

ACCESS, OPPRESSION, AND SOCIAL (IN)JUSTICE IN EPIDEMIC CONTROL

Race, profession, and communication in SARS Outbreaks in Canada and Singapore

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This article investigates issues of social injustice experienced by various oppressed groups in SARS outbreaks in 2003, paying particular attention to medical care workers in Canada and Singapore, with many of them being immigrants from East Asia and Southeast Asia. It identifies communication strategies employed by civic networks, especially nonprofit organizations, to help marginalized groups acquire institutional and literacy accesses so that they could respond more effectively to such injustices in complicated and multicultural contexts. Through combined use of Jost and Kay's work on the three types of social justice (2010), oppression (Young, 1990), and access (Porter, 1998), this study produces rich and multifaceted insights about issues of social injustice in SARS outbreaks. More importantly, it elaborates on the theoretical connections among the three social justice theories and shows possible entry points, particularly the conjunction between process control and informational justice, for professional communicators to produce constructive responses to social injustices and to promote social justice and access for marginalized groups.

Keywords. Epidemic control, Quarantine, Social justice, Professional communication, Health crisis management.



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International travelers, epicenters, masks, quarantines, and border screening. This list may remind one of SARS in 2003, H1N1 flu in 2009, or the Ebola outbreaks in 2015. Epidemics respect no boundaries, be it national, ethnic, professional, or economic. When emerging epidemics sweep across countries, however, epidemic control measures become deeply intertwined with human dynamics such as economic, political, and cultural forces, resulting too often in politics taking precedence over public health considerations. The history of epidemics is one of discrimination, stigmatization, and political and economic oppression because epidemic control measures, for instance, quarantine and isolation, were often used to marginalize and exploit the powerless groups such as ethnic minorities and economically disadvantaged communities (Ding, 2014; Echenberg, 2007; Mohr, 2005). In other words, epidemics provide a convenient pretext to purge those who are considered socially unclean and morally evil in order to restore some presumed ideal political and economic order. Structural oppression is not the only form of social injustice, however; privileged communities and individuals also participate in the oppression of their fellow citizens for political, economic, and personal gain.

But how does social injustice exhibit itself in epidemic control and what communication strategies can be employed to promote more socially just policies and practices? This article provides preliminary responses to these questions by investigating issues of social injustice that medical care workers (MCWs) encountered in the SARS outbreaks in Canada and Singapore. We choose to examine issues of social injustice in Toronto and Singapore for three reasons. First, both epicenters were known for their ethnically diverse populations, with large numbers of immigrants from East Asia and Southeast Asia. This unique feature offers us an opportunity to examine how social injustice affects the Global South, even though we focus mostly on impacts on Asian immigrants in North America and Southeast Asian immigrants in Singapore. Second, focusing on these epicenters allows us to examine intercultural dynamics in epidemic control and the different ways the “Cultural Other” was excluded, neglected, or absorbed in national campaigns against epidemics. Finally, this analysis enables the

exploration of the different issues related to social injustice in North America and Asia and the interconnections among different theories of social justice.

Scholars such as Appadurai (1996), Grewal (2005), Ong (1999), and Starke-Meyerring (2005) called for the move from the use of nation-states as the unit of study in intercultural communication research and advocated for the study of the transcultural, which emphasizes flows of people and ideas as well as situated difference among cultures at different levels. This article shares their focus *on the cultural* and examines how social injustice impacted immigrants and foreign workers from the Global South who lived or worked in the Global North during the SARS outbreaks. We will start with a literature review of social justice and professional communication before moving on to analyze how social justice intersected epidemic control measures employed in SARS outbreaks in Canada and Singapore in 2003.

Social Justice and Professional Communication

Frey et al. (1996) listed several features of social justice, i.e., “ethical concerns,” “structural analyses of ethical problems,” “activist orientation,” and “identification with others” (p. 111). Disenfranchised and marginalized groups, i.e., the poor, the unemployed/underemployed, and people of color are excluded from participating in the “process that creates their social worlds” and are “most in need of resources and advocacy” (p. 112). Leydens (2012) identifies two forms of thinking which are fundamental to definitions of social justice: contextual thinking, which investigates “the unique circumstances of each case and context,” and systemic thinking, which goes beyond individual ethical deliberation and focuses on “broad social, systemic—and thus often invisible—injustices” (p. 1). The “macro-ethical, systemic focus” afforded by social justice provides professional communication researchers with “language and a conceptual framework” to examine societal and policy applications of research findings (Leydens, 2012, p. 1). Leydens’ framework provides professional communicators with tools to analyze the systems, institutions, and practices that contribute to social injustice as well as possible strategies to invent constructive responses to such injustice.

Social justice is underdeveloped in the field of professional communication, because of both the absence of social justice in the formal training of professional communication researchers and the tendency for professional communication pedagogy to focus on preparing students for apolitical work in industry (Leydens, 2012). Professional communication research, however, offers great potential to inform efforts to promote social justice, because of its concerns about public interest in policy making processes (Ding, 2013; 2014b; Grabill & Simmons, 1998; Scott, 2003), civic engagement (Scott, 2009; Walton, 2013;), advocacy and activism (Agboka, 2013; Jones, 2012), and service learning (Crabtree & Sapp, 2005). While little scholarship in professional communication uses social justice as an explicit construct, Walton and Jones (2013) identified “the juncture of social justice, complex contexts, and communication” as a promising site for productive research and called for careful methodological, pedagogical, and critical work. This study investigates issues of social injustice experienced by various groups in epidemics and the communication strategies employed by communities to address such issues in complicated, multiethnic contexts. It is situated squarely in professional communication because of its focus on decision-making, advocacy and activism, and communication strategies.

Oppression, Access, Social Injustice, and Civic Infrastructure

One of us (Ding, 2013; 2014a; 2014b; Ding & Pitts, 2013; Zhang & Ding, 2013) has been examining issues of risk communication, risk management, and public participation in global epidemics such as SARS, H1N1 flu, and HIV/AIDS. One little explored area in rhetoric of epidemics deals with power dynamics, access, social justice, and negotiations between authorities and various publics to mitigate impacts brought by epidemic control measures. To explore these issues, this project examines how *oppression* (Young 1990) operates in health crises and what communication strategies communities can employ to build *civic-based networks* (Schoch-Spana et al, 2007) to promote *access* (Porter, 1998) and thus *social justice* (Jost & Kay, 2010). To achieve this goal, we apply the four theoretical frameworks

mentioned above in our historical cases to fully investigate possible connections between communication and social justice. Our cases, in turn, give us the opportunity to synthesize the interconnections among these theoretical apparatuses and to highlight possible ways for professional communicators to help promote access and thus social justice for marginalized and powerless groups.

Young (1990) uses the term oppression to name unjust practices outside a distributive framework. She partitions sociocultural systematic—at the structural, cultural, or personal level—oppression into five categories, or faces: exploitation, marginalization, powerlessness, cultural imperialism, and violence (p. 40). As an “unequal [group based and structurally persistent] distribution of wealth, income, and other resources,” **exploitation** “occurs through a steady process of the transfer of the results of the labor of one group to benefit another” (Young, 1990, p. 50, 53). Young views the workplace as an important site of gender exploitation, where “women’s energies are expended in jobs that . . . comfort others” and the “gender-based labors” of nurses and other caretakers “often go unnoticed and undercompensated” (p. 51). **Marginalization** refers to the structural expulsion of “a whole category of people . . . from useful participation in social life and thus potentially subjected to severe material deprivation and even extermination” (p. 53). As “the most dangerous form of oppression,” marginalization “involves both distributive injustice and the deprivation of cultural, practical, and institutionalized conditions for exercising capacities in a context of recognition and interaction (p. 55).” Young emphasizes that racial oppression is a type of marginalization, not exploitation. **Powerlessness** refers to people, often nonprofessionals, who lack authority of power and “over whom power is exercised without their exercising it” (p. 57). Seeing division of labor as the cause, Young lists three types of injustices associated with powerlessness: “inhibition in the development of one’s capacities, lack of decision-making power in one’s working life, and exposure to disrespectful treatment because of the status one occupies” (p. 58). **Cultural imperialism** refers to “a paradoxical oppression, [in which the culturally dominated] are both marked out by stereotypes and at the same time rendered invisible” (p. 59). It is caused by the “establishment of a dominant group’s experience as the norm” and requires the creation of a “political space for such differences” (p. 61). Finally, **violence** refers to a systematic social practice

that renders “members of some groups [to] live with the knowledge that they must fear random, unprovoked attacks on their persons or property, which have no motive but to damage, humiliate, or destroy the person” (p. 61). Also included in this category are “less severe incidents of harassment, intimidation, or ridicule simply for the purpose of degrading, humiliating, or stigmatizing group members” (p. 61). Young considers it sufficient to call a group oppressed if any of the five conditions mentioned above exists.

Two supplementary yet potentially useful theories are offered by Porter (1998) and Schoch-Spana et al. (2007). Porter (1998) defines three types of access: infrastructural (resources), educational (literacy, skills, and expertise), and social (community acceptance) in his analysis of the use of computer resources (pp. 102-105). Grabill and Simmons (1998) elaborated on the meaning of access in decision making about risk policies, stating, “Infrastructural access means access to the process of decision making within an institution, literacy means the discursive means to participate effectively, and acceptance refers to a ‘listening stance,’ or a commitment to collaborative decision making” (p. 427). Schoch-Spana et al. (2007) employ the term of “civic infrastructure” to describe the “dynamic assembly of interdependent people, voluntary associations, and social service organizations who can pool their collective wisdom, practical experience, specialized skills, social expectations, and material assets to work on behalf of constituent members . . . for a larger public good” (p. 11). They emphasize the unique capacities of civic-based networks to remedy disasters if authorities can effectively catalyze and integrate such networks into the risk management processes. These two theories work well together since communities and individuals have to acquire accesses to resources, literacy, and community acceptance before putting any civic-based networks together.

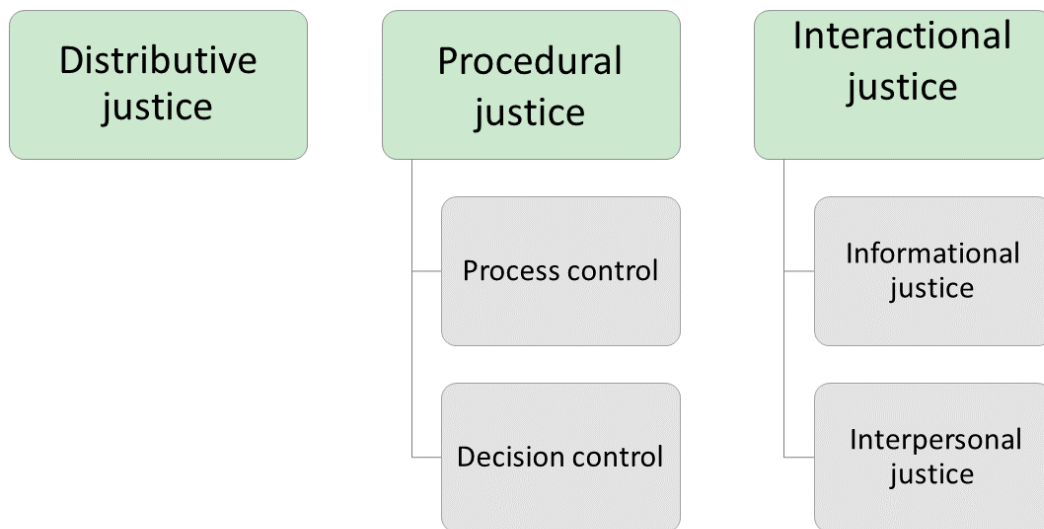
In order to continue and look forward into examining social and structural injustices, John Jost and Aaron Kay (2010) offered a three-part definition for social justice: distributive, procedural, and interactional. They assert that in a state of affairs that is socially just, (a) the benefits and burdens in society are dispersed in accordance with some allocation principle or set of principles; (b) procedures, norms, and rules that govern political and other forms of decision making preserve the basic rights, liberties, and entitlements of individuals and groups; and (c)

human beings are treated with dignity and respect not only by authorities but also by other relevant social actors including fellow citizens (p. 1122). These three-part definitions are widely accepted in studies of social justice.

While the three types of social justice were not introduced by Jost and Kay (2010), their definition gives us a good starting point for our analysis. It should be emphasized that the three types of social justice can function at institutional, organizational, and communal levels and that they focus on different things. Distributive justice deals with the fairness of outcomes (Leventhal, 1980; Thibaut & Walker, 1975) and “exists in all situations where individuals or groups enter into exchanges” (Blodgett, Hill, & Tax, 1997, p. 188; Deutsch, 1985). As our study will illuminate, while the dynamic of distributive justice is not intersecting as directly as procedural or interactional, when excessive burden was put on part-time MCWs without adequate reward or protection, the MCWs were forced to shoulder most of the SARS-related risks in Toronto. As a result, the principle for the allocation of benefits and burdens in Canada during SARS served to uphold an unjust social order. Procedural justice is characterized by the fairness of the process by which outcomes are determined (Lind & Tyler, 1988) and it emphasizes both *process control*, namely, the opportunity for people to present their own side before any decision is made, and *decision control*, namely, the influence people have on “the actual rendering of a decision” (Jost & Kay, 2010, p. 1140; see Figure 1, p. 28). Injustices of this type occurred throughout our cases, more prevalently in the Toronto case, when nurses who worked most closely with patients encountered various forms of structural oppression, i.e., marginalization and powerlessness when trying to participate in risk decision-making processes. Finally, focusing on interpersonal behaviors, interactional justice can be broken down into “*informational justice*, which emphasizes communicative aspects, such as truthfulness and justification (adequate explanation), and *interpersonal justice*, which guarantees sensitive, respectful, and appropriate treatment” (Jost & Kay, 2010, p. 1143; see also Bies, 2005; Colquitt, 2001; Greenberg, 1993). The informality of the final type of justice can make it more difficult to tangibly identify ways to introduce structural improvements. However, MCWs encountered interactional injustice in their daily encounters with discrimination and stigma-

Figure 1

Three Types of Social Justice and their Components



tization from neighbors, colleagues, and strangers, which reveals the important roles professional communicators can play to explore ways to cultivate community acceptance and support from fellow citizens.

It is generally agreed that these three types of social justice are “strongly related, yet distinct constructs” (Cohen-Charash & Spector, 2001, p. 307). Constituting two important aspects of “fairness of treatment” (Van den Bos, 2005), procedural justice and interactional justice “overlap and correlate,” for instance, because they deal respectively with formal injustices directed at systems, or governing norms of the law or institution, and informal injustice “directed at human actors” who can be representatives of the system (Jost & Kay, 2010, pp. 1143-1144). Theoretical elaboration about the three types of social justice clearly shows the central role that communication plays in promoting social justice. While process control advances procedural justice in granting communities participatory access to decision making on the policies that affect them, interactional justice touches up the qualities of such communication practices by emphasizing the need for adequate and truthful information (informational justice) as well as respectful sharing of such information (interpersonal justice).

Our study aims to expand existing knowledge about social justice and professional communication in epidemic control by *looking at both the macroethical (i.e., systemic) and microlevel (i.e., contextual) issues* posed by SARS to affected communities as well as by *examining issues related to the quality of information and interaction in health risk communication endeavors* about quarantines (Leydens, 2012). At the end of this study, we synthesize and speculate on our findings in depth, regarding the relationships among the three social justice theories discussed above, and suggest possible strategies that organizations, communities, and professional communicators can use to put together civic-based networks that promote social justice in future health crises.

Social Justice and SARS Outbreaks in Canada and Singapore

This section analyzes how Canada and Singapore negotiated about rights and duties of medical care workers in SARS wards and about those quarantined or treated for SARS. Jacobs (2011) listed three types of potential rights concerns raised by quarantines, which include “the historical legacy of quarantine as a discriminatory practice . . . the confinement quarantine involves and the degree to which the burdens quarantine imposes are unfair in their distribution” (p. 89). We start with a survey of the SARS situations in those two countries before studying more closely the discourses surrounding those affected by SARS.

SARS Cases and Quarantines

The World Health Organization (WHO) (2003) reported that globally a total of 8,422 people were infected with SARS, which resulted in 916 deaths, a fatality rate of 11 percent. Singapore had 238 SARS cases, with 97 (41%) medical care workers (MCWs) and 141 non-MCWs. Many MCWs, with one out of three nurses in Tan Tock Seng Hospital, were foreign. Of the 225 cases Canada recorded in the Greater Toronto Area (GTA), MCWs accounted for 39% (88), almost twice as many as SARS patients (49). Two nurses and a doctor, all being

foreign, were among the 44 people who died from SARS in Canada (Nicolle et al., 2008). In Toronto, out of a population of approximately 3 million, about 30,000 people got quarantined (Naylor, 2003; Rothstein et al., 2003) and 39.5% of those quarantined were MCWs, in contrast with 41% in Singapore (DiGiovanni et al., 2004). While nurses counted for 46.4% of all MCWs in Canada, almost half of them were employed as contingent labor, holding two to three jobs to “make up full-time hours [and] working without benefits, or disability income protection” (Ontario Nurses’ Association, 2003). It is worth noticing that a large proportion of MCWs fighting in the frontline in Canada were female ethnic minorities or foreign workers.

Medical Care Workers, Nurses, and SARS Repercussions

Two groups that were particularly hit by SARS were medical care workers and paramedics who took care of SARS patients. We will explore two areas in which MCWs and people quarantined after exposure to SARS patients might encounter unjust treatments, namely, appropriate protection of MCWs fighting in the frontline against SARS and financial compensation offered to MCWs and those under quarantine from authorities and the wider public. While most MCWs were praised for their altruism and bravery, in Canada, nurses were often exposed to SARS patients without appropriate infection control measures as well as widespread discrimination and social avoidance. In addition, Canada relied on official compensation, which was not offered until late May 2003, whereas Singapore mobilized the public to demonstrate nationwide support for MCWs fighting in the frontline.

SARS, MCWs, Home and Work Quarantines, and Social Justice in Canada

Toronto witnessed two phases of SARS, which we will refer to as SARS I and SARS II below. In mid-February of 2003, a “superspreader” event in Metropole Hotel, Hong Kong sent ripples of infection to multiple countries. This incident

was referred to as “the gateway to horror” in Canada’s *SARS Commission Report* (2003, p. 43). Among the infected guests and visitors was Mrs. K, one 78-year-old Canadian woman, who travelled back to Toronto on February 23, 2003, developed symptoms of fever and a dry cough in two days, and died at home with a large family around her on March 5, 2003 (Campbell, 2006). The old woman’s son infected his physician and three nurses at Scarborough Grace Hospital before he passed away on March 13, 2003. Scarborough Grace later became the epicenter in Toronto.

On March 15, WHO issued a rare emergency travel advisory warning of the “worldwide health threat” and included Toronto in its list of areas with recent transmission (WHO). Ontario declared SARS as a provincial emergency on March 26 and all hospitals were required to create units to care for SARS patients. On March 29, the Ontario Ministry of Health and Long-Term Care ordered all hospitals in the Greater Toronto Area to activate their “Code Orange” emergency plans which required hospitals to establish isolation units for potential SARS cases, implement around-the-clock infection control measures, suspend nonessential services, limit visitors, and provide protective clothing such as gowns, masks, and goggles to exposed staff (*Learning from SARS*, p. 28). On April 23, 2003, WHO listed Toronto, along with Beijing and Inner Mongolia, as areas where nonessential travel should be postponed. Toronto was removed from WHO’s travel advisory, however, one week later due to immense political pressure from Canada (see Ding, 2014b, pp. 210-215 for detailed analysis). Toronto reported its last transmission of SARS on April 19 (Galloway, 2003). SARS I was thought to be contained in early May and WHO removed Toronto from the list of areas with recent local transmissions on May 14. As a part of the political campaigns to remove Toronto from WHO’s advisory, infection control measures and workplace safety precautions in hospitals were relaxed on May 13 and the provincial emergency and Code Orange for hospitals were lifted on May 17. These politically driven decisions to relax safety precaution left MCWs feeling “betrayed by a system that expects them to care but does not adequately protect them as they do so” (RNAO, 2003, p. 10). As stated in our introduction, often epidemics provide an opportunity for those in positions of hegemonic power to

use subversive tactics to purge the “Cultural Other,” thus such decisions clearly show MCWs’ complete lack of process control and decision control in coping with health risks they confronted and thus the procedural injustice imposed upon them during the decision-making processes.

SARS II started when a cluster of five cases of acute respiratory illness was identified by health officials on May 20, 2003 and was reported to WHO on May 22. Investigations clearly showed that there was never a second separate SARS outbreak, but an ongoing, undetected outbreak simmering at North York General Hospital between April 20 and May 7 which then spread to other hospitals (National Advisory Committee on SARS and Public Health, 2003). Toronto was added back to WHO’s list of areas with ongoing SARS transmission on May 26 and was not removed until July 2. *The SARS Commission Executive Summary* raised the question whether MCWs were adequately protected during the two SARS outbreaks, and it answered with a firm “no”. In addition to the three deaths of MCWs in Canada, other health workers, “including paramedics, medical technicians and cleaners,” contracted SARS on the job and many of them unknowingly infected their families” (Campbell, 2003, p. 22). The continuous infection of health workers during SARS II reveals “the full extent of worker safety failings” and the tragic impacts of official decisions to relax precautions in all Toronto hospitals when SARS was simmering in North York in late April and early May (p. 22). As demonstrated below, individual whistleblowers and grassroots leaders in civic organizations played vital roles in communicating about such systemic issues of social injustice to authorities and the public. Their strategic entries into the power systems helped to advocate for basic interests of marginalized groups such as contingent MCWs and ethnic minorities, which in turn contributed to the promotion of social justice.

Responses from Professional Organizations to Issues of Injustice

Toronto started to adopt quarantine measures on March 26 when over 25 health workers and staff from Scarborough were put in hospital isolation rooms, and

their family members were requested to have a 10-day home quarantine. Thousands of people who “set foot in Toronto's Scarborough Grace Hospital on March 16 or since then” were considered at risk of developing SARS and were required to place themselves under quarantine for ten days from the time of their visits (Abraham, 2003). Canadian media called these *voluntary quarantines*, which were officially requested. No official orders were issued, however, as in the case of Singapore, and no systematic efforts were made to track down and monitor individuals serving the ten-day quarantine except phone calls from health officials.

During SARS II, Canada started the so-called “*working quarantine*” for hospital staff members and Emergency Medical Services paramedics who worked in an institution with “evidence of recent transmission of SARS.” The working quarantine required the staff to “take full precaution by wearing masks, gowns and gloves while working in affected areas . . . [and] go into self-isolation [after returning home], wearing a mask in the presence of their families, using their own cutlery and utensils” (Talaga, 2003, p. A01). Staff relying on public transit to commute to work were asked to take a taxi instead, for which the hospitals would pay (Talaga & Powell, 2003). Hospital staff and paramedics were required to work during quarantines to ensure enough manpower to respond to emergencies when the workers only had “extremely low chance” to be “incubating SARS” (Talaga & Powell, 2003, p. A01). This working quarantine policy brought exhaustion, increased health risks, stigmatization, loss of privacy, and family challenges to MCWs and other supporting staff because of extended working hours and duration of separation from their families.

Support staff, including workers such as housekeeping, dietary and clerical staff were “the last to be informed and the last to be trained” during SARS despite their constant contact with patients (Service Employees International Union, 2003, p. 3). Housekeepers were sent to clean SARS-related isolation rooms without adequate risk communication, training, or protection. In one case, when a cleaner tried to understand the risks he would be exposed to, he was reprimanded in writing by his supervisor who stated, “it’s my expectation that when you are asked to do something, you will do it” (p. 14).

Professional organizations such as the Ontario Nurses' Association (ONA), Registered Nurses' Association of Ontario (RNAO), and the Ontario Public Service Employees Union (OPSEU) took the lead in advocating for the basic rights of their members. These organizations delivered powerful presentations to the SARS Commission in public hearings held in September 2003. Compiling both focus group and interview data as well as personal narratives from thousands of nurses directly impacted by SARS, reports from ONA and RNAO discussed numerous problems faced by nurses: segregation, stigmatization, economic, and physical and emotional repercussions brought by SARS. RNAO (2003) reported nurses' strong emotional responses to their SARS experiences, which included "fear, anxiety and exhaustion; isolation and stigma [and] frustration and anger" (p. 16). While SARS I brought fear and anxiety, SARS II caused widespread panic among MCWs because of the "perceived secrecy [of government decisions] and the accumulated exhaustion [of MCWs]" (RNAO, 2003, p. 17). Many nurses felt like they were "in jail" and used the phrase "social pariah" to explain the isolation and stigma they experienced during SARS (RNAO, 2003, pp. 17, 18). Obviously both support staff and MCWs suffered from informational injustice because of the minimal risk information they obtained. In addition, they also confronted interpersonal injustice because of the disrespectful treatment they encountered when requesting such information.

Also identified were broader infrastructural systemic issues such as "insufficient infection control policies, unsafe practices, ineffective communications," nursing shortage, government underfunding, and shortage of personal protective equipment (Ontario Nurses' Association [ONA], 2003, p. 1). In addition, when nurses identified "a cluster of patients with SARS-like symptoms and reported it to management and the medical staff," their concerns were being "ignored and suppressed" (ONA, 2003, p. 5; RNAO, 2003, p. 18). Barb Wahl, President of ONA, urged for a proactive approach and criticized the lack of clear protocols to prevent the spread of SARS even in September, 2003. Wahl (2003) criticized the exclusion of nurses from the decision-making processes about patient care and urged for "respect and recognition [of nurses] as professionals and essential members of the health care team" (p. 6). Such dismissal

of nurses' practical knowledge suggests procedural injustice because nurse whistleblowers' lack of both process control and decision control in making decisions that would have impacts on their own health. It eventually led to the relaxed infection control policies and subsequently the second SARS outbreak in Toronto.

RNAO made active efforts to lobby politicians for a full public inquiry into the SARS outbreaks. Howard Hampton, a politician in Ontario, urged Premier Ernie Eves to consider nurses', particularly RNAO's request for a public inquiry into SARS II, saying, "They raised warnings with hospital administrators and other officials early on that SARS was reemerging in our hospitals, yet their concerns were ignored" (Di Costanzo, 2013). RNAO's board of directors held a press conference to request a full public inquiry and employed powerful rhetorical strategies to call attention to the issues surrounding the systemic disregard of nurses' expertise. Doris Grinspun, a key figure who worked with the president of RNAO to organize the event, wrote about their strategies in a reflective article published in the tenth anniversary of SARS:

We organized a media conference with nurses who were trying to blow the whistle on their workplaces and the disregard shown to nurses' concerns . . . The next morning, every major newspaper across the nation published the images of nurses at RNAO's press conference wearing masks that read: "muzzled," "silenced" and "ignored" (Grinspun, 2013, p. 6).

By obtaining extensive media access to the whistleblowers who were originally neglected and silenced, the press conference circumvented the institutional barriers that excluded nurses from deliberation processes about infection and epidemic policies at various levels. These high-profile lobbying efforts helped nurses to acquire infrastructural access to the system, which in turn promoted procedural justice in terms of process control and decision control by requesting independent evaluation of official responses to and MCWs' experiences in SARS. Such efforts eventually led to two full-scale investigations about the ways Toronto dealt with SARS in 2003 (Grinspun, 2013, p. 6).

Controversy Surrounding Official Compensation Packages

Fear of loss of income was cited as the main reason for noncompliance among people advised to take voluntary quarantines (Jacobs, 2011). The provincial government had insisted that it saw no need to offer compensation packages to those in quarantine before April 24, 2003. Although the Premier promised to provide support so that “people will not have to choose between doing the right thing and putting food on the table” in late April, no real action was taken until May 27 when a \$190 million compensation package was provided for MCWs who had lost incomes due to SARS (Campbell, 2003, p. 34). Officials offered no “compensation allowance” for nonhealthcare workers who had missed work due to quarantine until June 13, 2003. The Ontario College of Family Physicians (2003), however, complained about the government’s unfulfilled promise to provide “adequate worker’s compensation and disability benefits” for physicians who became sick on the job (p. 8). This official offer “was never put in writing” and was “withdrawn without notification” when physicians were working in the SARS wards (p. 8).

The ONA’s report urged Canada to move beyond “run[ning] newspaper ads proclaiming that MCWs are ‘heroes’” even though such sentiment was appreciated. The report warned, “if nurses don’t get the respect and protection they deserve in their workplaces, all of these accolades mean nothing – and only add to their cynicism and frustration” (Ontario Nurses’ Association, 2003, p. 7). Without appropriate compensation and protection policies implemented for the frontline MCWs, symbolic official and public gestures of support carry little weight for those who confront viral threats to their survival on a daily basis. Even in September 2003, members of the ONA who contracted SARS or got quarantined because of SARS still did not receive compensation. Numerous presentations given by MCW organizations in the SARS Commission public hearings emphasized MCWs’ loss of trust in the system due to the poor responses and the lack of adequate support they experienced during the SARS outbreak.

SARS, MCWs, Home Quarantines, and Social Justice in Singapore

MCWs attracted wide attention from the beginning of the SARS outbreak in Singapore, though with little attention to ethnicity, hiring status, or gender. From the very beginning, MCWs were exalted as the heroes fighting at the frontline and needing all-out support to continue defending Singapore from SARS. Meanwhile, rigorous infection control measures were taken from the beginning of the epidemic. Ding and Pitts (2013) examined how Singaporean authorities resorted to not only police forces and private security companies but also official compensation packages and community volunteers to implement its ten-day home quarantine orders for close contacts of SARS patients. Singapore's quarantine policies grew increasingly stringent as its outbreak spread, with the use of surveillance cameras and electronic tags for early quarantine breakers and hefty fines and imprisonment for continuous violation, which resulted in questions about human-rights violations from Western media. However, its quarantine policies were well received due to its consistent, frequent, and transparent communication practices, its repeated appeals to nationalism and patriotism, and its early policies to compensate those under home quarantines for their lost incomes.

Compensation and Courage Fund: Corporate, Personal, and Official Efforts

Compensation in Singapore took an interesting turn because of the early involvement of civic networks. Instead of relying on the government for support, professional organizations such as the Singapore Medical Association (SMA) and the Singapore Nurses Association (SNA) set up the SARS Relief Fund on April 2 to raise funds for victims and their families (Sim, 2003). On April 10, National Healthcare Group, Singapore Health Services, Singapore Medical Association, Singapore Nurses Association, and Singapore Press Holdings launched what was called the Courage Fund "in honor of Singapore's health-care workers, especially those who have fallen ill or suffered in their battle against the virus" (Courage

Fund, 2003). Dr. Lim Suet Wun, CEO of Tan Tock Seng Hospital (TTSH) and Chairman of the fund's working committee, applauded the heroism of MCWs who had made up over 50 percent of SARS victims by then, saying, "Health-care workers have to walk daily into wards, where they know there are SARS patients. There is no means for them to attack, there is only defense. And the defense is only things like thin little masks, the gowns and the gloves which they wear" (Sim, 2003). He emphasized that, despite exposure to daily health risks, MCWs had "come together to continue to serve the patients," with only two out of 3600 TTSH staff quitting their jobs (Sim, 2003).

Corporations and individuals quickly worked together to demonstrate their support for MCWs and people affected by quarantines. The *Straits Times* ran a total of 131 reports on Courage Fund between April and September 30, 2003, which showed a trend of quick growth of personal and corporate donations. On April 21, ten days after the launch of the fund, the public donation went over \$2 million, which was widely applauded as uplifting news for MCWs fighting in the frontline against SARS (Donations to SARS fund). Many advertisements were published in newspapers to thank frontline MCWs for their altruistic work. For instance, *Lianhe Zaobao*, a leading Chinese-language newspaper in Singapore, published a one-and-a-half-page long advertisement which was jointly funded by 205 Chinese nonprofit organizations, chambers of commerce, regional groups, and ethnic clans. Titled "Sincere appreciation," the advertisement thanked brave MCWs fighting around the clock against SARS for their devotion to patients and listed all parties that sponsored its appearance in *Lianhe Zaobao*. Such grassroots-sponsored advertisements demonstrated both the efforts actively made by ethnic groups and the integral roles played by civic organizations to contribute to the national battle against SARS.

On April 17, the government of Singapore donated \$1 million to the Courage Fund and matched, dollar for dollar, all donations made to the fund. In addition, it pledged tax deductions for donors, doubling the amount of their donations. Deputy Prime Minister Lee Hsien Loong announced the plan in a press conference, emphasizing the sacrifice made by MCWs who risked their lives to defend Singapore from SARS: "It's a war and we are in battle, and on the front

line are health-care workers . . . So we set up this fund to help the victims and health-care workers. We hope through this, we can show how we feel and perhaps give a useful boost to our health-care workers” (“\$1m Boost”). The first compensation package was issued on April 20 and the fund would give up to \$70 a day to those who had to be quarantined at home or warded for observation or treatment (Lian, 2003).

Singapore provided financial assistance not only to individuals affected by SARS and its quarantine policies but also to industries and small businesses suffering business losses due to SARS. On April 17, Singapore offered a \$230 million aid package for industries hardest hit by the virus outbreak, with \$155 million dedicated to tourism-related industries (Kong, 2003). In addition, cost reduction, fee waivers, and tax rebates were provided for commercial properties, aircrafts, cruise ships, and taxi.

Discussion and Conclusion

Access, Communication, and Social Justice in Singapore and Toronto

Our analysis of MCWs’ experiences in Singapore demonstrates the importance of access in ensuring social justice: MCWs had constant access to infrastructure, literacy, and community acceptance, which in turn promoted Singapore’s national battle against SARS. To begin with, appeals to patriotism were made at the very beginning to launch an all-out war and to mobilize all parties in contract tracing by taking voluntary or mandatory home quarantines (Ding & Pitts, 2013). People from all walks of life actively expressed their appreciation of MCWs’ sacrifices by publishing thank-you advertisements in newspapers, supporting fundraising efforts, providing food delivery services, and sending thank-you cards and letters. Such extensive grassroots participation demonstrates widespread community acceptance and moral support that MCWs received in Singapore’s SARS outbreak. Meanwhile, authorities employed transparent risk communication,

aggressive training procedures, and rigorous infection control measures to proactively prevent in-hospital transmission. Such efforts provided MCWs with excellent access to resources and education, which in turn greatly facilitated Singapore's national battle against SARS. In addition, the early release of official compensation packages for MCWs and people serving quarantine orders demonstrates Singapore authorities' determination to ensure the fair distribution of benefits and burdens for those who contributed to its national anti-SARS campaign through either professional heroism or compliance with quarantine orders.

While the experiences of MCWs in Singapore posed fewer challenges related to social justice, the experiences of their counterparts in Canada were much more problematic. The problems MCWs and other supporting staff encountered correspond with both the three types of social justice and Young's constructs of marginalization, powerlessness, and cultural imperialism. To start with, when excessive burden was put on part-time MCWs without adequate reward or protection, it posed issues of distributive injustice and exploitation. While MCWs shouldered most of the burdens in fighting against SARS, they faced the additional burdens of "unequal distribution of benefits [and risks]" because they had to suffer financially due to their inability to work multiple jobs after being put on work quarantine in one hospital and their lack of access to health or disability insurance if they contracted SARS on the job. In addition, nurses who worked most closely with patients encountered structural oppression, i.e., marginalization and powerlessness when trying to participate in risk decision-making processes. They had no voice in making decisions about ways to contain local outbreaks even though they were the ones taking care of suspected SARS patients and raising concerns about possible clusters that led to SARS II. Often working on several jobs to make ends meet, nurses and supporting staff suffered from inadequate access to infrastructural resources such as protective gear or disability benefits and to literacy resources to stay informed of latest infection control measures and to protect themselves against possible infection. Finally, the discrimination and stigmatization from neighbors, colleagues, and strangers in daily encounters reveals their lack of access to community acceptance and the subsequent interpersonal injustice, for MCWs had to constantly cope with

disrespect, isolation, and social avoidance from fellow citizens. It also suggests cultural imperialism because nurses and supporting staff were both made invisible in institutional hierarchies and subject to stereotypes as possible sources of infection to the larger community.

Because of all these issues with social justice, professional organizations such as Ontario Nurses' Association (ONA) and Registered Nurses Association of Ontario (RNAO) actively sought to protect their members against unfair treatment. As civic-based, nursing advocacy networks, they fought hard to obtain infrastructural and educational access for the marginalized nurses and supporting staff by conducting extensive qualitative research on MCWs' individual experiences with SARS. They also produced highly rhetorical reports about the lack of worker health and safety protection in Canada's health-care facilities and about the devastating impacts of these conditions on frontline MCWs. In addition, these civic organizations managed to gain institutional access to represent the collective interests of their members in public hearings held by the SARS Commission and thus brought their concerns to public platforms. Their presentations exposed not only the hardships MCWs experienced, but, more importantly, the systemic challenges Canada's public health system faced because of its continuous efforts to streamline the system. Therefore, they proposed system-wide solutions, including hiring more full-time nurses, implementing better infection control mechanism, and adopting more transparent and effective risk communication approaches. Finally, ONA filed a lawsuit on behalf of 53 nurses who contracted SARS to protest against negligence in officials' handling of SARS and the lack of worker health and safety in healthcare facilities ("SARS Outbreak," 2009). These acts of advocacy promoted procedural justice by earning both process control and decision control for nurses in post-SARS investigations and in decision-making processes about compensation for MCWs contracting SARS.

Use of Civic Infrastructure and Communication Strategies to Promote Social Justice

Our study clearly points to the need for participation from both authorities and fellow citizens to ensure social justice in epidemics. Authorities should work at the

early stage of epidemics to ensure the fair and clear distribution of benefits and burdens among professions and stakeholders fighting against and affected by epidemics. Moreover, protecting the basic rights of the wider public plays an essential role in facilitating interactional justice, namely, community acceptance of and support for those who sacrifice their own interests to protect the wellbeing of the wider community.

Our findings show that Singapore managed to mobilize its civic infrastructure by encouraging organizations and individuals to contribute actively to the Courage Fund. While it relied on police and contract security companies to carry out its quarantine orders, it encouraged individual citizens to comply with quarantine policies through the use of rhetoric of nationalism. Singapore did not fully mobilize its civic-based networks in the implementation of quarantine orders, as was achieved in Mainland China through the active involvement of neighborhood committees and other grassroots organizations (Ding, 2013; Ding, 2014a). Civic infrastructure seems to have played a minimal role in Canada's battle against SARS, and only in a retrospective manner, when various professional nurse organizations started to protest against the lack of appropriate protection of and compensation for nurses and other health professionals. This sharp contrast in the ways civic infrastructure functioned in Singapore and Canada suggests that, in future epidemics, authorities, MCWs, communities, and individual citizens should equally shoulder this public responsibility and collaborate in mobilizing civic infrastructure. Only by doing so can they achieve the shared goals to ensure better surveillance, to implement good risk reduction measures, to take better care of affected communities and individuals, and to take viral bodies out of circulation. Participating actively in policy making processes, civic-based networks will also help to promote procedural justice and interactional justice by giving process and decision controls to marginalized communities. Such processes will also promote transparent communication, namely, informational justice, and fair treatment, namely, interpersonal justice.

It should be emphasized that SARS marked the transformational moments when civic organizations such as RNAO and ONA started to fight aggressively for the basic rights of their marginalized members. In 2006, RNAO

published a booklet titled “Lobbying Senior Administrators and Politicians,” which offered a systematic approach to advocacy for nurses. It described in great detail three types of advocacy game plans, namely, low profile strategy, medium profile strategy, and high profile strategy, which aim to “build alliance” rather than creating antagonism. Starting with the low-profile strategy of letter writing, the advocacy game plans quickly move on to medium profile strategies such as arranging meeting with officials and public meetings in the Minister’s riding as well as high profile strategies, i.e., organizing demonstrations, releasing news briefs, having news conferences, and obtaining “a group occupy in the Minister’s constituency office” (Lobbying, 2006, pp. 6-7). The booklet also provides detailed instruction on the creation of key documents such as letters and submissions to federal, municipal, and local authorities. Its emphasis on advocacy and high-impact genres suggests RNAO’s attempt to gain institutional access for its members, which in turn leads to educational and social access by developing media skills and inviting community acceptance. Professional organizations that support civic participation, such as the RNAO and ONA, developed the ability to participate effectively in political negotiations through their active advocacy efforts during the SARS outbreak, which in turn forced others in more powerful positions to listen to their arguments. This newly acquired rhetorical capacity clearly marked them as participants in the civic infrastructure that worked to empower marginalized groups and to address systematic injustices by gaining a seat in the negotiating table.

Theoretical Speculation: Connection among Social Justice, Oppression, and Access

Our study allows us to speculate a little here on the interconnectedness of the three types of social justice, oppression (Young, 1990), and access (Porter, 1998). Our analysis shows that distributive, procedural, and interactional justices are closely related, and sometimes slightly overlapping, in epidemic control settings. For instance, when Toronto decided to relax infection control measures in hospitals, the policy was imposed in a top-down manner on hospital authorities

and frontline MCWs. This practice reveals issues related to both procedural injustice because of the closed-door decision-making process and distributive justice because of the sudden exposure of MCWs to unnecessary health hazards. When frontline staff raised questions about such practices, their challenges were quickly dismissed and they were told simply to follow rules without asking questions. The official dismissal that MCWs encountered both suggests informational injustice and interpersonal injustice. It can be also interpreted as procedural injustice because in such encounters, the MCWs' basic rights to health were neglected by authorities and the frontline workers had no power to intervene in the decision-making process, thus losing both process control and decision control. While distributive justice and procedural justice often require access to infrastructure, access to literacy may help to promote procedural justice and interactional justice. Finally, access to community acceptance plays a vital role in interactional justice (see Figure 2, p. 45).

Young (1990) emphasized that oppression focuses on systematic institutional processes that prevent people from learning skills or communicating effectively with others. In the five faces of oppression, exploitation deals mostly with distributive injustice and marginalization is more related to procedural injustice. Powerlessness and cultural imperialism seem related to both procedural injustice and interactional injustice, though the former is more procedural while the latter is more interactional. Finally, we wonder whether violence brings injustice in distribution and interaction because of its attacks on persons and properties (see Figure 3, p. 45).

Implications for Professional Communication

The combined use of the three different frameworks, namely, Jost and Kay (2010), Young (1990), and Porter (1998), helps to produce rich and multifaceted insights about issues of social injustice in SARS outbreaks. Our study reveals that social injustice and oppression operated in covert manners in SARS and was more procedural and interactional than distributive. It also shows possible entry points for professional communicators to produce constructive responses to social unjust-

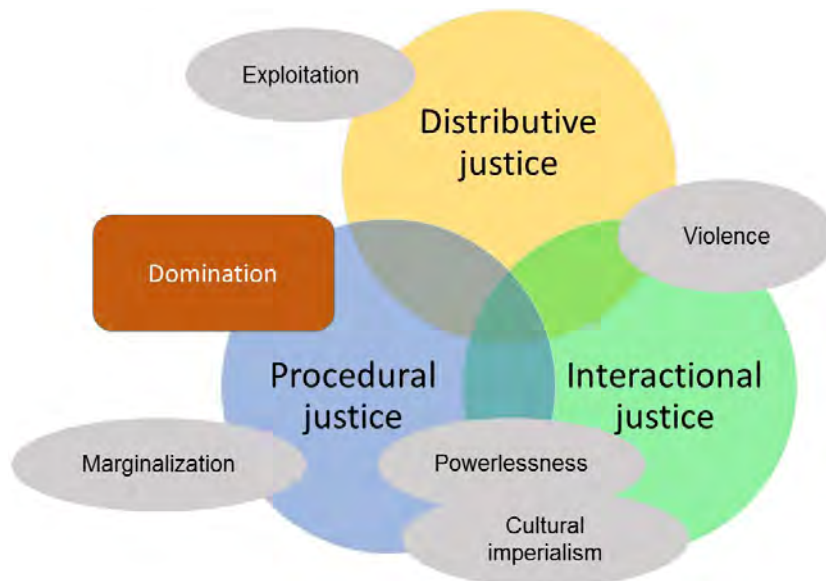
Figure 2

Connections between social justice and Porter's Framework of Access



Figure 3

Connections between social justice and Young's Framework of Oppression

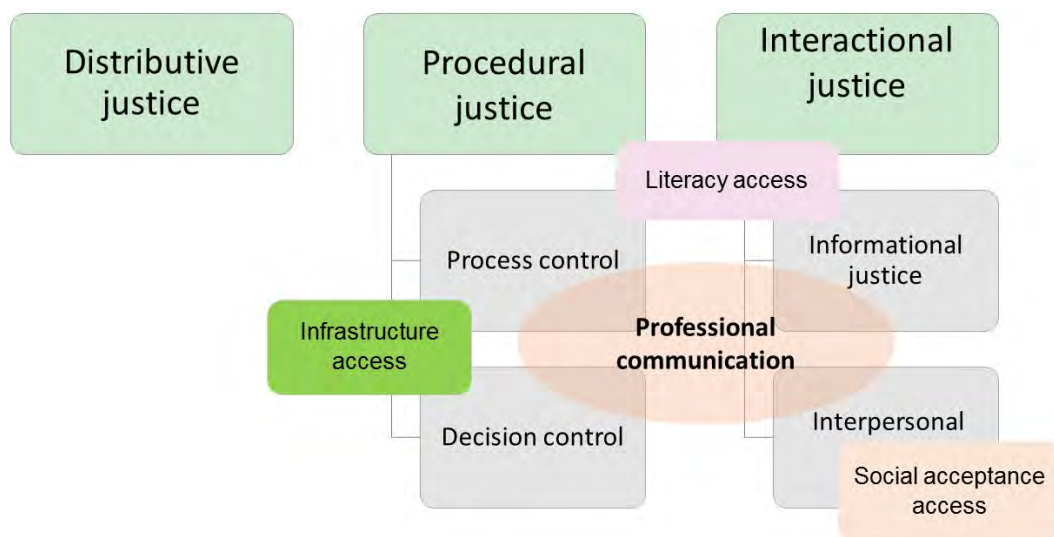


ices and participate in the negotiation processes to promote social justice and access for the marginalized and powerless groups. One of the key areas for such entrance is the conjunction between procedural justice and interactional justice, particularly that between process control and informational justice. As demonstrated by RNAO's advocacy game plan, by enhancing communities' literacy access, civic organizations can improve process control in decision-making processes, which often leads to better decision control and thus more procedural justice. Enhanced literacy access also improves informational justice provided to parties involved in such processes (see Figure 4). These goals can be achieved by advocating for the inclusion of communal and individual stakeholders in the deliberating processes and by pushing for open and sufficient information. They require knowledge about ways to obtain access to institutional and media resources and the rhetorical capacity to create powerful messages that lead to access to such resources.

Professional communication scholars and practitioners can play pivotal roles in efforts to promote process control and informational justice in risk

Figure 4

Connections among access, social justice, and professional communication



communication efforts in health crises by cultivating students' rhetorical and critical thinking skills in the classroom. Achieving this pedagogical goal requires us to move beyond the traditional service role that our field plays in industry since professional communicators such as leaders of RNAO often have to fight against the power apparatuses to promote social justice for the marginalized groups. It also requires our renewed commitment to service courses in professional communication so that we can better reach out to and influence future professionals. Only by doing so can we help to "educate and produce more critical and conscientious professionals with the knowledge and skills to act ethically in difficult communicative situations" (Ding, 2014b, p. 245). Such conscientious professionals, with their critical rhetorical skills and attention to civic matters, have the potential to become future leaders of civic organizations and to employ strong professional communication skills to help marginalized groups to acquire all three kinds of access to combat issues of social injustice inflicted upon them and others.

It should be emphasized that our analysis of social injustice in epidemics here is exploratory and more studies should be conducted to examine how social justice, oppression, access, and civic infrastructure function in other health crises. As suggested by our cases, only when individuals affected by epidemic control measures are treated with respect and care will they fully participate in and contribute to anti-epidemic campaigns. To enlist domestic citizens and transnational sojourners in the national campaigns against emerging epidemics requires respect and socially just treatment for all individuals, provision of access to resources, education, and community acceptance, and mobilization of civic-based networks so that everyone can participate in the battle to contain and eradicate old or new epidemics. ■

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