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few remaining strings. My dad's accident, unforeseen and sudden, led my mom to make lots of decisions that were no longer solely about her. When I think of strength and sacrifice, I think of my mom. I could never imagine going through what she endured at 18 years old. I cannot fathom the intensity of my mom's pain when she found out her best friend would never be the same.

My dad is a fully functioning adult with college degrees and unsteady employment. His recovery was truly a miracle. Despite what veneer is exposed to families experiencing the fallout of an accident, or any major life-altering event, there is no sugar coating the before and after version of each person. My mom loved Mike before the accident, and she loves Mike after the accident. They are partly the same Mike, but no one in my family will deny that he's never returned back to who he once was. With the amount of brain damage he sustained, how could he? What they all may fail to notice is their own lack of return to how they once were. Love is powerful; its unconditionality ignites a glimmer of hope that love will always prevail in the darkest of times.

March 25, 1990. "Our long awaited day has finally arrived. You're coming home today. Your memory is improving, so is your speech. The past months have been long and unbearable at times. You are a fighter, Mike. Welcome home!"

March 25, 2017: My 18th birthday. "Jen, do you want a PB&J for lunch?" I respond calmly, "No thanks Dad, I'm allergic to peanuts." I've been allergic to peanuts for 18 years.

So where does this leave me? Looking back on a story that only became mine 9 years after it began is a difficult feat. How can I do justice to a narrative, with so many perspectives, so much pain, but yet so much hope and triumph? How do I live a life of my own, when the one I lead is deeply influenced by the events that came before me?

The dynamic answer that continues to change is complex: this narrative is only partly mine, it leaves me at Boston College, on the precipice of the past and the future. Boston College is a place where I am forging my own path, but also walking the same lanes my dad walked when his life was forever changed. I believe F. Scott Fitzgerald could offer some form of hiatus to a narrative currently in action, one unfinished, "Gatsby believed in the green light, the orgastic future that year by year recedes before us. It eluded us then, but that's no matter...So we beat on, boats against the current, borne back ceaselessly into the past."

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# A FEARFUL RESPONSE: HEALTHCARE WORKERS AND EBOLA

MITCHELL LAVOIE

In 2014, the extremely fatal Ebola virus ravaged through the countries of Sierra Leone, Guinea, and Liberia, killing over 11,000 people and infecting even more. This outbreak led to a significant response mounted by the Centers for Disease Control and Prevention (CDC) of the United States. Many healthcare workers from the United States answered the call to serve and were initially applauded for their heroic actions abroad. They even managed to land a spot in Time Magazine's prestigious Person of the Year issue, honoring all of the Ebola fighters as "the ones who answered the call" ("TIME Person of the Year"). However, this warm U.S. response was not consistent for healthcare workers Dr. Craig Spencer and nurse Kaci Hickox, Ebola workers who spent time in Guinea and Sierra Leone respectively. Instead, they were greeted at America's borders with hostility and utter fear. The media narrative only fueled this fear, further vilifying them. Their image was not one that resembled the other healthcare workers in TIME as the U.S. met their return with hasty public health policy and negative public opinion. These two healthcare workers were presented as the "superspreader" as discussed in Priscilla Wald's *Contagious*, representing a major characteristic in the outbreak narrative which helped drive the fear. The fear has even deeper roots, though, resulting from previous outbreak narratives of Ebola and hemorrhagic fever, such as Richard Preston's 1994 novel *The Hot Zone* which, in an effort to find meaning out of an epidemic, only caused mass hysteria and fear (Rosenberg, Quammen). As a result, the initial positive U.S. response towards the Ebola workers in 2014 was replaced by stigma and poor treatment for many of these same individuals.

*Healthcare Workers following 2003 SARS outbreak in the U.S. and abroad: Policy and Treatment*

To first understand the poor treatment of U.S. healthcare workers after the 2014 Ebola outbreak, specifically that of Dr. Spencer and nurse Kaci Hickox, it is necessary to grasp how the poor treatment they endured, such as the stigma for their work abroad and the stringent policy put in place upon their arrival to the U.S., was not as significant in the SARS outbreak in 2003. Severe acute respiratory syndrome (SARS) is a respiratory illness that is caused by coronavirus and infected people in more than two dozen countries (SARS CDC). In the United States, Canada, and Hong Kong, constant surveillance and quarantine or home isolation for those who contracted SARS was common policy and enacted worldwide (Cetron et al.). Furthermore, in the U.S. the CDC only recommended passive surveillance for those exposed to SARS or whom came from an area of SARS transmission, such as healthcare workers, stating that they should monitor themselves for 10 days and seek out medical care if they become symptomatic (Cetron et al.). This was not the case for other nations such as Canada and China, where even if an individual was exposed to SARS, they needed to be isolated in their home. The U.S. followed the CDC recommendation however, and opted for this passive surveillance, as it would not impede on an individual's "due process" or civil liberties (Cetron et al.). What is more is that in the United States, travel advisories and health alerts were created for flights traveling to and from places where SARS transmission was present, recommending 10-day personal surveillance for healthcare workers and others after they returned. This response from the United States was much more mild compared to what was set in motion in China, Canada, and Singapore. In

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these countries, a much more stringent policy at the borders was put in place, where pre and post travel screenings were mandated, isolating all ill travelers who entered the country. While the screenings may seem warranted, it was the mandatory quarantine of healthy travelers coming from areas of high SARS transmission that had damaging effects (Cetron et al). It is through the comparison to these policies that makes evident that healthcare workers returning to the United States were treated far better than those in other countries, with a nation that rightfully respected the civil liberties of individuals by not throwing healthy individuals into quarantine.

SARS, however, was an outbreak somewhat different than the Ebola outbreak in West Africa in 2014. SARS traveled rapidly and many healthcare workers became patients because of the work they did (Singer et al). This characteristic is not consistent with the Ebola outbreak in 2014. Much of this can be attributed to the more stringent usage of personal protective equipment in West Africa for Ebola versus relatively less intense equipment in nations like Canada and China, with gloves and an N95 respirator masks for SARS (Cetron et al). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (YaMei et al) (Nickell et al). This was different than that for Ebola, where both healthcare workers Dr. Spencer and Kaci Hickox received overwhelming stigma in the form of negative public opinion. This begs the question of why stigma was not as prevalent in a terrifying outbreak such as SARS as compared to the 2014 Ebola outbreak.

#### *Why Ebola in 2014 was different: the effect of the outbreak narrative*

The outbreak narrative, as Wald describes it, “begins with an emerging infection, follows it through the global networks of contact, and ends with its containment.” This

is only a piece of the outbreak narrative formula, but it is one that is very evident in the outbreak narratives that have helped foster the fear that characterized the 2014 Ebola outbreak in West Africa (Quammen). Furthermore, it is typical for the outbreak narrative to cast Africa as “an epidemiological ground zero, otherworldly, a primordial state out of which anything might arise” (Wald 32). Africa is often where an infection emerges and can then travel through the global networks of contact. As Wald also notes, “an infection may be endemic to an impoverished area, but it emerges when it appears-or threatens to appear-in a metropolitan center of the North,” clearly demonstrating that the fear that comes out of Ebola and its transmission takes full form when it comes out of Africa and slowly travels elsewhere (34). This traveling is represented as the dots and lines on epidemiological maps that are indicative of an outbreak narrative, bringing “fear and reassurance” to many (Wald 37). The fear that emerges from these maps comes from these representations of the spreading infection through modes of transportation, and out of Africa to places like the United States (Wald 37).

Richard Preston’s 1994 *The Hot Zone* gripped the attention of many, painting a horrifying picture of Ebola and hemorrhagic fever while capturing Wald’s outbreak narrative formula, especially the out of Africa component. At the start of the novel, character Charles Monet contracts a hemorrhagic fever and boards a plane in an effort to seek medical attention elsewhere. His infection was a “hot virus from the rainforest” which “lives within a twenty-four-hour plane flight from every city on Earth” (Preston 11). In his outbreak narrative, the infection did in fact emerge from Africa and was traveling through the global networks of contact. In addition, Preston notes that “all of earth’s cities are connected by a web of airline routes. The web is a network. Once a virus hits the net, it can shoot anywhere in a day - Paris, Tokyo, New York, Los Angeles, wherever planes can fly. Charles Monet and the life form inside him had entered the net” (12). The potential path of the virus paints Monet as

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a “super spreader” of disease that could infect thousands of people, encouraging a fear of infection (Wald). The fear emanating from the threat of these “networks” spreading Ebola globally incited mass fear. However, the fear that emanated around Ebola from *The Hot Zone* had other sources as well.

The fear of transmission of Ebola came more specifically from the lack of knowledge of how it actually was transmitted. In an interview with *The New York Times* in the wake of the 2014 epidemic, Preston associates part of the fear of Ebola from his book with the limited knowledge of the disease and its transmission back in 1994. “Initially, there were a lot of fears that Ebola could mutate to become the airborne Andromeda strain that would wipe us all out,” stated Preston, also noting that “With what we know now about the genetic code of the virus, Ebola does not travel through the air in airborne form and is very unlikely to mutate that way” (Alter). The fear of airborne transmission was enough to cause mass panic, even if the claims were proven wrong years later. That initial fear persisted, even horror novel writer Stephen King called it “one of the most horrifying things I’ve ever read” (Alter). Preston also notes that what is “terrifying about Ebola” is that “Ebola is invisible. It’s a monster without a face. With the science that we have now, we can perceive Ebola as being not one thing but as a swarm, and the swarm is moving through the human population and expanding its numbers. It’s the nonhuman other that all human beings are contending with in many different ways” (Alter). This non-human aspect of Ebola and its monster-like ravaging abilities are a significant factor of the fear that emanated from it.

Preston’s vivid descriptions of Ebola’s effects on the human body brought this monster to life, yet it was his parallel of the origins of Ebola with HIV that made Ebola a more imminent threat to many Americans. In his book, Preston describes Monet’s plane ride on his way to Nairobi in vivid detail. According to Preston “you see

that his lips are smeared with something slippery and red, mixed with black specks, as if he has been chewing coffee grounds. His eyes are the color of rubies, and his face is an expressionless mass of bruises... the muscles of his face droop. The connective tissue in his face is dissolving, and his face appears to hang from the underlying bone, as if the face is detaching itself from the skull” (17-18). Monet liquified and lost all personality from a damaged brain due to the virus, and this dehumanization establishes the horror of the infection (Wald 35). Charles Rosenberg in his book *Explaining Epidemics* focuses on the framing of disease. He mentions that “disease does not exist as a social phenomenon until we agree that it does - until it is named,” and in this case, characterized (306). Preston’s description of the horrifying features is enough to incite fear, only to heighten the sense when he compares it with HIV’s breadth of transmission as well as its African origins. Preston brought the roots of HIV to the foot of Mount Elgon where Monet is thought to have contracted the virus in Kenya. Preston notes that HIV “does not travel easily from person to person” however, which makes the easy transmission of a virus like Ebola, and its “volatile and rapid” nature much more frightening (Wald 35). The dehumanizing nature of the disease, along with its African origins, similar to that of HIV, created the path for fear to emanate out of Africa, just like the disease itself. It was Wald, however, that characterized this phenomenon, “Preston’s depiction of its effects reads like a description of the ravages of HIV on fast forward,” potentially as widespread and equally as fearful (Wald 35).

#### *The Narratives of Fear: Dr. Craig Spencer*

The progression of the outbreak narrative as described by Wald corresponds closely to the specific narratives that emerged around the U.S. healthcare workers. In the typical outbreak narrative, there are the global networks of contact that a disease can infiltrate, which is represented quite well by the specific narrative of Dr. Craig

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Spencer. Dr. Spencer was a U.S. healthcare worker stationed in Guinea to help fight Ebola in 2014. In October of 2014, he returned to New York City where he attempted to assimilate back into everyday life. He stated that “I slept long hours and had a hard time connecting with old friends” after returning from Guinea (Spencer). On October 23, 2014 Dr. Spencer became New York’s first Ebola patient, reporting a high fever and testing positive for the disease. Overnight, a heroic fighter of disease was cast as a pariah.

People fear the unknown, and Ebola, a once foreign disease now on U.S. soil, suddenly became close to home for many Americans. In the days leading up to his quarantine, Dr. Spencer took the subway, went out to eat, and even went bowling in New York City in an effort to maintain normalcy. However, after his quarantine, these actions were widely criticized, as people all across New York City, and even the country, feared that Ebola could be transmitted as easily as the common cold. According to Rosenberg, “An epidemic is almost by definition frightening; numbers of unfortunates are seized with grave illness, one after another exhibiting similarly alarming and alarmingly similar symptoms” (293). As a healthcare worker returning from a place of epidemic and subsequently contracting the disease, the fear of epidemic was much more potent. Due to this fear, Spencer’s seemingly insignificant actions in New York City prior to his hospitalization were condemned and he was deemed a “fraud,” among other things (Spencer). Even Donald Trump criticized Dr. Spencer, tweeting “The Ebola doctor who just flew to N.Y. from West Africa and went on the subway, bowling and dining is a very SELFISH man-should have known,” which only gave into hysteria that ensued (Jula et al). The potential for him to become a “super spreader” and infect all of New York City, similar to the narrative legacies of “Typhoid Mary” and “Patient Zero,” regarding the AIDS epidemic, certainly contributed to this public fear, with the public condemnations only adding fuel to the fire (Wald, 70).

After Dr. Spencer fell sick public fear led to negative opinion regarding Spencer’s actions preceding his hospitalization, directly leading to the stigma against him. Specifically, the lack of scientific knowledge among politicians and the public alike aided in the manifestation of fear. Spencer chided those who encouraged this stigma, stating that “after my diagnosis, the media and politicians could have educated the public about Ebola. Instead, they spent hours retracing my steps through New York and debating whether Ebola can be transmitted through a bowling ball” (Spencer). The fear that Ebola could have been transmitted so easily was a major player in the fear of the disease. What is more is that in the typical outbreak narrative, as defined by Wald, as well as in Spencer’s specific case, the carrier and potential spreader have a social responsibility, a “measure of citizenship,” to be cognizant of their space in society, as the “bodily interconnectedness” in the city of New York could easily transmit a disease through shared spaces, such as a bowling alley (Wald 70). Spencer’s violation of this social contract cast him as a villain and outcast for not upholding his responsibility as a citizen and subsequently threatening the health of many (Wald 70). His work in Guinea was nowhere to be mentioned, but his Sunday afternoon at the bowling alley was all over the news. This fear further exacerbated negative public opinion through outlandish media headlines such as “Ebola: the ISIS of Biological Agents?” and “Nurses in safety gear got Ebola, why wouldn’t you?” (Spencer). This only contributed more to Spencer being treated as a pariah as well as the general public fear towards other Ebola aid workers. Scientifically however, it was nearly impossible for Spencer to have transmitted the disease when he was afebrile (Spencer, Ebola CDC). Yet this knowledge stayed out of the news which left fear to be the only tangible thought seen by the public.

In this moment of uncertainty and fear, public officials instituted policy to further isolate the heroic fighters of disease, using Dr. Spencer’s narrative to influence public health measures. At the time of Dr. Spencer’s quarantine,

Governors from New York and New Jersey gave into public fear and took advantage of it to enforce their executive power and implemented strict 21-day quarantine laws even if said worker wore their personal protective equipment (PPE) when in contact with Ebola patients in West Africa (Csebestyen). These policies were not based in scientific fact, ignoring the CDC’s recommendation of personal monitoring or monitoring by public health officials, stating nothing of a mandated quarantine recommendation (“Public Health Professionals Gateway”). This then begs the question of why such stringent public policy was instituted. It is important to note the proximity of Dr. Spencer’s quarantine, late October 2014, with the impending midterm elections in early November. Spencer eluded to politicians utilizing public fear to institute strict quarantine laws, stating that “We all lose when we allow irrational fear, fueled in part by prime-time ratings and political expediency, to supersede pragmatic public health preparedness” (Spencer). Furthermore, after the midterm elections on November 4, 2014, Spencer noted that to politicians “the ebola epidemic ended,” bringing light to the lack of public attention after the elections (Spencer). Rosenberg also clearly characterizes these actions through his work in framing disease, stating that “perception implies explanation. Certainly this is the case during epidemics, when fear and anxiety create an imperative need for understanding and thus reassurance” (294). Politicians played off of the opportunity to reassure the public that they were safe. Therefore, the institution of such policy was a tangible way in which fear aided in the elections of politicians at the expense of healthcare workers.

#### *The Narratives of Fear: Nurse Kaci Hickox*

Dr. Spencer’s narrative however is not the only one that clearly demonstrates such a negative response towards Ebola healthcare workers. Nurse Kaci Hickox is one such worker who experienced negative response upon reentry to the U.S., although she was plagued with a different kind

of fear and response than Dr. Spencer. Hickox is a nurse from Maine who worked in Sierra Leone fighting Ebola in 2014 under the auspices of Doctors Without Borders, around the same time that Dr. Spencer was stationed in Guinea. The medical team lead for a 35-bed Ebola case management center, she worked 12 to 14 hour shifts while wearing the cumbersome PPE that theoretically isolates the aid worker from the fatal infection (“TIME Person of The Year”). She returned to Newark International Airport on October 24, 2014, and was met by a frenzy of officials asking her questions regarding her stay in West Africa. Eventually, after six hours of being in an airport, she ran a high temperature with a forehead scan thermometer, which often yields falsely high readings for people under stress (Miles). She was subsequently ordered into a quarantine tent in a New Jersey hospital by Governor Chris Christie, where she tested asymptomatic and negative for the disease but remained for three days (Miles). In New Jersey, Kaci Hickox was seen as a potential superspreader and through the utilization of public fear, the governor relegated her to dehumanizing and unwarranted quarantine in an apparent political showing of strength and supposed commitment to the protection of his state, “reassuring” the public but also working towards his midterm election agenda (Miles 2).

Governor Chris Christie, however, was not the only official to utilize public fear of Hickox’s potential infection to stigmatize and quarantine her. In fact, when Hickox was released to Maine under secret convoy, governor Paul LePage ordered her to be quarantined in her home for 21 days, threatening any defiance with a court order. To further exacerbate the situation, Maine’s CDC released their newly revised Ebola policy, which stated that for “A traveler who did come into direct contact with or treat Ebola- positive individuals and who is not currently exhibiting symptoms of disease... we will work collaboratively with the affected individual to establish quarantine of the individual in his or her home for 21 days after the last possible exposure to Ebola” (Miles). The policy also mentioned the protection of

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public safety through an “abundance of caution,” of which they will use when a “healthcare worker who came into contact with Ebola-positive individuals returns soon from New Jersey” (Miles 1). This policy was tailor made to Ms. Hickox, as seen in the blatant referral to her return from New Jersey. Priscilla Wald points that there is a “conflict arising from the state’s obligation to safeguard both civil liberties and public health and well being” (70). The civil liberties of Hickox, she claimed, were violated and the mandatory quarantine policies in Maine, New Jersey, and New York are a flagrant utilization of public fear to implement hasty public policy that is not based in scientific fact or evidence but for political expediency at the expense of an individual’s “personal civil rights” (Miles) (“Matt Lauer and US Nurse Kaci Hickox”).

What is different about Hickox’s situation, as opposed to Spencer’s, was that she did not in fact have Ebola. Her subsequent quarantine was enabled through a lack of coordination and a sense of public fear that surrounded the Ebola epidemic. The Maine court system that rejected Governor LePage’s court order recognized this public fear and the lack of scientific evidence for taking an “abundance of caution,” stating that “the court is fully aware of the misconception, misinformation, bad science, and bad information being spread from shore to shore in our country with respect to Ebola. The court is fully aware that people are acting out of fear and this fear is not entirely rational” (Miles 2). While this fear is present, it is due to misconceptions of Ebola itself and how it is transmitted, such as that it can be transmitted if someone is asymptomatic of the disease. Rosenberg again clearly articulates the motives of these political leaders, stating “Disease is... an occasion for and potential legitimization of public policy, an aspect of social role and individual identity” (305). An opportunity was seen to institute policy that would reassure constituents all in the name of politics (Miles, Rosenberg 294). The institution of such policy, however, simultaneously removed her “individual identity” in the quarantine. The transmission

misconception played directly into Hickox’s quarantine, casting her as a hazard and human vector, like the age old tales of Typhoid Mary and Patient Zero, as mentioned by Wald, and like Charles Monet in Preston’s book (Wald 70).

Public fear led to even more criticism and poor treatment of Hickox as well as other healthcare workers. In an interview with Kaci Hickox in 2014, Today show host Matt Lauer interrupted the villainized Hickox and pointed out that days before her arrival, Dr. Craig Spencer had been walking around New York with Ebola. He proceeded to ask her “do you understand what that did to the psyche of public officials in what is a metropolis of 9 million people?” (“Matt Lauer and US Nurse Kaci Hickox”). This irrational fear from Dr. Spencer’s initial quarantine and diagnosis was enough to justify the quarantine of Hickox (Miles). The workers were consequently seen as public dissidents not caring about, as Wald called it, their “social responsibility” or measure of “citizenship” to quarantine themselves. Furthermore, in this interview Hickox stated that “if you are going to put a policy like that in place [21 day quarantine] that impedes on my civil rights, then you need to have the administrative details worked out before you detain me in an airport” (“Matt Lauer and US Nurse Kaci Hickox”). Hickox’s disenfranchisement further demonstrates the negative response and stigma toward an individual who worked so hard to save many lives abroad. Wald’s outbreak narrative construction is again poignant, stating that “conflict arising from the state’s obligation to safeguard both civil liberties and public health and well being” (70). In this case, the state infringed on her civil liberties in an effort to institute public policy that would alienate her and cast her as a health hazard for “political expediency” (Miles).

#### *Change in Policy Since 2014*

Kaci Hickox did not stand for this abhorrent treatment however and in 2017 filed a lawsuit against Governor Chris Christie for his violation of her civil liberties (Santora). She initially sought compensation in the amount

of \$250,000 but dropped the suit under the agreement to create a ‘Bill of Rights’ for “individuals subject to possible quarantine or isolation in New Jersey” and this “sets a model for other states to replicate” (Harrison). This policy sparked by Hickox achieves many things. First, Quarantine or isolation will be imposed only when “medically and epidemiologically necessary to prevent the spread of Ebola,” however they must be carried out in the “least restrictive means to prevent the spread of Ebola,” and after less restrictive measures have been explored (Harrison). Finally, there must be a comprehensive order documenting information such as the legal authority under which the order is issued, the medical basis, and a statement explaining the right to hold an attorney and appeal (Harrison). While this is only one policy change since the disastrous display in 2014, it is a step in the right direction, one that “upholds the values of liberty and due process” (Santora).

#### *Conclusion and Implications*

The debilitating quarantine policy implemented by politicians during the Ebola outbreak in 2014 was a novel response to epidemic among healthcare workers in the United States. In the 2003 SARS outbreak, there was a clear line in the sand that the United States would not cross, the violation of civil liberties. It would not institute the mandatory quarantine of healthy travelers from areas of high SARS transmission, something that other nations like China did (Cetron et al). The U.S. instead followed CDC recommendation and aided on the side of not potentially violating any civil liberties or “due process” of aid workers (Cetron et al). The novelty of the U.S. response in 2014 then came not from precedent, but from public fear and the utilization of this fear by politicians.

Dr. Craig Spencer and Kaci Hickox’s heroic actions were met with intense and turbulent public fear that they would be Wald’s “superspreader” that brought Ebola back to the United States. While in Africa, their heroic actions saved many, but at home, they were health hazards that

belonged no where near the American public. Not all outbreak narratives are the same however, and Hickox was plagued with pronounced neglect of civil liberties while Spencer was shamed for his actions. As a result of their hard work and efforts, governors from New York, New Jersey, and Maine instituted strict 21-day home quarantine laws that went against CDC recommendation of simple self monitoring, the practice that Dr. Spencer underwent when he reported himself to the board of health (Spencer). Fear drove a response that resulted in stigma and negative public opinion which culminated in public health policies that could, as Hickox mentions, “have a chilling effect” on future generations of workers in their willingness to fight disease (“Matt Lauer and US Nurse Kaci Hickox”). These mandatory quarantine laws essentially cast returning aid workers as pariahs and hazards to greater public health. Spencer argues that this negative response will have debilitating effects on the decision of future aid workers to help fight Ebola and other epidemics (Spencer).

Public health policy was therefore informed by the politics of fear and as Spencer mentions “if the U.S. public policy response undermined efforts to send more volunteers to West Africa, and thus allowed the outbreak to continue longer than it might have, we would all be culpable” (Spencer). This could undermine the ability to fight disease effectively and the response of the United States could have put many lives at stake (Spencer). The outbreak narratives of Dr. Spencer and Kaci Hickox, and the detrimental effects that resulted, demonstrate a need for pragmatic public health policy to inhibit a similar situation from happening again. The fear of being quarantined however is not as strong as the call to serve as can be seen with Hickox’s belief in systemic quarantine policy change. Ms. Hickox did not take the money in an effort to effect real change that would protect the civil liberties of other heroic and asymptomatic healthcare workers on their return from fighting Ebola.

While the fear and the U.S. response reduced the humanity of Dr. Spencer and Kaci Hickox to vectors of disease, paralleling the concepts of Wald’s outbreak narrative as well as Preston’s presentation of Ebola itself as a dehumanizing monster, resulting in a disastrous and harsh quarantine policy, they both stated that they would go back to West Africa to help fight Ebola (Spencer, “Matt Lauer and US Nurse Kaci Hickox”). Through the understanding of the source of fear surrounding Ebola using the outbreak narrative and Preston’s novel, as well as the comparison to the SARS outbreak, one can grasp the novelty of U.S. response in 2014 in its neglect for aid workers through the politics of fear. However, Hickox’s commitment to the betterment of quarantine policy and rights of healthcare workers is apparent through her institution and work towards a “bill of rights” for those quarantined. Furthermore, even though it was discovered that politicians utilized this fear for their own gain, individuals like Hickox and Dr. Spencer will not be stopped, and will continue their efforts in West Africa and beyond. The call to serve and the commitment to the oppressed may outshine the narratives and politics of fear.

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# HEALTHCARE SYSTEMS: A COMPARATIVE ANALYSIS OF HEALTHCARE IN IRELAND, NORTHERN IRELAND, AND SCOTLAND

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All citizens of the countries of Ireland, Northern Ireland, and Scotland are entitled to receive public health care. However, with different systems set in place in each country, the treatments and processes involving this care fluctuate. Even citizens in the same country are often victims of issues with their respective healthcare systems. Irishmen and women who live on Inis Oirr, the smallest of the three Aran Islands – part of the greater Republic of Ireland – must suffer through great difficulties in times of medical needs. A representative from the island, while claiming that their health services are “on par” with that of the mainland, also admitted that elders and pregnant women need to travel to the mainland – with all expenses paid out of their own pocket – just to have access to this mainland healthcare. Similarly, a study involving the Scottish Social Attitudes Survey also feel that emergency coverage is significantly weaker in rural areas, once more putting at-risk groups such as the elderly in an unsafe situation. Despite these policies containing vast differences between each country and severe disparities between groups and locations within the countries, healthcare is still seen as essential within the major nations of the British Isles. This paper will go further into detail concerning the specific healthcare systems of Ireland, Northern Ireland, and Scotland, and will explore how these differences affect the citizens of each respective country.

Overview of healthcare and its importance

There are many different types of healthcare systems that countries choose to utilize. While each country creates their own variation, forming the vast differentiation

of policies, there are four basic models which all healthcare is based on the Beveridge, Bismarck, National Health Insurance, and Out-of-Pocket Model. The Beveridge model, which is observed in states such as Great Britain and Spain, provides medical services to their citizens through governmental taxes. In theory, most hospitals are owned by the government. The Bismarck model, seen in Germany, France, and Japan, for example, utilizes an insurance system with privatized hospitals. The National Health Insurance model, primarily found in Canada and South Korea, uses private-sector providers with government funding. The Out-of-Pocket model is seen in less developed countries. In this system, if one can afford medical care, they will purchase it. If they cannot afford the proper medical attention, they will be forced into staying sick or dying.

Despite there being only four basic models, when it comes to healthcare policy nearly every country has distinct variations. Jacob S. Hacker, an expert of healthcare policy from Yale University, explains that the form of these policies “depends on the market structures, policy ideas, interest group strategies, and public views.” In other words, each nation has its own history, political ideologies, and economic abilities. These differences in the political institutions of each nation “influences...the types of interests and ideas...and the kinds of policies that countries adopt.” This is how a country like the United States can have a healthcare system with aspects from all four models; or how two nations utilizing the same model can have vastly different policies.