Trust, terrorism and public health

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ABSTRACT

Policies to promote public health are based on trust. There is a danger that public trust may be lost, especially where policies are seen to be influenced by vested interests or conflict with available evidence. Although trust in public health policies in the UK is high, some commentators have questioned recent responses to the threat of pandemic flu, suggesting that they may be driven, in part, by those seeking to profit from health scares, and drawing a direct comparison with terrorist scares. We argue that the approach to evidence by the public health and counter-terrorist communities differ markedly. Public health professionals must ensure that their actions do not undermine their credibility, in particular those involved in response to the threat of bioterrorism.

Keywords

health intelligence

Commentary

Public health can only be effective if it is based on public trust; once trust is lost, it is very difficult to regain. John Major’s government refused to accept that there was even a possibility of a link between nvCJD and BSE until the evidence became overwhelming.1 This coincided with a range of government policies, on issues such as alcohol and school meals, that seemed to owe more to the protection of commercial interests than those of the public and, collectively, undermined the credibility of pronouncements on other aspects of public health.2 This was a factor in the distrust that greeted reassurances on the safety of the measles, mumps and rubella vaccine3 and, more recently, trust in government has been shown to be an important determinant of uptake of the vaccine against human papillomavirus.4 The public health community has learned lessons from these events, especially in relation to risk communication.5 Importantly, it has also benefited from taking strong stances on issues where politicians have vacillated, such as the smoking ban in England. Indeed, the campaign in favour of a smoking ban in the face of political opposition was cited by media commentators in support of the Chief Medical Officer for England when he proposed minimum prices for alcohol.6

Yet there is no room for complacency. Simon Jenkins, writing in the Guardian newspaper about fears of possible pandemic influenza spreading from Mexico, argued that the risks were being wildly exaggerated. Health scares, he suggested, ‘enable media-hungry doctors, public health officials and drugs companies to benefit by manipulating fright’ and singled out for criticism both the European Commission and the World Health Organisation.7 The following day, Ben Goldacre, writing in the same paper, recounted how he had taken numerous calls from media organizations hoping he would dismiss the growing concerns as hype.8 Some of those questioning whether there are ulterior motives behind the warning of a possible influenza pandemic are the usual conspiracy theorists, who miss no opportunity to uncover imaginary plots to create a world government that will stifle individual liberty. However, the concerns voiced by respected and well-informed media commentators such as Jenkins do need to be taken seriously. One clue to the origin of his concerns is where he writes ‘Health scares are like terrorist ones. Someone somewhere has an interest in it’.

His linkage of these two issues is understandable. Terrorists and micro-organisms pose threats that are real but are intrinsically difficult to quantify. They both require contingency measures based on limited information and an inevitable tendency to be (at least) one step behind the
threat. And of course, the two merge in the theoretical threat from bioterrorism. Yet it also poses dangers, especially when it is suggested that public health may be serving vested interests.

There is no doubt that the ‘war against terror’ has been extremely profitable for many people. Rajiv Chandrasekaran, the former Baghdad Bureau Chief for the Washington Post, has painted a picture of life in that city’s Green Zone characterized by profligate waste overseen by people with no relevant technical qualifications but the right political connections. This allowed American (and a few British) contractors, many with the same political connections, to reap enormous profits for doing almost nothing. An unexceptional example was the California-based company that was paid in full for a $500 million contract to upgrade health centres, despite completing only 6 of 140 facilities.

In the UK, the major beneficiaries have included the companies providing ever more complex (and expensive) security equipment as part of a strategy to ensure that no aspect of daily life is unrecorded, with the government’s own Information Commissioner warning of the danger that we are ‘sleepwalking into a surveillance society’. Yet, at a time when policies in other areas are being subjected to requirements to demonstrate value for money, anti-terrorism measures have largely escaped any independent scrutiny. Indeed, a systematic review conducted within the Campbell Collaboration concluded that ‘There is almost a complete absence of high quality scientific evaluation evidence on counter-terrorism strategies’ and ‘what evidence there is does not indicate consistently positive results—some counter terrorism interventions show no evidence of reducing terrorism and may even increase the likelihood of terrorism and terrorism-related harm’. One of the very few measures found to be effective was the use of metal detectors at airports to reduce hijackings, although a meta-analysis supported earlier evidence that they simply displaced terrorist activities to easier targets.

An obvious criticism of this review is that the intelligence services must possess evidence of effectiveness that would justify the measures being taken but are not able to share it with us. First, this is intrinsically counter-intuitive: as much of the measures taken defy any conceivable logic. Thus, as several commentators have noted, the accumulation of ever greater amounts of information on the activities of the public is the equivalent of trying to find a needle in a haystack by tipping another haystack on top of it, a lesson that should have been learnt from the experience of the East German Stasi. As epidemiologists researching disease clusters have long known, trawling through data with no prior hypothesis can give very misleading results.

Second, there is now considerable information in the public domain of how the intelligence services do use evidence. Here, revelations about how they came to believe that there were weapons of mass destruction in Iraq have been especially informative. Thus, the extremely detailed report of the official Commission on the Intelligence Capabilities of the United States Regarding Weapons of Mass Destruction describes how the US intelligence community displayed an ‘inability to collect good information about Iraq’s WMD programs, serious errors in analyzing what information it could gather and a failure to make clear just how much of its analysis was based on assumptions rather than good evidence’. The situation was, of course, compounded by the subsequent introduction of serious distortions by politicians, both in Washington and in London, where a particularly amateurish effort introduced the term ‘dodgy dossier’.

Other insights come from the few occasions when operational intelligence is subject to independent review by juries. Two high-profile cases attracted much media attention because of the nature of the threat alleged, the so-called ricin and liquid bomb plots. Yet although the publicity given to the arrests has ensured that they remain in the popular consciousness, it is often forgotten that no ricin was ever detected in the former case and of those accused in the latter case, only some were eventually convicted of terrorist offences, after several retrials, largely due to an inability to produce credible scientific evidence that what was suggested was actually feasible. In both cases, there are strong grounds for believing that the allegations came from suspects being tortured abroad, a notoriously ineffective means of ascertaining the truth.

The approach to evidence in the public health community is fundamentally different. Most obviously, it is subject to independent scrutiny and arguments can be challenged by those who take dissenting views. It understands the many forms of bias, both statistical and cognitive, and has developed complex methods to synthesize evidence from different sources, whether quantitative (such as meta-analysis) or qualitative, such as triangulation. This makes it easier to avoid the phenomenon of ‘groupthink’, whereby members of a group seek to minimize conflict and reach consensus without critically testing, analyzing and evaluating ideas. Crucially, it weeds out ideas that are simply fantasies, such as the reports of Iraqi attempts to obtain uranium ore from Niger, a story that recalls Graham Greene’s story of ‘Our man in Havana’, where a vacuum cleaner salesman erroneously recruited by the British intelligence service simply manufactures information. It also involves an ability to learn lessons from failings, otherwise termed reflective
practice, something that is not apparent within the intelligence community. Thus, failures to bring charges against those arrested in high-profile operations are excused by innuendoes that ‘evidence’ existed but was insufficient, an argument that is simply not credible given the current reach of anti-terrorist legislation, extending to Icelandic banks and Austrian tourists photographing underground stations.

In contrast, the ability to reflect on past failings has been crucial in developing an appropriate response to the current threat of Swine Flu, drawing in particular on the weaknesses of the US response to an earlier outbreak in 1976. Contrary to what Jenkins suggests, the media response to the current outbreak has acted largely responsibly. This is largely a reflection of communications strategies developed in advance, by the Health Protection Agency and health departments, based on a tested strategy incorporating a sophisticated understanding of risk and, with it, an acceptance that competing views should be aired and a readiness to adapt to emerging evidence. This transparent culture of critique, developed over decades, has resulted in public health having a much better track record than intelligence services of getting things right.

Cynicism about warnings of terrorist plots may even create confusion about concepts of risk, as seems to have happened to Jenkins. He suggests that the risk from Swine Flu is ‘tiny’ and that we have lost the ability to judge risk or ‘set a statistic in context’. His fundamental error is to assume that risk is static, something that is clearly not the case with the threat posed by infectious diseases. The World Health Organization has been, if anything, cautious in its upgrading of phases. Though the public health consequences of H1N1 swine flu remain, at the time of writing, very uncertain, some things should inform our understanding of the potential threat posed. These include the fact that pandemics do occur, and though we may not be witnessing one now, we surely will some time. We should also recall that it was the second and third waves of the H1N1 1918 pandemic that had the highest mortality rates. One lesson from the 1976 swine flu episode in the US was that, despite the errors made, it was still better to err on the side of overreaction than underreaction (the direct cost of the 1976 swine flu program was $137 million, less than $500 million today; the potential cost of a pandemic runs into the trillions).

A more measured approach to Jenkins’ analysis of risk and the public health threat posed by swine flu appeared in the pages of the Guardian’s sister paper, the Observer. Nick Cohen, commenting on the two contrasting stances being taken by some sections of the media, recalled Kingsley Amis’ notorious ‘berks’ and ‘wankers’. From this perspective, Jenkins is seen as a berk, suggesting that alarm was being spread unjustifiably and that no one need change their behavior because the warnings being sounded are ‘overkill’ and the World Health Organization and other public health institutions are ‘initiating panic to increase their funding and importance’. (Wankers, in Amis’ parlance, in contrast, want ever tighter controls and ‘revile [the authorities] for not being alarmist enough.’) As Cohen notes, the berks have had the best tunes for years, but the measured response of the WHO and health ministers and chief medical officers in the UK, drawing on available evidence before making pronouncements on swine flu, suggests that it is possible to find a middle way between Amis’ dogmatic protagonists. The models that many public health policymakers draw upon have embedded within them assumptions. These may be optimistic, pessimistic and sometimes hopelessly heroic. But they are explicit. Policy-making thus reflects a democratization of evidence and assumption that informs expert opinion in public health.

Our analysis has important implications for public health. First, some public health professionals working in health protection will, on occasions, have to act on the basis of evidence supplied by the intelligence services. Often the information they receive will be fragmentary and released on a ‘need to know’ basis. In the past, they might have accepted this on trust; this is clearly no longer defensible and they have a duty to ensure themselves that the information withstands critical scrutiny. However, its implications extend throughout the public health community. Rightly or wrongly, many members of the public will confuse genuine warnings of risks to public health, such as the emergence of influenza in Mexico, with what they perceive as cynical attempts to create fear about imaginary terrorist plots. Simon Jenkins has given us a timely reminder of why it is incumbent on us to ensure that we continue to place our evidence in the public domain and to accept that there is often genuine uncertainty. Only by doing so will we retain the trust of the population we seek to protect.

References


