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When Public Health and Government Officials Violate their Own Precautions: Lessons for the Next Crisis

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Running head: Officials and public health example

On Sept 19, 2024, the New York Times reported that Dr. Jay Varma, former NYC's senior advisor for public health, was captured on hidden camera discussing his participation in sex parties[1] and at least one rave[2] in the summer and fall of 2020. At the same time Mr. Varma presided over some of the strongest public health restrictions in NYC, including limitations on the number of individuals who could gather privately, visitor restrictions in hospitals, and closures and bans for public school and funerals. Although it is unclear if Dr. Varma's explicitly disobeyed the letter of the law, it is clear his actions were inconsistent with the spirit of the law.

Dr. Varma is not alone. Other influential scientific advisors and politicians themselves were found to be in violation of policies they supported, devised, or implemented. Neil Ferguson of Imperial College London repeatedly met a woman outside of his household during the UK lockdown.[3] Gavin Newsom participated in a dining event at the upscale French Laundry restaurant while these events were prohibited in California.[4] Boris Johnson notoriously participated in #partygate while the UK experienced COVID-19 restrictions.[5] There are many other examples.

In the wake of these revelations, surveys show dramatic declines in trust in physicians and public health officials.[6] Specifically between 2020 and 2024, the percentage of the public with a high degree of trust in physicians declined from 71.5% to 40.1%. Another study found over 24% of Americans have no trust at all or very little trust in the CDC and 21% for state public health agencies.[7] The contradiction between public health officials and government leaders' policy, rhetoric, and behavior reveals four lessons.

First, restrictions utilized during COVID-19 were antithetical to human nature. The aforementioned individuals violated policies in part because socialization, companionship, and intimacy are important human values. Yet, these considerations were under-discussed during the pandemic, and policy makers failed to embrace the principle of harm reduction. Rather than prohibiting activities, providing a safer alternative for these desires and emotions may have helped preserve trust.

Second, these examples illustrate the broader tension in public health between restrictions and resources. In times of crisis, public health can either utilize aspects of the police or carceral state to preclude or prevent actions, including fining or imprisoning individuals who gather against the rules or fail to mask. Alternatively, public health can work to empower individuals to embrace safer choices by providing paid sick leave, free tests, or services. In all instances, where hypocrisy was demonstrated, it is because public health chose the stick and not the carrot.

Third, the lack of evidence generation regarding these rules and policies is concerning. It is reasonable for public health and government officials to implement time-limited policies in times of crisis without evidence, but it is problematic if these policies continue, year over year, or if they are implemented in a way such that evidence can never be generated. A recent paper by Eran Bendavid and Chirag Patel highlights how we will never know which pandemic policies helped.[8] The authors constructed a dataset of various pandemic policies, across nations, and

rates of COVID-19 spread. They then create 99,736 models with varying iterations of included covariates and analytic plans, to try to gauge reliable estimates of the impact of various policies such as border closure, masking requirements, and school closures on health outcomes. The most common result of their analysis is null associations— the intervention was not associated with more or less covid cases, but often the authors got both answers. The intervention increased or decreased covid cases, depending on the analytic plan. Bendavid and Patel show that there is more noise than signal, and it is unlikely we will ever have consensus on which pandemic policies helped and which were ineffective or counterproductive.

Fourth, these public health officials and politicians remind us of the law of unintended consequences. School closure had an uncertain or trivial impact on viral spread,[8] but has led to massive learning losses. Learning losses appear to have washed away 20 to 30 years of hard-fought improvements in education. The impact of this on children as they reach adulthood is entirely unprecedented and concerning. Similarly, the unintended impact of the disclosure of violations like Jay Varma and others remains unknown. The public is rightfully indignant about the hypocrisy of leaders, and trust may further decline as additional examples are brought to light. Lack of trust in public health is a vulnerability for a future emergency.

Rebuilding trust in public health will be a decade long project and demands continued introspection among public health and political leaders. Although it is tempting to fault misinformation and disinformation as the root causes of mistrust in public health, it is plausible that discrepancies between the policies and behavior of officials have accelerated public distrust. Admission of these shortcomings is a prerequisite to building trust. In the future, public health should be cautious with implementing restrictions antithetical to human nature in a manner that prevents their evaluation. Staggered implementation, cluster randomization, stepped-wedge are alternative designs that may help clarify the impact of policies. Ultimately, like many human endeavors, integrity and solidarity are needed for good leadership. Public health officials and policy makers should refrain from setting policies which they themselves cannot obey.

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