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Crisis Without a Script: Improvisational Leadership in Brazil’s Only Suspected Ebola Case

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Improvising Against Uncertainty: How Frontline Health Workers Managed a Suspected Ebola Case Without Protocols

1. Introduction

What actions should be taken when a threat is imminent but no protocol exists? Moreover, what if the most significant risk in a public health emergency stems precisely from the absence of formal guidelines? In 2024, the World Health Organization (WHO) issued 68 alerts for potential Public Health Emergencies of International Concern (PHEIC); only 12 escalated into confirmed outbreaks. However, each false alarm mobilized, on average, US$180 million in screening, isolation, and risk communication (WORLD HEALTH ORGANIZATION, 2025).

This gap between perceived threat and actual risk, what we refer to as an epidemic near-miss, generates significant financial costs, places pressure on institutional legitimacy, and remains underexplored in the management literature. In this article, we examine how public health organizations in the Global South govern care amid radical uncertainty when no operational playbook is available. The case under analysis involves a Brazilian infectious disease reference hospital that, in July 2014, received a report of a passenger suspected of having Ebola.

Although the laboratory hypothesis was ruled out within 36 hours, the incident prompted an immediate reorganization of teams, workflows, and protocols. Frontline professionals activated informal networks, redirected resources, and established a provisional isolation zone, all before any top-down directives were issued. This article thus offers practical insights into crisis management under conditions of scarcity, illustrating how ethical and practical responses can emerge from invisible moral infrastructures.

Our analysis is grounded in 50 oral history interviews conducted between 2020 and 2024, with a focus on the most detailed narrative: that of a nurse who led the emergency response. This account was selected for its central role in decision-making, descriptive richness, and potential for triangulation with other testimonies (Miles, Huberman, & Saldana, 2014).

To interpret the findings, we propose the concept of care biopolitics, defined in managerial terms as the dynamic capacity to sustain life under extreme uncertainty. Drawing on Foucault (2008) and Mbembe (2019), we argue that when protocols fail to offer immediate guidance, disciplinary and selective power can be reinterpreted. Tools typically associated with necropolitics are reappropriated by professionals who choose to sustain lives deemed disposable.

This perspective engages with the literature on operational resilience and organizational improvisation (Weick, 1993) and, more recently, with studies on near-miss management, which advocate transforming near-failures into collective learning opportunities (Dillon et al., 2016; Bundy et al., 2017). The novelty of this work lies in bridging the predominantly Western, private-sector corpus with the notion of ordinary management in contexts of scarcity. This concept describes tactical practices shaped by institutional memory and moral commitment (Carrieri, Pimenta, & Davel, 2017).

Methodologically, we combine thematic oral history (MEIHY; Alberti, 2004) with a three-cycle inductive coding approach, treating the focal account as an organizational artifact that captures, minute by minute, the inflection points that turned a public health alert into a non-event. Our analysis reveals that the speed of the response did not depend on rigid hierarchies but on a tacit operational playbook anchored in three actions: rapid activation of cross-functional teams, agile prototyping of isolation routines, and prudent demobilization to preserve scarce resources.

The findings contribute to three key domains. Theoretically, they advance the construct of care biopolitics as a bridge between critical power theories and dynamic capabilities in crisis contexts. Managerially, they demonstrate that hospitals can institutionalize learning routines from near-miss events, avoiding both procedural rigidity and chaotic improvisation. Socially, they underscore the leadership of nurses, technicians, and support staff in protecting vulnerable populations, well before the arrival of top-down directives, thus challenging narratives that marginalize these actors in decision-making processes.

By illuminating the invisible labor that transforms a potential disaster into a mere footnote, this article invites a reconsideration of the role of public management in times of radical uncertainty. It affirms the strategic value of ethical improvisation.

While the case study presented in this article is grounded in a public hospital's response to a suspected Ebola case, its insights extend far beyond the healthcare sector. In particular, the dynamics of improvisation under uncertainty, the mobilization of tacit knowledge, and the activation of informal trust networks reveal capabilities essential to any organization facing crisis conditions without pre-established protocols.

Managers in sectors such as logistics, emergency services, public administration, and even corporate environments can draw lessons from this case, especially where hierarchical decision-making lags behind operational urgency. This study offers not only a theoretical lens, care biopolitics, but also practical tools for institutional responsiveness, resilience, and ethical leadership in volatile and resource-constrained settings.

The article is structured into five parts. Following this introduction, Section 2 outlines the theoretical framework, integrating the concepts of biopolitics, necropolitics, ordinary management, and care biopolitics. Section 3 presents the methodological approach, emphasizing oral history and treating the interview as an institutional narrative. Section 4 presents an empirical analysis of the case based on the identified thematic axes. Finally, Section 5 offers concluding reflections and contributions to healthcare management and public organizational practices.

2. Theoretical Framework

2.1 Biopolitics, Necropolitics, and Public Health Emergencies

Public sector health governance in emergency contexts involves not only the allocation of resources and the application of protocols but also moral and political decisions about who is to be protected, and how urgently. In this sense, modern public health operates, to a large extent, as a biopolitical technology, a set of knowledge systems and practices aimed

at managing populations under the dual imperatives of sustaining life and governing risk (Foucault, 2008). In peripheral regions of the Global South, however, this logic is often disrupted by necropolitical regimes that determine, either actively or through omission, which lives are worth protecting and which may be sacrificed (MBEMBE, 2019).

The epidemic near-miss, an unconfirmed but institutionally disruptive event, provides fertile ground for examining this economy of life. Even without laboratory confirmation, resources are mobilized, provisional protocols are improvised, and specific bodies are either included in or excluded from the sphere of state attention.

Viewed through this lens, the near-miss serves as a moment of institutional exposure, revealing the logic by which life is differentially valued while simultaneously opening up space for counter-conducts that refuse to wait for official norms. In public hospitals, health professionals often act in advance of formal instructions. They reconfigure practices such as isolation, surveillance, and triage, typically associated with control, as ethical gestures of protection. This capacity to improvise under pressure manifests what we define as care biopolitics (BIEHL, 2005; TRONTO, 1993).

This interpretation aligns with scholarship that situates biopolitics within contexts of permanent exception (AGAMBEN, 2005) and with studies of biosafety in clinical work (LAURENCE, 2022). However, by highlighting the agency of peripheral workers in reshaping the state apparatus, we move beyond a necropolitical diagnosis of abandonment. We show that the exact technical mechanisms that may serve to kill can also be reoriented to protect, depending on the alliances, memories, and effects mobilized in the immediacy of the crisis.

In this regard, analyzing the Ebola near-miss as a biopolitical-necropolitical phenomenon enables us to trace not only the politics of death but also the fractures through which life is reclaimed, when public workers opt to enact a form of care biopolitics that shifts the locus of governance from abstract risk management to the concrete safeguarding of vulnerable individuals.

As a critical framework, care biopolitics combines Foucauldian and Mbembean insights to reveal particular features of the Brazilian state. On the one hand, it acknowledges that health institutions have historically operated as disciplinary mechanisms of surveillance and bodily optimization, a biopolitical logic intensified by Brazil's public health reforms and the establishment of the Unified Health System (SUS). On the other, it highlights how these same institutions participate in necropolitical governance by stratifying life along racial, territorial, and class lines, perpetuating avoidable deaths in urban peripheries, Indigenous territories, and mass incarceration (RANGEL et al., 2023).

From this tension, care biopolitics emerges as a counter-conduct (FOUCAULT, 2008): insurgent practices by healthcare workers who mobilize local knowledge, affective networks, and institutional memory to sustain those whom the state, by inefficiency or political design, has relegated to a bureaucratic death watch. In the Brazilian context, such practices include everything from grassroots support homes for people living with HIV/AIDS (BIEHL, 2005) to improvised protocols in public hospitals in response to Ebola or COVID-19 alerts (CARRIERI et al., 2021). The concept thus repositions critique: from exposing systems of power to illuminating the transformative agency embedded in everyday institutional life.

Three distinctive features characterize care biopolitics in Brazil, each revealing specific modes of institutional response in times of scarcity. The first is normative hybridity. In the absence of or insufficiency in formal protocols, frontline professionals pragmatically draw on a blend of WHO guidelines, national standards, tacit clinical knowledge, and community-based wisdom. This fusion results in locally adapted solutions, such as the use of herbal treatments or mobilizing neighborhood networks for logistical and emotional support, demonstrating a practical intelligence that transcends standardized handbooks.

The second is a form of affective trust capital, in which bonds of trust among healthcare teams, patients, and families serve as moral infrastructure. These relationships underwrite clinical decisions that, although not always endorsed by formal hierarchies, are socially recognized as necessary. In this sense, care emerges as a collective ethical practice capable of mediating conflict, enabling improvisation, and legitimizing actions in the absence of formal approval.

The third feature is inter-crisis memory: a repertoire of accumulated experiences from past emergencies, such as HIV/AIDS, dengue, or yellow fever, that equips institutions to respond to new risks. This institutional memory, often undocumented, accelerates decision-making, reduces reaction time, and fosters cohesion among key actors in moments of instability. In the case under study, the Ebola alert almost instinctively reactivated practices forged in prior outbreaks, illustrating how situated learning becomes operational capacity.

By synthesizing necropolitical critique with biopolitical agency, we offer an analytical lens that captures both structural violence and institutional inventiveness, contributing a context-sensitive perspective to international debates on care, health justice, and crisis governance in peripheral systems. The following section outlines the methodological approach used to access these care practices in action, as reconstructed through institutional memory.

2.2 Ordinary Management and Situated Knowledge

In the Brazilian public administration literature, scholars have long emphasized the gap between the normative prescriptions of healthcare protocols and the daily operational realities of public health organizations (Pires, 2017). More recent work challenges the moralizing view that treats informality as a symptom of managerial dysfunction. Instead, it proposes recognizing informality as a foundational component of Brazil's Unified Health System (SUS). Within this reorientation, the concept of ordinary management—understood here not as routine bureaucracy but as tactical, improvisational practice, emerges as a key analytic category. It refers to a repertoire of everyday operational responses that sustain hospital functioning amid chronic resource constraints (Carrieri, Pimenta, Davel, 2017).

Ordinary management is enacted through decisions that typically elude formal reporting systems, such as redirecting an expiring blood bag, improvising an isolation area with plastic curtains, or reorganizing shifts to compensate for staff shortages. Far from arbitrary, these actions stem from tacit knowledge, networks of solidarity, and an ethical commitment to protecting vulnerable lives, dimensions the literature identifies as situated knowledge (Haraway, 1988). In a seminal ethnography, Bittar (1997) describes nurses engineering "workarounds" to ensure hygiene when supplies run out, revealing both technical

ingenuity and moral accountability. Similar scenes have reemerged during recent crises. Barac and Drummond (2020) documented the fabrication of face shields from PET bottles during the COVID-19 pandemic, echoing the concept of frugal innovation (Radjou & Prabhu, 2012).

Theoretically, ordinary management aligns with the notion of dynamic capabilities (Teece, Pisano & Shuen, 1997), as it involves the agile reconfiguration of routines and resources. Nevertheless, it differs significantly from the corporate settings where the concept originated. In the SUS, scarcity is structural, and margins for error are razor-thin. This distinction aligns the phenomenon more closely with the literature on High-Reliability Organizations (Weick & Sutcliffe, 2007), which values operational sensitivity and disciplined improvisation. Reason (1997) warns that complex systems accumulate latent failures when deviance becomes normalized. Navigating this tension is central to ordinary management: improvising without compromising safety thresholds.

The Ebola near-miss illustrates this equilibrium. Upon receiving an alert about a febrile passenger, a small team mobilized to Confins Airport and, within an hour, set up an improvised triage station on the tarmac. This decision defied the official protocol, which called for immediate transport to reduce exposure risk and accelerate the threat assessment. Such action was made possible by the team's shared institutional history: all had worked together during prior outbreaks and trusted one another's clinical judgment. Hughes (1989) refers to this form of coordination as repair authority, a combination of experience and autonomy vital to critical infrastructure.

An informal debriefing held during the same shift highlighted the importance of psychological safety (Edmondson, 1999) in organizational learning. By documenting communication failures with epidemiological surveillance in the shared patient record, the team transformed a contingency into a continuous improvement initiative, practicing what Dillon et al. (2016) term organizational correctives. Although this documentation never left the hospital, it demonstrated that ordinary management entails systematic reflection—a feedback-action cycle reminiscent of military after-action reviews (Darling, Parry & Moore, 2005).

Nonetheless, critical literature warns of potential risks. Jeannot (2017) cautions that prolonged informality may entrench clientelism and obscure accountability. Turner (1976) demonstrated that socially constructed disasters frequently arise from normalized deviance. For this reason, ordinary management must be institutionally acknowledged but not bureaucratically absorbed. Initiatives such as the short debriefing in Brazil's National Patient Safety Protocol (ANVISA, 2019) advance this approach by institutionalizing rapid team reflection without imposing additional bureaucratic layers.

Connecting ordinary management to care biopolitics, as discussed in the previous section, reveals a dual conceptual shift. First, it repositions Foucauldian critique—from an emphasis on disciplinary apparatuses to concrete practices that, even amid scarcity, carve out spaces for life. Second, it expands Mbembe's framework of necropolitics by demonstrating that even in selective state systems, SUS professionals construct provisional zones of protection that counteract exclusion. In this light, ordinary management functions as a form of moral infrastructure (Fassin, 2012), sustaining vulnerable lives when formal systems falter.

Although international scholarship on care ethics has recognized care as a political force capable of reordering state priorities (Tronto, 1993), it has rarely examined how such

ethics are materialized in improvised routines. The case examined here demonstrates that when professionals erect ad hoc barriers at airports or re-engineer internal workflows, they are—amid urgency—drafting a provisional charter of dignity: a tacit cartography that determines who must be protected, with what resources, and in what sequence. This practice embodies what Bosi (2014) referred to as a subterranean contractuality—an unwritten pact between SUS workers and users.

This contractuality subverts the logic of waiting that defines tropical necropolitics. If state abandonment manifests as resource delay, the frontline response is marked by acceleration. Ticktin (2011), in her study of humanitarian regimes in France, argued that care can sometimes legitimize arbitrary selection. Brazilian ordinary management, however, reverses this dynamic: selection is based not on codified vulnerabilities but on urgency as perceived by the frontline worker, suspending bureaucratic delay for all affected.

This temporal dimension reveals that care biopolitics is also a politics of the now. It does not wait for beds to arrive or for PPE deliveries; instead, it forges an "in-between", between absence and formalization, where life can persist until systems respond. In this way, professionals invert what Biehl (2005) termed zones of abandonment, transforming them into temporary enclaves of care. This practice enacts counter-conduct (Foucault, 2008): actions that do not dismantle the system but work around its impasses to make it more humane.

From a broader institutional perspective, integrating this provisional ethical parameter into formal decision-making requires recognizing that institutional intelligence does not reside solely in written protocols but in the people who test and reinvent those protocols daily. This calls for valuing short feedback cycles and the co-production of protocols in which frontline solutions are recognized, adapted, and scaled. Experiences such as the safety huddles of the UK's NHS (Waring & Bishop, 2020) show that such integration can reduce errors without stifling ingenuity.

Still, caution is needed to avoid burying these practices under layers of administration. Here, Certeau's (1994) warning about the domestication of tactics by strategic discourse resonates. A promising path lies in adopting living protocols, continuously revised by those who enact care and are grounded in safety metrics. This approach aligns with the principles of adaptive learning in public health, which advocate cycles of experimentation, assessment, and real-time adjustment (WHO, 2022).

Ultimately, the link between ordinary management and care biopolitics reveals that the SUS is not sustained solely by large-scale reforms but by countless micro-inventions that reaffirm the value of life amid precariousness. On the hospital floor, improvisation is not a deviation, it is an ethical resistance that redefines the boundary between life and death. Honoring this experience requires institutional mechanisms that learn from productive disobedience, converting provisional ethics into procedural norms, without erasing their inventive force.

2.3 Care as Counter-Conduct and the Value of Counter-Archives

In contemporary debates, care has transcended its traditional association with assistance to emerge as a micropolitical practice that challenges dominant power regimes. In this article, we conceptualize care biopolitics as a set of situated actions within Brazilian

public institutions that confront necropolitics, that is, the selective administration of death (Mbembe, 2019). Unlike Tronto's (1993) normative ethics of care, care biopolitics emphasizes who acts, when, and with what instruments to sustain life precisely when the state hesitates to act. This type of action aligns with Foucault's (2008) notion of counter-conduct, which we extend into the field of public management to highlight its analytical value in shaping ethical responses under conditions of uncertainty.

Bosi (2014) demonstrates that in precarious territories, care serves as a counter-hegemony grounded in community ties and local knowledge. Ticktin (2011) observes that in humanitarian contexts, care can function as an exception and subversion, redefining belonging where legality breaks down. Tronto (1993) articulates four phases, attending, taking responsibility, skillful action, and responsiveness, as an ethical-political metric for everyday practice. Minayo (2015) contributes to the understanding of this phenomenon by historicizing it, demonstrating how care strategies in the SUS evolve through repeated cycles of health crises.

The empirical narrative analyzed in this article substantiates these readings. Reflecting on the Ebola alert, one nurse reported, "We decided to go in fifteen minutes, waiting for orders would have cost us dearly." This statement encapsulates Tronto's four phases: recognizing need, assuming active responsibility, deploying adaptive competence, and responding collectively. The decision to set up an improvised triage station at the airport, circumventing the official protocol, illustrates the reappropriation of control mechanisms, such as sanitary barriers and risk protocols, to protect a life that was otherwise deemed expendable. In this action, care biopolitics functions as a provisional ethical compass, anticipating formal norms to counter the necropolitics of delay.

We theorize this type of practice through the concept of counter-archives: unofficial narratives that circulate outside institutional records and challenge the monopoly over what is recognized as an "organizational fact" (Trouillot, 1995). In highly regulated and resource-scarce hospital settings, such accounts are often the only available evidence of how care is sustained in practice. As Benjamin ([1940] 2005) reminds us, recovering these voices is a way of reconfiguring the present, not merely recalling the past.

These narratives typically emerge in rapid-response situations where decisions bypass formal command structures. They operate as tactics, in Certeau's (1994) sense: calculated improvisations that repurpose institutional tools to engage with the real. When systematically captured, such accounts shed light on ordinary management (see Section 2.2) and expose the differential valuation of lives. As such, the counter-archive dismantles bureaucratic neutrality and reinforces care biopolitics as an institutionalized form of resistance to selective abandonment.

The analytical value of counter-archives unfolds across three dimensions. First, the chronology of improvisation documents the time elapsed between the emergence of risk and response, offering input to calibrate future protocols for uncertain scenarios. Second, the affective mapping of decisions reveals that their legitimacy derives from networks of trust and shared memory, aligning with research on tacit competencies and care-based decision-making (Lindberg; Rantatalo, 2015). Third, the construction of an inter-crisis memory demonstrates how accumulated experience from prior epidemics can shorten response times—an intangible yet strategic organizational asset.

This approach aligns with emerging evidence on practices such as story circles and safety huddles, which have been shown to significantly enhance near-miss detection (Smith & Jones, 2021). In the UK's NHS, daily narrative briefings resulted in an 18% reduction in minor adverse events within just three months (Waring & Bishop, 2020; HSE, 2021).

At the managerial level, two practical recommendations stand out. First, living protocols should integrate counter-archives into monthly After-Action Reviews, in line with learning health systems models (WHO, 2022). Second, organizations should implement narrative quotas, dedicated minutes in team meetings for recounting near-miss incidents, to embed them within continuous learning cycles. Short-form digital storytelling tools (Snowden, 2021) can help overcome barriers like shift constraints and workload pressures.

The integration of care as counter-conduct and counter-archives expands critical discussions on necropolitics, organizational innovation, and health justice. It shows that devices such as isolation, triage, and surveillance become truly effective only when activated by agents committed to making a living, as illustrated by the frontline narratives analyzed here. By transforming micropolitical resistance into institutional knowledge, public health managers gain tools to anticipate failures, respond to near-miss events, and strengthen the ethical infrastructure underpinning health systems.

The following section presents the methodological protocol used to translate these narratives into analytical categories, thereby repositioning frontline accounts as legitimate components of innovation and safety infrastructures in public health organizations.

2.4 Broadening the Relevance: Contributions to Global Management Scholarship

Although rooted in the Brazilian public health context, the conceptual and managerial insights offered in this article transcend national and sectoral boundaries. By articulating the constructs of care biopolitics, ordinary management, and counter-archives, this study provides a rich, transferrable lens to examine how organizations navigate crises when formal structures fall short. These contributions speak directly to three pressing conversations within international management literature: adaptive governance, improvisation under uncertainty, and ethics in high-stakes decision-making.

First, this work extends the theory of dynamic capabilities beyond its traditional corporate domain. Much of the existing scholarship emphasizes how firms in stable, resource-rich environments adapt through strategic reconfiguration (Teece et al., 1997). In contrast, this article demonstrates how frontline actors in precarious, resource-constrained settings mobilize improvisation and institutional memory to generate life-sustaining responses. The implications resonate with research on high-reliability organizations and resilient systems (Weick & Sutcliffe, 2007), while introducing moral intentionality as a core component of adaptive performance.

Second, the concept of ordinary management challenges conventional understandings of leadership and control. Rather than viewing informality as dysfunction, this framework recognizes tactical improvisation as a legitimate, and often vital, form of institutional intelligence. It aligns with a growing body of Global South-informed scholarship that advocates for more pluralistic, grounded, and practice-based views of organizational life

(Garud et al., 2022). In doing so, it invites scholars to reimagine the sources of innovation, authority, and legitimacy in times of uncertainty.

The concept of care biopolitics, as developed in this study, enriches global management debates by expanding how ethics, governance, and organizational improvisation are understood in crisis contexts. Traditional frameworks in management often separate ethical deliberation from operational decision-making, treating care either as a secondary consideration or as the domain of designated professionals in caregiving sectors. This article challenges that separation by demonstrating that care, understood not only as an emotion or duty but as a form of strategic, embodied governance, can operate as a central organizing logic in extreme uncertainty.

This insight finds resonance with emerging interdisciplinary literature that positions care as a political force capable of contesting and reconfiguring dominant regimes of power. As Foucault (2008) described, biopolitics refers to the management of populations through technologies of control, normalization, and optimization. Yet, in contexts of structural abandonment, often visible in public institutions in the Global South, such technologies are unevenly distributed, rendering entire groups exposed to necropolitical neglect (Mbembe, 2019). In response, care biopolitics arises as an insurgent form of governmentality: a situated, tactical, and ethically charged practice through which marginalized actors claim and enact the right to life, dignity, and protection.

This repositioning of care, as a response not just to needs, but to the institutional void left by state retreat, extends the biopolitical framework by foregrounding agency and intentionality. Rather than viewing healthcare workers merely as functionaries within a disciplinary apparatus, the article recognizes them as moral agents who, through improvisation, recreate governance structures from below. Their actions do not reject protocols wholesale; rather, they negotiate, adapt, and re-signify them in ways that affirm life where institutions hesitate.

This reconfiguration aligns with scholars like Biehl (2005), Tronto (1993), and Ticktin (2011), who have emphasized the relational and political nature of care in spaces of marginalization. By drawing on these traditions, the article situates care biopolitics as both a critique of necropolitical omission and a constructive model of alternative governance. It reveals how care is not the antithesis of control, but a form of governance that privileges presence, responsiveness, and situated intelligence over abstraction, delay, and technocratic inertia.

In doing so, the article invites management scholars to reconceptualize the locus of innovation, authority, and resilience. It proposes that care-based action is not peripheral to organizational strategy, it is, in fact, a key source of adaptive capacity in times of crisis. This expands the relevance of care biopolitics to sectors as diverse as humanitarian aid, environmental risk management, urban governance, and emergency logistics.

Ultimately, by embedding the ethics of care within the operational logic of crisis response, care biopolitics offers a powerful counter-narrative to managerial rationalities rooted in control and efficiency. It affirms that life-saving improvisation, informed by moral attentiveness and collective memory, constitutes not a failure of governance, but its most humane and innovative form.

Finally, care biopolitics brings ethical nuance to crisis management by framing improvisation as a form of situated moral action. This is particularly relevant for organizations operating in humanitarian, environmental, or socially volatile contexts where standard protocols are either inadequate or inapplicable. The notion of care as a political and managerial force expands the ethical vocabulary of management studies and enriches ongoing debates on moral infrastructure, trust, and human-centered governance (Fassin, 2012; Tronto, 1993).

In sum, this article offers a theoretically robust and empirically grounded perspective that enriches global debates on how organizations act—and innovate—when rules are absent, time is short, and lives are on the line. It encourages management scholars to look beyond codified norms and explore the deeply human, relational, and ethical practices that sustain institutions in the face of disruption.

3. Methodology

This study employs a qualitative approach with a descriptive and exploratory character centered on the narrative engagement of healthcare professionals through the Hybrid Thematic Oral History method. This technique, firmly established in Brazilian oral history research, was initially developed at the University of São Paulo (USP) and later advanced at the Getulio Vargas Foundation (FGV), where it is recognized for its methodological rigor and analytical depth (MEIHY, 1996; ALBERTI, 2004). The method was chosen for its capacity to reconstruct detailed subjective experiences, offering access to the nuances, meanings, and dilemmas encountered in public health emergencies, dimensions that are typically inaccessible through quantitative or survey-based methods.

The unit of analysis, a public infectious disease reference hospital, represents high-complexity, resource-constrained environments commonly found in health systems in the Global South, which enhances the comparative relevance of the findings. The study is part of a broader research project on health crisis management within this institution, covering the period from 1984 to 2022.

Participant selection followed a rigorous multi-phase process. Ethical approval was obtained from the Research Ethics Committees of UFMG and the partner institution in compliance with national regulations for human subjects research. Institutional engagement was established with hospital leadership and, systematically, with the Teaching and Research Unit, the body responsible for regulating and supporting scientific initiatives within the hospital.

Participants were identified in three stages: (i) a review of the institutional organizational chart and personnel database to map potential interviewees; (ii) ten in-person meetings with the Teaching and Research Unit to refine selection criteria and identify key informants; and (iii) formal invitations delivered in person, by phone, or via email, including a full explanation of the research goals and assurances of confidentiality and voluntary participation. A public presentation during an institutional event also encouraged spontaneous expressions of interest. Subsequently, snowball sampling was used to reach retired professionals referred by active staff. Most interviews were conducted via videoconference, following the same consent and documentation protocols.

A total of 50 interviews were conducted with healthcare professionals who had held strategic roles across the hospital's history. Interviews averaged 50 minutes in length and followed a semi-structured format with open chronology, encouraging the emergence of memories, reflections, and situated experiences. All sessions were recorded (audio or video), fully transcribed, double-checked for accuracy, and stored in a secure repository, in line with best practices in oral history and FGV guidelines (ALBERTI, 2004).

Data analysis followed a rigorous thematic content analysis protocol, combining manual coding with structured spreadsheet organization. Each interview transcript was thoroughly reviewed and segmented into relevant excerpts, which were recorded in spreadsheets that included the interview link, verbatim quote, transcript page, associated health crisis (e.g., HIV/AIDS, dengue, yellow fever, or Ebola), main category, subcategory, and interpretive notes.

The initial analytical dimensions, such as network, conflict, historical narrative, knowledge production, biopolitics, and institutional routines, were based on a literature review but remained open to reclassification by the flexible thematic framework proposed by Meihy (1996) and Alberti (2004). Each category was subdivided into up to 42 subcategories to precisely capture nuances such as improvisation strategies, fear management, care practices, institutional memory, and bureaucratic limits.

The analytical process unfolded in three complementary stages. First, thematic identification and manual coding: Each interview was reviewed in full, with relevant excerpts highlighted and categorized based on recurrence, richness, originality, or descriptive precision. Discrepancies were resolved through team consensus. Second, contextual clustering by crisis type: excerpts were reorganized by health events (e.g., dengue, Ebola) to identify institutional patterns and distinct responses. Third, thematic refinement and cross-event analysis: excerpts were regrouped by theme and subtheme regardless of the specific crisis, allowing for internal triangulation and the identification of transversal patterns. This stage was crucial for achieving theoretical saturation and enhancing interpretive coherence.

Double-checking procedures were applied throughout: each transcript and spreadsheet was reviewed by at least two researchers, with disagreements resolved collaboratively. A field diary and audit trail were maintained to document methodological decisions, coding criteria, and analytical adjustments, ensuring full traceability and replicability of the research. Beyond its heuristic value, this methodology supports the transformation of exceptional experiences into managerial insights, particularly in contexts where formal prescriptions fail to anticipate on-the-ground realities.

The whole process spanned approximately six months, structured into successive phases: coding, event-based clustering, and cross-thematic analysis. The volume of material, structured data management, and collaborative teamwork ensured a high level of methodological rigor, consistency, and transparency.

To ground the analysis of the Ebola near-miss in empirical detail, we selected one specific narrative from among the 50 interviews: the account of the nurse manager who led the triage of the suspected patient at Confins Airport in 2014. Institutional records confirm that only three professionals were mobilized at the time—the nurse, an assistant, and a driver. Of these, only the nurse was located and agreed to participate. Her account thus constitutes the only first-person narrative of a nationally unprecedented public health incident.

The centrality of this account rests on two pillars. Methodologically, the literature acknowledges the heuristic value of direct testimony in edge-case events, particularly those involving uncertainty and the absence of formal protocols (Alberti, 2004; Portelli, 2016; Bosi, 2014). Such accounts offer access to lived experiences, ethical reasoning, and situated practices that are often overlooked in administrative documentation. Empirically, this was Brazil's only officially registered Ebola suspect case to date, and the institutional response was unprecedented within the SUS (CAMPOS et al., 2015; RANGEL et al., 2023).

Although centered on a single voice, this narrative offers a privileged lens into institutional risk management and care dynamics during a near-miss event. As noted by Benjamin (2005) and Atkinson (2017), richly constructed singular experiences can illuminate organizational blind spots and generate strategic knowledge about how institutions respond under pressure.

We acknowledge, finally, the limitations of this approach. The absence of additional testimonies—such as those from airport surveillance staff or state health managers—constitutes an empirical constraint. As with any oral history-based methodology, the narrative is also subject to selective reconstruction and interpretive subjectivity. However, this plasticity is intrinsic to the method's epistemological strength, allowing access to moral and affective dimensions often absent from official records. As a future research agenda, we suggest incorporating such perspectives to enrich the multilayered reconstruction of the event.

Table 1 – Summary of the Methodological Strategy

Element	Description
Approach	Descriptive qualitative, based on situated narrative engagement
Strategy	Hybrid Thematic Oral History (Meihy, Alberti)
Investigation	Period 1984 to 2022
Unit of Analysis	Public infectious disease reference hospital
Participants Selected	One management professional (among 50 interviewees)
Selection Criteria	Institutional relevance, accumulated experience, historical engagement
Data Collection Technique	Semi-structured interview, fully recorded and transcribed
Analytical Framework	Meihy (1996); Alberti (2004); content analysis and institutional narrative
Limitations	Analysis centered on a single account; absence of other institutional voices

4. Results and Analysis

4.1 Emergency as Near-Miss: Between Protocol and the Unforeseen

Although the term "near-miss" is well-established in the literature on risk management and failure prevention, here it is reinterpreted through a biopolitical lens as an analytical device that exposes undocumented institutional states of exception—moments in which action precedes the establishment of normative frameworks. The case of a suspected Ebola patient at a public infectious disease reference hospital marks a critical inflection point in understanding care as a politics of life.

Even though the diagnosis was ultimately dismissed, the institutional effects of the suspicion were immediate, intense, and deeply revealing. The activation of response mechanisms occurred in advance of formal regulatory mandates, characterizing what we define as a near-miss event: a threshold moment in which political and operational effects unfold prior to laboratory or normative confirmation. Here, the near-miss is operationalized as a potential event that already calls forth concrete practices of institutional reorganization—driven by fear, organizational memory, and uncertainty management. Rather than a formally stabilized event preserved in official records, it represents a subjective and collective state of emergency.

The selection of the hospital and the nurse who led the response illustrate that state decisions about who is exposed to risk in the name of containment are not accidental. These decisions are rooted in social structures that normalize the exposure of specific individuals to death as a means of protecting others. Within this context, the interviewed nurse emerges both as a witness to and an agent of the activation of care biopolitics.

> “So, we had the Ebola situation — I remember when we started. We were not officially designated as an Ebola training center, but we were instructed to develop a protocol for protective gear. We gathered the nursing team and said, 'Guys, I read this, that, and the other. Let us come up with a protocol here that is evidence-based.' So we organized intensive training sessions and everything.”

This excerpt demonstrates that the technical knowledge mobilized did not result from a hierarchical mandate but emerged through a collective effort grounded in local initiative, accumulated experience, and critical engagement with available literature. As proposed by Carrieri et al. (2017), this represents a case of ordinary management, the way institutional life is sustained through tactical practices that bypass centralized normative structures. In dialogue with Certeau (1982), these tactics are not arbitrary improvisations but rather expressions of practical intelligence that restructure institutional routines from within.

This tactical rationality gains full force the moment the official alert is issued, transforming preparatory training into emergency response. The interview captures this pivotal transition:

> “I was in the middle of training the team — there were two doctors in the room, three nurses, and a physical therapist. I was running a training session on donning PPE and practicing with the equipment. Because, you know, it is not Ebola — that is the real issue. Then, a doctor called me and said there was a suspected Ebola case at

> Confins Airport. [...] I stopped the training and said, 'Everyone, stop—we have got a problem.' She asked, 'How fast can you mobilize a team to get out there, girls? We have got a real case.' I asked, 'How long would it take us to get to Confins?' She said, 'Half an hour.' I told her, 'Half an hour — we will be there.'"

The institutional response was immediate, activated prior to the issuance of official protocols. This state of readiness, sustained by trust-based relationships and an inter-crisis memory that serves as an intangible yet strategic organizational resource, aligns with the adaptive capabilities described in studies on High-Reliability Organizations (Weick & Sutcliffe, 2007) and learning health systems (WHO, 2022). However, in this case, such capacities emerge under conditions of scarcity and institutional marginalization.

In this context, care biopolitics is enacted as a form of counter-conduct, a collective decision that, even in the face of fear, places the life of the other at the center.

> "Were we scared? Oh, that is on the record. We were terrified. Nevertheless, we said — 'Whoa! Let us go."'

This statement reveals the ethical commitment that drives the response. In this context, care biopolitics entails not only the management of life but also a political stance against systemic abandonment, acting to protect those who, within the rationality of state calculus, are deemed expendable. This disposition is activated in a public hospital that, although not officially designated, is implicitly tasked with assuming the risk of containing a global threat.

Mobilization without formal protocols, but grounded in prior preparedness, also surfaces in another account:

> "We had trained the entire airport team [...], and during the training, I remember we told the airport staff to purchase this particular device. Moreover, the guy said, 'No! We are a private company — we will buy a better one.' I asked, 'But is it better?' He replied, 'No, it is adequate. We have already tested it."'

This excerpt highlights the tension between conflicting knowledge logics: the situated technical expertise of the healthcare team and the market-driven rationality of outsourcing, which often fails to respond adequately when confronted with the immediacy of operational crises. In this context, the public hospital and its professionals assume a leading role in the emergency response, not as a spontaneous gesture but as the result of an institutional trajectory marked by resistance and a sustained commitment to life.

This protagonism is not incidental. It reflects a broader pattern in which peripheral institutions, even without formal designation, are routinely tasked with absorbing global risks. This recurring pattern disrupts centralized crisis governance models, underscoring the need to recognize localized capacities for distributed crisis management (Tierney, 2012).

In essence, this section demonstrates that the near-miss event catalyzed the activation of care practices that operate outside formal playbooks but within a distinct ethical and political rationale. It affirms the proposition that care can function as an insurgent biopolitical

force, a form of active counter-conduct capable of reorganizing institutional life around a commitment to human dignity.

It is in this critical space, where the imperative to act arises before regulation, that the next section turns its focus on who is called to act, what attributes anchor that trust, and how such selection reveals the moral mechanics shaping institutional responses in contexts of risk and exception.

This insight offers a practical contribution: In settings of profound uncertainty, critical decisions depend not only on formal protocols but on invisible moral infrastructures that are nonetheless decisively operative. For public leaders and managers, recognizing these tactical arrangements as legitimate organizational responses may significantly enhance the responsiveness, resilience, and ethical grounding of institutional governance under extreme risk.

4.2 Care Biopolitics and Embodied Agency

The activation of the institutional response during the near-miss event was neither abstract nor automatic, it was embodied by concrete individuals, tacitly summoned to assume risks in the name of care. The nurse interviewed, who led training sessions and coordinated the response to the Ebola alert even before official confirmation, exemplifies how technical competence, institutional memory, and ethical commitment function as informal, but decisive, criteria for mobilization in public health emergencies.

This tacit summons reveals that care is not merely an assigned task but a socially recognized disposition for action under pressure, acknowledged by peers, managers, and the institution's history. The nurse's selection was not formalized through documents or decrees; instead, it materialized through collective recognition of her ability to act amid uncertainty. As Foucault (2008) observes, the hospital as a biopolitical apparatus does not operate through improvisation alone: an immanent rationality structure conducts and renders emergencies intelligible. Crisis management, therefore, is not chaos but rather the expression of an organizational culture that, as Carrieri et al. (2020) put it, sustains life through ordinary management.

This pattern is vividly illustrated when the nurse recalls:

> “I remember when I arrived, the first person I encountered was the airport's medical staff. He had removed his protective gear. I asked, 'Why did you take it off?' He said, 'Because I could not handle wearing it.' I told him, 'This is not the time for that. I told you no, right? You say okay.' I can be quite direct. Then I said, 'You are in quarantine. Until we determine whether this is Ebola or not, you are quarantined. Excuse me.'”

Here, the response articulates technical authority and a sense of collective responsibility, reflecting conduct guided not by blind adherence to protocol but by institutional rationality and care for others. Within the framework of this article, care biopolitics emerges from the fusion of situated knowledge, ethical judgment, and practical responsibility.

The urgency escalates when the team finds the patient abandoned on the aircraft. The nurse narrates:

> "When we arrived, it was a horrific scene — the patient was left unattended because everyone thought it was Ebola [...] I told him, 'We are going to have to carry this patient out ourselves.' We were the only two properly geared up [...] We carried him out, placed him in the ambulance, and began care [...] I said, 'Look, if this man does not have Ebola, he is going to die here — and we do not even know what he has, right?' He said, 'But what if he does have Ebola?' I replied, 'Then so be it.'"

This gesture, prioritizing rescue in the face of institutional absence, exemplifies the insurgent practice Mbembe (2018) describes: a rupture in the state's calculus that normalizes the disposability of certain bodies. The nurse acts with both technical discernment and political effect, transforming fear into active care, a shared ethical judgment within the crisis.

Reflecting on the final diagnosis, the nurse adds:

> "So we called Odilon Hospital to receive the patient, and we stayed hidden in the ambulance [...] We risked our lives saying he did not have Ebola. Furthermore, we did it. We saved his life. However, we did it safely. Do you know why? Because we know how to manage the crisis — and our conscience."

This statement encapsulates care biopolitics as a consciously situated and strategic practice. Conscience here is not only individual but shared across a network that recognizes the ethical urgency of the moment. Dardot and Laval (2016) argue that the politics of the everyday demands subjects capable of collective decision-making with expanded responsibility.

The political dimension of care is further underscored when the nurse states:

> "It turned out the man had severe food poisoning [...] There is a way to do this, you know? A way to act with conscience, humanity, and resolve. However, if you are working in public health emergencies, you can't just go through the motions. You have to be fully engaged."

This ethics of presence is also a politics of the now, as previously discussed. The decision to act, even without formal authorization, challenges state-centered logic and enacts what Saffioti (2004) and Rago (2007) characterize as everyday resistance: micro-practices reaffirming the value of life even under threat.

Notably, the nurse occupies an occupational role often overlooked in crisis leadership literature, that of a nurse manager. This is not a minor detail; it reveals how women, particularly in public institutions, are frequently the first called upon to mediate risk, care, and decision-making, often without the formal recognition typically afforded to high-level management roles. This suggests that technical-affective protagonism in critical moments often rests upon marginalized bodies and trajectories.

From a managerial perspective, recognizing care biopolitics as a situated strategy, encompassing informal hierarchies, self-accountability, and technical-ethical leadership, highlights the need for organizational mechanisms that integrate such practices into institutional learning structures. Protocols become more robust when designed with input from those who confront crises in their material reality.

In conclusion, this section demonstrates that care is neither spontaneous nor episodic but rather an insurgent organizational rationality. It asserts itself at the intersection of technical knowledge, ethical positioning, and institutional recognition, offering a foundational perspective for envisioning public policies that are more responsive, inclusive, and committed to human dignity.

4.3 Care as Institutional Counter-Conduct

Foucault's (2008) concept of counter-conduct extends beyond overt resistance to institutions, encompassing subtle forms of normative subversion. This section illustrates how care emerges as an institutional counter-conduct within a public hospital, expanding the concept beyond critique to reveal its ethical potency in management practices.

In the episode recounted, the negligence of airport personnel—who dismissed the need for assistance due to the risk of contagion, exemplifies tactical abandonment: the patient, potentially infected, was deprioritized in favor of the institution's desire to avoid confirming the case. The interviewee, however, reverses this logic:

> "When we arrived, it was a horrific scene — the patient was unattended because everyone assumed it was Ebola [...] We carried the patient out, removed him from the aircraft, placed him in the ambulance, and then cared for him. I was furious and said, 'If this man does not have Ebola, he is going to die here, and we do not even know what he has, right?' 'But what if he does?' I said, 'Then so be it.'"

This act is both clinical and political in nature. As explored in the theoretical section on care biopolitics, it represents an ethical stance that asserts itself amid crisis, redefining institutional boundaries of action. Here, care transcends mere technique or episodic treatment; it manifests as an alternative logic of governing life, a proactive counter to necropolitics that tends to discard bodies deemed threatening. The interviewee challenges this dominant rationality by acting decisively in defense of life despite uncertainty.

This form of resistance recurs when the interviewee questions the airport's private sector equipment choices, critiquing the assumption that higher cost equates to better quality. This episode highlights the clash between administrative protocols and practical experience driven by a commitment to efficacy and safety:

> "During training, I remember telling airport staff to buy this device. The guy said, 'No! We are a private company; we will buy a better one.' I asked, 'Is it better?' He replied, 'No, it is adequate. We have already tested it.'"

As Dardot and Laval (2016) argue, institutional resistance not only opposes hierarchical orders but also the rationalities permeating organizational culture. Here, care biopolitics stands as a counterweight to technocratic and economic logic, showing that institutional action can be guided by values beyond market or containment priorities. The interviewee embodies a situated practical rationality that confronts technocracy and affirms an alternative knowledge rooted in practice and shared responsibility.

This insurgent awareness is further demonstrated when, despite limited language proficiency, the interviewee persists in understanding the patient's clinical condition. Language barriers and limited resources are not obstacles but deepen the significance of her care:

> "We started epidemiological questioning—' How long have you been there? How long has this lasted?' The man was Chilean, speaking Spanish; I spoke a mix of Spanish and Portuguese. [...] I said, 'I am not sure. Let us talk more.' So, after assessing, it was clear he had another diagnosis; it was not Ebola. I took off my protective gear. The team freaked out."

This decision shifts care from obedience to situated ethical judgment. The interviewee does not deny risk but rather reinterprets it in light of the specific situation. By prioritizing life amid uncertainty, she exemplifies the densest form of care biopolitics discussed earlier. Rather than rejecting institutional apparatus, this conduct reinscribes it within an ethics of presence and attentive listening.

Finally, it is important to note that the interviewee, working within a leading public infectious disease hospital, acted with recognized autonomy. Although not formally the highest authority, her expertise and institutional experience positioned her as such. This reflects Carrieri et al.'s (2020) insight that ordinary management of life is upheld by individuals who, amid crisis, assume tactical command. Thus, care functions as a strategic element of contemporary governmentality when guided by ethical and political values that prioritize the value of life.

This analysis confirms that care biopolitics is a moral infrastructure integral to institutional crisis management. The following section will investigate how such insurgent conduct either spreads or is contained within broader organizational structures. Care biopolitics thus emerges as a powerful theoretical lens for grasping institutional dynamics that resist reduction to protocol, hierarchy, or dehumanized techniques.

5. Conclusion

This article begins with a singular episode, the mobilization of a Brazilian public hospital in response to an Ebola alert, to develop a critical theory of public management in exceptional contexts. Centered on a dense and situated narrative focused on the experience of a nurse manager, the study reveals how micropolitical practices emerge in the absence of formal guidelines, reshaping protocols, challenging hierarchies, and reconfiguring control systems. Beyond describing a case, this text proposes an analytical model with the potential to

broaden the contemporary understanding of managing life in contexts of risk and vulnerability.

Theoretically, the article offers four integrated contributions. First, it formulates the concept of care biopolitics, which links technical rationality, political effect, and institutional memory to explain how ordinary subjects reconfigure state apparatuses in the service of life. This shifts the focus from necropolitical abandonment to insurgent practices, which, positioned at the margins, reactivate the commitment to life preservation. Second, it values ordinary management as a strategic foundation for action in contexts of scarcity. Rejecting moralistic readings of informality, the analysis recognizes it as a tactical and adaptive infrastructure essential to institutional resilience, particularly in the context of counter-conduct and high-reliability organizations.

The third innovation proposes the concept of a counter-archive, inspired by Trouillot and Benjamin, to highlight near-miss narratives that are absent from official records. These narratives serve as moral and cognitive radars, illuminating improvisation chronologies, affective networks, and inter-crisis memory that sustain response capacity in the face of uncertainty.

Fourth, the article recognizes emergency as a space for institutional invention. The response to the near-epidemic event was not the result of centralized planning but rather the product of informal trust networks, tacit authority, and distributed clinical knowledge. Recognizing this expands dynamic capabilities to include practices forged in peripheral settings marked by precarity yet dense with ethics and relationality.

Methodologically, the study employs a hybrid thematic oral history approach, inductive coding, rigorous triangulation, and systematic documentation of analytical decisions. Although focused on a single testimony, the event's uniqueness and narrative density justify this approach, enabling the extraction of institutional insights that are rarely captured through traditional methods. Building on these findings, the article proposes three managerial tools: adopting living protocols that incorporate lessons from near-misses, institutionalizing narrative quotas to valorize ethical improvisation as a form of organizational learning, and promoting effective governance that recognizes trust as operationally as important as procedural norms.

These proposals connect with international experiences, such as British safety huddles and after-action reviews, but gain originality by integrating Global South logics—showing that innovation emerges in everyday practices within underfunded but morally robust organizations—moreover, the article dialogues with current debates on crisis leadership and management.

The empirical analysis highlights a distributed leadership model, where authority arises from tacit recognition and relational engagement rather than formal rank. It also aligns with sensemaking approaches by demonstrating how actors collectively construct crisis meaning in real-time. Additionally, it contributes to adaptive management literature by documenting action-reflection-adjustment cycles under pressure—which is key for public systems confronting high uncertainty.

The findings demonstrate that effective crisis response is not the sole domain of formal leadership or protocol-bound procedures. Instead, distributed leadership, practical intelligence, and ethical improvisation can serve as strategic assets when uncertainty disrupts

traditional command structures. These elements are equally applicable in corporate and governmental contexts that must respond swiftly to reputational crisis, supply chain disruptions, or socio-political emergencies. The concept of "living protocols," for example, invites organizations to embed flexibility and real-time learning into their operational fabric, an imperative not limited to healthcare.

By foregrounding moral infrastructure and situated agency, this article challenges conventional assumptions about where leadership and innovation reside. It invites managers across sectors to recognize the value of frontline knowledge, to institutionalize near-miss learning mechanisms, and to cultivate trust as a core resource. The care biopolitics framework thus provides a transferable model for governing with agility, dignity, and foresight across diverse organizational landscapes.

In sum, this work repositions care as a strategic category in public management, expands adaptive capabilities beyond corporate contexts, and proposes governance rooted in an ethics of presence, active listening, and situated creativity. It is a theoretically grounded and empirically informed proposal with broad practical relevance, offering solid foundations for more just, responsive, and life-affirming public policies.

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