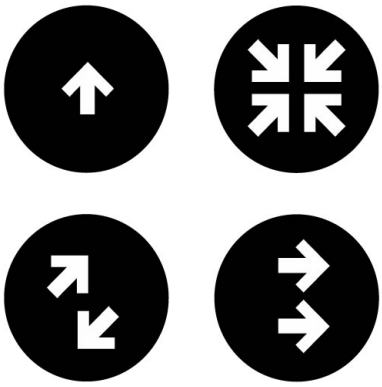

How to Lead during Bioattacks with the Public's Trust and Help

A Manual for Mayors, Governors, and Top Health Officials

UPMC CENTER FOR BIOSECURITY

The aim of a bioattack is to create suffering and disruption caused by an epidemic of infectious disease. Whether “natural” or “deliberate” in origin, a large outbreak poses unique governing dilemmas. Leaders must tend to immediate life-and-death matters such as caring for the sick, ward off socially corrosive effects like ostracism of the afflicted, and stem dramatic economic effects for victims and affected locales alike. Conflicts of interest, priority, and purpose can emerge in pursuit of these goals. The Center for Biosecurity of the University of Pittsburgh Medical Center (UPMC) convened the *Working Group on ‘Governance Dilemmas’ in Bioterrorism Response* to advise leaders on helpful approaches to these complex situations.

Working Group recommendations are covered in more detail online at:
www.upmc-biosecurity.org/pages/resources/leadership.html

Adapted from “Leading During Bioattacks and Epidemics with the Public’s Trust and Help,” *Biosecurity and Bioterrorism* 2004; 2(1):25-40.

What defines 'leadership' during an epidemic or biological attack?

Five strategic goals help distinguish successful leadership during an epidemic or bioattack in 21st century America. An informed and involved public, along with guidance and material support from respected leaders, can help achieve these aims:

01. Limit death and suffering through proper preventive, curative, and supportive care; tend to the greater vulnerability of children, the frail elderly, and the physically compromised.

02. Defend civil liberties by using the least restrictive interventions to contain an infectious agent that causes communicable disease.

03. Preserve economic stability, managing the financial blow to victims as well as the near- and long-term losses of hard-hit industries, cities, and neighborhoods.

04. Discourage scapegoating, hate crimes, and the stigmatization of specific people or places as "contaminated" or unhealthy.

05. Bolster the ability of individuals and the larger community to rebound from unpredictable and traumatic events; provide mental health support to those who need it.

Why do bioattacks present special challenges and high-stakes decisions for leaders?

A deliberate epidemic poses compounded, unfamiliar dangers in today's setting. Most elected U.S. officials, health authorities, and the public have no direct experience with large outbreaks, nor do they know the best ways to control them. Even less familiar is the premeditated use of disease as a weapon.

A. Epidemics are complicated events due to their biology, but also because they provoke fear, contradictory impulses, and competing social aims:

01. An epidemic's outcomes—suffering, death, lost livelihood and commerce—are troubling to consider. Leaders and the public may deny that a problem exists, or intervene too quickly without regard to the negative effects of their actions.

02. People need to make sense of random and terrifying events, but epidemics elude quick and easy explanation. The nature of a disease, a population's vitality, and the responsiveness of health institutions affect how an epidemic unfolds.

03. A mysterious disease can trigger the human reflex to isolate oneself and blame others for the tragedy or, in deep contrast, to care for victims without regard to one's own safety.

Why do bioattacks present special challenges and high-stakes decisions for leaders?

B. Features of modern society can speed up and disperse an epidemic's negative impact and make some people more vulnerable than others:

01. Global media and around-the-clock news reports cause anxiety and dread in people, even those who are in places far from immediate danger.

02. Today's transportation systems move people quickly across vast distances, potentially accelerating the spread of disease.

03. Epidemics have broad, indirect financial impacts due to close ties among global, national, and local economies.

04. Poverty, lack of health insurance, and distrust of the healthcare system mean that those who are most vulnerable during disease outbreaks are least able to protect themselves.

05. Personnel shortages and lean budgets limit the emergency response capabilities of U.S. hospitals and state and local public health agencies; they are spread thin on a "normal" day.

CASE STUDY

More than 4,000 SARS cases (half the total global count) can be traced to a chance encounter by a handful of international travelers with the virus at a four-star Hong Kong hotel; among the guests on the ninth floor was an infected doctor who had treated patients in Guangdong Province, where the outbreak first emerged.

When the global SARS outbreak peaked, some New Yorkers transposed news reports on conditions in hard-hit cities like Hong Kong to *their* hometown, where impact was negligible.

Why do bioattacks present special challenges and high-stakes decisions for leaders?

C. A calculated attack further magnifies the consequences of an epidemic:

01. An attacker's motivations and tactics—for example, attacks on multiple cities, over a prolonged period, or on random victims—heighten an epidemic's uncertainties.

02. Scapegoating will be more severe in the case of bioterrorism than in natural outbreaks as people demand to know, "Who did this?!"

03. If a disease is weaponized or infects people through an unusual route (such as the mail), it may be harder to detect and treat. What is known about natural outbreaks of the same disease may not apply.

04. The wide range of scenarios—scares, discrete non-lethal attacks, a campaign of mass casualty attacks—makes planning for every contingency impossible.

CASE STUDY

During the 2001 anthrax attacks, frustration and confusion arose from lack of immediate answers to basic, factual questions. Who did this? How many letters were involved? Health authorities and clinicians had to make critical decisions based on absent or partial scientific knowledge. What is the best treatment? Who should receive preventive antibiotics and for how long? Which mailrooms should be closed and surveyed? Apparent inconsistencies and gaps in the government's response fostered more uncertainty. Were officials withholding information about the severity of the attack? Was treatment for postal workers and Capitol Hill employees really different, and why?

What leadership dilemmas may arise in a deliberate epidemic, and how might they be averted?

An epidemic exerts immense political and social pressure for decisive, visible action—more so in the case of a bioattack. Apparent and sometimes genuine conflicts among strategic goals can arise in this charged setting. The most common dilemmas facing past leaders have been balancing disease control imperatives with those of individual liberty, economic stability, and preventing stigma.

A. Stopping disease that spreads person-to-person while upholding individual freedoms

01. Make bioterrorism response plans public before a crisis occurs; a well-informed population is more likely to cooperate with advice for reducing the spread of disease.

02. Sketch out the “big picture”; make concrete the fact that personal actions can affect the safety of others—for example, remind people that staying home from work or keeping children out of school when they are ill protects others from getting sick.

03. Use disease controls that respect ideals of autonomy, self-determination, and equality—public cooperation limits illness and death; public resistance does not.

04. Provide goods and services that help people comply with health orders—for example, set up vaccination clinics in locations accessible to people without cars.

05. Restrict civil liberties, if necessary, *only* in a transparent and equitable way.

What leadership dilemmas may arise in a deliberate epidemic, and how might they be averted?

B. Protecting the economy while using disease controls that disrupt commerce

01. Be mindful of the goal of long-term financial recovery when controlling disease; do not react based solely on the desire to avert short-term economic loss.

02. Recognize public trust as precious "capital" that grows the economy—for example, if people see their health as your top priority, confidence in your efforts to safeguard the economy will follow.

03. Account for the less visible and more scattered monetary impacts when making epidemic control decisions (e.g., costs of victims' healthcare; economic toll of stigma).

CASE STUDY

In 1982, Johnson & Johnson executives faced a terrifying scenario: 7 Chicago-area residents died after taking Extra-Strength Tylenol capsules that an extortionist had laced with cyanide. Setting consumer safety as the top priority, managers promptly halted Tylenol manufacture, withdrew the product worldwide, and invited customers to return their product for refund or replacement. The company destroyed $100 million in inventory, saw an 87% drop in market share, and faced expert predictions of the brand's demise. After a brief period and with an advertising blitz, Johnson & Johnson reintroduced Tylenol products with tamper-resistant packaging. In response to the company's civic-minded behavior, consumer confidence rebounded, quickly returning market share to pre-crisis levels.

What leadership dilemmas may arise in a deliberate epidemic, and how might they be averted?

A. Restoring social bonds when people feel at the mercy of a mysterious disease or attacker

01. Express empathy for people's fears about getting sick from others; follow up with meaningful medical details that allow people to gauge personal risk accurately.

02. Demonstrate compassion toward victims of disease; explain to the community-at-large the social costs of avoiding people out of fear, rather than out of actual danger.

03. Provide frequent updates on the criminal investigation; counsel people not to lash out against others who "look like" presumed perpetrators.

04. Spotlight community projects aimed at bringing people together across social divisions sensitized by the crisis—for example, ethnic and religious affiliations in the case of 9/11.

05. Direct law enforcement to deal appropriately with hate crimes in the event prevention fails.

06. Coordinate volunteers, relief groups, and civic organizations in humanitarian response, with extra focus on assisting the most vulnerable—for example, children, the frail elderly, and disabled people of all ages.

CASE STUDY

Some employees of American Media, Inc., the site of the first inhalational anthrax case in 2001, were doubly victimized. Physically threatened by potential exposure to anthrax, they sometimes found themselves shunned by other community members: long-time physicians refused to care for them; schools turned away their children; and those moonlighting as housekeepers were not allowed into homes to clean.

What situations splinter the social trust necessary to cope with health crises, and how might they be defused?

Breaches of social trust are a common predicament for leaders during outbreaks and are likely to arise during a bioattack. Social and economic fault lines as well as preconceived notions about "the government," "the public," and "the media" can alienate leaders and the public, and community members from one another.

A. Preventing unproductive fear, denial, or skepticism on the part of the public when delivering crisis updates

01. Share what you know. Do not withhold information because you think people will panic. Creative coping is the norm; panic is the exception.

02. Hold press briefings early and often to reach the public. Answering questions is not a distraction from managing the crisis; it *is* managing the crisis.

03. Confirm that local health agencies and medical facilities are prepared to handle an onslaught of questions from concerned individuals, in person and by phone.

04. Convey basic health facts clearly and quickly so that people have peace of mind that they are safe or so that they seek out care, if need be; similarly, brief healthcare and emergency workers so they have a realistic understanding about job safety.

05. View rumors as a normal sign of people's need to make sense of vague or disturbing events. Refine your outreach efforts; the current ones may not be working.

What situations splinter the social trust necessary to cope with health crises, and how might they be defused?

B. Earning confidence in the use of scarce resources despite existing social and economic gaps

01. Account for income disparities in response plans; anticipate the need for free or low-cost prevention and treatment.

02. Make planning transparent so that the public sees that access to life-saving resources is based on medical need and not on wealth or favored status.

03. Be open about eligibility criteria for goods and services, especially when tough choices arise unexpectedly—for example, which botulism attack victims will receive the limited antitoxin that exists.

04. Show thorough preparations to protect vulnerable populations like children and the frail elderly, thus bolstering *everyone's* sense of security.

CASE STUDY

Given routine differentials in access to health care and the prevalent belief that inequity *will* prevail during a bioterrorism response, leaders are in the unfortunate position of having to prove otherwise. One of every seven Americans lacks health insurance, with minorities overrepresented. Of respondents to a December 2002 national poll, 72% said they believed that if it were not possible to vaccinate everyone quickly during a smallpox outbreak in their community, wealthy and influential people would get the vaccine first.

What situations splinter the social trust necessary to cope with health crises, and how might they be defused?

C. Maintaining credibility when decisions must be made before all the facts are in

01. Advise the community at the outset if crisis conditions are evolving or could be prolonged.

02. Offer more detail rather than less, even when the unknowns outnumber what is known; resist the urge to reassure for reassurance sake alone.

03. Be frank about any uncertainty regarding “facts”; describe plans to fill in knowledge gaps.

04. Vary your means of reaching the public. Mix high-tech outreach (internet, cable, network, print, radio, cell phone, automated hotlines) with contact through grassroots leaders.

CASE STUDY

In the fall of 2001, the Secretary of Health’s definitive reassurances that Bob Stevens’s inhalational anthrax was “an isolated case” and that “there is no terrorism” came before all the facts were in. The results created the impression that the government was not being forthcoming about the extent of the problem, especially when more cases of infection and anthrax-laden letters turned up.

Working Group on 'Governance Dilemmas' in Bioterrorism Response

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