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Epidemiological placism in public health emergencies: Ebola in two Dallas neighborhoods

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ABSTRACT

Super-diverse cities face distinctive challenges during infectious disease outbreaks. For refugee and immigrant groups from epidemic source locations, identities of place blend with epidemiological logics in convoluted ways during these crises. This research investigated the relationships of place and stigma during the Dallas Ebola crisis. Ethnographic results illustrate how Africanness, more than neighborhood stigma, informed Dallas residents' experience of stigma. The problems of place-based stigma, the imprecision of epidemiological placism, and the cohesion of stigma to semiotically powerful levels of place – rather than to realistic risk categories – are discussed. Taking its authority from epidemiology, placism is an important source of potential stigma with critical implications for the success of public health messaging.

1. Introduction

The Dallas Ebola crisis was unlike the rest of the West African epidemic, but it is instructive for super-diverse global cities facing new spatial scales of infectious threat (Ali and Keil, 2006; Vertovec, 2007). Building on the argument that "marginalization within the city" corresponds with health inequity (Wutich et al., 2014:2), my research aimed to understand the relationships of place and stigma during the Dallas Ebola crisis. The study reveals the powerful stigmatizing trope of epidemiological placism, and points to the role played by imprecision of place in the racializing of modern infectious disease epidemics.

In epidemiological logic, infectious disease can (theoretically) be traced to an origin in space, time, and bodies (see Giesecke, 2001). The preferential treatment of those origins of infection is not an irrational prejudice, it is a containment imperative. But if we observe the varied interpretations of epidemiological place information, and witness the migration and re-interpretation of that information through professional and lay audiences, the problem of place-based stigma – a form of prejudice called "placism" – becomes clear.

Placism, as a concept, is sparsely used in geography and education literature, such as Jimerson, (2005) article on the exclusionary education policies for rural school systems, and across fields such as architecture, urban planning, aesthetics of place, and social studies of place (Carter, 2004; Cartier, 2008; Ford and Griffin, 1979; Giblett, 2009; Hage, 1997; Palmer, 2011; Stocker, 2005; Ward, 2003). I use the term placism to refer to the process by which certain places gain disproportionate epidemiological blame over local risk realities, typically because they adhere to historical or familiar cultural logics. In this conversation, I do not question the trauma experienced in an infected place, nor the genuine risk of exposure to viruses that infected travellers may pose. Instead, I build on anthropologies and medical geographies of space to argue that locational scale and the imprecision of place complicate existing models of place-based epidemiology in ways important for global public health interventions. In particular, the study uncovered diffuse continent-level placism against Africans. In my discussion, I situate these findings at the intersection of medical geography, research on semiotic and place-based stigma, and studies of structural and ideological prejudice in public health.

2. Background to the crisis

Eric Duncan, a Liberian man who had been exposed to Ebola

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days before his trip to visit family in Dallas, landed on September 20, 2014. He was entering a semiotic landscape that was home to over 20,000 resettled refugees and an approximate foreign born population of 1,134,709 (FactFinder, 2013). He was diagnosed with Ebola and admitted to Presbyterian Hospital on September 29th and he died on October 8th. Two of his nurses were subsequently diagnosed, treated, and recovered: Nina Pham, diagnosed on October 11 and cleared on October 24th; and Amber Vinson, diagnosed on October 15 and cleared on October 22. Tremendous public health, governmental, medical, and media attention was given to these cases, particularly Mr. Duncan's and to the actions of Presbyterian Hospital. National and international media trucks were visible in the neighborhoods of Mr. Duncan and Ms. Pham (these neighborhoods are described below) for several days and reports of aggressive tactics by journalists in Mr. Duncan's neighborhood are given in the narratives below. No other cases of Ebola were recorded in Dallas following these three, though the West African Ebola epidemic, which peaked in 2014, produced cases into 2016.

When his diagnosis was confirmed, Eric Duncan's identity was swiftly encapsulated in local media as his *neighborhood*, Vickery Meadow:

> The Ebola crisis *in Vickery Meadow* is truly tragic; tragic for Thomas Duncan, tragic for his family and tragic for his larger community. The fear associated with it is completely understandable, and in many ways it resembles the early days of the AIDS epidemic. This is a deadly virus that is poorly understood by most of us outside the medical profession. Caution is certainly warranted, but I hope we can prevent this tragedy from spreading by not letting our concern turn into fear or intolerance.
>
> Stephanie Hunt, Dallas
>
> The root of this crisis *is Vickery Meadow*. You can't stuff that many poor immigrants, refugees and undocumented aliens together then look away, as this city has been doing. Vickery Meadow is a boiling pot that will spill over again if we keep ignoring it.
>
> Jason Nancarrow,
>
> Dallas/Preston Hollow
> Dallas Morning News
> October 6, (2014) (Letters to the Editor, emphasis added)

Could neighborhood, as these letters suggest, be pivotal to one's experience of the Ebola crisis in Dallas? Anthropologists engaged in crises and epidemics have insisted that local vulnerabilities dramatically affect behaviors, understandings, and containment; that subgroups need special attention, and that institutions must be scaled to engage in local, individual, and community trust-building in order to be effective (Abramovitz et al, 2014, Moran and Hoffman, 2014). The Hewletts (2007) captured these types of data for Ebola in Central Africa, as did a great number of social scientists working in the recent West African Ebola epidemic. Their emphasis on the local – local culture and knowledge, local resource needs and assets, and engagement with local participants – were crucial to the epidemic's conclusion in West Africa.

But tensions between epidemiological (population-level) truths regarding globally mobile infections, and the details of local places and contexts, continue to frustrate public health interventions and international collaborations (Biruk, 2014; Brown et al., 2015). There is, on the one hand, epidemiological logic for identifying an infectious disease with its geographic source or index case; and on the other hand, there are local advocates insisting on locally sensitive, semiotically relevant, and sustainable responses. Widening the divide between these approaches is the inflammatory rhetoric of emergency, which allows social and media discourse to catastrophize particular places regardless of actual risk (Fassin and Pandolfi, 2010). In the Dallas Ebola crisis, a strategic – and distinctively epidemiological – form of placism grew up around (apparent) Africans via the coalescence of epidemiological and lay discourses of imprecise place.

3. This research

As stated above, this research set out to compare resident experiences of the Ebola crisis in two neighborhoods of Dallas, each having one Ebola victim in residence. The goal was to assess whether stigma for Ebola could be tied to one's residential proximity near an infected person, or whether stigma adhered to some other variable. Stigma is one of the most evocative themes in the study of disease and society, and is highly influential during epidemics (Barrett and Brown, 2008; Des Jarlais et al., 2006; Hickson et al., 2004), with the relationship between perceived neighborhood stigma and poorer health being well established (Gupta and Ferguson, 1992; Hillemeier et al., 2003; Kawachi and Berkman, 2003; Kelaher et al., 2010; Wutich et al., 2014). Yet stigma is a particularly important element of crisis because it is a social tool, albeit a blunt one, for managing uncertainty and fear. If Ebola stigma is attached to neighborhood, then we could expect roughly equal patterns of stigma in these two neighborhoods. If not, then ethnographic interviews would help decipher what other patterns in stigma, fear, or semiotic place did exist.

3.1. Research setting

There were two primary field sites: the low-income and high refugee population area of Vickery Meadow where Mr. Duncan was visiting; and the predominantly white, middle-class M Streets/Lakewood Heights neighborhood where the nurse Nina Pham lived. Although these communities are not unequivocally bounded or defined (Gupta and Ferguson, 1997; MacQueen et al., 2001; Smith-Morris, 2006), each (as named neighborhoods in Dallas) has enough symbolic cohesion to warrant the study design.

Vickery Meadow is "a 3.5-square mile area 'created' in 1993, when a group of apartment owners formed the [Vickery Meadow Improvement District] VMID and started to work with the Dallas Police Department to address rising crime rates in the area" (Haayen, 2014). Its distinctiveness as a community has been the subject of periodic attention, mainly as one of Dallas' poorer, high-density neighborhoods. The 2014 population for Vickery Meadow's zip code was approximately 60,000. To this high density is added tremendous, and growing diversity. The International Rescue Committee uses this site to resettle a significant number of refugee families. And as Haayen reports, "the residents of Vickery Meadow represent 40 countries from around the world, and local school administrators count at least 27 languages spoken within the area" (Haayen, 2014). Median income for the zip code is $32,011, with 68.2% in the labor force and unemployment at 7.2%. Households in this neighborhood have a child dependency ratio of 42.2, and media age 30.1 years. 74.1% are high school graduates or higher, and 28.9% have a Bachelor's degree or higher. Ethnic and Refugee/Immigration status are reported in the Tables below.

The M Streets neighborhood, in contrast, has been demarcated as a neighborhood in multiple ways, increasing in size in successive online maps due to the area's rising property values. Initially, the M