On Fear, Distrust, and Ebola

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Soon after the first US case of Ebola was diagnosed in Dallas, I decided that Maryland’s Department of Health and Mental Hygiene should have a press conference (http://bit.ly/1Ajy09F). With leading infectious disease experts from the University of Maryland and Johns Hopkins, we answered questions from virtually every news outlet in the area for about 45 minutes.

After the health care workers became infected in Dallas, we called the media back for another press conference (http://bit.ly/14EqDAu). It involved the same team, plus Maryland’s governor, Martin O’Malley. Later, after we designated 3 facilities to care for patients with Ebola should federally funded beds not be available, we did it yet again, adding experts from the MedStar Health System, a nonprofit, community-based health system that serves the Baltimore/Washington region (http://1.usa.gov/158073d).

Effective communication during a public health emergency requires a carefully orchestrated effort. When it’s my job to be the conductor, my goal is not only for the team to play the right notes, but also to make sure that listeners can hear the melody.

During the 3 press conferences, our notes were the details: how the Ebola virus is transmitted, how personal protective equipment is worn, and how the state’s emergency medical services and hospital system will respond if there is a suspect case.

But the real value of public health communications, especially during emergencies, is the melody, the underlying message. Our simple melody was that the state and the leading health care institutions in Maryland are present, focused, and working together to protect the public.

Fear during epidemics is based in distrust. People are quick to doubt experts, they criticize health officials for any perceived mistake, and they wonder aloud why more attention is not being paid to worst-case scenarios. As one frightened Texas congressman memorably said, “Every outbreak novel or zombie movie you see starts with somebody from the government sitting in front of a panel like this saying there’s nothing to worry about (http://bit.ly/1FqnQd5).”

The distrust extends beyond the health care system. People question whether employers are doing enough to protect the workplace and whether schools are doing enough to protect children. They look sideways at the person next to them on the subway, or on the bus, or living next door.

Distrust unsettles and contributes to fear. Fear can lead to panic, as well as to discrimination, scapegoating, and even violence.

In an emergency, public officials who simply reflect public anxiety, distrust, and fear are not helping anyone. However, those who tell people not to be afraid may only wind up increasing the public’s anxiety. A more promising approach is for government officials to join with respected health care leaders and organizations and address the public. Doing so demonstrates to the public that familiar and trusted sources of care are not going to abandon them. The family physician, in effect, is still on the job.

In late October, 3 governors announced a policy of quarantining all returning health care workers, suggesting that the public can do little but trust these heroes to stay out of harm’s way (http://wapo.st/1G2ewyB). Maryland’s governor, well experienced in emergency management, did not reflexively follow them. With his support, Maryland’s Health Department stepped forward with a different approach, based on science and developed with our health care leaders and organizations. Our strategy distinguished between health care workers with known exposures and those without, and involved quarantine only as a last resort.

Thanks in part to the public health communications that preceded it, our message was broadly accepted (http://bsun.md/1AjBla3). For the moment, at least, the public and media in Maryland were singing our song.

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