War on All Fronts

A Theory of Health Security Justice

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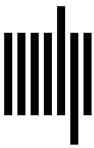

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8 Drawing up the Troops: Waging War on Disease

The *Time* Person of the Year for 2014 was not one person, but a group: the "Ebola Fighters," the many healthcare workers active in Liberia, Guinea, and Sierra Leone. The article closed with one of those classic war metaphors:

> Early in the epidemic, CDC director Frieden spoke of Ebola's "fog of war." Its shroud covers the battlefield. Eventually—though no one can say when—the Ebola fighters are going to be victorious. The fog will clear, leaving the hard truth in view: this won't be the last epidemic. And when the next one comes, the world must learn the lessons of this one: Be better prepared, less fearful, less reactive. Run toward the fire and put it out together. Even more important, though, when the next one comes, remember the Ebola fighters and hope that we see their like again.[1]

The work of healthcare workers is tireless and potentially risky at the best of times, but during a crisis that burden is impossible to sustain long term. Public health emergencies allowed to go on will inevitably deplete healthcare workers of their energy, their time, and their concentration; eventually, it can and does kill them. During the 2013–2016 Ebola virus disease outbreak, the already fragile Liberia lost 8 percent of its healthcare workers to the virus.[2] Healthcare workers are perhaps the most precious and scarce resource in a pandemic. Their experience and training takes years or even decades to replace, and yet they are routinely ignored as a vulnerable and scarce resource during a pandemic.[3]

This chapter is about the people of pandemics. It might seem that here, the securitization of health breaks down most completely. This is because healthcare workers and soldiers are not at all the same. They are not trained the same; they do not have the same social and institutional structure or serve similar ends. Nonetheless, an account of just health security, drawing from military ethics, can teach us a few things.

In what follows, I apply the insights from the impersonal account of disease, and of last resort and liberty-limiting measures, to healthcare workers. After a brief comment on "essential personnel," I argue that under just health security, an emergency response that unduly jeopardizes healthcare workers is unjust. This injustice conflicts with the individual fiduciary duties healthcare workers possess to those under their care, who—unlike soldiers with those they fight—have strong positive reasons to provide care. The people they protect, however, may at times be hostile to them. Keeping to the method of this book, I frame this as an ethical and political-philosophical problem and discuss the institutional role that needs to be played to protect healthcare worker safety. Healthcare workers may be heroes, as Frieden suggests—but heroes often exist because leaders fail us.

I turn then to the role of those *leaders* in public health. I note that much like military strategy on securing cooperation (e.g., "winning hearts and minds") requires leadership, public health authorities also need to be vested with a certain kind of leadership. This leadership, I argue, has a normative ethical component to it that suggests what leaders ought to be and how they ought to behave. I conclude with an example, again from COVID-19, that demonstrates how the state as legitimate authority and the ethics of leadership can fail in public health, as a way to solidify the claim about their importance.

"Essential Personnel"

Before continuing, two more clarifications are required, particularly in terms of the current outbreak. The first concerns "essential personnel." When we discuss essential personnel in medical ethics, we typically have physicians, or more broadly healthcare workers in mind.[4] These are essential in the sense that without them, clinical care for individuals suffering from COVID-19 would not happen. We are concerned about these personnel in terms of the continuing functioning of the healthcare system.

Contrast this with "essential businesses," including those found in government ordinances around COVID-19.[5] What constitutes "essential" here is considerably broader than simply healthcare organizations. It certainly includes basic government services ("businesses" very broadly construed) including power and sanitation, but also employees at grocery stores and food service companies, law enforcement offices, scientists who need to engage in lab

work as part of the outbreak response, lab techs who may need lab access to preserve samples even if experiments are halted, and so on. These are very broad categories and may vary from state to state.

This is significant, as what type and how many people in a population count as "essential" may impact the degree to which social distancing measures work or are justified. For example, on March 20, 2020, the US Undersecretary for Defense for Acquisition and Sustainment, Ellen Lord, released a memo declaring defense contractors essential personnel, and requiring them to continue to deliver products on time.[6] While some defense contractors may be engaged in essential work in the same way as healthcare workers, and indeed support them through the development of personal protective equipment or vaccines, others perform work far outside such a mandate. In cities and towns with large numbers of defense contractors whose work (truly essential or not) requires them to leave their homes, the population active and capable of transmitting COVID-19—and the population that therefore needs to support them in the form of transit workers, grocery store clerks, fast food workers, custodial staff, and more—will remain higher than in other locations.

I think that by and large, there is a sense in which "essential personnel" is a term that can be subject to reasonable disagreement. It can be based on substantive disagreements on what individuals and communities take to be essential; it could also potentially change based on the etiology of a particular disease or health crisis. What I take to be a core element of what makes someone essential personnel is that their continued work *in the setting in which they typically work* is necessary to maintain some kind of critical community function, or outbreak response. This includes clinical care, yes, but would include keeping the lights on, but also keeping people fed, properties from falling into disarray that may endanger community welfare, promoting rule of law, and scientific research aimed at resolving the crisis. Their essential role, moreover, typically means that in the context of the crisis they are exposed to some kind of risk in virtue of maintaining their role in its usual setting.

The content of "essential personnel" in a public health state becomes important because it broaches a question that my anthropologist colleagues might take on: "Essential for whom?" When we talk about the public health state, taking essential personnel to only be healthcare workers frames the role of state in providing a public health institution only in terms of

its healthcare workforce. It may mean, for example, that the provision of masks to hospitals is seen as the only significant site of a public health masking campaign, rather than ensuring that service workers also get high-quality masks or respirators. Even within healthcare facilities, we might find that, as happened during the early stages of the COVID-19 pandemic, only the *clinical* healthcare workforce "counts" for mask allocation. This means that custodial staff at hospitals, who make take on extensive risky activities in cleaning and disinfecting rooms, may be denied masks because while they are genuinely essential to a response effort, they are not *counted* as essential, and thus not ensured the kind of protections we would otherwise think should be provided to these individuals.[7]

We can think of this as part of the justice of our emergency preparedness. If we are building a stockpile of equipment for our pandemic, we might decide that we need X masks, where X is defined as Y times the number of essential personnel, Z. What Z counts as, then, is of extreme importance, and has moral content. Failure to properly account for who contributes to essential roles in prosecuting a public health emergency means we have failed to prepare adequately. And failure to prepare adequately can mean that public health emergency declarations are not truly necessary (because we had other means at our disposal that we elected not to take), or that our actions are unjust within an emergency (because we fail to assume liability for protecting individuals from the harms of our public health actions when we could do otherwise).

Duty to Treat

Healthcare workers are frequently exposed to risks. At times, those risks are extreme. This has produced a literature on "duty to treat" in which bioethicists have asked whether, and under what conditions healthcare workers (but particularly physicians, arising from prejudices in the AIDS crisis) could refuse to treat infectious patients.[8] In general, the consensus has been that physicians do have a duty to treat, as do other healthcare workers, and that the duty to treat is quite strong. However, a lack of access to sufficient PPE and other safety equipment may arguably call this into question.[9]

What is asked less frequently is how these individual ethical decisions are bracketed by their social and political context. The decision to treat is not made in isolation. Writing in 1996, Leigh Turner asked of individuals arriving

in critical care units with gunshot wounds "why do we not interrogate how they ended up here?"[10] This is particularly salient in a public health emergency, in which the degree to which patients arrive in a hospital over time reflects gaps in the capacities of public health to prevent illnesses from occurring. This does not place culpability for that risk on public health strictly—healthcare workers still have autonomy—but it does place healthcare workers at the most acute end of a series of decisions over which they may not have control.

Much like, it turns out, soldiers.

Traditionally, soldiers have been subject to what is known as the *unlimited liability thesis*, a doctrine that states that soldiers are expected to take on risks in the pursuit of the aims of war, including risks that will inevitably lead to their deaths.[11] This is a strong doctrine, and controversial for it. It is certain healthcare workers are not subject to unlimited liability, but recent debate about the thesis reveals how we might think about them in the context of public health emergencies.

The unlimited liability thesis in war has come into question. The consonance between human rights and international humanitarian law in the previous chapters. It follows that if soldiers do not forfeit their human rights by virtue of being soldiers, then their rights to life are not absolutely waived. They may be ordered to place themselves at risk, but that does not give commanders unlimited license with the lives of their troops. The principle of necessity should be respected in its strict form with one's own soldiers as well as noncombatants and enemies.[12]

This has important implications for healthcare workers when we view their liability through the lens of just health security. While healthcare workers have no human enemy under the impersonal account of disease, they still take on liability in their roles defending the public against this threat and in ways that respond to the rights of individuals under their care or on whom public health measures are imposed. They may care for acutely ill patients, patients' families, fill prescriptions, contact trace, conduct surveillance testing, administer vaccines, and so on. All of these can impose serious risk on a healthcare worker.

Healthcare workers thus take on considerable liability during public health emergencies. They do so in virtue of their professional role, serving in the fundamental social institution that is public health. But that liability ought not be unlimited. In particular, the state may act unjustly when

it imposes upon healthcare workers significant but avoidable risks in the discharge of their duties. Like everyone else, healthcare workers engaged in the work of responding to a justly declared public health emergency have not waived their rights. Imposing significant extra risk on them violates their rights in the same way as I described in the previous chapter around liberty-limiting measures—it fails to respect their security and interests as persons. This is true in war, under international humanitarian law; so too is it true in public health. The public health state is not one that can condone the equivalent of Tennyson's description of British cavalry in the *Charge of the Light Brigade*:

> Theirs not to reason why,
> Theirs not to make reply,
> Theirs but to do and die.[13]

Two cases illustrate this case. The first are in cases of substandard personal protective equipment, a common feature of the COVID-19 pandemic. In cases where authorities cannot provide access to basic equipment, healthcare workers are jeopardized in ways not required of them by virtue of their professional role. When states fail to act on their obligations to bring an emergency to a close quickly and to limit the spread of disease with appropriate supports, they place healthcare workers at unnecessary risk. Healthcare workers are wronged to the degree that they are placed at greater than necessary risk of infectious disease where permissible alternate pathways to prevent the transmission of disease exist, and thus treating patients in an emergency can be limited. And to head off accusations that this is a case in which the government had no obligation because it was an unforeseen issue (a form of "ought implies can"), a projected lack of personal protective equipment has been a hallmark of the health security community that has dominated the policy landscape for decades, making it not just foreseeable but *foreseen*.[14]

The second case illustrates how we might expect (suitably attired, trained, and supported) healthcare workers to risk their lives in service of a public health goal. It is increasingly common that nations are turning to technological solutions to manage contact tracing. A plethora of contact tracing apps arose over the course of the COVID-19 pandemics but this technology was also pioneered, to considerable failure, during the 2013–2016 Ebola virus disease outbreak.[15] Yet these same episodes show that there is considerable

evidence to suggest that contact tracing apps are less effective than older means.[16] Older means may be more costly; this is the role of the public health state. They may also be riskier because they require additional interaction with close contacts of infected individuals; this is the role of healthcare workers. Taking risks to ensure that contact tracing is done correctly, by going to local communities and engaging with them directly, exposes a healthcare worker to a higher chance of disease. But it is in the service of an arguably necessary component of a strategy to resolve a public health emergency.

This risk, however, should be imposed for a version of contact tracing that is necessary and expected to succeed in a crisis. What this ought to mean is not imposing greater risk on existing healthcare workers, but an obligation on behalf of states to recruit, train, and retain many more of them. This will mean maintaining larger volumes of public health workers on staff in local communities than currently exist. And like soldiers in war, it means maintaining sufficient numbers to rotate them off their duties as needed so they don't burn out or become so tired that they compromise the effectiveness of the mission; and give them work outside of a crisis so that their skills are maintained and they can be called up as needed. One of the key features of a modern military is that its soldiers spend the majority of their time not fighting wars. Public health can and should afford to be the same way. It is arguably justified under a public health state that takes seriously a principle of last resort—an early response involving contact tracing is rights preserving and even if activated as a partly securitized means is more likely to satisfy the principle of de-escalation than most other practices.

Public Health Leadership

The second kind of role I want to address is public health *leadership*. The role of leaders is almost totally understudied in public health ethics. This is a mistake, and it is significant that we have not individual but collections of moral accounts of physicians, police officers, and warfighters as leaders,[17] but none for public health officials. The study of public health leadership is also important given the political moment in which this book is written and the need for an *action guiding* account of public health ethics. Leadership is both understudied and in current public health often fragmented and weak as an institutional property. Those leaders that do exist, moreover, may lack

the legitimacy or the authority to direct a public health response. This is a significant problem for the prospect of responding to public health needs. It is not to say those leaders that exist are not good leaders in principle; it is often that they do not occupy institutional roles that allow their leadership to be effective.

To illustrate this, consider the comments of the editorial board of the *New England Journal of Medicine* in October 2020:

> The response of our nation's leaders has been consistently inadequate. The federal government has largely abandoned disease control to the states. Governors have varied in their responses, not so much by party as by competence. But whatever their competence, governors do not have the tools that Washington controls. Instead of using those tools, the federal government has undermined them. The Centers for Disease Control and Prevention, which was the world's leading disease response organization, has been eviscerated and has suffered dramatic testing and policy failures. The National Institutes of Health have played a key role in vaccine development but have been excluded from much crucial government decision making. And the Food and Drug Administration has been shamefully politicized, appearing to respond to pressure from the administration rather than scientific evidence. Our current leaders have undercut trust in science and in government, causing damage that will certainly outlast them. Instead of relying on expertise, the administration has turned to uninformed "opinion leaders" and charlatans who obscure the truth and facilitate the promulgation of outright lies.[18]

This is a startling level of candor by a longtime medical institution such as the *New England Journal of Medicine*. It would not be the last: Holden Thorpe, editor in chief of *Science*, would in 2022 accuse the Biden administration of "sheepishly waving a checkered flag on the pandemic." He obliquely mentions leadership in closing:

> Legendary public health leader Paul Farmer summed up this situation well: "Those whose lives are rarely touched by structural violence are uniquely prone to recommend resignation as a response to it," he said. "In settings in which all of us are at risk, as is sometimes true of contagion shared through the air we breathe, we must also contemplate containment nihilism—the attitude that preventing contagion simply isn't worth it."[19]

Here, Thorpe invokes the late Paul Farmer, whose role in pandemics has been less official than that of a president or surgeon general, and more through his professional status and long career of excellence in the field of global health.

These examples provide a couple of useful distinctions. We can distinguish first between leadership as a character trait, and leadership as a role. The former is a set of properties that arise from an individual that makes them capable of effectively directing individuals to group action, including those skills that motivate people to act in coordinated ways. Good leaders can arise anywhere and need not occupy institutional roles. Students in group discussion can exercise good leadership, for example, in directing conversation even in the absence of an instructor's direction. Good leaders guide action, and model appropriate behavior and other positive group traits to their subordinates. Farmer held leadership roles at Harvard University and Brigham and Women's Hospital, but he also stood as a voice of authority in public health.

Leadership as a role is a property of institutions that function in a coordinating and action-guiding role over a collective action. Leadership can be more or less proximate, such as a leader of a unit in a government department, or an attending physician in a war in a hospital. At their most extreme they can be ultimate, such as a head of state or government. Leadership as a role is about guiding institutions or organizations to set aims and being held accountable for organizational failures. Anthony Fauci, as the director of the National Institute of Allergy and Infectious Diseases, occupies an institutional leadership position within that organization and within its parent organization, the National Institutes of Health. However, he does not occupy the kind of leadership position that, in the United States, would require confirmation of the Senate; nor does the National Institutes of Health hold a position within the executive branch of the United States that sets public health policy. Likewise, the chief medical officer of many countries is capable of advising government on public health, but has no leadership powers in the sense of executive control over a function of government.

Leadership in institutions is not necessarily a hierarchical role, though it can be and often is. Leaders need not always have higher levels of entitlements in an institution. Market theories of labor might suggest that leaders ought to have higher pay or more perks in order to attract the best candidates but it is never clear the degree to which this kind of incentive actually places good leaders in the right roles. It is plausible that the only thing that ultimately separates leaders from others is their coordination role.

Sometimes leadership roles are context specific. Military physicians, for example, may exercise leadership *qua* coordination and executive power in medical matters in the armed forces, but they have no power regarding strategic troop deployment. We could also envisage more radical institutional leadership dynamics, such as transient leadership roles for individual tasks such as the appointment of an *ad hoc* leader for a single task, or *de minimis* direction powers for a leader, such as the leadership of a traditional labor union in which a leader might have the capacity to prioritize or bring to order certain coordination activities, but direction on the ground is taken by members.

The traits and institutional roles of leaders come apart in important ways. Everyone has had the experience, I suspect, of interacting with someone in an institutional leadership role who is manifestly unfit to lead in terms of their character. We have also probably interacted with individuals who exercise strong leadership as a disposition but have no formal institutional role. It is possible that institutions sometimes serve their purpose even when corrupted or mismanaged by leaders because the latter exist to interpret, subvert, or act in spite of the former.

If leadership is an institutional role, however, it must be for the moral ends of the institution. In part, we judge institutional leaders and their actions in the context of their institution's purported ends, and the degree to which those ends are achieved. Organized criminal networks have leaders,[20] but those leaders are unethical in part because they are leading unethical organizations: they are directing an organization to immoral ends. Alternately, CEOs might lead companies, but a "moral CEO" may sound incongruous given that companies, in virtue of not being institutions guided by a moral purpose, have no moral ends. Leaders might be seen as compromised, even if acting within their means and in otherwise justified ways, if it is seen that the ultimate purpose of an institution has been compromised. I suspect that, for example, opponents of the US torture program will view leaders within US institutions that practice or did practice torture as compromised to the degree that the torture program represents a form of institutional corruption.[21]

The faces of leadership, good and bad, can be seen in the response to the COVID-19 outbreak. On the one hand, a common characterization of the diagnoses for the failure of states to respond adequately to the pandemic is a failure of leadership.[22] On the other hand, individuals who display

leadership outside institutional roles have emerged as the public has turned to informal channels for education in an information-rich, knowledge-poor outbreak.

Still others have emerged and exhibited leadership despite occupying roles that are not appropriate for the purpose. Dr. Anthony Fauci emerged in the early days of the outbreak in the US as a clear voice of leadership and authority, owing in part to his previous role in the eventual US government response to the HIV/AIDS crisis. Fauci has no statutory authority, however, from which to coordinate and direct a public health response; Fauci's *de facto* leadership role was diminished following his removal from the White House Coronavirus Task Force under the Trump administration and then reelevated under the Biden administration. Nonetheless—and giving full credit to Fauci's dispositional leadership and coordination powers—it is unclear what leadership role the director of the National Institute for Allergy and Infectious Disease *should* take, now that Fauci has departed.

Fauci's role, and those of the various "czars" and taskforce heads in the US government, however, point to the lack of actual leadership displayed by those people who occupied formal *roles* in the US. President Trump, most infamously, was revealed by Bob Woodward in September of 2020 to have known of the seriousness of the pandemic but refused to act for his own reasons related to reelection.[23] To invoke securitized language, the commander in chief was caught in dereliction of his duty as a leader. Likewise, later reports from the CDC showed how leaders within that organization had been slowly divested of authority and corrupted away from their institutional roles by ordering subordinates to delete emails seeking to downplay COVID-19's risk to children.[24]

These are all examples of leadership troubles, but what is less explored is the fragmented and fundamentally weak leadership structure of American public health. Public health in America, unlike war in America, is not coordinated or directed in a way that even pretends to be grounded in reasons of any kind—moral or not. It, moreover, is one that has been eroded not just during the Trump administration, but over decades. Public health in the United States, after all, has its origins in military movements and the US Surgeon General's Office, which carries with it leadership of the United States Public Health Service Commissioned Corps. The surgeon general looks like a leadership office in the US if ever there was one.

Yet the surgeon general's office is a curious position. A full history of the office is provided by Stobbe, who describes its beginnings as a coordinating role in managing Naval quarantine hospitals.[25] But over time, the surgeon general's position was subsumed into the larger portfolio of what is now the Department of Health and Human Services. Caught between the larger political office of the department, and the power of the National Institutes of Health within that agency (and which Stobbe identifies as a historic enemy of the field of public health), the office was ultimately neutered by successive secretaries until it reached its present form, which is more a public relations office than a leadership position in the coordination sense I identified above. This leaves a public health system stranded between a massive and internally fragmented department, state agencies, local authorities, and the president, with occasional input from the National Security Council. While the US Department of Defense is hardly a streamlined organization, the US public health system is positively broken in comparison.

The discussion of leadership has been rehearsed recently in Australia, regarding state and federal leadership positions. Across states, the powers of state chief medical officers differ. In the state of Queensland, the chief medical officer not only has binding legal authority, but also financial authority over public health matters, and holds a senior position within the state bureaucracy.[26] In Victoria, however, neither of these conditions obtain to the state chief medical officer—it has been argued that the failure to manage hotel quarantine procedures, and in particular the hiring of security personnel instead of public health and medical personnel to oversee the quarantines, was in part because the chief medical officer has no final say in the operation of public health measures in that state.[27]

In light of this, we might consider a few normative requirements for public health leadership as an institutional property. First, leadership roles should comprise a line of coordination for relevant stakeholders, including state authorities pursuing an outbreak response. The primary function of leadership in public health is to promote the nonemergency ends of the institution and, in cases of public health emergency, utilize the tools of the public health state to resolve crises and return a state to public health "peacetime." In this way, the leadership structure of public health should be reflective of its institutional ends. This will depend on the jurisdiction, but following from my argument for the public health state in chapter 5, it is likely that at its highest point leadership for public health will occur on a

national level, and serve as a coordinating and executive role between sub-state public health actors (such as provincial, state, and local governments). Public health is local but, as COVID-19 has shown us, the kinds of public health threat that provide a justification for an emergency declaration are likely to span at least nations, if not the world.

Second, leadership must be conferred legitimacy in addition to its legal powers. This provides a positive reason for legislatively authorized, independent offices that act as a coordinating body for public health responses. A chief benefit of a permanent, independent public health office is that it would provide institutional memory over successive outbreaks rather than a series of taskforces and *ad hoc* groups managed in some nations and remove the leadership over public health crises from the partisanship of executive office. In the US, for example, this could be accomplished by relocating and expanding the Office of the Surgeon General and reinvesting that office with appropriate powers to coordinate and make decisions about public health. Alternately, it could be constructed as a new office, with the surgeon general as a member of a leadership council on public health.

Finally, this leadership position must be capable of being held to account in cases of government overreach or error. This stems from the liberty-limiting powers of the public health state, and their capacity to seriously infringe on the rights of individuals. The legal powers of a public health office might be considerable, and so its leadership should be accountable in cases where it oversteps its bounds. Failures of leadership are inevitable, but a key component of rebuilding trust is the ability to hold leaders to account. Ultimately, the institution and its legitimate role are more important than the individuals who occupy leadership positions within that institution, and maintaining trust requires the ability to course correct when the institution goes astray.

This seems an ambitious set of requirements, but in light of the current absence of coordinated leadership, states have an opportunity to develop a more robust and coordinated set of institutions that govern public health. In thinking about war metaphors, war is so important that we relegate the decision-making power to go to war to the highest offices but entrust the operations and conduct of that war to specific and experienced institutional roles. We sorely underappreciate the role of leadership as an element of institutional design in public health. In his tribute to Jonathan Mann, Lawrence Gostin has noted that "leadership and politics" are important elements of public health.[28] Getting the former, however, will require some of the latter.

Conclusions

In the sum of things, wars are fought not with guns and tanks but with people. So too, with public health. A key lesson in pandemics present and past is that public health responses to communicable disease outbreaks may be helped by science but are ultimately responded to and resolved by people. The relationships those people have with those in their care is ultimately more important than any virologist's sample collection or any epidemiologist's model.

In this chapter I argued that an account of just health security establishes two things. The first is that healthcare workers accept, as part of their professional role, some personal liability in aid of resolving a public health emergency. However, that liability is not unlimited, and a public health action and response is unjust insofar as it exceeds that liability.

Second, I maintained that the legitimacy of the state confers a need for adequate leadership over a public health emergency. That leadership should inform institutional design, comprise a line of coordination for the relevant stakeholders in a response, be legislatively authorized and with the appropriate legitimacy. These qualities provide a backbone against which the remainder of an institution rests and generate the norms that individuals believe we have lost in public health. However, given the long absence of real leadership as an institutional quality, it is uncertain when—or if—that loss occurred.

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