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SHORT REPORT

Public health nonfeasance, misfeasance and malfeasance in the U.S. government response to COVID-19

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Received 2 November 2020; accepted 3 November 2020
Available online 11 November 2020

KEYWORDS
Coronavirus; COVID-19; Government public health malfeasance; Public health performance; SARS-CoV-2

Summary In the midst of the political leadership crisis caused by the COVID-19 pandemic in the United States, a framework of public health nonfeasance, misfeasance and malfeasance is described in order to define, categorize and understand the various forms of public health performance failure of the U.S. government during the COVID-19 outbreak response thus far. The framework in turn prompts a number of critical ethical and legal questions whose consideration are in the nation’s current and future public health interest, as the nation struggles to engage effective disease control measures to reduce spread of this, and future, pandemics.

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The United States currently leads the world in number of SARS-CoV-2 infections and deaths, remarkable given the nation’s significant public health capabilities and preparation to respond to an outbreak of an emerging infection. Governmental leadership of the outbreak response has been problematic, and adapting a legal framework can help describe unprecedented failures in government COVID-19 response. Malfeasance is intentional conduct by officials and public employees that is wrongful or unlawful — the willful, intentional act of doing harm. It is a higher level of wrongdoing than nonfeasance, which is failure to act where/when there was a duty to act. Misfeasance is lawful conduct that is inappropriate, when government officials engage action but fail to perform correctly, and can be unintentional. Over the course of the COVID-19 pandemic response, U.S. government leaders have demonstrated each form of conduct, progressing from public health nonfeasance through misfeasance to malfeasance, where the nation finds itself today.

To the detriment of public health, an unprecedented politicization has characterized the U.S. COVID-19 outbreak response, with political leaders failing to endorse and, when necessary, enforce public adoption of benign, non-injurious preventive measures such as wearing facial masks.

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https://doi.org/10.1016/j.jemep.2020.100611
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and social distancing precautions. Early in the SARS-CoV-2 pandemic, President Trump demonstrated nonfeasance in his failure to lead a coordinated national disease control response essential to controlling the outbreak, given that individual American states are not prepared or equipped to effect pan-national viral containment in the absence of federal leadership, capabilities and investment, and given the porousness of state borders ensuring ongoing disease spread.

The U.S. needed to impose a nationwide social-economic closure, extensive testing and mandatory public adoption of prevention measures simultaneously across all 50 states, long enough to significantly depress community transmission of the pathogen. Democracies in Europe, Oceania and Asia were able to do this rapidly and effectively because most have smaller populations and geography than the U.S., and an ability to leverage comparatively well integrated national health care systems. Less extensive health care, social and economic inequities, less prevalent cultural distrust of public institutions, and less social-political divisiveness also enabled more effective COVID-19 disease control in these nations. However, they also had leaders who recognized their obligations to act as faithful stewards of the public’s health and trust. This is the basis for the longstanding and current incidence gap between Europe and the U.S. With such a highly contagious pathogen, and in the absence of a vaccine, the U.S. will continue to have aggressive and chaotic outbreak growth until all states interrupt community transmission over the same, sustained time period, during which a large majority of existing infections run their course in isolation. The president committed public health nonfeasance by failing to act when there was a clear duty to act early in the outbreak to lead, rather than belatedly follow (and then abandon) implementation of effective disease control measures.

When the president advocated that Americans take hydroxychloroquine as a COVID-19 therapy after evidence showed no favorable impact on treatment outcomes (and potential adverse effects), and when he suggested Americans ingest/inhale toxic cleaning disinfectants, his actions — lawful but wrong — constituted public health malfeasance. Premature economic reopening could be regarded as government officials weighing the negative public health impact of income loss and social isolation against the risk of illness/death due to COVID-19. In these acts, the president and other officials sought to respond to the public health crisis, but the actions and recommendations were medically inappropriate and harmful to the nation, further public health malfeasance.

However, the president’s actions over recent months, endeavoring to return the economy to normal operation while disease incidence escalates across the nation, and repeatedly communicating that the outbreak is improving — when evidence clearly demonstrates climbing infections, hospitalizations and deaths — is clearly public health malfeasance. The president’s resumption of election rallies that served as coronavirus super-spreader events, is further evident public health malfeasance. These deliberate acts, pursued secondary to a political objective of re-election, caused harm by convincing Americans they are not at risk of getting or spreading infection, and undermined disease control efforts. Congregating large gatherings where preventive measures are ignored or discouraged also constitutes public health malfeasance, as does communicating that schools must reopen with children physically present in the absence of protective measures for school staff and students. This intentional wrongful conduct by public officials injures the public health of all Americans. Moreover, as the effectiveness of social distancing and isolation, economic closure and personal preventive measures to control disease spread was demonstrated in Europe and elsewhere, the president’s failure to engage the essential federal leadership role in defining and coordinating an all-states path out of the crisis, and to replicate global successes in depressing viral transmission, constituted public health malfeasance. The explicit or de facto adoption by government officials of policies that reopened the economy prematurely, intentionally allowing the virus to propagate across the U.S. population in order to achieve herd immunity, and involving the likely infection, hospitalization and death of millions of Americans with predisposing medical conditions, health care and economic inequities, should be regarded as further public health malfeasance since it well known that unrestrained viral spread will severely impact such highly vulnerable individuals.

These actions, failures to act and the deliberate, repeated communication of false state-of-the-epidemic information to the public have precipitated serious ethical and legal questions that government leaders, public health authorities, and the American public at large could have never hitherto imagined. But what exactly constitutes deliberate public health malfeasance from national and state leaders who have taken an oath to protect the public? How can such malfeasance be stopped. and by what methods? What degree of public dis/misinformation, denial or misrepresentation of scientific fact/evidence constitutes public health malfeasance? Is it possible to define public health malfeasance in outbreak response in quantitative terms, such as some percentage gap in incidence or deaths between countries succeeding at disease control versus the dismal U.S. failure? Is five or ten times greater preventable disease or death at a population level versus other advanced industrialized nations enough to initiate corrective legal and constitutional actions, such as impeachment?

Characterizing and quantifying disease control performance that warrants action to halt public health malfeasance by government officials raises complex and difficult questions, but given the troubling U.S. government response to COVID-19 thus far, essential. At what point does the ongoing conduct of public health malfeasance, of deliberate acts to mislead/misinform the American public for electoral or other political advantage become a high crime, misdemeanor, or violation of the public trust of sufficient magnitude to warrant rapid removal from office through impeachment and/or possible criminal prosecution? Does public health malfeasance in current governmental COVID-19 (or future pandemic) response have to achieve some threshold of preventable American death/disease to become an impeachable offense? Will 1–2 million preventable deaths from COVID-19 (or a future outbreak) warrant removal from office? If not, how many Americans must die preventable deaths before leaders who undermine effective governmental response are forced to halt such efforts and/or lose their authority and leave office? Will it
require the preventable deaths of 5% of the nation’s population, or 10%?

Despite the suffering of those who have been or yet will be infected, who have died or will yet die from COVID-19, epidemiologically speaking humanity was fortunate this virus has a relatively low 1–3% fatality rate, rather than the higher lethality of other viruses in its family, which are 10 times more deadly. With the undermining, abandonment or chaotic implementation of proven disease control measures, if SARS-CoV-2 burns through a high enough percentage of the U.S. population before a vaccine is distributed (and accepted) by Americans, its death tally could number in the millions. Even more, if one considers avoidable deaths due to the diversion of health care and social welfare systems from caring for non-COVID maladies. If the next viral epidemic has a fatality rate of 15–20%, will that impact how rapidly action is engaged to stop public health malfeasance by government officials whose obligation to protect the public health has been corrupted by politicization, pursuit of electoral or other self-interest, and/or who are demonstrably incompetent and unable to respond with a disease control effort and impact comparable to other nations? If this or the next U.S. Congress does not investigate and prosecute this president’s and a number of state governors’ conduct of public health malfeasance, what does that imply for its future ability or inclination to do so, and what precedent will be defined by such an act of Congressional omission and nonfeasance? If these individuals avoid bearing responsibility for the preventable deaths and disease that their public health malfeasance caused, a very dangerous precedent will have been established.

It is clear from the fact such questions are appropriately and legitimately asked at this time that the COVID-19 pandemic in the United States has precipitated a serious, historically unprecedented crisis of public health malfeasance perpetrated by political leadership equal to — or exceeding — the health care crisis caused by the virus itself. Public health leaders must engage and help drive national governmental responses to these failures, even if the nation soon achieves control of the outbreak, in order to ensure that future public health nonfeasance, misfeasance and malfeasance by the nation’s leaders do not result in the preventable deaths of hundreds of thousands (or potentially millions) of Americans, as occurred in 2020 and which will continue well into 2021.

Funding

This work was not supported by any funding.

Disclosure of interest

The author declares that he has no competing interests.