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Breaking news! Big Shift in Biomediatization from "Swine Flu" to H3N2 to the Trump Administration's Attack on Breastfeeding

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By Charles L. Briggs

The H3N2 epidemic didn't really take off until early January 2018—at least as far as US media coverage is concerned. A crucial marker was the *New York Times*' publication of an op-ed by a prominent germ cold warrior, Michael Osterholm, along with Mark Olshaker, co-author of *Deadliest Enemy: Our War against Killer Germs*. Osterholm, extensively profiled by Andrew Lakoff (2017), crafted the quintessential preparedness soundbite projecting the inevitability of a massive viral catastrophe: "It is not a question of if, but when." The 8 January op-ed, predictably entitled "We're Not Ready for a Flu Pandemic," opened with references to overflowing ERs, children's flu deaths, and a claim that the season's influenza vaccine is ineffective. Alluding yet again to 50-100 million deaths from the 1918-1919 "Spanish flu" epidemic, Osterholm and Olshaker used H3N2 to sound the basic preparedness message even as they reconfigured the rationale for even more massive biosecurity investments: "Yet as bad as this winter's epidemic is, it won't compare with the flu pandemic that is almost certainly on the horizon if we don't dedicate energy and resources to a universal vaccine."

Reading the op-ed as signaling how the *Times* would treat H3N2—and thus influence national and global coverage—I figured that this past flu season would be déjà vu all over again, that it would replay the barrage of articles that helped construct the "swine flu [H1N1] pandemic" of 2009. My diagnosis was wrong. The more deeply I looked into newspaper, television, radio, and social media reporting of H3N2, the more I found evidence of an important shift. My work on biomediatization, in collaboration with media studies scholar Daniel Hallin (Briggs and Hallin 2016), suggested that health news stories provide just one manifestation of a process conducted not only in newsrooms but in clinics, laboratories, public health offices, and on cellphones that co-produces medical objects and subjects through entanglements of seemingly opposing professional practices and ideologies. After presenting—for purposes of comparison—brief notes on 2009 H1N1 coverage, I look here at how H3N2 reporting in 2018 stepped back from the preparedness logic that Osterholm so enthusiastically promotes. Rather, the deeper engagement of health

journalists within the biomediatization of epidemics during this period seems to be partially undermining such biosecurity logics. A factor that lies behind this shift, I suggest, may be journalistic reactions to what are perceived as incursions into health policies by the conservative politics of the Trump administration. All of this offers, I argue, new analytic challenges for anthropology and important possibilities for more effectively engaging the politics of the contemporary.

Crafting the "Swine Flu Pandemic" Narrative in 24 Hours: Biomediatization on Steroids

On 23 April 2009, NBC and *TheNew York Times* presented short, routine stories reporting a Centers for Disease Control and Prevention (CDC) conference call discussing seven US cases of "swine flu." The following night, however, "swine flu" was the lead story on NBC's Nightly News. After anchor Brian Williams introduced Science Correspondent Robert Bazell, CDC Interim Director Richard Besser appeared at a news conference, warning: "This is something we are worried about, and we are treating very seriously, and I think that it's important that people should be paying attention to what's going on." After Bazell cautioned "The big question now, how much further will the virus spread?" we got the predictable unpredictability sound bite from Osterholm: "We really are in a very difficult position right now, where we have much more uncertainty than we do certainty, and unfortunately that uncertainty all bodes poorly for the future, if we show ongoing transmission." (The linguistic anthropologist in me cannot help but appreciate Osterholm's mastery of the poetics of soundbites.) Bazell concluded that"it would be a good time for communities to review the preparedness plans they were supposed to come up with." Donald McNeil's story, co-authored by the *Times'* Mexico correspondent, presented an even more complex scientific narrative, comparing H1N1 to H2, H3, and H5 viruses. H1N1 became one of the leading U.S. news stories of 2009 and was widely reported globally; the narrative was remarkably stable until the rollout of the vaccine in August of that year.

Studying "the pandemic" as biomediatization rather than as a decontextualized textual corpus involved conducting ethnography with public health officials from local to national levels, including Besser, television, print, radio, and online health journalists, flu researchers, clinicians, bureaucrats, and laypersons (Briggs and Hallin 2016). This research suggested how developing a powerful narrative in 24 hours was made possible by years of work creating a vast preparedness-specific biomediatization repertoire of texts, images, and practices. Besser told us that "the materials were there. They had to be modified, because we'd

been planning for bird flu, and this was pig flu." The CDC had built a vast network of leading health and security officials, researchers, clinicians, and journalists through "crisis and emergency risk communication" manuals and courses and hundreds of biosecurity "exercises" or "scenarios." As Besser put it, "we had also been exercising around pandemic flu for years," and the CDC had given "states and locals … money to exercise on flu." Audiences had been trained cognitively and affectively through prior biomediatizations of influenza, SARS, Ebola, and such fictional germ thrillers as *Outbreak* and *Contagion*. Producing the H1N1 narrative of epidemic uncertainty transformed the largest and most expensive rehearsal process in the history of the planet (with the possible exception of "civil defense" preparations for nuclear war) into a global performance. The "swine flu" narrative reoriented public health expenditures and policy practically overnight, in the nearly complete absence of epidemiological or clinical data. Ultimately, the 2009 H1N1 strain turned out to be less lethal that most seasonal influenza viruses.[1]

Transforming Biomediatization from H1N1 to H3N2[2]

Fast-forward to 2017-2018 and coverage of H3N2. National network television news echoed some of the alarm frames evident in 2009 coverage. A CBS Evening News broadcast of 6 January featured anchor Reena Ninan and reporter John Blackstone cautioning that 27 people had died in California alone, that ERs were so overcrowded that some hospitals were erecting tents to accommodate patients, and health officials were "sounding the alarm." If the story had unfolded like 2009 H1N1 coverage, we would have expected to hear from CDC Director Brenda Fitzgerald, but CBS featured San Diego-area emergency room physicians as sources. Rather than shots of scary Level 4 laboratories and ominous music, we got the sights and sounds of doctors moving between computers and patients, scenes witnessed nearly any day in emergency rooms. Physicians reported that the season is "moderately severe," but numbers were placed in the context of "ordinary" flu seasons: "every year we see an influx of flu patients. This year it just hit very hard and very quickly." An ABC Evening News report the following night similarly provided the familiar scary flu graphics, with 46 states on a US map colored bright red. An affectively charged human-interest angle emerged as a mother told viewers that she didn't foresee the influenza death of her young son, his sister sobbing in the background. A Santa Monica doctor opined that "this is, I would say, the worst flu season that I've seen." Not a national or even local health official, she is not even named. Like most of these stories, this one ends with a normalization segment focused on identifying flu symptoms and a plea that viewers get vaccinated.

You might think that we could count on Donald McNeil, key architect of the H1N1 pandemic story, to take us back to 2009 influenza biomediatization practices. Nevertheless, his first big story during the January 2018 surge —of news articles—is pegged to just the sort of biomediatization event that gave rise to his initial, low-key 23 April 2009[3] story: a telephone conference with a lower-level official, the director of the CDC's influenza division, Daniel Jernigan. McNeil quotes Jernigan as saying "H3N2 is a bad virus. We hate H3N2," and as warning that "H3N2 tends to kill more of the very young and very old." McNeil again constructs this epidemic vis-à-vis previous ones, as CBS does in relating H3N2 to H1N1 in 2009, but intertexuality—weaving an unfolding story into ones known to audience members—took a very different turn with H3N2. Rejecting any sense of alarm, McNeil notes for H1N1 that "although millions caught it, it turned out to be relatively mild, and few died." If there is a self-critical note here, McNeil does not make it explicit.

McNeil continues: "Warnings about the "Killer Aussie Flu" were raised as far back as September — mostly by British media outlets." The way he discounts these journalists is crucial. McNeil cites Anthony S. Fauci, director of the National Institute of Allergy and Infectious Diseases, in suggesting that "those fears are probably exaggerated because of two important differences between this country and Australia." McNeil cites a policy difference in which Australian authorities only recommend flu vaccine for health care workers and "high risk" groups, versus US guidelines that urge vaccination for everyone older than six months of age. Other stories suggested that Australian authorities failed to fulfill their proper role in biomediatization by failing to recommend clearly and forcefully that everyone get vaccinated and to compile adequate statistics on vaccinations, cases, and deaths. Note how intimately journalists linked two dimensions of biocommunicability—the circulation of pathogens and of communication. McNeil concludes his article:

> Some flu experts have privately complained that this year, the C.D.C. appears to be promoting vaccination less vigorously than usual, especially given the "Aussie flu" worries.
>
> Dr. Jernigan expressed surprise at hearing that, but said changes in leadership within the Trump administration might have shifted media attention away from the issue.
>
> Normally, the C.D.C. director holds a news conference each September to assess the coming season and urge Americans to get vaccinated. This year, Dr. Jernigan noted, the news conference was led by Tom Price, who was then the secretary of health and human Services, which oversees the C.D.C.; Dr. Price, a physician, publicly got a flu shot.

> But Dr. Price was at that time under intense scrutiny for his private jet travel, and political reporters were following his every move more closely than health reporters. He resigned under pressurethe day after getting his shot.

A key focus for McNeil is thus how H3N2 has been biomediatized. This is not unprecedented. Indeed, 2009 coverage often constructed a binary that characterized H1N1 as either a global killer or "pure hype," the latter referring to deliberate journalistic misrepresentations of medical knowledge (Briggs and Nichter 2009). Although the "pure hype" trope invites critical, ironic, and humorous tones—in social media and Jon Stewart's *The Daily Show* and even in "mainstream" coverage itself—it reiterates three centuries of boundary-work (Gieryn 1983) in opposing science and language/communication (see Bauman and Briggs 2003). The binary's premise implies that news stories should perfectly mirror biomedical knowledge, thereby keeping health journalism separate from and subordinate to medicine.

But things unfolded differently in 2018 due to a transformation in relations between practices of biomediatization and the manner in which they are ideologically projected, which I have termed biocommunicability. The latter involves the construction of shifting, intimate, and inverse relationships between of the circulation of communicable pathogens on the one hand and medical knowledge on the other (Briggs and Hallin 2016). In 2009, although journalists were deeply enmeshed in the complex assemblage of sites, logics, actors, and practices that give rise to news stories as much as to drugs, policies, diseases, and treatments, news stories contained simplifying biocommunicable projections that positioned health professionals as medical knowledge producers and journalists as watching from the outside, located in a separate realm of "communication." As if health journalists had read *Making Health Public* (some have, we know), biomediatization practices and biocommunicable models for epidemics were much more closely aligned in H3N2 coverage. McNeil's story thus constructs health officials, researchers, journalists, and laypersons as sharing complementary roles and responsibilities. For coverage of epidemics—although not for all health news stories—the boundary between medicine and communication, between health and journalism professionals, seems to have given ground to projections of a shared commitment to healthy biocommunicability, to facilitating the circulation of legitimate knowledge and controlling the spread of both non-knowledge and pathogens.

From H3N2 to the Trump Administration's Attack on WHO

Breastfeeding Policy

Few anthropologists would expect, however, that all forms of boundary-work would disappear. Let us accordingly return to McNeil's article to see how the "media hype" frame, rather than dividing health officials and journalists, points to a different locus of differentiation. McNeil does not project bounded domains of medicine and communication, the former occupied by "flu experts" and the latter by journalists: the "experts" are rather tracking not just the "flu activity" of pathogens but the CDC's biomediatization activity. Medical specialists' role in mediatization goes beyond appearing, like Osterholm, as sources in stories to include "privately" evaluating a type of flu communicability in which biological and communicative elements are intimately enmeshed. To be sure, the assertion that the CDC "appears to be promoting vaccination less vigorously than usual" may reflect concern that the "anti-vax" position of sectors of Trump's political base was influencing H3N2 biomediatization. The CDC's Jernigan shoots back, accusing "the media" of failing to fulfill its biomediatizing role by focusing on politics—instability among Trump administration officials—rather than on biomedical facts. Jernigan suggests that presenting Secretary Price on camera for the annual flu season projection and vaccination promo proved that Trump officials took vaccination health communication *more* seriously than previous administrations. Indeed, in a 2012 interview, Besser told Hallin that the CDC signals the depth of its biomediatization efforts—and the kind of response it hopes to achieve—through whether it offers journalists an on-camera press conference with the director or just a backchannel "telebriefing"—a telephone call for journalists— in which a subordinate official provides facts and interpretation and in which visuals are obviously absent.

McNeil nails this counter-defense in two ways. One weakness is that CDC Director Fitzgerald did not appear on camera announcing the agency's emerging influenza strategy. This decision might have been related to political fire regarding her tobacco and health industry investments, which led to her resignation in late January 2018. McNeil points out what he sees as a second flaw: Jernigan's conflation of "political reporters"—who follow scandals regarding officials' questionable expenses and conflicts of interest—with health journalists like McNeil. Herein lies what I see as a major shift in epidemic biomediatization—specialist journalists' projection of themselves as located *inside* epidemic biomediatization, together with "expert" clinicians and medical researchers. Health officials are deep insiders, of course, but only when they do their epidemic biomediatization jobs without allowing personal improprieties or political pressure to undermine their ability to influence the circulation of medical knowledge and pathogens.

This issue takes me back to a *Washington Post* story of 15 December 2017 reporting that "The Trump administration" had prohibited CDC officials "from using a list of seven words or phrases" in budget documents, which I discussed in a previous *Somatosphere* post. It was reported by Lena Sun, who focuses on health issues, and Juliet Eilperin, the *Post*'s "senior national affairs correspondent." Wouldn't this collaboration violate the boundary-work that McNeil posits? Actually, the opposite is true. The implicit allegation was that the Trump administration had violated the integrity of public health policymaking by imposing a list of "forbidden words" that reportedly included "transgender," "fetus," "evidence-based" and "science-based." The boundary reportedly violated here is, of course, what Bruno Latour (1993) identified as a fundamental basis of modernity, purifying the domains of science and politics. Covering the issue—and restoring the boundary between politics and public health—would thus require a political reporter covering how conservative agendas are shaping administrative policies and a health reporter getting inside the CDC. In short, one binary with 300-year-old roots—the opposition of language and science—seems to be receding in favor of sustaining another, that of science and politics.

Ouch! Even as I was writing the preceding lines, another *Times* article—"Opposition to Breast-Feeding Resolution by U.S. Stuns World Health Officials"—popped up on my screen. Here it *was* déjà vu all over again as I read that Trump officials were returning to the intensity of Reagan-era efforts to force the World Health Organization to embrace corporate efforts to rollback public health measures that reduce profits. The article focused on a largely unsuccessful campaign in 2018 to kill a WHO resolution that supports breastfeeding and urges member countries "to limit the inaccurate or misleading marketing of breast milk substitutes." The article placed this issue in the context of "the Trump administration siding with corporate interests on numerous public health and environmental issues." Given the administration's ongoing attack on scientific evidence, the ironic demand—according to the article—that WHO qualify breastfeeding recommendations with the words "evidence-based" brought to mind anthropological work on the politics of evidence in public health (see Adams 2013).

Reading the article could almost prompt me to put aside work by anthropologists and others scholars that reveals how projecting ideological boundaries between science and medicine, politics, and capitalism helps produce and reify these categories. Indeed, I could celebrate how *Times* journalist Andrew Jacobs, who often reports relationships between obesity, diabetes, and corporate interests, worked insider circuits of both international politics and of public health research and activism in reporting this stunning news, to evoke his title. At the same time, my long engagement with biomediatization prompts me to refrain from taking at

face value content that so neatly fits the analysis I have presented about shifting loci of boundary-work—not to mention my own political sensibilities—and think critically about what comes along for the biocommunicable ride. Shifting gears, a couple of contradictions appear.

First, Jacobs describes an anonymous Department of Health and Human Services spokesperson's emailed defense of women who cannot breastfeed, suggesting that the administration was supporting their "'choice and access to alternatives for the health of their babies, and not be stigmatized for the ways in which they are able to do so.'" Jacobs again seems to be playing on the irony of a Trump administration official deploying a logic defending the rights of individuals to make consumer choices unconstrained by what are projected as excessive regulation or liberal dogmas as a cover for supporting corporate agendas. We should bear in mind, however, that US health news also prominently projects the figure of the individual patient-consumer who actively seeks out multiple sources of information relevant to his or her health and then freely and rationally chooses from available prevention and treatment strategies (Briggs and Hallin 2016). Although health journalists seldom evoke the patient-consumer model in reporting epidemics, it is quite common in coverage of other issues, particularly those projected as revolving around lifestyle choices.

Second, the Trump administration threatened, according to Jacobs, to "unleash punishing trade measures and withdraw crucial military aid" from Ecuador unless it withdrew sponsorship of the resolution. As we know, Trump used the "national security" clause of the 1962 US Trade Expansion Act to justify such "trade measures." The implicit moral outrage that a health reporter displays in drawing attention to the administration's linking of national security to efforts to shape public discourse about health issues is itself complicated by the active role that journalists have played in securitizing health. Here is a key reason that I think that coverage of H3N2 is so significant. Ethnographic and archival work suggests to me that preparedness logics are neither monolithic nor pervasive. 2009 may have been the heyday of their co-production by "experts," politicians, and public health officials as well as by journalists, but even then they were performatively produced and often mixed with or actively confronted by a host of other logics, including the professional ideologies of physicians, public health professionals, and journalists and healthy doses of humor, irony, and skepticism.

By 2018, additional years of experience inside the belly of the biomediatization beast—along with the specificities of the 2017-2018 flu season—seems to have prompted health reporters to limit the role of preparedness logics in shaping their narratives. In 2018, CBS, McNeil, and other prominent journalists seem to have shifted to a process of *slow,*

cautious epidemic biomediatization for H3N2, of placing their reporting not "in front of" viruses whose lethality was enshrouded in uncertainty and alarm but within an ongoing, normalized process of biocommunicable surveillance in which a wide range of disinterested and knowledgeable actors were promoting the circulation of legitimate biomedical knowledge—and thus limiting the circulation of dangerous pathogens. The consummately mediatizated Trump administration's constant attack on "the media" as "fake news" and the high profile of anti-science voices within it—officials' violations of politics versus science/medicine boundary-work—may be part of this story, but I offer this observation only as cautious speculation. I think it likely, however, that what is going on is that intense engagement with epidemic biomediatization over years is pushing journalists to help usher us into a *post-(un)preparedness epoch*.

On Biocommunicable Futures and the Role of Anthropologists

I end with several caveats and a challenge for anthropologists. The medicine/communication boundary has not disappeared from health news coverage; producing new risks, threats, and miraculous treatments often involves constructing health journalists and their audiences as outsiders looking in on medical realms that we can only visit on the coattails of experts, including doctors and highly specialized journalists (some of whom are physicians). Also, as Hallin and I argue, biomediatization unfolds in distinct ways in relation to different types of coverage: epidemics, pharmaceuticals and biotech, and what are projected as ethnic or racial differences in health involve different biocommunicable models and processes of biomediatization. Moreover, I have only tried here to read an emerging trend, not predict the future. As with H3N2, the construction of any new epidemic will include elements of alarm and containment, strategies for engaging anxieties and then mitigating them (Ungar 2008). It is entirely possible that a new "crisis" will resurrect H1N1-like biomediatization, that is, projecting uncertainty, danger, and the need for massive affective and infrastructural investments. Note how *San Diego Union-Tribune* reporter Paul Sisson mitigated strong unpreparedness statements, such as "The flu contributed to the death of another child last week, further highlighting the severity of what is shaping up to be the worst influenza epidemic since the pandemic year of 2009," by reporting that H3N2 in 2017-2018 is "definitely not" like 2009-2010, because "a novel flu virus" like H1N1 is not "in broad circulation this year." Future reports of "a new flu virus" could thus culture a new strain of biosecuritization. Osterholm's op-ed warns us that there is still a powerful network of researchers, clinicians, journalists, popular writers, politicians, military and homeland security personnel, and corporations out there promoting the securitization of health.

Lastly, the challenge for anthropology. You may have noted that I have not included anthropologists in these biomediatization networks, and for good reason: *anthropologists have largely excluded themselves*. Some medical anthropologists, such as Paul Farmer and Nancy Scheper-Hughes, are go-to sources for journalists, and their soundbites appear frequently. Nevertheless, medical anthropologists generally position themselves in one of two relationships to health journalism—as either able to adequately grasp complex biomediatization processes through literal readings of the content of stories or as circumventing altogether the need to look at this seemingly superficial domain of communication by going upstream to sites where biomedical knowledge is actually produced. Both positions beautifully reproduce naïve biocommunicable models. I have argued that biomediatization takes place in laboratories, clinical settings, public health offices, and corporations as much as in newsrooms and social media sites, that it helps produce particular types of microbes and bodies as much as it engenders its most obvious and easily accessible manifestation: media content. Unfortunately, anthropologists too seldom join health journalists, medical "experts," corporate media employees and consultants, and public health officials in thinking reflexively about biomediatization and our own roles within it. We only too infrequently deploy our own powerful technology—ethnography—in investigating how biomediatization is constantly unfolding and how it is making and being made by the frightening, maddening world in which we currently live. Beyond helping us see how such things as epidemics, corporate attacks on the promotion of breastfeeding, and laws and policies that limit reproductive rights are made, thinking critically about our roles inside biomediatization would help us explore ways that anthropologists can help create more adequate biocommunicable models and biomedizatization practices—and thus put themselves in a better position to confront the plague of unhealthy policies that currently surrounds us.

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Endowment for the Humanities, the Lichtenberg-Kolleg, and the Center for Advanced Studies in the Behavioral Sciences.

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Notes

[1]For a sampling of relevant anthropological research, see MacPhail's (2014) work on "viral networks" of H1N1 epidemiology and virology and Caduff (2015) and Lakoff (2017) on preparedness and biosecurity.

[2]I thank Daniel Hallin and Bobby Stahl for sending me H3N2 stories.

[3]The story appeared digitally on 23 April and in print the following day.

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