

This article was first published in *Studies in Political Economy*, <http://spe.library.utoronto.ca/index.php/spe>

Citation: Hooker, C., and Ali, H. (2009), ' SARS and Security: Health in the ' New Normal ' , *Studies in Political Economy*, 84, Fall, 101-128

SARS AND SECURITY: HEALTH IN THE “NEW NORMAL”

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The notion of the “new normal” first claimed centre stage in public discourse shortly after the terrorist attacks of 11 September 2001 (referred to as 9/11) during a Republican Party event in which Vice President Dick Cheney remarked that “Many of the steps we have been forced to take will become permanent in American life. They represent an understanding as it is, and dangers we must guard against perhaps for decades to come. I think of it as the new normalcy.”¹ This new normalcy (or the “new normal” as it soon became known) quickly came to denote an ongoing state of uncertainty — indeed, of quasi-emergency — in which the “landscape of fear” has changed due to a diminished level of confidence that the world is as safe and secure as it once was.²

In our analysis, the new normal is a coherent set of discourses and practices that construct the world as newly insecure. It has been especially prominent in the aftermath of the various “crises” that are taken to be hallmarks of a new era of insecurity.³ As commentators from several disciplines, but above all sociology, have remarked, the contemporary world is often conceptualized as newly and inherently insecure, and insecurity exists at all levels of existence: in biology, in intimate relations and individual careers, and in governmental and economic systems.⁴ The new normal encapsulates a way of (re)constructing and responding to this insecurity, at least in the early part of the twenty-first century. What interests us is not so much the exact boundaries of the term itself (which is widely used in colloquial arenas such as blogs and in formal publications) as the parallels and links it generates across different domains: military and political, economic, and (our interest) public health.

In the aftermath of 9/11, the new normal perspective served to legitimize changes to long-held understandings of the social and legal makeup of American society, leading to a general loss of freedoms and/or invasions of privacy in various ways: by *inter alia* allowing government investigators to use roving wiretaps; tripling the number of border patrol and immigration personnel that work the Canada-US border; indefinitely detaining immigrants;⁵ and allowing the FBI to secretly access personal information about any citizen, including library, medical, education, internet, telephone, and financial records, without demonstrating that those under suspicion have any involvement in espionage or terrorism.⁶ In other words, at this time the new normal became a legitimizing discourse for American neoconservatism, a point to which we shall return below.

While the discourses and practices of national security have been worrying social commentators for some time, more recently the same kinds of worries have begun to reach into an apparently separate arena: public health. The study of health risks within public health and health promotion has been concerned largely with characterizing target populations' perceptions of specific health risks, with the aims of devising more effective interventions and generating behavioural change in a manner similar to the use of social marketing techniques directed at consumer behaviours.⁷ But since the advent of high-impact events such as the anthrax letters, mad cow disease (bovine spongiform encephalopathy), avian influenza, and, of course, the global outbreaks of sudden acute respiratory syndrome (SARS) in 2003, health academics and professionals have expressed considerable interest in, and concern about, the parallels between public health practices and measures taken in the name of national security. These concerns have developed, in part, from recent questioning of the wider context in which health promotion campaigns and health risk communication take place.⁸

We feel that the health/security nexus may be profitably explored from the critical perspective on risk developed by scholars in the Foucauldian or governmentality tradition, who have longed warned of the dangers of pursuing health promotional projects encouraged by neoliberal governments as a substitute for social welfare investments.⁹ For example, Calhoun observes that it is critical to consider not simply the prominence of risk, but also the

specific ways in which risk and threat are conceptualized, for it is through such a perspective that we can understand how the social organization of fear and the distribution of a sense of vulnerability are established within a given society.¹⁰ Our interest in the ideological influence of the new normal arose from our hypothesis that this discourse offers an insight into these issues and reveals something of how health and security issues have most recently been intertwined.

In this paper, therefore, we examine the discursive and practical convergence in politics and in public health around issues of security, and some of the consequences of this new normal. We are interested in how the expanded influence of the new normal can be seen in the arena of public health, especially as evidenced by the public health responses to the 2003 SARS outbreaks in Toronto in particular, but also worldwide. We begin by looking at which elements of the “emergency imaginary”¹¹ existed in the outbreaks to make SARS so frightening that its outcomes were framed as the new normal. We then analyze the new normal as a discursive package, and simultaneously as a specific set of government instruments and practices. We conclude by showing how these ideologies and practices shaped and justified a paradoxical form of contemporary governance — one that validates neoliberal policies of individual rather than social investments on the grounds of autonomy, but develops highly intrusive, authoritarian governing practices as a necessary consequence of those policies.¹²

The relationship between neoliberalism, neoconservatism, and the new normal was, and is, complicated. Neoliberalism and neoconservatism are often regarded as being simply contradictory: after all, the former maximizes individual capacity to act by removing government regulation and is associated with internationalism, while the latter curtails freedoms of all kinds through increased government surveillance and coercive intervention, and reasserts US national sovereignty and imperialism. Yet, in fact, the two converge in many of their values and instrumentalities.¹³ Our study of the new normal bears out the view that neoconservatism is not an irrational or arbitrary strategy, but, rather, is conditioned by structural shifts within the global political economy that are related to the dynamics and contradictions of neoliberal globalization.¹⁴ In our analysis of the new normal in

Canadian public health, these conditions of neoliberalism produced a crisis event (i.e., the 2003 SARS outbreaks), the response to which called into operation a set of neoconservative discourses and practices. The new normal was the discursive and instrumental aftermath in which both old and new practices and their ideological justifications were negotiated within a new discourse of insecurity. In the area of health and, we would argue, in other domains also, this helped to mute perceived contradictions between neoliberalism and neoconservative policies, and to enable a mix of both practices, rather than policy shifts that might sustain or transform a truly public health.

For this study, we gathered a wide range of primary source material that explicated or utilized the concept of the new normal to explore its range, discursive character, and core components. We then conducted a specialized study of the concept as it was developed and understood during the 2003 SARS outbreaks in Toronto. Our perspective is very much that of North America, where the discourse of the new normal had particular weight. We located source material relating to the new normal by using the phrase as a search term in extensive searches of sociological, media, public affairs, and public health databases, and then snowballing to saturation through article references. This material was then interpretively analyzed in light of recent compelling sociological theory on risk.¹⁵ Many materials relating to the SARS outbreaks were located through the same process, supplemented by materials and references supplied by many of the actors involved in responding to the outbreak. Additional context was provided by the two extensive and detailed commissions of inquiry held into the outbreaks by the provincial and federal governments respectively,¹⁶ and by published materials on responses to the outbreak that appeared quite frequently in medical and health sciences journals in 2004 and 2005.

Background: The SARS Outbreaks To North Americans — Canadians, in particular — SARS was scary because it was new, because it spread through coincident and contingent (hence unpredictable) circumstances, eluding informational and physical control mechanisms alike. It was scary because it was invisible: no one could tell dangerous (infective) people from “innocents.”¹⁷ It shared these characteristics with the other defining concerns

of the new normal: economic catastrophes, natural disasters, and terrorism. SARS was also terrifying for the simple reason that it exposed significant weaknesses in health care systems, rendering the very places of care and security insecure.

The first two points are illustrated in the story of how the outbreak began.¹⁸ SARS took Canada by surprise. Although on 19 February 2003, Health Canada had recommended that all provinces be vigilant for influenza-like illnesses in travellers returning from Hong Kong or China, as a result of information from internet reporting systems about an outbreak of (what was then described as) atypical pneumonia in Guangdong province, the index case in Toronto went unrecognized. SARS came to Toronto through a single moment of coincidental contact: an elderly Toronto woman, in Hong Kong for family reasons, shared a hotel elevator with a doctor who had treated patients with atypical pneumonia in Guangdong. This woman became ill two days after her return home to Toronto and died shortly thereafter. The index case went unrecognized in Canada until 7 March, when her 44-year-old son, Mr. K, arrived in the emergency waiting room of Scarborough Grace, a major Toronto hospital, with high fever and difficulty breathing. There the disease spread through coincidental contact, as many patients, staff members, and visitors were exposed to him during his 18-to-20-hour stay in the open observation ward of a busy emergency department while awaiting admission to intensive care, and as a result of a contingent circumstance — the need for intubation (a tube inserted into the trachea), an act that is potentially capable of transforming infectious droplets into an infectious aerosol. Thus, Mr. K became the originator of the first SARS cluster in Toronto, which quickly spread to other major Toronto hospitals as the infected carried the disease to more emergency waiting rooms and more and more staff.

What was terrifying about SARS in those early days was that, to the committee of senior physicians and medical officers for health that advised the Ontario government about infection control measures during the outbreak, it looked like “another 1918” (referring to the 1918 Spanish flu epidemic that led to the loss of an estimated 20 to 40 million lives worldwide).¹⁹ The committee was particularly worried by the 30 March outbreak

of 324 SARS cases among residents in an apartment complex in Hong Kong, which arose from a single resident's casual contact with a SARS patient. This outbreak led the advisory committee to believe they were witnessing fast-paced community spread, with transmission adaptive to varying circumstances, and to recommend containment measures on an enormous scale. On 26 March, with one hospital (Scarborough Grace) closed, all negative pressure rooms in the city in use, and 10 infected hospital staff members waiting for admission while others waited to be examined, a state of emergency was formally declared. Social distance measures, including school closures and event cancellations, were instituted. Close to 30,000 people were examined for quarantine,²⁰ and 800,000 travellers were thermally scanned for raised temperatures, though no one needed further medical treatment.²¹

There is no doubt that SARS generated a strong sense of insecurity, resulting as much from the containment measures as from the mortality and morbidity the disease caused. Saturation media coverage, especially the "SARS soap" — the daily 2 pm press briefing — and the disruptions wrought by social distance policies contributed to a sense of crisis. Quarantine was immensely stressful, leading many subjects to have anxiety attacks, nightmares, and raised blood pressure.²² With hospital closures and an inefficient and outdated data management and communication system between three levels of government, health resources were massively overstrained.²³ More people died from their inability to access full care during this period than died from SARS itself.²⁴ Airlines were nearly bankrupted and tourism to Ontario was decimated, while Torontonians avoided Chinatown and restaurants remained empty. The total cost of the SARS crisis was eventually reckoned in the billions of dollars.²⁵ The sense of insecurity was heightened by a second Toronto outbreak — a second wave hit two weeks after officials thought the first was contained, spread by a patient with unrecognized symptoms.

Even though the outbreaks lasted only a couple of months, and, in the end, the death toll (44) from SARS was miniscule compared with common forms of preventable death such as car accidents and smoking-related illness, the economic, institutional, and personal recovery from SARS was slow and

difficult. Parallels were drawn between the experience of SARS and that of the 9/11 attacks on the World Trade Center in New York and with other emergencies,²⁶ especially with respect to a novel, communal sense of insecurity that has become subsumed under the emergent hegemony of the new normal.

The New Normal and Infectious Disease as Security Threats: Discursive

Dimensions The primary influence of the phrase “the new normal” is at the discursive or ideological level: it constructs the world as a newly insecure place, with particular concomitant requirements for action. One aspect of this insecurity is that adverse events are expected to be sudden, acute, and catastrophic, erupting in the midst of apparent stability. In the new normal, individuals are to consider their world as always in danger of sudden, unexpected, and cataclysmic collapse. Incidents related under the banner of the new normal include terrorism, outbreaks of emerging diseases such as West Nile virus, mad cow disease and haemorrhagic fevers, and environmental disasters, such as the 2004 tsunami or Hurricane Katrina. One corollary is that in the new normal, security is always deceptive. Things previously considered safe and secure — one’s home or workplace, hospitals, letters, neighbours — turn into risks. One journalist, lamenting the lost innocence of her children in the year of 9/11, the anthrax letters, reports of child abductions, war and shooting deaths, summed up the new normal as “a sniper day.”²⁷

The new normal has given a new discursive twist to the longstanding close relationship between public health and what in the past might have been called national security.²⁸ Protecting the health of the people from external plagues has been a government function since fourteenth-century city-states imposed quarantine — a 40-day waiting period — on incomers in an effort to exclude bubonic plague.²⁹ Now, after some decades in which public and political attention was turned more to the internal lifestyle threats to health, this function has become important again with the rise of the Emerging Diseases Worldview.³⁰ Nicholas King has argued that, recently, medicine has become increasingly concerned, at the highest levels of government and research (including the Centers for Disease Control and the World

Health Organisation (WHO)), with “new and re-emerging infectious diseases,” that is, entirely novel diseases, such as SARS, diseases that are spreading beyond their traditional geographical boundaries, and diseases that are resistant to standard treatments, such as tuberculosis and cholera. These diseases are viewed as posing a global threat, and considerable resources are devoted to tracking and combatting them. King argues that these concerns, and the methods of response to them often undertaken by Western nations, principally the United States, constitute a new paradigm of international health, which he terms the Emerging Diseases Worldview.

This worldview provides actors with a consistent, self-contained ontology of diseases whose incidence in humans has increased dramatically during the last two decades, or that are spreading to new geographical areas, including their causes and consequences, the patterns of risks they present, and the most appropriate methods for the prevention and management of such risk.³¹ It is notable that, under the Emerging Diseases Worldview, federal funding in the United States is funnelled through the Defence Department.³² Likewise, it is significant that although this worldview discursively reconstructs colonial era structures — the concern that centres might become contaminated by Othered peripheries — it has to simultaneously accept that the connective effects generated by a globalized world tend to render traditional responses, such as segregation, ineffective. Consequentially, the Emerging Diseases Worldview has begun to stress the importance of informational practices in pre-emptively identifying and managing risks before they became epidemic threats to the centre. These discursive dimensions significantly shaped responses to SARS.

The SARS outbreaks produced a convergence between the Emerging Diseases Worldview and the discourse of the new normal. This convergence was strongly present in the news media. The media made frequent allusions to other catastrophic diseases (e.g., Spanish flu, AIDS, and West Nile virus), and their associated death tolls were often used to illustrate the devastating potential of SARS,³³ thus reinforcing the Emerging Diseases Worldview. The association of the new normal and the Emerging Diseases Worldview is frequently and implicitly alluded to by officials quoted in the media, as in this typical excerpt from the Director of the US Centers for Disease

Control: “The rapid-fire-emergence of diseases like SARS, West Nile virus, monkey pox, and avian influenza point to a future where new and serious health threats arise on a regular basis from nature. We are living in a new normal.”³⁴

One product of this convergence is the call for an explicit “health security” paradigm³⁵ in which infectious diseases are seen as undermining national prosperity, governance, control of state territories, and regional authority. In this context, therefore, it is not surprising that a state security agency — the Central Intelligence Agency — prepared its own report entitled “SARS: Lessons from the First Epidemic of the 21st Century: A Collaborative Analysis with Outside Experts.” This report itself is an archetypal illustration of the new health paradigm in practice. For example, the report notes that:

The early containment of SARS in the United States was greatly facilitated by existing bioterrorism preparedness measures, as officials from health, security, and public safety communicated with and, in many cases, trained together before the advent of the disease in the United States.³⁶

Another example of the renewed association of public health with the domain of security and disaster management is illustrated by the fact that the Chief Coroner of Ontario, Dr. James Young — a physician centrally involved in the Toronto SARS response — was appointed to become Commissioner of Emergency Management for the province.³⁷ Soon leaving to take the position of Special Advisor to the federal deputy minister of Public Safety and Emergency Preparedness Canada, Dr. Young was replaced by the former chief of the Toronto Police Service³⁸ — a move that also illustrates the association of health and security with defence considerations.

The ideological support for the development of a new health security paradigm based on merging the Emerging Diseases Worldview with the new normal, and health with defence issues, is also evident in remarks made by former US President Bush: “By putting in place and exercising pandemic emergency plans across the nation, we can help our nation prepare for other dangers — such as terrorist attack or using chemical or biological weapons.”³⁹

Despite the rhetoric, it is interesting to note Mike Davis’s findings that the budget for the US Centers for Disease Control’s emergency public health

assistance was cut by one-eighth in fiscal 2005.⁴⁰ Second, Davis notes that although the US government's program on bioterrorism (Project Bioshield) received increased funding — from \$3 billion in 2002 to \$5 billion in 2004 — the vast majority of the funding was not directed towards the more likely disease threats (such as a pandemic of H5N1 influenza), but towards those highly unlikely and exotic bioterrorist pathogens (pathogens that could be “weaponized,” such as anthrax).⁴¹

In the health security paradigm, however, emergency planning is not simply a matter of state governance. The new normal is host to disaster management consultants who utilize discourses of insecurity to promote (their versions of) individual and local preparedness. One author, a disaster management consultant, writes that:

Today's world is an uncertain one — no one knows what will happen, or when. This is the 'new normal.' In the new normal, there are events you cannot control, regardless of what you do ... acts of terror have taken away the sense of security of many American citizens ... Solutions for living in the new normal must limit risk and maximize the ability to respond to crisis. This requires a subtle shift from full dependence on government protection to increased local responsibility.⁴²

This shift from dependence on government protection to increased local responsibility is telling. Despite the rhetoric of national security with which the new normal is so closely linked, and which, at an official level at least, has produced the health security paradigm, it seems that a significant aspect of it is discursively congruent with the ideologies of devolved government and individual responsibility that have subsisted in much of the English-speaking west for the last couple of decades, under the broad label neoliberalism.⁴³ And neoliberalism, we suggest, provides the basic political and analytical frame for the practices of the new normal, by generating the conditions for catastrophe while at the same time providing the ideological justification for responses to it.

Gary Alan Fine notes that the responses to one particular social problem may create the conditions for generating another type of social problem; he refers to this process as the “chaining of social problems.”⁴⁴ For example,

banning alcohol during Prohibition may have established the groundwork for the strengthening of organized crime syndicates and an increase in the crime rate in general.⁴⁵ Similarly, an unintended effect of the “war on terror” and the new normal may be a sort of domain expansion in which the potential arises for draconian control measures to be applied to other social sectors, such as the public health sector, on the basis of “crisis politics.” In this connection, it is perhaps instructive to consider the frame or “schemata of interpretation”⁴⁶ of the new normal, particularly as it relates to the process of “frame alignment,” that is, the grafting or incorporation of a new frame on an existing interpretive scheme.⁴⁷ In relation to the new normal and public health, the SARS outbreak could be considered a catalyst in which existing public concerns about security in the aftermath of the terrorist attacks could be extended to the field of public health. At the same time, however, the process of frame alignment may not be complete; rather, an ideological fissure in alignment of two frames may serve as an opportunity for a reflexive questioning of the taken-for-granted sense of reality held by citizens. We explore this latter potentiality in the following section.

SARS and the Critique of Neoliberalism At one level, the SARS outbreaks provided the basis for a critique of neoliberalism to resonate outside of academic circles. This resulted largely from the very public commissions of inquiry that all levels of government held into the outbreaks, each of which attributed the length and impact of the outbreaks, if not their original cause, to the neoliberal policies of the preceding two decades and called for nothing short of a renewal of public health in Canada. Here, we summarize some of their major findings.⁴⁸

Facilities and Hospital Resources The son of the index case went to the emergency department of a major Toronto hospital. There, he spent several hours in a crowded room awaiting admission, and following admission he was treated in a ward surrounded by only a cloth partition. This resulted in the virus spreading to his family, other patients and visitors to the hospital, and several staff members. The number of staff members who rapidly became ill led to the closure of this hospital. Patients were distributed elsewhere.

The patients were distributed among different hospitals because of a lack of resources — both of available beds and of negative pressure (total isolation) rooms — and, thus, the outbreak was spread through the local hospital system. Later in the outbreak, due to a lack of resources, hospitals found themselves unable to implement Ministry of Health infection control directives, such as the requirement that all personnel wear fit tested N95 masks.

Emergency Preparedness and Communications Structures The province declared a state of emergency 10 days after the admission of the second patient. Yet the work of containment was severely hampered by lack of communications resources. Contact tracing and epidemiological tracking by Toronto public health officials proceeded without adequate information systems, using whiteboards and post-it notes because a computerized tracking system was not in operation as a result of funding shortfalls. There were difficulties in sharing and accessing information between the three levels of government involved — municipal, provincial, and federal — and between the provincial emergency operations centre and health care staff in hospitals, doctors, and other health workers. Hospital staff found it difficult to get ministry data on SARS, and found some of the communications mechanisms — such as a daily teleconference involving literally thousands of communications or infection control staff from hospitals around Canada — unworkable. This inadequate communication was blamed as a major contributor to the WHO travel advisory.

Personnel and Human Resources Shortfalls of health care workers were felt in every sector, and lack of personnel strained system capacity to the limit during the outbreak, with most responders working 16 to 18 hours a day. The worst human resources issue lay in nursing. As a result of neoliberal hospital workplace reforms in the 1980s and 1990s, a majority of the nursing staff members held casual positions — their jobs were not permanent or full time, and hence they had no access to benefits, such as sick leave. Many nurses worked shifts at three or four hospitals per week to generate an adequate income. Since nurses were the primary group infected by SARS, this political economic circumstance raised the risk of transmission between

hospitals considerably. It also generated difficulties for securing care for SARS patients at all. Lacking loyalty or trust in their institutions, many nurses were skeptical that the infection control measures put in place in hospitals could secure their safety, and some refused to work with SARS patients. Furthermore, nurses felt economically coerced in response to SARS, since they were first limited to working at only one hospital, which diminished their income, and those confined to working at a SARS hospital faced the choice between a further drop in income or working with patients who placed them at risk of infection. The SARS commissions of inquiry stated flatly that the province needed to reach a goal of having a minimum of 70 percent full-time nursing staff in order to have a workable public health system.

Outside the health system, two decades of neoliberal policies that had dismantled industrial relations agreements had left employees vulnerable in ways that could have an impact on an outbreak. People placed in quarantine were not guaranteed job security, nor paid for their leave of absence, and although compliance was high, there was significant incentive for unauthorized returns to work. A few such cases led to spectacular mass quarantines and severe economic losses.

The lessons were quite evident. Toronto need not have experienced an outbreak beyond the first affected family and its immediate caregivers at all if only emergency rooms were better equipped and less crowded, which would require offering sufficient health and social support services to the community to reduce the demand for emergency care. It could have been limited to one hospital if that hospital had been adequately resourced and had a full-time staff that could negotiate care. Even if it had spread, it could have been contained with adequate communications systems to trace contacts, limit the number of quarantines required, and support those in quarantine. As it was, by the time the SARS outbreak was over, the WHO had issued a travel advisory against coming to Toronto, the province had lost billions of dollars in revenue, and more people had died from an inability to access medical resources than from SARS itself.⁴⁹ Public health professionals were shaking their heads over the strain on resources that SARS had imposed, wondering how the province would cope if the coronavirus had turned out not to be so obligingly low in its transmissibility, or somewhat

more fierce in its mortality rate.

The Commissions of Inquiry were utterly straightforward in their critique of the policies that had so amplified the outbreak and in their recommendations for the remedy, that is, a revitalized, transformed, public and publicly funded health system. Certainly in the political fallout that resulted from SARS, some of their recommendations — such as building a new centralized public health agency, a kind of CDC north — were subsequently pursued. But not only were the provincial and municipal governments struggling with enormous budget deficits — a result of policies that downloaded service provision responsibilities from federal to provincial to municipal control, with fewer resources to meet these new responsibilities⁵⁰ — the lower tiers of government were somewhat hamstrung in any desire to make the recommended post-SARS structural changes because these needs were deftly set aside by the discourse of the new normal, which proposed a mix of authoritarian intervention and individual responsibility as an ideological and policy solution.

Infection Control: An Imposed Response Government responses to the SARS outbreaks reveal two apparently contradictory political principles at work. The principles of neoliberalism required the retreat of government intervention from public life, with the responsibilities for public health and security increasingly being downloaded to the local level and ultimately to the individual.⁵¹ At the same time, a second countervailing force could be identified in terms of a response to the outbreak based on an hierarchical, authoritarian, command-and-control model of governance,⁵² which is normally associated with neoconservative thought.⁵³ The hegemony of the new normal in the arena of public health is thus based on tension between these two ostensibly competing forces. The neoconservative tendency within the ideological context of the new normal may represent an attempt to reassert state power under circumstances in which much of this power has been relinquished to individual capital and private corporations. As such, state power under the reactionary circumstances of the new normal is further intensified and reasserted in those areas in which the state has traditionally retained and exerted controlling power, namely public health and what are

commonly referred to as public security controls. There are striking parallels in the governmental approaches to the regulation of these ostensibly different domains within the new normal context, especially in the hybrid instrument of border management.

Border management became a key ideology and instrument because the threat of both new infectious diseases and terrorism were similarly conceptualized in two ways. First, the threat of terrorism in western nations after 9/11 — an influential discourse often explicitly associated with the outbreak of SARS⁵⁴ — and the threat of a pandemic have a commonality in that both are conceived of as external threats from distant and contaminating Others — dangerous Others that, in common parlance, “do not respect borders.”⁵⁵ For this reason, border security has become an increasingly significant political concern, and issues related to the movement of “certain types” of people and pathogens across borders has become increasingly prominent. As an activity, travel is a site of especial concern and surveillance. SARS has been considered the exemplar of a new type of threat: a disease of travel.⁵⁶

Secondly, the problem of confronting both threats was constructed in the same terms that bedeviled professionals in both health and criminology in the past: the problem that Foucault described as that of the dangerous individual.⁵⁷ Dangerous individuals were those in whom danger is considered somehow inherent, but who are unpredictable in their capacity to cause harm. They are terrifying because they bear no sign of their dangerousness and so their actions cannot be prevented. At different historical moments, asymptomatic carriers of disease have been constructed as enormously threatening for these reasons,⁵⁸ as was the undiagnosed SARS patient, spreading the deadly infection through casual and momentary contact with others, a quintessential embodiment of that part of the “emergency imaginary” concerned with pandemic illness.

The problem with dangerous individuals is that they are virtually impossible to identify before they cause harm, and even if identified, virtually impossible to contain or neutralize, for logistical reasons if for no others. Yet various forms of neoliberal government have nonetheless gone to extraordinary authoritarian measures in order to accomplish these twin projects of identification and containment, which are also central to the new normal.

Let us consider the attempts at the surveillance of travellers during the SARS outbreak — a border control practice that was considered explicitly in public health circles as one of the instruments that defines the new normal. Canada issued leaflets of different colours to both incoming and outgoing passengers at all international airports and at many land borders.⁵⁹ The leaflets detailed SARS symptoms and requested that passengers who had experienced these symptoms, or had been in contact with any possible SARS cases, to self-report to a public health nurse. By July, one million people had received the leaflets and 3,000 had been examined by a nurse. In addition, Canada began compulsory thermal screening of air passengers for raised temperatures and scanned 800,000 people by the epidemic's end. In Hong Kong, 90 million people were screened at the border; in China, thermal scanners were established internally and scanned all travellers to and from Beijing, screening 14 million people. In other countries, a further 31 million air travellers were screened for SARS.

These extraordinary surveillance measures were proven to be entirely ineffective: of 120 million scanned air travellers, 26 probable or suspect cases of SARS were identified. In Canada, between March and May, only five people infected with SARS entered the country, and none were symptomatic while flying or in airports. The problem lay with the nature of the disease as well as with the nature of social and economic relationships. Some 10 percent of all travellers contract a respiratory illness or fever on their journey, according to one study⁶⁰; it was next to impossible to screen precisely for travellers affected by SARS, whose early symptoms are indistinguishable from a range of other illnesses. It was hard to track travellers inbound to Canada because so many stopped and transferred aircraft somewhere on the continental United States. Moreover, a small but significant percentage of travellers were likely to have strong emotional and financial incentives to ignore travel advisories and to elude screening techniques. The author of one study concluded that “interventions at borders should not detract from efforts to identify and isolate infected persons within a country”⁶¹; another concluded that the money Canada spent on the thermal scanners would have been much more effective if used to staff and resource the hospitals actually combating the illness.⁶² Retrospective reports similarly concluded that the majority

of imposed measures — i.e., quarantine, social distance (such as school or function closures), hospital closures, no-visitor policies and the like — were similarly ineffective at best, and downright harmful at worst.⁶³

Yet these strategies, along with calls to give health officials speedy access to comprehensive passenger information on all aircraft globally, are expected to be a continued important feature of infection control in the new normal. Each nation is to take responsibility for patrolling its borders, using all information systems possible, with people self-propagating these infection control systems through self-report and contact identification. Suspicion will be first directed at particular kinds of travellers from particular areas — a geography marked by illness more than by race, but in which illness, class, and race are expected to be frequently associated.

Ronen Shamir has noted that, although much of the emphasis in the literature on globalization deals with those issues of cross-border exchanges and transactions in terms of networks, flows, and transnationalism, there may now be a need to focus on how certain reactions to these types of globalization processes are unfolding, particularly those measures that attempt to prevent movement or block access across borders.⁶⁴ In this connection, Shamir identifies the existence of what he terms a “global mobility regime” that seeks to actively contain social movement both within and across borders. Notably, this closure orientation is based on a “paradigm of suspicion” in which individuals and groups are classified according to principles of perceived threats. In essence, the paradigm of suspicion is based on an ideological position that conflates the perceived threats of crime, immigration, and terrorism — and to this we would add, threat of infection. At the same time, it should be kept in mind that the relationship between ethnicity and the threat of infectious disease (and its associated racist overtones) has a long history, as exemplified by the imposed quarantine and razing of Chinatowns in western nations to deal with various disease threats in the early twentieth century.⁶⁵

A couple of considerations and qualifications should be noted in comparing the responses to terrorism versus the threat of infectious disease. First, unlike border patrol in the United States after 9/11, the surveillance and border control measures in response to SARS were not likely intended

to represent significant, ongoing infractions of privacy and human rights, nor were the consequences of being detected intended to be inhumane. Nevertheless, they do validate and make use of extensive border control systems that identify nation-states as a primary means of infection control. Or rather, in an era of globalization, these infection control procedures reproduce national identity and nation-state power in an age of viral assaults. These disease control procedures also highlight the need to consider certain ethical questions in regards to the relationship between health, security, and civil rights in the new normal. For example, Gostin et al., in an article in the *Journal of the American Medical Association*, raise the following questions: what limits are justified by surveillance designed to characterize SARS outbreaks, permit contact investigation, and open the way to other interventions? What restrictions of movement and economic liberty are justified by travel advisories to and from areas with SARS?⁶⁶

Unlike the case of terrorism after 9/11, issues related to the infringement of civil liberties received much more prominent attention in public health reflections on SARS. Too much scrutiny, and too much intervention in the general public at large, led both to public resistance and, more significantly, to people hiding signs of illness out of fear of stigmatization. However, the level of sensitivity afforded to these types of issues varied from place to place with respect to the SARS outbreak response. In Singapore, responsibility for the conduct of tracing was assigned to the military, and in Hong Kong to the police. Furthermore, in Singapore thousands were subjected to quarantine, while authorities used thermal scanners, web cameras, and electronic bracelets to enforce quarantine, supervised by a security agency; in Hong Kong, the police department's electronic tracking system was used to enforce quarantine.⁶⁷ There was no international agreement about where appropriate lines could be drawn — in some countries, the names of superspreaders were made public.

A second set of related issues involving the use of border control perspective on infectious disease control involves important questions about personal stigma, group prejudice, and the economic viability of businesses, cities, and countries.⁶⁸ There is no doubt that, in Toronto, the outbreak produced various forms of negative stigmatization of people of Asian backgrounds,

and of health care workers.⁶⁹ Clinical staff worried about patient confidentiality when one of their number became ill, while the practice of singling out those infected on the basis of racial or ethnic characteristics was an especially problematic issue during the SARS outbreak. Notably, such a process of Othering has particular implications for the recasting of infection control as border control in the context of globalizing forces and the new normal. In this connection, Ungar notes that “the strategy of othering is a direct counterpoint to the theme of globalization. . . . Whereas globalization is predicated on a leveling of nations and individuals, othering aims to reverse the rites of inclusion and protect the social order by erecting barriers of exclusion.”⁷⁰ In a sense, these two countervailing forces identified by Ungar are perhaps different manifestations of the contradictory forces of neoliberalism versus neoconservatism that reach the tenuous balance that characterizes the new normal condition. This is illustrated, for example, in the way a respondent in a study conducted by Leung and Guan drew comparisons between what happened with SARS and Chinese and Southeast/East Asian communities with other events that greatly affected other groups:

SARS reminds me of things like 9/11 when Muslim and South Asian communities were targeted. They were treated like they are all responsible for terrorism. It's racial profiling. Members of those communities have also talked about how they get regarded differently. There are similarities there.⁷¹

Furthermore, Leung and Guan found that, in the mainstream media coverage of the SARS outbreak, there was a heavy reliance on already existent and circulating ideas about immigrants as a threat to national security and health.⁷² This association of race/ethnicity and the disease threat is also pertinent to other people and diseases. For example, Markel and Stern note the current concerns about immigrants introducing drug-resistant tuberculosis into American cities and the relatively recent quarantine of Haitians suspected of HIV seropositivity on Guantánamo Bay, Cuba.⁷³

This type of Othering process seen in the response to SARS was also quite evident within the broader context of the new normal. One indication of this is illustrated by an agreement reached between Canada and the

United States to share advanced passenger information and passenger name records on high-risk travellers destined to either country. As Zureik and Hindle note, although the agreement does not spell out what constitutes high-risk travellers, it is becoming clear that the designation refers to people of colour, minorities, immigrants, and refugees, and according to these authors, such policies of exclusion and categorization of national groups do not bode well for multicultural societies, among which Canada occupies a special position.⁷⁴

The new normal that health care workers in Canada spoke of in the aftermath of the SARS outbreaks was, of course, not a dystopia of rights-infringing, mandated limits on human movement and expression whose result was not infection control, but the stigmatization of particular social groups who could be successfully blamed for the crisis, as Jews, foreigners, and other unwanted Others have been in the past.⁷⁵ In public health contexts, the new normal was more about border control within health care settings, and these multiple borders — e.g., between skin and air, patient and doctor, instrument and body, room and room — were to be carefully policed, not by authoritarian fiat so much as by the care and self-discipline of health care professionals. For them, the new normal was not more sinister than an era of constant glove, mask, and gown wearing (even in routine paediatric consultation) and immensely detailed new sterilization and hand-washing techniques.⁷⁶ As the Director of Health Canada's Centre for Emergency Preparedness and Response put it:

The old concept of quarantine at the border is outdated. The new 'border' for infectious diseases in Canada is the door of our hospitals, not the airport. There is a need for rapid detection, diagnosis and response capacity, principally in hospitals.⁷⁷

The fact remains that, even in the critical context of public health, the discourse of the new normal made border control the central focus of policy attention: a set of practices that invited government action (for example, in the form of influenza preparedness planning committees) that was easier to take than rebuilding the public health infrastructure lost to neoliberal policies, in the way the commissions of inquiry suggested.

Conclusion This analysis of the responses to SARS in Toronto, and worldwide, reveals the “new normal” as a discursive authorization of what might otherwise appear as the contradictory intrusion of neoconservative instrumentalities that emphasize control and management of the population under the mantle of security into (ongoing) neoliberal policies that emphasize the rule of the market, including the privatization and individualization of responsibility in all spheres of social life, including health.

As such, the new normal represents the latest version of the liberal problematic of security in governance. It both validates neoliberal policies and justifies the reimposition of authoritarian government in order to maintain security. In fact, in an age of globalization, we argue that infectious disease control has been a primary mechanism for the reassertion of state power and of some forms of national identity. This is occurring despite some investment in forms of multilateral surveillance and global public health governance.⁷⁸

We have argued that neoliberal policies in Canada — i.e., decreases in public health funding, the casualization of nursing staff, a lack of surge capacity, a lack of coordination between health agencies, crowded hospital waiting rooms, and the absence of up-to-date electronic epidemiological tracking systems — contributed to two terrifying outbreaks and to a socially and economically problematic outbreak response in Toronto. In the ideology of the new normal, critiques of such policies, and concomitant policy solutions requiring substantive investment in public health systems, were often not pursued by provincial and federal governments, in favour of validating authoritarian interventions and constructing a new notion of good citizenship in which obedience and the acceptance of restrictions on liberty, especially liberty of movement, is regarded as central.⁷⁹ At the same time, the basic principles of neoliberalism were ostensibly reinforced and legitimated by calls for all citizens to be self-responsible for emergency preparedness, as well as by those issue entrepreneurs, such as those selling security technologies, who exploit this ideology for profit. (Marcuse notes, for example, that sales in private security measures for individuals have increased exponentially since 9/11).⁸⁰ Many of the impositions on citizens made in the name of controlling SARS were relatively benign as compared

with civil liberty infractions generated by the provisions of national security in the United States after 9/11, largely for pragmatic reasons. (Infectiousness, unlike terrorist intentions, is a time-limited quality, and illness is not a secret to be uncovered through surveillance and torture.) Measures taken against HIV-affected individuals in some countries, or against those with leprosy in the all-too-recent past,⁸¹ remind us that this may not always be the case. The fact remains that, in both cases, the new normal has had unhappy results in the production of stigmatized social groups constructed as particularly risky, if not dangerous, individuals and of distanced, stressful, self-patrolled social interactions. The positive aspect to responses to the new normal for public health is renewed interest in public hygiene. The tough part is the physician stuck forever behind a mask despite the contradictory desire for bodily and facial significations of care.⁸²

Fortunately, SARS proved to be relatively easily contained, but, as the experts all warn, pandemic influenza will likely prove to be another story.⁸³ Such a drama is unfolding, with the WHO moving to pandemic phase 6 (that is, declaring a pandemic) with respect to the recent outbreaks of H1N1 (swine influenza), and many countries around the world activating their pandemic plans in consequence. These actions demonstrate the ideological and practical continuation of the security measures enacted after the outbreaks of SARS and the increasing securitization of health.⁸⁴ The most dramatic responses to SARS (i.e., hospital closures, quarantines, and so on) of course lasted little longer than the epidemic itself, but the new risk-management structure, expressed through various states' pandemic plans and their coordination through post-Westphalian institutions of governance,⁸⁵ is long lasting.

The new normal cannot and ought not to be the unmooring of government practice from established principles and procedures of justice, process, ethics, law, and, we would add in a health context, care. In fact, it should be the reverse. From the point of view of those in authority who responded to the outbreak and those who examined their response, the key to addressing the radical insecurity and uncertainty of the new normal lay in investment in state-based collective action. Certainly some part of infection control was imagined to require authoritarian intervention, such as maintaining

quarantine. But, here, the principles of precaution, low intrusion, justice, sensitivity to minority rights, and transparency need much more careful consideration in shaping health policy in the future. Special attention needs to be drawn to such matters because the emergency imaginary of the new normal has the dangerous potential tendency to naturalize (and therefore to depoliticize and make it appear as socially necessary) the need to violate civil rights under the guise of security (a proclivity noted by C. Wright Mills (1957) some time ago in regards to national security interests within the context of the Cold War — as opposed to today's War on Terror).⁸⁶ Such tendencies are not only morally unpalatable, ironically they are likely to exacerbate disease outbreaks in the future by discouraging those who are ill from seeking proper medical treatment for fear of social and political mistreatment.

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