The Ashgate Research Companion to Moral Panics

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Is This One It? Viral Moral Panics

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As infectious diseases retreated in the first half of the twentieth century because of a combination of medical and socio-economic factors, the US Surgeon General informed Congress in 1969 that it was conceivable to “close the book on infectious disease” (Garrett 1994). Perhaps the gods were riled by such hubris, as these diseases have resurfaced and become a major source of social anxiety. While penicillin seemed to provide a magical jab, new forms of resistant gonorrhea, followed by herpes and then AIDS revived the threat of sexually transmitted diseases. Tuberculosis made a comeback in a multi-drug resistant form and other bacteria, such as MRSA, also evolved in ways that rendered them exceedingly difficult to treat. Swine flu Fort Dix, Ebola, mad cow or CJD, West Nile, SARS, avian flu, and swine flu redux or 2009 H1N1 have all engendered dire warnings of runaway outbreaks and prompted concerted societal efforts to contain them.

While prediction (especially of the future) is always difficult, it is evident that none of the above-mentioned apocalyptic forecasts materialized. These recurring exaggerations seem to fit, at least with hindsight, the disproportionality criterion central to moral panics (Goode and Ben-Yehuda 2009). Applying the concept of moral panic, this chapter seeks to retrodict the abiding tendency to treat every new and emerging viral outbreak other than the seasonal flu as if it portended an all-but-unprecedented catastrophe. Since volatile discourses have become routine reactions to viral upsurges, it aims to show that there are converging and reinforcing conditions and processes that promote sensational claims making.

The deep structure of fear generation is linked to enhanced contagion monitoring and associated technological innovations that render organized responses feasible and thereby create a moral incumbency on political and medical authorities—the “guardians of public safety”—to respond in a timely way.

Whereas the sensational claims made by these guardians of public safety have generally provoked corresponding reactions by the media and local health providers, there are signs of attenuated effects in the public realm. Compared to conventional moral panics, which are often localized epiphenomena with impacts more symbolic than real, viral moral panics typically involve efforts to use morality to regulate public behaviors. Principled obligations include calls to stay at home when symptomatic, to conform to applicable quarantine regulations, and to be
vaccinated. As the target of widespread attention, fears, and social engineering, viral moral panics also tend to become constituents of the collective memory and hence fabled resources with metaphorical import. Ebola, for example, has become the touchstone of terrifying and deadly exotic diseases. Swine flu Fort Dix is recalled as a fiasco, with an ill-fated vaccination program for an epidemic that never happened. Wild predictions about West Nile, SARS, avian flu, and the recent outbreak of swine flu have also accumulated in collective memory, and the reception of the last in Toronto revealed elements of distrust and resistance that seemingly recall this record of overblown scares. As events unfolded, guardians of public safety lost control over the moral panic they fomented and were confronted by a range of disagreements that converged in opposition to the vaccine.

**Moral Panic in Flux**

Moral panic is approaching its fortieth anniversary, but that has done nothing to slow down its development. Indeed, we are witnessing a variety of efforts to redefine and refocus the concept. These can be seen in the publication of a Special Issue of the *British Journal of Criminology* (2009), as well as the substantially revised second edition of the well-known book by Erich Goode and Nachman Ben-Yehuda (2009). In its totality, this work pries open virtually every aspect of the concept, from its definition to whether it retains any value. Sociologist Sean P. Hier (2008), for example, seeks to subsume moral panic in a broader conception of the moralization of everyday life. Chas Critcher (2009) finds the idea of moral regulation problematic, concluding that it obscures the very idea of moral panic. Taking a heretical position, sociologist Stuart Waiton proffers “a new framework of amoral panics” (2008: 104, emphasis in original). At the same time, Goode and Ben-Yehuda (2009) update their fairly conventional model and mount a spirited defense against revisionists. All this activity can be seen as either a sign of renewal or an indication that the concept has lost its footing.

This chapter does not address these conceptual developments directly but rather examines the use and value of moral panic in understanding societal reactions to viral outbreaks. Work on moral panic has largely developed around deviance and youth (for example, Krinsky 2008). In this context, the focus has been on disproportionality. Whether we move from Stanley Cohen’s (2002) first detailed description of the concept in 1972 through his subsequent statements, review the bulk of the empirical research, or examine the media use of the concept to confront politicians for trying to “incite” panics (McRobbie and Thornton 1995), the common element is a perception that expressed fears and hostilities are out of proportion to the actual threat. Such exaggeration encapsulates the political agenda motivating this research domain: specifically, the power of moral entrepreneurs to exercise social control by amplifying deviance and orchestrating social reactions. Disproportionality is also a *leitmotif* among social constructionists. They are keen on showing that social reactions are largely determined by the activities of claims
makers rather than the objective standing of the condition (Ungar 1998a). An ideal constructionist research paper reveals that a condition is improving even as claims makers successful foment a moral panic about it.

Critics of disproportionality focus on the problem of measuring and specifying the seriousness of the objective threat (Critcher 2009, Hier 2008). Thus, Hier (2008: 178) observes that we are “short of some reliable indication of what constitutes a realistic level of concern, anxiety, or alarm.” He further notes that researchers commonly belittle reactions to the putative threat, viewing them as “irrational” (Hier 2008: 180). Goode and Ben-Yehuda (2009: 40–41) acknowledge that determining and assessing the objective dimension is often a tricky proposition. They go to great lengths to salvage disproportionality, observing, “We must be cautious, modest, and tentative about making statements concerning what is real and true about events in the social world.” To be fairly confident that some statements are more likely to be true than others, they list “inventions,” “fabrications” and “irrationalities” as indicators of disproportionality (Goode and Ben-Yehuda 2009: 40–41). Hier (2008: 174) substitutes instead the idea of the “volatility of moralizations,” suggesting that moral panic discourse tends to be “sensational, inflammatory and spectacular.” These criteria are presumably less problematic to identify than exaggerations of a threat that goes well beyond what any “realistic appraisal” of the “objective condition” could uphold.

These alternative formulations are thrown into relief when applied to infectious diseases. Goode and Ben-Yehuda (2009: 42) make some rather curious assertions in this regard:

There are some supposedly threatening, dangerous or risky conditions which qualify according to the criterion of disproportion but lack the ‘folk devil’ element: nuclear energy, swine flu, bird flu, e coli, global warming, the shrinking ozone layer, diseases of every description, accidents, the ‘military industrial complex,’ and so on.

Their contention that the flu and other diseases lack ‘folk devils’ or the element of hostility is baffling. AIDS was initially termed a “gay plague” and the association between germs and the “stranger” (Jews, immigrants) is both ancient and still potent, as seen in the reaction to SARS in Toronto (Keil and Harris 2008).

But their assertion that diseases of every description qualify according to the criterion of disproportionality is even more puzzling. In viral outbreaks, scientists constantly declare and emphasize that it is impossible to predict how a particular virus will mutate and hence the future course or virulence of an outbreak (Mehta 2009). The media duly reiterate the impossibility of determining the nature of the objective threat. So, unless Goode and Ben Yehuda know things that virologists do not know, it is clear that claims about disproportionality cannot be warranted in the context of such roulette dynamics. It is only after the outbreak has subsided that such claims can be somewhat justified. The qualification stems from the possibility that, to take one example, the bird flu could reappear, again with an unpredictable virulence.
Without prior knowledge about how an outbreak will evolve, the question of how to characterize the threat of a new or emerging virus is central, unavoidable and invariably problematic. Yet, for each of the recent outbreaks listed in the introduction to this chapter, the most prominent and powerful guardians of public safety—The World Health Organization (WHO), the US Centers for Disease Control, and other national health and regulatory authorities, as well as health ministers and associated government officials—made extremely alarming claims, especially during the early stages of each viral threat (Ungar 2008). These were, in Hier’s terms, volatile discourses that managed to be sensational, spectacular, and inflammatory. This repeated pattern of volatile claims making can hardly be regarded as indiscriminate slipups. Rather, the next section of this chapter draws on a range of factors and processes to retrodict what can be regarded as the expectable use of moral panic in the public staging of viral outbreaks. Building on this, the subsequent section suggests that viral moral panics are neither discrete nor vanishing events. Rather, the accumulation of volatile claims and moralizations has the unintended effect of generating mistrust and reactance, as the “errors” accumulate and engender a sense of *déjà vu*.

**The Embeddedness of Volatile Viral Claims**

It is abundantly clear that new viral outbreaks in the past few decades have been accompanied by sensational and spectacular claims that typically give rise to concerted personal and social measures to protect against the purported threat. Consider a few examples. In the case of swine flu Fort Dix, F. David Mathews (quoted in Di Justo 2009), the US Secretary of Health, Education, and Welfare, declared, “There is evidence there will be a major flu epidemic this coming fall. The indication is that we will see a return of the 1918 flu virus that is the most virulent form of the flu. In 1918 a half million Americans died. The projections are that this virus will kill one million Americans in 1976.” The fear was sufficient to inaugurate a national vaccination program, with immunizations starting about six months after the virus was discovered. While this flu caused one death and then mysteriously disappeared, the vaccine came to be associated with Guillain-Barré syndrome. About 500 people were affected, and more than 30 died, leading to the cancellation of the program. This vaccination fiasco has become a memorable resource in subsequent viral discourses.

Ebola Zaire was designated a “disease that could threaten the world” and the “symbol of the biological apocalypse” (Ungar 1998b: 46). With exquisite timing, the Ebola outbreak was announced by the WHO only a few weeks after the release of the hit movie, *Outbreak*. A frenzy of international media coverage from the *hot zone* created the image of a monster virus on a rampage. This all dissipated quickly as the outbreak remained localized and was contained fairly quickly. The metaphor persists.
West Nile disease has consumed considerable media attention, extending from reportage of cases and surveillance of dead birds, to dire warnings and attendant advice on how to avoid mosquito bites. Interest has waned as the number of annual cases has fallen significantly, indicating that relatively few people actually react to the virus.

SARS has been pointedly examined as a health scare, with the WHO predicting up to one hundred million deaths (see, for example, Hooker 2008). The recent swine flu is discussed in the next section. These two bracket the most extraordinary viral moral panic: avian flu. Perhaps the details are getting fuzzy with the passage of time, so it is worth recalling that a well-regarded journal like the *New Scientist*, echoing various medical authorities, asserted that a mutated avian virus could cause billions of deaths (Ungar 2008). Such numbers are beyond history. Yet, they were further sensationalized by assertions that the spread of bird flu among humans was all but certain; the question was no longer *if*, but *when*. Dr. David Nabarro (quoted in Ungar 2008: 11), the senior United Nations coordinator for human and avian flu, warned, “It is like a combination of global warming and HIV AIDS.”

The alarmed and volatile discourses that follow the discovery of each of the aforementioned viral outbreaks cannot be dismissed as random errors. Presumably, there is some logic to these experts getting it so wrong so regularly. The ensuing analysis aims to pry open the deep structure of fear generation that renders such all-but-apocalyptic claims making about novel viral outbreaks routine and expectable. This deep structure derives from a number of converging and reinforcing conditions and processes. At the bottom-most level, enhanced contagion monitoring has been allied to technological innovations and new theoretical insights that afford a more revealing picture of viral mutations and their attendant risks. Superimposed on these basal developments are altered expectations about the efficacy of public health responses. As new technologies and understandings have developed, there is a greater incumbency on guardians of public safety to plan and prepare for fresh outbreaks. Failure to respond in an adequate and timely way is apt to create a furore over issues related to accountability.

Just as scientists studying the physical world use webs of sensors to take repeated real-time measurements of numerous variables of interest (Broad 2005), disease monitoring teams and networks are constantly seeking to spot new outbreaks or “spores” at their earliest recognizable stages. This is relatively new, and includes organizations like Promed and Global Viral Forecasting Initiative. Promed, for example, depending as it does on worldwide informants with access to computers and the Internet, has been tracking global disease occurrences online since 1994. These efforts can be seen as first order monitoring, “listening posts” for “viral chatter” that serve to unearth localized outbreaks that might otherwise go unnoticed.\(^1\) A second order of monitoring is conducted by national and international disease prevention and control centers that seek to cull those outbreaks that portend novel or large-scale risks. At a third level, mass media

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1 Jones et al. (2008) find a significant increase in the incidence of infectious diseases between 1940 and 2004, at least part of which was due to better viral surveillance.
outlets selectively disseminate information about worrying developments that threaten to spread to their areas of reporting or herald a global import.

It must be supposed that this enhanced disease-monitoring spawns a heightened sense of a world at risk. Regular scanning of Promed and the websites of second-order disease control centers (for example, the WHO) is instructive and startling. There is a veritable plethora of viruses knocking at the gates. Most of these emerge in less developed countries, where it is easier to find a backdoor. If such disease occurrences are generally unknown, on occasion they do get publicized by public medical authorities and the media. Thus, Ebola would hardly have been recognized without teams of Western medical experts and the media descending on Zaire. This outbreak was news. However, the disease was not new and would probably have been contained by local, indigenous actions, as apparently happened in the past (Ungar 1998b: 48). Coming at the end of World War I, the 1918 Spanish flu has been termed the “forgotten pandemic” because it quickly faded from public memory. It was not revived as the most fearsome of all pandemics until the late 1990s, when isolated cases of the spread of bird flu to humans were detected (Crosby 2003). Through censorship, China was able effectively to hide the advent of SARS, at least until it spread to neighboring countries.

When coupled with new technologies, monitoring that exposes viruses that are obscure or percolating at the spore stage has a further essential aspect, specifically, the capacity to conduct full genetic sequencing of microorganisms and hence rapidly to identify their genetic phylogeny (or genealogy) and track subsequent mutations. While the first bacterial genome was sequenced in 1977, it was in the 2000s that leading laboratories realized the practice termed “virtuosic” and “ultradeep” sequencing (Gould 2007). Research reveals that genetic mutations leading to differences in just a single amino-acid component of a protein can make a virus unrecognizable by the immune system, even if the victim was previously immune. This recently revealed capacity of viruses to skirt the immune system renders them far more volatile and fearsome than previously thought. Tracking mutations that often occur at a rapid rate feeds into the fear-generating models that virologists and associated experts draw upon.

To pick up on the last point, flu specialists seem to occupy a world of simmering anxieties, one never far from boiling over. Apprehension can be considered an occupational hazard, both in theoretical and practical ways. The constant surveillance and analysis of viral spores, with the occasional all-nighter central to the disease-hunter archetype, are buttressed by, and simultaneously give credence to, the “mutation-contagion” interpretative package prevalent in the field (Ungar 1998b), a package that entails a rhetoric of endangerment. The complex of images and metaphors it covers include the following: “microbes are on a rampage,” “microbes are cleverer than us,” “they know no boundaries,” and we are just “waiting for the next plague” (Ungar 1998b: 43–5). Mutation-contagion is partially based on the unintended creation of new viral pathways connecting humanity together, as roads and the like have been cut into rain forests and other previously secluded environments. At the same time, mutation-contagion is consistent with a radical shift in evolutionary theory over the last few decades. Specifically,
gradualism in evolution has been displaced to a great extent by a model of explosive change (Gould 2007). There can be few assurances when even relatively benign viruses that have accommodated to their hosts can suddenly transmute through a process of antigenic shift and become lethal. For virologists at least, the tiny objects of their studies represent the single biggest threat to our continued dominance on the planet.

Mutation-contagion is more than a metaphor in this context. Virologists, both in recognizing the types of threats that they seek to contain and in selling these to everyone else, use the 1918 Spanish flu as their archetype. That pandemic, which is believed to have come in two waves, killed quickly (often in less than 24 hours) and efficiently, with estimates ranging from 50 to 100 million dead in one year. Unlike the seasonal flu, it targeted young adults. Samples of this influenza were recovered in 1998 from a victim buried in Alaskan permafrost. The virus was sequenced in 2005 (Brown 2005). It has been proposed that its origin was an avian flu. Sequencing of the recent swine flu, that is, H1N1, indicates that it is a descendant or subtype of the 1918 Spanish flu. Viruses are not hoarders or isolates, but efficiently exchange and share bits of DNA, allowing for surprises.

If our perceived vulnerability to a runaway pandemic is stoked by constant disease surveillance coupled with revealing new technologies and theoretical understandings, the encampment with the 1918 Spanish flu exploits a worst-case scenario that is certainly sensational, inflammatory and spectacular. We may be just “waiting for” novel outbreaks, but unpredictability hardly guarantees that it will be plague-like in its impacts or that we are “due” for the big one. There is considerable backward blindness in evaluating past outbreaks. However, from 1700 onwards (and probably from 1500), for which assorted records and proxies are available, it is clear that the Spanish flu is an extreme outlier, with no earlier or subsequent pandemic being nearly as lethal (Jones et al. 2008). The twentieth century witnessed two other pandemics: the 1957–58 Asian flu, with an estimated 1.5 to 2 million deaths, and the 1968–69 Hong Kong flu, with an estimated 1 million deaths. The temporal proximity of these two pandemics seemingly violates the twice a century/every 50 years rule of thumb common in pandemic claims making.

All these developments have a practical side. In the discovery of a novel (read, unpredictable) viral outbreak, medical and political officials are likely to feel that they are acting “under the gun” and do not want to be caught holding the “hot potato” should it turn out to be particularly lethal. The cost of over-reacting, of using positions of oversight to stoke moral panic, is a seemingly less costly option for guardians of public safety than to be rendered the targets of moral outrage for vaccinating and not doing enough to prepare for the threat. Uncertainty and unpredictability appear to provide a workable justification for sensationalizing the threat; but they hardly justify inaction should events spiral out of control. In other words, after-the-fact recriminations are more likely to set off a witch-hunt than precautionary actions. The failure to act, whether due to disregard or incompetence, readily shades into a sense of moral and criminal negligence, especially when the consequences are grave. In Walkerton, Ontario, the failure of town authorities to treat and test drinking water adequately, coupled with their subsequent failure to
advise people about E. coli contamination, resulted in at least ten deaths and over 2,000 ill (Ungar 2001). The ensuing hunt for “folk devils” stalked water managers, town officials, and even the Ministry of the Environment, which terminated their water testing in favor of privatization. These failures, in light of the ensuing catastrophe, were seen as transcending incompetence and entailing reckless and immoral neglect, and indeed turpitude.

Responding, if it is to entail more than issuing dire warnings, depends on having the capacity to act in a timely and efficacious way. The medical developments outlined above have improved treatment options. In the 1968 pandemic, vaccine became available in limited amounts one month after the outbreaks peaked in the United States. Better monitoring and sequencing resulted in the availability of vaccine before the second wave of 2009 H1N1 was expected to hit.\(^2\) In contrast to the medical helplessness during the 1918 outbreak, doctors now have some methods to treat the infected. Full genetic sequencing of viruses abetted the development of antiviral drugs, most notably Tamiflu, which has been available since 1999 (Watson 2006). 2009 H1N1 deaths were mostly due to respiratory failure, including secondary bacterial infections (pneumonia), which can lead to a systemic inflammatory response (2009 H1N1 2010). Ventilators and, in the last resort, cardiac bypass machines have been useful in treating many (though not all) victims.

Though these new technologies have improved medical treatment, their efficacy is limited by shortages, especially in large outbreaks, when medical systems can be overwhelmed. As a result of the medical successes that led to the misplaced hubris of the US Surgeon General in 1969, there were severe cutbacks to the public health systems in most advanced nations. Hence, it is not surprising that from the alarmed reaction to Ebola Zaire through the cascading scares engendered by the avian flu, a lack of preparedness has been stressed by health officials and others. And while, as elaborated later in this chapter, there can be some cynicism regarding efforts by medical officials to command greater resources, it is also the case that the relatively small outbreak of SARS brought the health system in Toronto to the point of breakdown (Hooker 2008).

The extended chain connecting mysterious viral spores to an easily infected humanity—intrusions into hitherto isolated viral reservoirs, enhanced monitoring, rapid genetic sequencing, a mutation-contagion interpretative package linking back to the Spanish flu, prospective vaccines that make immediate decisions imperative, limited treatments in short supply, and deficient public health systems—constitutes the deep structure of fear generation. Not only have an astonishing array of viruses been unearthed, but there is also an uneasy realization of just how unpredictable they are as they traverse evermore convenient pathways of infection. The medical arsenal for countering such seemingly dangerous developments is limited, and virologists are compelled to operate under acute time constraints. Intensive public health preparations and responses are costly and often intrusive, and there

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\(^2\) The production of vaccine was the main holdup in the context of these other innovations. Vaccine is still grown in eggs, and accelerating the production process may depend on learning to assemble molecules through synthetic biology.
is a pressing need to surmount political and public ignorance and indifference, especially when threats do not have the immediacy of a hot crisis.\(^3\) Given such chains of contingency, it is hardly surprising that guardians of public safety rev up the doomsday machine when novel outbreaks with possibly lethal impacts are discovered. Apocalyptic claims not only command considerable public attention, but also facilitate medical and other institutional preparations that in turn provide a degree of reassurance to offset the fearful claims.

Responses to 2009 H1N1: Complications Set In

2009 H1N1, following soon after SARS and the bird flu, was the third major viral scare of the twenty-first century. As with its predecessors, its alarmed discovery in March and April 2009 was attended by the expected use of sensational claims and occurrences. The H1N1 virus emerged in Mexico, where it spread rapidly and caused a number of deaths, especially among the young. Schools and universities were closed, and public events such as soccer matches cancelled. The virus was quickly deemed “non-stoppable” by the WHO, which warned of up to two billion cases worldwide and from two to ten million deaths (Hellerman 2009). By June, the WHO classified it as a phase 6 outbreak, or pandemic. While 2009 H1N1 was termed the first pandemic of the twentieth century (indeed, the first since 1958), the distinction between an epidemic and a pandemic was often blurred in public discourse. The latter has to do with how widely a virus has spread, not how dangerous it is. However, pandemic was all too often associated with a deadly disease. Since it is impossible even to begin to examine worldwide coverage of a pandemic, the focus here is on Toronto, both because the author resides there and the fact that Toronto was the only city outside South Asia to have had a SARS outbreak. The ensuing discussion is derived from two sources: a daily Google alert for “swine flu” and coverage in the four Toronto newspapers. Perusal of these sources was commenced in June just prior to the pandemic announcement.

The outbreak slowed during the summer in North America but still occasioned a range of volatile claims. While the evidence to this point suggested that 2009 H1N1 was actually milder than the seasonal flu, the threat of a second and far more virulent wave in the coming winter was sounded so frequently that it almost became a mantra. In August, there were warnings about a severe new strain that directly attacked the lungs of otherwise healthy young people. This was often associated with the lung infections that are believed to have rendered the 1918 pandemic so
lethal. It was further observed that 2009 H1N1 spreads at alarming rates, much faster than most viruses (Jameson 2009). Hence, the start of the school year provided ideal conditions for contagion, exacerbated by the concern that there would not be sufficient respirators for those developing severe lung infections. Effectively, a race for life and death was being fashioned, with a dangerous virus piggybacking on the cold pitted against all-out efforts to produce a life-saving vaccine.

Viral moral panics have been exceptional in mobilizing public responses. Unrelenting publicity about the apocalyptic potential of the bird flu not only lead to the wholesale slaughter of countless millions of fowl, but compelled European governments to make and publicize plans for dealing with a looming outbreak. Planning included stockpiling antiviral drugs, making preparations for the production of a vaccine, developing rapid reaction plans for hospitals, arranging for alternative treatment facilities (even if only tents), and preparing to alter social patterns, from the closing of schools to banning public events, hospital visits and so on (Ungar 2008). The sensational claims made about 2009 H1N1 also triggered a number of costly and intrusive plans and programs. The most significant of these was the swift production of a vaccine, coupled with administrative plans to inoculate as much of the population as possible. So grave was the looming threat of a second wave that governments, businesses, and schools and universities were encouraged to set up “task forces” and “epidemic action plans” to prepare for the worst. In Toronto, there was broad compliance with planning requests, and city residents were inundated with warnings and information. Hand sanitizer pumps seemed to pop up everywhere. Universities made contingency plans to continue courses online and waived requirements for doctors’ notes for exams missed due to illness (University of Toronto 2009). Plans were also made to create “isolation wards” in student residences, and doorknobs and similar surfaces were wiped down as often as every 45 minutes.

While the WHO’s fearful perspective prevailed through summer and the start of the school year, by sometime between mid-October and early November, it became apparent, at least in public discourse, that the second wave was relatively mild. This transition in perceptions is not abrupt, but extends over several weeks in a zigzag pattern. As a whirlwind of overlapping and compressed events branch off in disparate directions, authorities lose control of the problem. First the flu itself, followed by the vaccine, and then the role and interests of the leading guardians of public safety become sites of contestation.

The start of the school year did bring a significant increase in the number of reported cases, but these were generally mild. Medical authorities kept warning that the number of hospitalizations remained high, that potentially dangerous mutations were found in several countries (for example, Ukraine), and that resistance to Tamiflu was occurring (Jameson 2009). But these remained distant and abstract threats. The events that counted were mainly local. Thus, in Toronto, the October 27 death of a teen without any pre-existing medical conditions resurrected the fear, as parents worried about how to protect their children (Vallis 2009). Intense coverage that seemed to amount to a public memorial for the young victim continued for more than a week. People were once again wary, but in the absence of additional
deaths anxieties soon dissipated. In this regard, evidence indicates that the public wants an absolute yes/no answer to questions about risk (Ali 1999). Repeated exposure to seasonal flues is an unavoidable part of everyone’s experience, and 2009 H1N1 was tamed as it came to be regarded as akin to a seasonal flu.

As fear of 2009 H1N1 began to subside, space opened up in the public realm for disparate voices. Dissident scientists found a number of reasons for challenging the WHO scare scenario, including the generally mild nature of 2009 H1N1, the mild second wave observed in the Australian winter, and the prospect, now given more media attention, that a second wave can be less threatening as many people develop immunity in the first wave. The head of the CDC had questioned the more extreme predictions about 2009 H1N1 in late August, though he was largely ignored (Schapiro 2009). But by early November these isolated rebuttals had become commonplace. In a striking inversion, this ostensibly dangerous outbreak is now broadly perceived as less threatening than the seasonal flu. Over the next few weeks, the pandemic is memorably dubbed a “dud” and sometimes called a “fake” (Jordans 2010).

Considerable attention and hope was initially invested in the impending vaccine. It was estimated that inoculating 70 percent of the population would stop the outbreak. Vaccine became available toward the end of October in Toronto. At the outset, it was reserved for those deemed most at risk, including children and pregnant women. In terms of timing, the vaccine comes on stream as the transition in the public perception of the danger of H1N1 is getting underway. Hence, the initial demand is high (most understandably for those deemed high risk) and remains high for several weeks as vaccinations are being made available to everyone. Then a series of difficulties attend the vaccination program. By the fourth week of the program, there are acute shortages of vaccine and line-ups are cut off (CTV.ca News Staff 2009). The sense of bungling officials became a staple of news coverage, and was made worse by the confusion created by sudden shifts in vaccine requirements. Just as shortages became an issue, officials, citing the WHO, suggested that one dose was sufficient for children less than ten years old. Health Canada originally stipulated that children receive two shots, 21 days apart.

The sense that officials were unprepared and disorganized was perhaps excusable given the unprecedented nature of the vaccine program (McComas 2004). But subsequent errors, which overlapped with shortages, entailed what were perceived to be inexcusable moral oversights. Hockey players, members of hospital boards (not frontline health workers), and selected others were able to jump queues and get vaccines now in short supply. There were numerous reports in Toronto of the “privileged few” buying their way to the front of the line. This set off a storm of protests, with the advantaged mounting various justifications for not having to wait (Valpy 2009). Political and medical authorities, including the head of the vaccination program, asserted that everybody should wait their turn. But this was rather disingenuous, as politicians frequently jumped to the head of the line, as well. Significantly, objections to this preferential treatment seemed to be predominately framed around fairness, rather than who might live or die.
As fear of H1N1 continued to subside, fear of the vaccine came to the fore. Shortages of vaccine were abruptly replaced by shortages of customers. That people opined with their feet is clearly seen in the closure of a number of clinics in Toronto and the absence of waiting times in others. Opposition, which migrated onto the Internet and talk radio, focused on claims that the vaccine was not safe, that it had been produced too quickly and without sufficient testing (Mustafa 2009). Recalling the swine flu vaccine fiasco of 1976 and drawing on such disparate phenomena as the belief that the MMR vaccine is responsible for autism, up to 40 percent of polled Americans said they would not get the vaccine for their children. Far more reported that they would not themselves be vaccinated (McNeil 2010). With the Internet functioning as an echo chamber, fear of an unsafe vaccine merged with sundry mythologies about vaccines and the fear of both big government and big business (see Griffin et al. 2008). Both Glenn Beck and Rush Limbaugh questioned the Obama administration’s recommendation that Americans get vaccinated. Limbaugh objected to the “pig flu vaccine” and suggested people would be healthier if they did the opposite of what the government advised (Maugh 2009). Latent antagonisms and anxieties could now be directed at officials who had overblown the threat of 2009 H1N1.

The gap between the public demise of the pandemic and the concerns of leading medical authorities is particularly visible in the New Year. Michael Osterholm, director of the Center for Infectious Disease Research and Policy at the University of Minnesota, said he “was not surprised” by how few received shots: “But that could all change overnight if we get a third wave in late February—and we still could,” he added. “That would make this half-time data, not end-of-the-game data” (Bowron 2010). By this point, however, scientific credibility about the issue had been forfeited and the WHO and other medical actors were starting to be cast as “folk devils” who were trying to create panic in order to morally regulate public behavior for their own ends. Harking back continually to the speciously apocalyptic claims made about the bird flu and the medical preparations that followed, the doubling of these errors with 2009 H1N1 led to charges that scientists had inappropriate links with drug companies. Generating fear was seen as a way of generating massive orders for vaccines and antiviral drugs. Besides the financial motivations, health authorities were also maligned for perceived empire building, for trying to command more resources and getting more decision-making powers. The WHO authorities were accused of seeking to impose their own vision of global social justice by efforts to transfer resources from the rich to the poor. Such was the new reality that it became incumbent on the WHO and associated bodies to defend the notion that the pandemic was “real” (Jordans 2010).

Conclusion

After asserting that “a whole industry is waiting for a pandemic,” a European epidemiologist contended that the WHO, public health officials, virologists, and
pharmaceutical companies “built this machine around the impending pandemic. And there’s a lot of money involved, and influence, and careers, and entire institutions! And all it took was one of these influenza viruses to mutate to start the machine grinding” (“Interview” 2009). In contrast to the elements of conspiracy intimated in this statement, this paper aimed to uncover the deep structure of fear generation. Volatile viral moral panics are traced back to a chain of developments connecting intrusions into previously secluded viral reservoirs, enhanced surveillance, rapid genetic sequencing, a mutation-contagion interpretative package, prospective vaccines that compel rapid decisions, limited treatments in short supply, and deficient public health systems. The guardians of public safety who are linked up to this chain inhabit an outlier’s world of fearsome possibilities. The latter give rise to moral and practical imperatives to react, and guardians are wont to employ claims that are sensational, inflammatory and spectacular as a way of mobilizing concerted social responses. Of course, it is only after the fact that their assertions can be deemed to have been disproportionate. Still, we have suggested that they may be (unintentionally) stoking a worst-case model by relying so heavily on the atypical 1918 pandemic.

Social responses to viral moral panic claims making activities reveal that the latter do tap into and stoke genuine public concerns. None of the major outbreaks sensationalized by virologists were greeted with complacency. Indeed, they generated concerted social responses. Perhaps viral claims making has been too successful, for it became apparent in Toronto that significant costs are associated with outbreaks that do not occur or are far less lethal than predicted. From SARS through the bird flu and then 2009 H1N1, the frightful outcomes predicted by virologists went unrealized. While virologists conclude that we have been lucky in dodging the worst of it, public discourse focuses on their errors and the associated tendency to blow risks out of proportion. What are ostensibly prudent precautions when taken singly undermine, as the mispredictions accumulate, confidence in authorities. Indeed, the skepticism and indifference that built up around 2009 H1N1 appears to have carried over and led to a significant reduction in the number of persons getting vaccinated in Ontario for the 2010 seasonal flu (Artuso and Blizzard 2011). At the extreme, these unrealized threats open a deep chasm of distrust, lending credence to opposing moral panics conjuring a world of conspiracies wrought by governments, business, scientists and international organizations. Regardless, with the explosive growth of Twitter and other social media, officials have surrendered considerable control over the message and will need to adjust to two-way communication. They are less and less able to exercise social control and orchestrate social responses in the ways envisioned in the classical model of moral panics.
References


