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The Impacts of Fear on Frontline Healthcare Responses to COVID-19

Dr. Birnholz:
Coming to you from the ReachMD Studios, this is *COVID-19: On the Frontlines.* I'm Dr. Matt Birnholz. On today's program, we caught up with Dr. Kelly Cawcutt, an infectious disease and critical care physician, and Associate Director of Infection Control and Hospital Epidemiology at the University of Nebraska Medical Center, site of one of the world's most preeminent biocontainment units where several of the very first American cases were managed. Dr. Cawcutt shared some insights on the impacts of fear in frontline healthcare responses to a global pandemic. Here's what she shared with us.

Dr. Cawcutt:
It is very interesting to look at the differences in practices in different parts of the country and in the world based on when they saw their first patients and whether or not they had any substantial pandemic planning in place early on. Even just the contamination of machinery or the use of full anticoagulation. We aren't seeing differences in our patients thus far, and we aren't as concerned about the equipment as other people have been because we know it's easily killed, and we have the equipment that can be wiped down, and we know how to do it, and I think having those resources and that expertise makes a huge difference.

I think our biggest struggle here still, even though we have that capacity and expertise, is trying to hold the line between the fear and the panic of what could happen and what could go wrong and say, "but there's the science and the evidence that says all the things that could go right," and we know when we diverge from science, patients actually tend to do worse. That's what happened in Ebola outbreaks, and it's very well-documented when we failed to do the right thing, the patients actually had worse outcomes. There was a fear scale developed, and in the public health setting, the higher the fear scale the more likely the public was to adhere to public health measures and mitigation strategies and things like hand hygiene. The reverse was actually true in healthcare workers. The higher the fear, especially among those who were not known to have been infected yet with the given virus, the more likely they were to diverge from infection control procedures and policies.

There is some data coming out in COVID-19 surrounding an adapted fear matrix from SARS to now and a little bit of similar data coming out early suggesting kind of the same phenomenon that happened in SARS. But the implications of that I think are huge, and it would have been so interesting to be able to go back to the beginning even just of the US outbreak where there was a little bit of lead time into some of the communities that had the first widespread cases and assess fear both in the public and healthcare workers but then also the outcomes of number of healthcare workers that got infected, issues with PPE adherence, other things like that. If we could have known what was coming and assessed for it early, I think it would be profoundly helpful to understand how to educate and support the healthcare teams in a way that I don't know that we have done really well historically.

Dr. Birnholz:
That was Dr. Kelly Cawcutt from the University of Nebraska Medical Center. For ReachMD, this is *COVID-19: On the Frontlines*. For continuing access to this and other episodes, and to add *your* perspectives toward the fight against this global pandemic, visit us at ReachMD.com and become Part of the Knowledge. Thank you for listening.