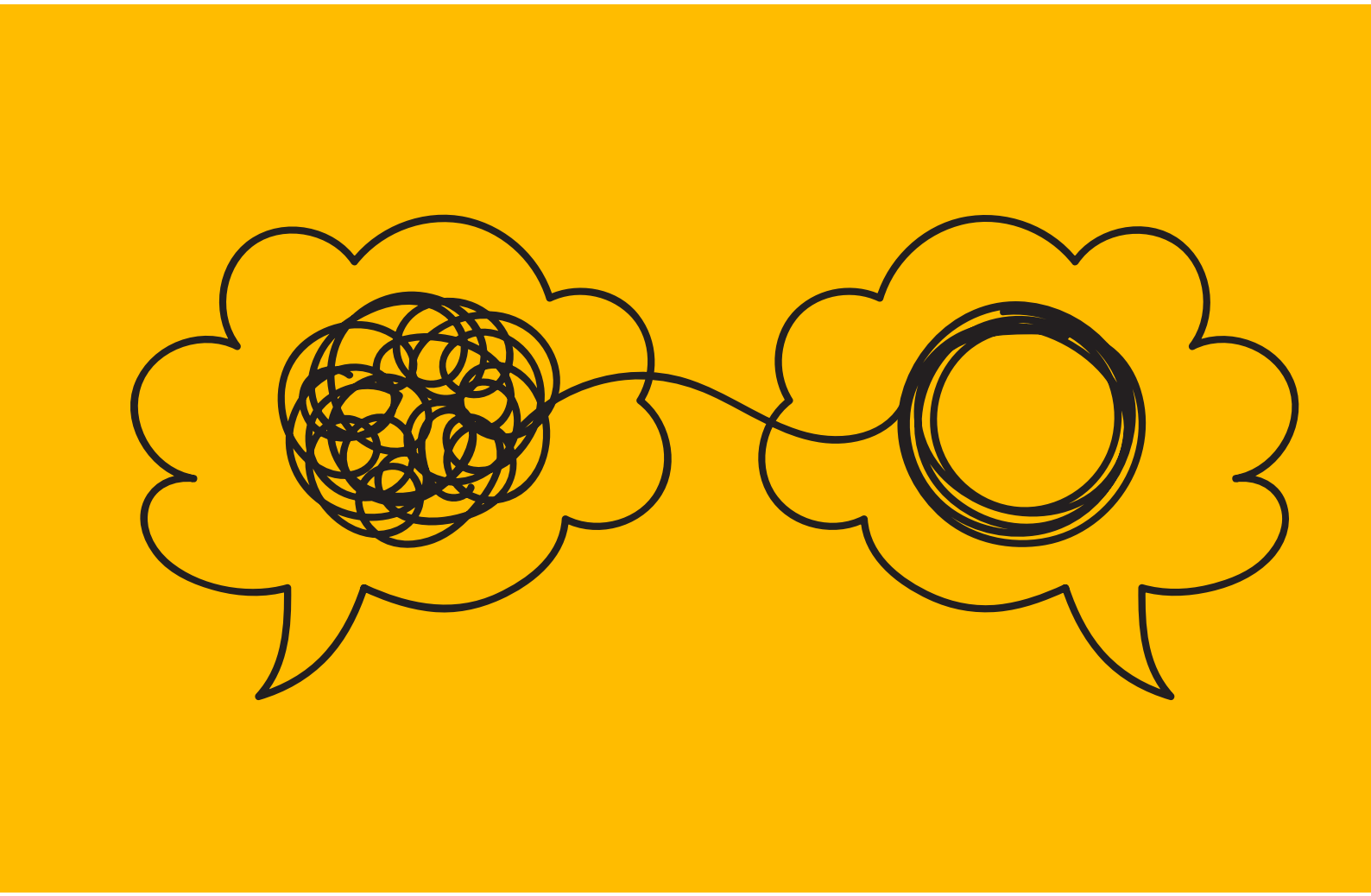
Crisis Communication: Challenges, Priorities and Perspectives



Summary: Communication during a crisis is always a challenge and even more so with the unprecedented COVID-19 pandemic. A group of experts from Ghent University in Belgium talked to HealthManagement.org about the elements of a communication strategy, workflow arrangements and adjustments required in critical times and the ways of how COVID-19 is changing communication as we know it.

While seasonal influenza has become an element of everyday life, COVID-19 is completely new to us, with no vaccine or treatment so far. And something new and unacquainted always causes more anxiety and uncertainty at all levels. It may well be that COVID-19 is here to stay, and with a partially immunised and partially vaccinated population (hopefully resulting in more mild cases but possibly not in eradication) it will also become something 'acceptable,' just another recurrent, manageable disease. But until then the coronavirus will remain a source of stress. Because without solid long-term data, which will be accumulated over time, it is very difficult to make reliable predictions and arrange communication around the virus. This does not mean, however, that we should not be prepared, manage our messages properly and be transparent about and acknowledge the uncertainties.

Communicating Infectious Disease Outbreaks

First of all, such outbreaks raise specific concerns about both patient and healthcare worker safety as we have seen with SARS, MERS, or Ebola. For communication, the most important would be effective and clear policies introduced early on, thus mitigating and avoiding as much as possible the spread of misinformation, speculations and fake news. Otherwise we run risks of losing trust with the public, which, if combined with accompanying economic hardships, is not a good mix.

Such communication policies, however, would be useless without preparedness for the eventuality of a pandemic, even more so with a high-risk pathogen. This preparedness needs to be pre-emptive, even in the absence of an active problem. Contingency plans must already be in place, including one for communication. This can be based on what has been learned in the past (eg recycling of prior plans developed in response to previous outbreaks such as Mexican flu). We should not wait until the problem is at our doorstep to start developing this framework. With COVID-19 we had an early warning back in January, with the outbreak in Wuhan, and the rest of the world should have anticipated the risks and invoked their contingency plans at that time. As an example of lack of anticipative preparedness, Belgium lacked a strategic PPE stock.

It is also necessary to be authentic and trustworthy. We do not know for how long this crisis will last, and there is nothing wrong in admitting that. Had the authorities and the medical community done so in due time, many lives could have been saved. Pursuing this path helps to address issues of unpredictability, uncertainty (especially when confronted with a new infectious agent) and anxiety.

Communication should be structured – one example would be the use of the WHO guidelines, eg on personal protective equipment, as a framework here. It should also be consistent throughout a health system, based on the previously discussed plans. With the structural complexity in Belgium this is particularly challenging. Different authorities need to be aligned and the advisory committees installed are multiple and require strong centralisation. Hospitals fall under the federal authorities and were better prepared for the COVID-19 epidemic than care homes for the elderly, which are under the responsibility of different community governments. The structures were not adapted, for example, to transfer personnel and trained nurses from hospitals to nursing homes, but this urgent need prevailed above regulatory restrictions.

Compulsory Elements of Strategy

During a crisis, responses need to be prompt, pre-emptive, systematic and up-to-date. The availability of new information and new developments require dynamic as well as considerate responses. In our world of social media, true and fake news, it takes no time for unnecessary speculations to spread. We need to communicate with our organisation directly, through a dedicated channel, so that everybody is updated on all the news. In other words, there should be the right communication at the right place at the right moment.

Practical questions raised by the community or the workforce require specific, trustworthy and clear answers. These answers can change over time, but at any given moment need to be coherent and realistic. Quality communication needs to include the rationale behind your decisions. And this stands at all levels, from country to hospital.

Any conflicting information carries a risk of harm, but unfortunately it abounds. In Belgium, we see this at ministerial level, for example. One minister says longer journeys outside are not allowed while another sees no need for this restriction, and this debate spills over to the media. Neither there is consistency at the European level. In France, the 1-1-1 rule is in place [at the time of the interview]: you can go out for one hour for one kilometre with one person. In Belgium, you can walk or bike as far as you wish. However, if you want to rest on a bench, you are not allowed to. Why do rules vary so much? How do we explain that to an already frustrated and tense public? In any case, the current crisis has been addressed mainly at national levels, and, in a way, the European approach has not prevailed.

Last but not the least part of a communication strategy, especially now, is empathy. We need to speak from our hearts and incite the feeling of empathy in our audiences. Otherwise people would have difficulties grasping the seriousness of our message. Our health minister at the federal level in Belgium has managed to do that with just a one-liner, 'Blijf in uw kot,' stay at home – and she will be remembered for that. That was a very short, powerful and transparent message and a sign of leadership.

What Does Not Matter

Personal or organisational agendas have to be put aside

giving way to the more general objective of community health targets. We need to coordinate with different hospitals across the whole health system. Again, this is easier said than done. In Belgium, hospitals are now in lockdown. But of course, everybody is thinking about how we restart the activities, the economy. Our organisation is planning to gradually go back to work – and do so in a cautious, deliberate and proportioned way in order to meet non-COVID-19 related healthcare demands that are at risk of being neglected. However, partner hospitals in our region demand the lockdown to be prolonged. This represents a potential conflict of personal/individual institution vs. the general community healthcare organisational agenda. Healthcare works as a network, and personal agendas need to be superseded by the needs of general capacity to accommodate patients during the peak, in particular to ensure sufficient intensive care capacity. And this, once again, highlights the importance of preparedness. The more prepared you are, the earlier you will be able to gradually return to normal activities, as well as to provide capacity during the peak phase of a pandemic and dynamically adapt.

There is, of course, a danger of frustration among staff. We see this imbalance in our teams. There are those who are actively involved in coping with the epidemic, they are engaged, they cooperate – the nurses in intensive care, the intensivists, the emergency department, pulmonary medicine and infectious diseases department staff. At the same time, facilities such as surgery, operation wards have been shut down, and a number of physicians are out of work and may feel neglected. Note that in Belgium physicians in the university hospitals have salaries, but in most private institutions their income depends on the number of surgical and other acts they perform. So now they may have less income, just like restaurants and hotels. This may generate tension, but the situation may also be a partial game changer. It would not be surprising to see the COVID-19 crisis facilitating the shift in how physicians are paid for their work. These shifts will differ from country to country and from situation to situation, but there may be major changes in society in general and the healthcare community in particular.

Work Arrangements

For remote work, SMART targets must be in place, developed by the leaders of the organisation and ensuring traceability, measurability and clear timeframes for all tasks. The organisation should also provide adequate IT support for uninterrupted workflow. Every staff member working remotely must have a single channel of instructions with goals clearly set and procedures explained.

In Ghent University Hospital, we have protocols, which define the outputs of all workers. Such protocols have to be prepared in advance, because when a crisis strikes, it may well prove too late to develop them in a hurry. Again, in Belgium the collaboration between communities may be hampered by complexity. Since a couple of years ago, hospitals have committed themselves to collaborate in regional networks of 4-8 hospitals. Within these networks we can share protocols that we can use, for example, during emergencies. So an emergency and a crisis such as the COVID-19 epidemic may or should represent an opportunity for accelerated cooperation on a wider scale, with protocol sharing in networks or nationwide. This is one useful lesson for us to learn from the pandemic – we can, in fact, rapidly work together when there is a problem, so we probably can also cooperate better when there are no problems. This is really an eye-opener for all the healthcare workers in Belgium proving strengths and resilience of the healthcare system.

The most important would be effective and clear policies introduced early on, thus mitigating the spread of misinformation, speculations and fake news

Having protocols in place, however, is not enough. People need to know how to apply them. The training centre of our hospital is putting a lot of effort into educating our staff on the practical implementation of those protocols, for example, teaching our nurses how to use personal protective gear.

All this applies not only to the staff workers but also to volunteers. What differs is that your messages to them need to be very down-to-earth, easily understandable and clear. Face-to-face sessions with an expert explaining the basics is an appropriate format. Tasks should be tailored to the competence, with clear guidelines, instructions and support. Also, workers and volunteers should feel our gratitude and appreciation. All of them are overloaded, so we have to invoke the feeling of mutual solidarity and be the role models for them. In the end, it all comes down to leadership. When you have a good leader, the rest will follow.

External Communication Policies

In healthcare, upholding ethical standards in communication is of utmost importance, and during a crisis this should

be reinforced, especially when it comes to privacy. In our organisation there is a workforce of up to 6,000 people, so, of course, it is impossible to completely avoid the leaks. The danger here is that workers may not have the correct information and what they release to the media or the public or the wider healthcare community may be misleading, and then urgent corrections would be needed. The golden rule of communication is to first communicate internally and afterwards externally. Therefore, each organisation must have one single point of contact for pre-emptive, correct and assertive external communication on hospital policies. This must be clearly relayed to all the staff with no exception.

There is as well a lot of communication happening internally, between the staff members. This is an important part of the workflow, and an organisation needs to guide it by strengthening formal channels, such as staff meetings, direct messages from the management, and so on. In our hospital the policies have been set from the very beginning by our CEO and Chief Medical Officer – we have a pandemic, there's a problem, and here's what our communication strategy is. Such structured approach is a sign of a strong organisational culture, which comes before anything else. You can have the best strategy, but if a culture is absent, nothing helps. As they say, culture eats strategy for breakfast.

Dealing with Stress and Overload

The current situation generates many uncertainties due to the lack of scientific data and evidence, and we need to acknowledge this. Here creating a trustworthy and caring environment is a must. Trust is a – if not the – key principle of risk communication. It is developed through responding to people's concerns, for example, with explanation of how to use protective gear or training personnel who are redeployed to unfamiliar healthcare settings. The staff should feel our empathy and gratitude for their extra efforts. For this, a strong intervision framework is necessary, so that people can talk with colleagues or receive psychological support if needed. On a very practical level, there needs to be baseline support, such as providing day care for children or catering.

What Will Change

One risk here is that our focus would narrow down to the crisis issues only while neglecting the upholding of normally required activities. We should keep this in mind and do our best to avoid such a scenario.

Our current experience will definitely lead to increasingly structured communication. A well-structured communication strategy and efficient communication flow from top to the floor are necessary. This means, for example, thoroughly explained and motivated decision-making with simultaneous strengthening of hierarchy and decrease in anarchy.

The opposite flow, however, is also very important. In the words of Michael Porter, management have to go down to the work floor to see what is happening there and talk to people. With COVID-19, the top level not only has the information on infection and mortality rates, but can put this in perspective by keeping in touch with the people at the front line. Furthermore, this, too, helps to develop a relationship of trust between the management and the staff.

Post-Crisis Communication

In our hospital, there has been a lot of mutual support among the members of the staff, and this is encouraging. And just as now, we will need to continue expressing our gratitude to all the workers and supporting them after the crisis has passed.

One of the ways would be adjusting work schedules. This would allow for proper recovery and 'delayed grieving.' For the moment there is a lot of stress but also great involvement from everyone in the hospital. After the pandemic, however, those who worked with COVID-19 patients in the intensive care, may face mental health issues, such as PTSD, sleep disorders, mood and anxiety disorders to name a few, and require psychological coaching. We are already seeing the signs of that, which means that we need to get prepared.

To ensure good work-life balance, we have a reserve of nurses on alert waiting to be called in for help. For those who are feeling overwhelmed, a hotline is operated by a team of a doctor, a nurse and a psychologist who can help with queries and issues. In each ward a dedicated person provides psychological support to those in need.

With all this in mind, it is encouraging to see the unprecedented levels of solidarity in the European healthcare – in the UK, France, Spain, Italy, between the hospitals, among health workers. Hopefully, this kind of solidarity will hold long after this crisis is over. And communication and sharing of experiences will support this. Where communication is well-structured, staff is more engaged and motivated to work for the sake of better healthcare, and this raises the quality of healthcare as a whole and may improve patient outcomes. ■

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