Perspective

Crisis: The Ultimate Test for You and Your Hospital

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Everyone knows that a crisis is not an option. It is not a matter of "if," but of "when," "how big," and "how damaging."

Crises share four common characteristics:

1. No matter how prepared a hospital – or any organization – thinks it is, there is always a price to be paid: at best a chip, at worst a chunk of reputation is questioned or lost.
2. A crisis virtually never happens when we are best prepared for one.
3. As often as not, we create our own crisis.
4. A crisis generally lasts a lot longer than we think it should.

Crises come in many shapes and sizes, and increasingly they are issue-driven (i.e., changing legislation, new regulations, funding, community relations). However, still too many organizations, if they plan at all, tend to focus their crisis-management/communications plans and processes on event-driven incidents (i.e., fire, a missing patient, food poisoning). As a result, they neither expect nor know how to effectively manage and overcome issue-driven crises. Yet more and more, crises currently tend to be issue-driven.

Consider one health centre that wanted to site an AIDS clinic a few blocks from its main building. Management found a location and quietly signed a lease. Word leaked, and within days there was a community-wide maelstrom of fear and anger the centre's management never expected. There was no contingency plan … nothing prepared to explain intent or allay unfounded fears. Worse yet, management was attacked for its secretiveness, and the entire worthwhile project slipped off the drawing board. Ironically, later it was discovered that a handful of doctors who had offices adjacent to the planned AIDS clinic actually started rumours that soon had the neighbourhood in total opposition. They did so because they feared their patients would be upset and possibly change doctors.

Consider the hospital that for two days "lost" a patient who had died. Naturally, the media had a field day. Bad enough that such an incident happened, but worse yet the fact that management refused to comment, and at no time expressed regret because hospital legal counsel advised against it for fear of admitting culpability. This, on the heals of an attempted suicide by a patient that nearly succeeded, caused incredible media scrutiny of the hospital's operating procedures and staffing practices.

Finally, consider the hospital that wanted to be one step ahead of Ontario's restructuring commission and concluded a secret deal with another hospital – all for the right reasons and logical longer-term benefits for the community. But secret deals have a way of backfiring, especially when local politicians are left out of the picture and have to play catch-up. So what started as a good idea became a nightmare, with just about everyone confused, angry and feeling threatened. And the marriage planned in heaven turned into the experience from hell when advocates united and arranged huge parades of protest. The protests were supported by many of the staff in both hospitals who, rightly, were concerned about their own jobs.

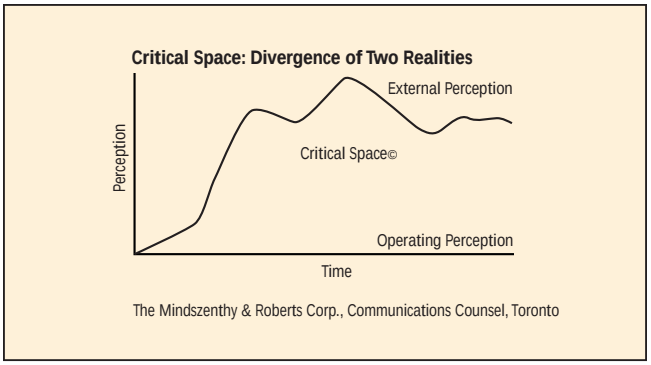
When Perception Becomes Reality

Marshall McLuhan, the brilliant Canadian media futurist, once said, "If I hadn't of believed it, I wouldn't have seen it."

He also said, "In the world of instant information, rumours are the real thing."

Both quotes are very relevant and appropriate when it comes to crisis management and communications. In the majority of crisis situations, the incident or the issue is actually magnified because there is an absence of timely, sustained information sharing and often a lack of senior-level visibility. The result: the rumour mill runs rampant. What observers of the crisis imagine or want to believe too often becomes "fact." And so perception becomes reality, with the result that a relatively minor crisis can take on menacing proportions.

To illustrate the dynamics of perception versus reality, we developed a diagram, called Critical Space. It shows that with time, the gap between external perceptions and internal reality tends to widen when decisive action is not taken and there is no effective, immediate supporting communications process.



By way of vivid example, recall the explosion of the NASA shuttle *Challenger*, shown live on television, and the hours of confusion and misinformation that followed. The gap between NASA's reality and external perception was widening rapidly the first 24 hours. Why? Because the trained spokespeople were locked into the mission control bunker near the launch pad. The procedures, since revised, called for the spokespeople to be in the bunker during the launch. What no one thought about was the fact that the bunker's huge protective doors automatically locked for 24 hours in the case of an accident. The reason: to ensure there could be a complete debrief. The result: Critical Space at work due to little or no accurate information provided by inexperienced spokespeople.

The Case of the Missing ER

There is a Canadian city with three hospitals where several years ago the ER physicians decided they wanted substantially more money and fewer hours to work. They announced they would stay away from work if their demands were not met. Concurrently, there was a municipal budget review underway, and in looking at ways to reduce costs, it was decided that rather than have three emergency rooms operating 24 hours a day, one was enough. Research also showed that upwards of 60% of those who came to the city's three ERs could have visited a doctor for treatment, but either did not have a regular family doctor or did not want to wait for an appointment.

As a result, there was a recommendation endorsed by the district health council to close the ERs in hospitals A and B between 6 AM and 10 PM; to operate the ER at hospital B with skeleton staff between 10 PM and 6 AM to handle only light cases; and to operate the ER at hospital C round the clock, but with no added staff. To further complicate the issue, it was suggested that the ER in the most centrally located hospital – hospital C – be designated the "ER of first choice." In other words, all ambulances would take patients there first.

Without too much discussion, the changes were announced and implemented almost immediately. There was an advertisement carried twice in the local daily newspaper; it was a quarter page and that did not allow room for maps and details. For a one-week period, 30-second radio announcements were run on three local stations, mostly during peak drive times. The local weekly shopping tabloid also printed a notice, and all media carried at least two or three short "reactions to the change"–type stories.

Just about all stakeholders reacted angrily. The ER doctors claimed the decision was recrimination for their threatened walkout. ER nurses alleged they probably could not cope. Citizens' groups warned of confusion and possible senseless deaths. Ambulance drivers complained that they would have longer runs and jeopardize those being rushed to hospital. The elderly expressed concerns about ease of access. Some city councillors expressed outrage. Even taxi drivers complained. There was ongoing confusion about what ER service was available where, and a general belief that there was only one ER now in the city.

About a week after the new arrangement was in place, an ambulance was involved in a collision with a car as it raced to the "ER of first choice." Three ambulances were quickly dispatched to now transfer the initial patient – a suspected victim of a heart attack – and three other people injured in the collision. Naturally, media showed graphic footage on television, carried intense interviews on radio, and bold headlines splashed across the front page of the daily newspaper. Talk and phone-in radio programs focused on the incident, citing the inherent danger of the recent change. And, of course, there was much grumbling on the part of citizens over fences and in the stores.

Throughout this period, the hospitals said virtually nothing, either to employees or to their constituency. Polite form letters that did little to reassure or outline the facts were mailed to those who called to complain or get clarification. Requests for interviews were turned down. The district health council stood by its position and said the hospitals could have implemented the overall program any number of ways. The Mayor, trapped between advocating fiscal restraint and supporting access to

healthcare for the poor and indigent, was doing her possible best to stay the middle course of expressing concern and talking about the harsh demands of balancing budgets.

Two days after the accident, in the middle of the night, there was a small fire in the ER area of hospital A. It was quickly discovered and contained, and by the time firefighters arrived it was extinguished. The president of hospital A quickly issued a three-line statement that said there was a small fire, no one was injured or had to be moved and that damage was limited. However, there was immediate speculation about sabotage. The fire marshal's office announced the next day that there was no indication of foul play and that the likely cause was an electrical short. By the time the city had absorbed the second incident, the rumour mill and speculation were in full flight.

Three days after the mysterious fire at hospital A, a man rushed his wife to that very ER only to be told there was no service; he jumped back in his car and raced to the ER with the skeleton staff. The wife was unconscious and allegedly had fallen off their back porch and hit her head. An ambulance was called and the man told that the "ER of first choice" had facilities and staff that could help immediately, while the ER at hospital B would have to call for help.

The woman was pronounced dead on arrival at hospital C. (Interestingly, no physician ever saw or actually examined the woman until she was taken into the ER at hospital C, and surprisingly, the ambulance crew that transferred her from the car and then into the hospital never checked her vital signs.)

Despite his grief, the man wasted no time in launching a huge lawsuit against the three hospitals and providing a number of emotional media interviews.

The level of media coverage was sustained. The outrage, anger, fear and concern expressed by just about everyone was intense and ongoing. It was a very bad time.

The presidents of hospitals A and C quickly issued statements expressing their regrets; the president of hospital B was on holidays. The local district health council said there would be a review of procedures. The Mayor said death of a single person was too high a price to pay for a balanced budget. Too bad for the hospitals, it was too little, too late.

What Did Not Happen . . . And What Should Have

This series of incidents was the result of a classic case of no planning and little preparation, poor coordination and haphazard, ad hoc communications. It culminated in a crisis of perception, a crisis of confidence and a number of event-based crises that, taken as a whole, created a volatile environment and damaged the reputations of all three hospitals.

What did not happen? Specifically …

- The rationale for ER changes was never properly explained.
- Inadequate time was allotted for the transition.
- Many people did not understand how and where to access ER services because there was little in the way of building public awareness about the changes, how they work and what people should consider and do.
- The hospitals failed to coordinate their actions and communications.
- Public fears were not acknowledged and addressed.
- The incidents were not perceived to have been taken as serious symptoms of a problem in need of fixing.

What should have happened?

- A thorough stakeholder assessment should have been

Crisis Probability Quotient™

Sectors

Factors	Hospitals	Factories	Hotels	Shopping Centres	Offices	Restaurants	Prisons	You
Ease of accessibility	10	2	7	10	2	7	0	
24-hour operation	10	7	10	5	0	0	10	
Intensity of client interaction	7	5	5	2	5	5	7	
Level of client expectations	10	5	7	5	7	7	2	
Range of life-threatening situations	5	5	2	2	2	5	7	
Vulnerability to external factors	5	5	2	5	5	2	2	
Technology dependence	10	10	5	5	7	2	7	
Poor crisis-response preparedness	0	2	2	5	10	7	0	
Level of employee discontent	?	?	?	?	?	?	?	
Inconsistent management practices	?	?	?	?	?	?	?	
Total	57+	41+	40+	39+	38+	35+	35+	

0 = None 2= Low 5 = Medium 7 = High 10 = Very High

conducted at the outset – defining the stakeholders and their probable positions.

- All those involved at the outset should have recognized the need for an issues-management process to help manage the changes in the ERs, and that a good, understood and shared contingency crisis-management plan should have been prepared and ready for use.
- The district health council, city hall and the three hospitals should have worked very closely together to plan a phased-in transition period.
- During this period, there should have been extensive (and extensive does not mean expensive) educational communications to staff, patients, the community, healthcare workers, media and other key stakeholders.
- All healthcare professionals and support staff should have been given briefings and asked to help spread the message on how the system will work.
- The heads of the three hospitals should have been prepared with a coordinated plan of action for any significant incident and been accessible at all times the first few weeks of the changeover.
- They also should have been much more visible and enlisted the active involvement of the Mayor and the head of the district health council, and representatives of other stakeholder groups that would be affected directly.
- Throughout, the hospital presidents should have demonstrated a much greater level of sensitivity to people's concerns and confusion.
- Particularly in the fire and the death, the city's healthcare system should have been highly visible in helping brief elected officials, the media and advocate groups.

The Bottom Line

Organizations have a propensity for rationalization. It is a natural phenomenon. It also is an extremely dangerous and expensive alternative to planning, testing and maintaining both an effective issues-management system and a crisis-management/communications plan and process.

Having worked with a number of organizations in the healthcare sector, from the federal level through to provincial agencies and a host of hospitals, we have developed great respect for the fundamental integrity and professionalism we see at every level. But we also have developed a great concern over the lack of well-maintained, detailed, understood and tested crisis-management/communications plans across the healthcare sector. Unfortunately, this is also the case with far too many organizations in the not-for-profit sector.

Equally important, we see remarkably little evidence of issues-management systems in place in hospitals. When well planned and applied, they can help prevent crises – especially the issues-based ones like the case outlined above. We always explain to those we counsel that an issue unresolved inevitably becomes a conflict, and a conflict most often simmers into a crisis.

In the current environment of litigation and change, it is not good enough to ride on noble thoughts, high hopes and a wing and a prayer. HQ

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