

## Realistic Expectations about Public Responses to Pandemic Flu

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### Introduction

Thank you, Congressman Gordon, for spotlighting the important contributions of social and behavioral science to pandemic influenza preparations. My gratitude also to the committee’s staff—in particular, Ms. Christal Sheppard—for organizing today’s roundtable, and to all of you for taking time out of your busy schedules to participate.

Devising pro-active public policy for a future health crisis is a tough job. I commend those individuals and agencies that have worked very hard to nurture an orphan public health issue. My comments today are intended to improve upon their efforts, not to diminish them.

Do the National Strategy and the Department of Health and Human Services’ (DHHS) Plan embody realistic expectations about public responses to pandemic influenza? Three issues emerge that require further scrutiny, in my reading of current doctrine and operational guidance: the anticipation of panic, the professionalization of response, and the myth of personal choice.

### 1. Panic

Both the National Strategy (p. 9) and the HHS plan (p. 23) set up the erroneous expectation that the public will panic unless an adequate risk communication campaign is in place. As Dr. Fischhoff will relate, communication is an essential tool for managing the social and bodily harm posed by an epidemic. The concept of panic, on the other hand, is not a useful tool for managing health crises. A person or mob consumed by sudden, unreasoning fear and acting without regard for others is a powerful and satisfying mental picture that has little-to-no basis in reality, based on extensive social research into extreme events, including disease outbreaks.

In place of this image, I offer three counter-intuitive arguments:

First, fear and dread are appropriate responses given the scale of human suffering and economic upheaval that is possible. To be over-confident and oblivious to the kind of harm that a flu pandemic can inflict is illogical and out of touch with material reality. Dr. DiGiovanni has already outlined for us the dire epidemiological possibilities.

Second, authorities often mistake reasonable behaviors in the face of a big outbreak for acts of sudden, unreasoning fear—clogging up health department phone lines for disease-related information, pouring into hospital emergency rooms for care, and seeking access to scarce life-saving vaccines. These actions may complicate things for doctors, hospital ad-

ministrators, health officials, political leaders and other authorities. BUT going to the health experts for health advice and medicine—especially in the face of a novel threat like pandemic flu—makes good sense.

Third, leaders should not try and “fix” the public. Authorities and news reporters often interpret reasonable demands for life-saving medical resources as evidence of mass panic. Seen in supply-and-demand terms, the irrationality exists at points of production and distribution NOT consumption. Seniors who are knowledgeable of their risks to flu and who tend to get vaccinated very early in the season were understandably anxious at news of last year’s flu vaccine shortage. A frantic call to locate vaccine or standing in line early and at length at a vaccine clinic was, from the patient perspective, a sensible thing to do. Long lines at flu shot clinics—a great news photo opportunity—were more likely a function of a centralized mass vaccination model, hampered by limited personnel and physical space, than of mobs of people driven by a “scarcity mentality.”

Institutional irrationalities most evident in the current U.S. plan centers on the problem of mass casualties. How federal officials intend to help mobilize a fragmented, mostly for-profit health care system to meet the crushing demand for medical services is uncertain.

## **2. Professionalized Response**

The second approach to pandemic flu planning that requires revision is that of a response solely by professionals. “Individual action,” argues the National Strategy, “is perhaps the most important element of pandemic preparedness and response” (p. 11). Yet, only 2 roles are envisioned for the population in the health crisis: passively receiving official information and restraining personal behavior that might spread contagion. Studies of collective responses to actual disasters contradict this minimalist agenda of leaving the tough decisions and actions to the authorities.

The National Strategy leaves us thinking about the U.S. population strictly in terms of individuals NOT whole neighborhoods, communities of faith, social clubs, and professional societies. These groups (or “civil society” institutions) around which people organize their day-to-day lives are the very same ones they use to rally humanitarian efforts in the face of disaster. The Independence Plaza neighborhood association in lower Manhattan, for example, self-organized “teams” to check on apartment residents following the 2001 World Trade Center Tower attacks. Commendably, the HHS plan recognizes the value of mobilizing the workplace in responding to pandemic flu.

The federal government, however, provides neither practical guidance nor material support to state and local authorities in rallying non-governmental, non-commercial organizations in pre-pandemic planning of a community-wide response. Civic engagement in pre-event pandemic planning can help strengthen the practical feasibility of plans as well as foster essential public trust in government leadership. A participatory model of governance is in keeping with what political theorists, historians, social scientists and ethicists have described as likely to produce the most legitimate and effective public policy.

## **3. Personal Choice**

The third operating principle within current U.S. pandemic flu preparedness with which social and behavioral science would take issue is the notion of personal choice. Skepticism toward or refusal to cooperate with public health orders, like the call for home quarantine, curtailed travel or mass vaccination is never strictly a matter of individual preference. The problem of “non-compliance” has less to do with handling willful, obstinate or ignorant individuals than with rectifying life circumstances that interfere with a person or group’s ability to act according to authorities’ reasonable requests.

The current recommendation that citizens keep “supplies of materials at home, as recommended by authorities, to support essential needs of the household for several days if necessary” and to stay home for up-to-10 “snow days” ignores

economic realities in the U.S. Many poor and working class Americans can barely get by on a day-to-day basis, let alone stockpile their larder for what is, for most, a theoretical danger. In addition, asking hourly employees to miss 10 days of work as part of a flu furlough creates a real fiscal crisis for their households.

Lastly, assuming that whole populations will line up without any hesitation to receive a novel, untested vaccine – once it becomes available in a pandemic—ignores the profound mistrust that many minority groups hold toward public health authorities and a broader skepticism about government oversight of biomedical products. Our present pandemic flu approaches are silent about how to handle the variable acceptance rates around immunization.

## **Conclusion**

Human suffering on an immense scale always begs the question, after the fact, if more could have been done to avert the tragedy. We have the gift of time and today's dialogue to assure that socially and behaviorally realistic protections are underway. The operating assumptions of “panic,” “professionalized response” and “personal choice” warrant serious reconsideration.



