping pandemic flu by containing the first cluster of human infections overseas, monitoring points of entry to and egress from affected areas, and imposing geographic quarantines at home.[1-2] At the November 2005 release of the *National Strategy for Pandemic Influenza*, the president invoked a forest fire image: "If caught early it might be extinguished with limited damage; if allowed to smolder undetected, it can grow to an inferno that spreads quickly beyond our ability to control."[3]

The May 2006 implementation plan reflects a continued belief in the elusive goals of halting the spread of disease overseas and interdicting sick travelers.[2] Border screening, however, has little proven ability to halt the spread of contagion. Thirty-five million people were screened at airports in four Asian nations for potential SARS infection during that outbreak, and not one case of SARS was detected.[4]

The virology, epidemiology, and sociology of a human influenza pandemic suggest profound faults with fortress thinking.[5] Past influenza pandemics have not developed in a slowly mounting linear fashion, but in quick multi-focal bursts. Targeting antiviral drugs and quarantine at the pandemic's point of origin (that is, promptly dousing the spark in the forest) is not feasible. Mathematical models of quarantine for flu show that there must be a nearly perfect degree of limitation of travel to be effective—another practically unachievable goal. Lastly, implying a foreign point of origin for the pandemic against which the country can and must be secured creates a "geography of blame" likely to stigmatize Asia and Asian-American peoples, neighborhoods, and commodities.[6]

The second point: A single-minded focus on containment can blind officials and the public to the need for more robust plans to care for the sick. How federal and local leaders intend to help mobilize a fragmented, mostly for-profit healthcare system to meet the crushing demand for medical services remains uncertain.

In a severe influenza pandemic, healthcare needs will be greater than the capacity of local hospitals and health professionals to treat flu patients and sustain other essential medical services according to everyday expectations.[7-9]Hospitals will not be able to operate effectively in the face of labor shortages that result from workers falling ill, having to care for sick family, and/or being concerned about bringing home contagion. Hospitals may facilitate transmission of the flu virus within their walls, due to infected patients converging on them. Healthcare facilities may run out of even basic supplies due to patient demands, just-in-time inventories, and interrupted delivery chains.

Based on the HHS planning assumption of a 1918-like pandemic and CDC's *FluSurge* software, local hospitals can expect to have only one mechanical respirator for every two flu patients, and only one bed for every four to five flu patients who need them at the peak of the crisis.[9] Hospitals will need to cancel elective surgeries and discharge the least ill to recover elsewhere. Today's so-called "elective" procedures, however, include cancer surgeries, angioplasties, and aneurysm surgeries, without which many patients may die.

The problem of keeping hospitals online during and after a pandemic has been raised numerous times, but real progress toward solutions is wanting. Questions that remain include the following: How can hospitals make decisions about the allocation of limited healthcare resources and alterations in standards of care and still maintain public confidence?[7-8] What support do people require to stay at home when mildly to moderately ill in a pandemic and to help reduce overcrowding and infection in hospitals?[2] How will U.S. hospitals remain solvent when faced with the costs of deferred elective surgeries and uncompensated care for the uninsured?[10]

The third and last point: Members of the public emerge in pandemic plans, on the one hand, as possible disease vectors subject to the punitive arm of public health, and on the other, as free agents who play an active role in their

own safety by stockpiling. Outfitting the home bunker is not, however, a full measure of citizen contributions to preparedness.

Officials need to work with citizens and civic groups before disaster strikes to promote all the ways the public can contribute, including taking part in policy decisions, building volunteer networks, getting support for tax or bond measures that limit vulnerability and improve health and safety agencies, and yes, having family emergency plans, too.[11] The public's role in disasters cannot be boiled down into a checklist of canned goods, drinking water, medicine, and phone numbers in case of an emergency.

The civic infrastructure—people who live, vote, play, work, and worship together—should be involved in emergency planning and poised to act before, during, and after an event. Civic groups and local opinion leaders can help officials decide in advance who gets scarce medical resources, give aid when the professionals cannot be there, comfort survivors over time, and set priorities for recovery and restoration.

"Effective" crisis managers are those leaders who actively engage the community before an event and not simply hone their mass media skills. Communication must be two-way, not just authorities sending out information and directions. A dialogue with community partners in advance will garner public trust and improve emergency plans. And, to achieve a genuine dialogue, leaders must take deliberate action to include groups who are usually not at the table, including poor and working class people, people of color, recent immigrants, and frail seniors, among others.

In closing, I would like to congratulate the ACLU and the authors on a timely and provocative report. The study's core messages help advance the public debate about what constitutes effective, human, and democratic approaches to managing an influenza pandemic.

Today, I've underscored 3 ways in which a "guarding the gates" model of pandemic preparedness fails us:

- Thinking about contagion in a linear fashion is inappropriate in the flu context given how both the virus and people behave in today's interconnected globe.
- Unbridled worrying about the containment issue potentially blinds us to the problem of caring for a lot of sick people in the context of an already fragile healthcare system.
- Members of the public have a critical role to play in managing a pandemic flu, and they cannot be reduced to stockpiling bunkers or avoiding the spread of contagion.

Many thanks for your time and attention.

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