Chapter Four: Communications

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Introduction

To effectively deal with infectious disease outbreaks and health emergencies, the province needs to provide credible, timely, and as much as possible, evidence-based information to the general public, healthcare providers and the system as a whole.

SARS was characterized by an unknown cause and had no clear diagnosis or treatment. The situation was unique in that Ontario did not have immediate answers. This made it difficult to communicate clearly with the public and healthcare stakeholders about the disease. That said, the difficult situation was made significantly more challenging by the absence of direct lines of communication to healthcare providers and the need to understand the number and diversity of stakeholder groups, and respond accordingly to their respective needs for information.

The Panel recognizes the challenges faced by all those who were involved in communicating to the public and to healthcare providers throughout the SARS crisis. The multiple lead spokespeople from across government, as well as the absence of effective mechanisms to communicate directly to providers, emerged as barriers that were unforeseen prior to the emergency. That the efforts of these key spokespeople were successful in delivering messages to many stakeholder groups, despite the major hurdles and lack of infrastructure, is a tribute to their commitment to containing an outbreak of unknown magnitude.

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One of the lasting lessons of SARS is the need for the Ministry to communicate effectively and in real-time with frontline healthcare providers during an outbreak. This lesson is absolutely central in order to have a strong emergency preparedness plan for the future. The Ministry lacked this capacity during the SARS outbreak, which resulted in delays in issuing warnings and in problems reaching certain providers effectively with vital information. Ontario must have this critical capacity next time.

The Panel heard very clearly that it is critical that the Ministry have in place adequate and organized communications strategies in order to respond to infectious disease outbreaks and other health emergencies. Specifically, the province must ensure that a comprehensive communications strategy has the two core components of public health risk communication and crisis communication. Public health risk communications delivers practical messages about the nature of risk to the public, in advance of as well as during a health emergency. On the other hand, crisis communication refers to the government's communications response during an emergency. The efforts of public health risk communication must support and be complementary to crisis communication efforts. These distinct strategies must be developed as integral components of a comprehensive communications strategy in order to achieve a balance between public health risk and crisis communications.

We strongly encourage the Ministry to ensure that the necessary and appropriate skills sets are positioned at the regional, local, and Public Health Unit levels to ensure a comprehensive communications strategy is in place to prepare for an infectious disease outbreak or other health emergency. Wherever possible, this should build on already-existing capacity and expertise.

An effective provincial communications strategy, encompassing a technologically advanced infrastructure, and a clearly defined approach, will be key to strengthening the province's response to infectious disease outbreaks in the future.

During the SARS outbreak, the technological infrastructure required to communicate with healthcare providers was not in place. This limitation created barriers to releasing scientific information to providers in a timely way. An effective provincial communications strategy, encompassing a technologically advanced infrastructure and a clearly defined approach, will be key to strengthening the province's response to infectious disease outbreaks in the future.

Moreover, we heard that poor communications contributed significantly to heightened confusion and anxiety for providers and the public; limited the ability of healthcare providers and the Ministry to deal with media sensationalism; and compounded sometimes unclear direction. The province cannot allow again a situation whereby the Ministry lacks the basic communications capacity to deal with a health emergency. As part of its response, the Ministry must also recognize the diversity of stakeholders affected by a health emergency. Communications must include targeted messages for all portions of the health sector (acute and non-acute hospitals, LTC, community-based providers), the public, the public as

patient, government, educational institutions, and other relevant groups such as the tourism sector.

SARS cannot be viewed as an aberration. We must assume that the next health crisis or the next emergency will also include many unknowns. But we must ensure that we have the means to communicate effectively what we know when we know it.

Key Learnings

There are two overarching issues that have emerged in the interviews and submissions to the Panel related to communications: overall preparedness and information dissemination capacity.

Preparedness and Contingency Planning

The sheer volume and nature of communications challenges during SARS were unlike anything that the Ministry and healthcare providers and organizations had ever experienced. In Toronto, SARS rapidly became a global news story, with every nuance and rumour of information having repercussions way beyond the borders of Ontario and even Canada.

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To some extent, we can attribute several communications challenges to the nature of the emergency. Still, Ontario needs to address the general absence of an emergency framework for communications in health emergencies, which includes the distinct capacity for developing public health risk communications and provider communications as part of an overall framework. The lack of capacity to undertake these two critical components is a shortfall that can be addressed in the near future.

During SARS, communications efforts were trying to reach several audiences at the same time – the public, healthcare providers, and potential patients and users of the healthcare system. While the information requirements of these audiences differed significantly, there was no clearly delineated plan to address each audience's needs in a coherent and coordinated way and through multiple channels. For example, without a coordinated approach, communications with the public was

managed inconsistently and presented numerous challenges. According to Toronto Public Health (TPH), "… the SARS Hotline was set up to provide an interface between public health and the citizens of Toronto. The roles of the Hotline included health education and counselling, case finding, contact identification, recognition and follow-up of emerging issues, and gathering and relaying of information between the community and TPH. Telehealth, the provincial health information line, was an important adjunct; however, consistent messaging and having the most up-to-date information on both lines was a challenge. Notably, the total volume of calls received on the TPH Hotline (over 300,000 calls altogether, with a daily peak of 47,567) exceeded the total number reported by Telehealth." During SARS, the volume of calls to Telehealth increased significantly and peaked at 13,000 a day.

The Panel believes that a comprehensive communications strategy would more effectively reach the public and reduce the need for ad hoc mechanisms, such as independent hotlines, to be established to respond to public concerns. There is no question that there was a province-wide need to respond to the thousands of individuals who sought out information during the SARS outbreak. However, many organizations, including Public Health Units, redirected some of their staff to the processes they established to respond to questions and concerns from the public. This took time, effort, and human resources that could have been better used elsewhere had the central support been stronger. By having a comprehensive communications strategy that addresses the public's information needs, it would free up these dedicated resources so that they can be used in other aspects of the emergency.

While the communications efforts reached much of the public, the Panel clearly heard that greater efforts are required in the future to effectively reach healthcare providers and specific sub-populations. More critically, the province needs far greater overall pre-planning to facilitate more consistent and coordinated communication. This planning should consider how healthcare providers need to be positioned to receive scientific information, to potentially respond to patient questions, and whether that should happen *in advance of communicating with the public*. Issues of confidentiality and privacy must also be considered with a view to ensuring that these issues are not inappropriately played out in the media.

This planning should consider how healthcare providers need to be positioned to receive scientific information, to potentially respond to patient questions, and [when that should happen].

We also heard that several of the specific communications challenges during SARS were symptomatic of role confusion. For example, communications roles were not clear in terms of who should give direction, to whom, and about what. Accordingly, the Panel heard that an inordinate amount of time was spent by healthcare providers addressing and re-addressing information requests from multiple sources, or simply clarifying the role and authority of one body vis-à-vis another. Without clear lines of authority and a known chain of command and reporting structure at the top, there is a significant potential to undermine *any* emergency response across the system and its associated communication framework.

Often, the absence of clarity was most acutely felt at the local level. Many respondents, especially those outside of the GTA, felt unclear about the role that their local Public Health Unit was playing or expected to play vis-à-vis the Provincial Operations Centre (POC).

During an emergency or infectious disease outbreak, the Ministry and other parties should be able to *immediately* operationalize a clear, commonly understood crisis communications plan. This plan should be refined with healthcare providers and other levels of government, and made available across the sector to appropriate stakeholders *in advance of an emergency*. Among the principles of such a plan are:

- Designated spokesperson(s)
- Standard communication protocols including clarity of roles and responsibilities
- Timely communication and dissemination mechanisms to the field
- Designated contact individuals identified
- Protocols to ensure consistency of messaging/information across audiences with emphasis on risk communication theory and practice
- Responsibility for preparing and producing supporting materials
- Open lines of communication i.e., two-way communication to support interpretation, clarification and implementation
- Rumour and misinformation control

Communications Infrastructure

Stakeholders described the technical aspect of the province's communications infrastructure as clearly inadequate. Despite significant investments in information technology over the past decade and considerable central communications capacity, the Ministry was unable to broadly distribute basic information at the early stage of the crisis. At the local level, a number of Public Health Units lacked some very basic resources like sufficient numbers of cell phones and computers. The

absence of a robust communications infrastructure impeded both the timeliness and effectiveness of getting critical information to healthcare providers.

One acute care hospital recommended, "The communication of information on a timely basis should be provided to the ICPs if the Ministry has directed that this person be available 24 hours. A network of fan-out communications to family physicians and emergency physicians is desperately needed as these large groups could be involved in the very initial recognition of an emerging communicable disease. Telephone, e-mail and fax should all be considered in the planning of communications." Building on the communications infrastructure, there is a need for a public health alert system to provide communication concerning infectious disease outbreaks and public health threats to all healthcare providers.

Furthermore, at the outset of SARS direct communication with family physicians, other healthcare practitioners and direct healthcare providers, such as clinics varied across the province. There were no centralized databases available with comprehensive up-to-date contact information for healthcare providers, which contributed early on to significant frustration and 'disconnectedness' in the healthcare sector. Without early, accurate and broadly disseminated information, rumours emerge and inconsistent information seeps out throughout the healthcare sector. This was also exacerbated by the absence of effective mechanisms for two-way communication required for clarification of often complex directions and ongoing dialogue regarding their implementation.

Information dissemination has been identified as a major problem. However, we must also examine the uptake of and access to information. The Panel has discussed in depth the shared responsibility in a health emergency of both disseminating critical information and the responsibility of healthcare providers to take reasonable steps to access available information. Crisis communications is a two-way street with shared responsibility. This raised the issue of standards of practice for electronic competency; that is, ensuring the ability to access and/or respond to e-mail, websites, and webcasts on a timely basis. Health professional bodies have an ongoing responsibility to ensure that all healthcare practitioners achieve electronic competency and incorporate this critical competency into their standards of practice. The Panel recommends that goals be set for achieving this within the next three years.

Given the limited distribution of the SARS directives to hospital CEOs and other designated staff (in the acute and long-term care sectors, at certain stages), it became critical for healthcare agencies and institutions to

disseminate information and communicate internally, in order to ensure clarity and to give frontline healthcare providers the information they needed. This, however, varied considerably.

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Some facilities and staff reported that highly effective internal communication mechanisms were put in place relatively quickly. These included daily newsletters, e-mail updates, staff teleconferences and video-conferences. Other facilities, however, reported limited distribution of information and poor access to information for frontline providers with directives disappearing into a black hole.

"VON had a communication infrastructure in place and within 24 hours was able to link its entire frontline management staff across the country via a listserv and website to ensure everyone had SARS info in a timely fashion. There was a dedicated 'SARS Point Person' identified at everyone's branch. VON quickly built and maintained a website to provide easy access to the WHO, Health Canada, POC and Public Health SARS resources."

The differing approaches to disseminating and using information within health care organizations created further confusion and frustration. The Panel heard how individuals working at one facility were provided with directives and up-to-date information upon beginning a shift in E.R., but were unable to access the same information in another facility later in the day. This lack of consistency in disseminating information to healthcare providers undermines confidence and heightens risk.

Despite enormous efforts to create a functional communications infrastructure during the crisis – as one interviewee rightly noted "the healthcare system is too big to pull together at the last second."

The Ministry, Ontario Hospital Association (OHA), Ontario Medical Association (OMA) and other provider organizations need to examine how to a) maximize direct information dissemination; b) ensure greater consistency in disseminating information at the facility and agency level; c) ensure consistent and complementary messaging with lay spokeperson(s) across sectors; and, d) ensure electronic competency among all healthcare practitioners.

Directives

No single aspect of communications has received more comment than the provincial directives. Directives were issued from the Provincial Operations Centre (POC) and later through the SARS Operations Centre (SOC) throughout the SARS emergency to provide direction to the health sector on issues related to emergency preparedness and response. Despite the amount of criticism that the directives have received, a number of submissions acknowledged the guidance provided by the directives. For all the limitations of the directive system and the conditions under which they were produced and disseminated, ultimately the process did assist the health sector in controlling the spread of SARS.

During the SARS outbreak, the POC/SOC worked against tremendous odds, with an ad-hoc scientific team assembled almost overnight, to deliver emergency directives to healthcare providers across the province. The team worked relentlessly, responding to numerous information requests and crafting directives under extreme pressure. The directives were created at a time when very little was known about SARS and when their efforts were hampered by the lack of an effective provincial communications infrastructure. By necessity, directives changed frequently as more information became available during the course of the outbreak.

Understandably, the initial directives… focused on acute care inpatient units… these directives were difficult to adapt to a wide range of other settings, leaving many sectors with different interpretations of the directives.

Understandably, this caused confusion, inconsistent application, duplication, and lower compliance and buy-in among healthcare providers. The distribution times were subject to significant criticism, especially when distribution took place on Friday evenings or weekends and the directives were to take effect immediately. Additionally, further problems emerged when Public Health Units did not access the information at the same time as hospitals and did not have staff in place after hours when directives were sent out. In certain areas, this resulted in gaps between what the acute care sector knew and what public health officials knew. This disjuncture contributed to undermining confidence in public health, for example, when hospital staff phoned a Public Health Unit for advice.

There were also concerns regarding the delays in distribution and the approval process for issuing directives. Specifically, significant issues have emerged concerning delays at the political level that were regarded as unnecessary and unhelpful; for instance, it "became political and slowed down the process." Another submission to the Panel noted that there was

"role confusion with increasing managerial and political involvement in SARS 2; [for example, the] SOC executive then included political office staff who wanted scientific content reviewed in [the] Minister's office – this was not helpful."

We learned that the organization, format and content of the directives made them difficult to interpret and created confusion over which directives were actually in effect. This may partly be attributed to the fact that there was a shortage of scientific evidence in the early directives, when there were many unknowns related to SARS. For example, a number of interviewees indicated that the early directives regarding service reduction were too broadly implemented and in some cases contributed to panic among staff and the public. The Panel recognizes that this concern appears valid in retrospect. However, early in the outbreak the extent of cross-hospital spread was completely unclear. In addition, delays in collecting and analyzing information, detailed elsewhere in this Report, resulted in the Ministry having limited real-time knowledge about SARS, which clearly contributed to the then-perceived need to establish 'blanket' directives.

The fact that healthcare providers and facilities have focused criticism so heavily on the directives is perhaps also indicative of broader issues in the absence of a comprehensive communications strategy designed to reach healthcare providers directly. The directives became a multi-purpose vehicle to convey all information – a role they were unsuited for, but a role they had to play in the absence of effective two-way communication.

Other issues that the Panel heard concerning the directives are as follows.

Broader participation in developing directives: It was suggested to the Panel that there should have been additional resources that included a broader team of experts to draft and assist with the directives. For example, some of critical care directives were specific to respiratory therapy and equipment and the Panel has heard concerns that the expertise of these professionals was not accessed early in the process. Similar concerns have been expressed of colleges and universities. While there are clearly instances where broader participation could and should have been pursued, we acknowledge the intense time pressure that existed to produce information for the field making broader stakeholder involvement immensely challenging.

We encourage the Ministry to establish in advance, as part of a comprehensive contingency plan, creative mechanisms for real-time input when establishing directives, which also include a scenario-based planning approach to text distribution.

One size fits all: The Panel has also heard that there was a sense that the initial directives used a 'one size fits all' approach. Understandably, the initial directives issued by the Provincial Operations Centre (POC) focused on acute care inpatient units where the initial risk was perceived to be greatest. As a result, these directives were difficult to adapt to a wide range of other settings, leaving many sectors with different interpretations of the directives. For example, non-acute organizations or facilities initially struggled with how to apply and implement the directives in their settings and some organizations experienced difficulty in understanding whether the directives met the specific needs of their institution or sector. Later in the outbreak, directives were produced for other health sectors. We noted in several submissions that the community sector was perceived as the lowest priority in terms of response time. The Panel recognized the complex factors that contributed to any confusion related to the development and dissemination of directives during this time of crisis.

Also, the intense time pressures did not always allow for directives to be established for organizations *outside of the affected area*. As one long-term care facility noted "Retirement homes were left entirely out of the loop." In another example, hospitals outside of the GTA were directed to cancel elective surgery. Although this may have been seen as appropriate at the time, the implementation of this directive left communities continuing to manage a backlog of elective surgery. One acute care hospital recommended that "it would have been helpful to have clearer differentiation between the GTA issues and the remainder of the province."

The Panel is acutely aware of the risk of 20/20 hindsight when reflecting on the province's emergency response. We must be sure that any future use of directives enables ongoing dialogue with key stakeholders and strives to achieve a balance between maintaining consistency and tailoring to local needs.

Capacity to implement: Organizations were not always ready and equipped to receive direction as it came out. They might have lacked the proper technology, designated point people to act on direction, internal roll-out plans, or expertise. The Ministry and healthcare organizations themselves need to consider their capacity to implement the directives, with realistic timelines and expectations for organizational response. We also need to recognize the critical importance in the future of designating point people in advance as part of the overall communications contingency planning.

"Consideration needs to be given to facility operations and the timing of releases (i.e., not at 9:00 or 10:00 p.m.) for immediate implementation

without consideration of the need to read, digest, translate to individual site situations, mobilize resources to make changes, communicate the change and then implement it."

Two-way communication: One of the key challenges related to the early directives was that they were not supported by the necessary mechanisms for two-way communication that facilitate ongoing dialogue. This would have enabled the field to receive clarification, support with interpretation and provide input and feedback.

This gap was partially filled as the outbreak evolved; respondents and interviewees reported that the teleconferences and healthcare provider desks at POC/SOC were particularly effective communication methods. However, several key individuals involved in managing SARS were frustrated by the sheer volume of teleconferences and lack of related coordination. Clearly, with no comprehensive communications strategy for healthcare providers, the telephone became a less-than-ideal substitute.

"The strongest efforts in place at the time were teleconference calls. This provided you with current data and allowed a question period for clarification..."

A District Health Council shared that "The strongest efforts in place at the time were teleconference calls… This provided you with current data and allowed a question period for clarification. The weakest factor was that not every conference call was pertinent for the infection control person to sit in on."

As part of future planning, the Ministry should try to reduce the need for teleconferences by exploring creative approaches to using two-way communications. More frequent webcasts, chat-rooms, video conferences, and taped training broadcasts and information all provide opportunities for better real-time exchange of information, enabling direct clarification and feedback. Moreover, there are likely significant opportunities for these mechanisms to be supported by regional networks, as proposed earlier in this Report. For example, web-based communications was strongly endorsed, and, specifically, the pass-coded website that the Ministry established for healthcare providers was recognized as a useful tool. Although there have been criticisms that the access to information was too restricted and the website was updated too infrequently (resulting in it being underused), web-based vehicles are seen by many as a valuable tool to reach a number of providers in an emergency situation and could be used far more creatively in the future. The Ministry should also consider using web-based Q&As, web-based training, demonstration videos, etc.

Communicating to the Public

Visitor policies: We learned from frontline providers that there was significant confusion among the public; for instance, the public did not know what to expect when arriving at a healthcare facility. It was difficult to communicate the reasons for restricted visitor policies to the public, and this appears to have presented problems for many facilities when attempting to police the restrictions.

One acute care hospital suggested, "There needed to be more press about hospital restrictions. We had a terrible time with visitors and people coming in with outpatients for dialysis, etc. during the SARS outbreak. The public [was] really nasty and many times non-compliant. There needed to be more HEALTH TEACHING done [for] the public over the radio and in the newspaper."

A more defined provincial communications strategy regarding public education could have assisted frontline providers enormously, in speaking to the public as citizens, as well as health system users. As it was, with only a limited explanation of the rationale and few support tools (e.g. letters, scripts, signage, advertising, etc.) available, healthcare providers found themselves the buffer between sometimes distraught family members and relatives inside the facility.

Furthermore, the tensions over visitor policies could have been mitigated by clearer overall communications and the development of standard materials by a central resource (see below). As part of any future health emergency communications plan, the Ministry and healthcare providers need to communicate consistently to both the general public and to those members of the public who are patients or family members of patients at the time.

Standardized materials: The Panel heard that practical communications support tools, produced centrally (such as standardized signage, patient information letters/templates, basic materials on visitor restrictions, advertising, etc.) could have greatly assisted healthcare providers. Also, centralized media/public information centre(s), attached to an emergency response office, which all healthcare sectors could contact, would be a valuable resource. The more comprehensive and standardized information that can be provided to the public as users of the healthcare system, the greater the consistency and the lower the pressure on healthcare providers in times of emergency.

Public/community awareness: "If I were looking to do things differently, I would look for ways to provide patients with more reassurance and more information."[1] Public education is a critical element of any overall strategy for infectious disease control, in preventing unnecessary panic and controlling the spread of the disease.

"Often measures were communicated to the public via media conferences before hospitals had a chance to react. This generates distrust and fear in the public that then must be addressed by health care facilities, slowing down the infection control response time within the facility because resources are limited."
In addition, we heard from some organizations that their experiences were that the public was unaware of the health emergency. "We felt that many persons entering our hospitals during the crisis had a staggering lack of knowledge about SARS even well into the crisis…. People did not seem to understand the precautions we had in place when we didn't have a case."

Many organizations dedicated significant resources to this effort during SARS, including websites, daily press conferences, 24-hour hotlines, radio forums with the Commissioners of Public Safety and Security and of Public Health, newspaper ads, patient learning materials in different languages, etc. "We also fielded hundreds/thousands of phone calls ourselves." These efforts resulted in some real successes and included fairly significant public health risk communications in Public Health Units and hospitals. However, the Panel also heard that they would have benefited from additional centralized Ministry coordination, particularly in the following areas.

Translation: Fairly early on in the outbreak, one of the major Public Health Units had already begun translating materials for the public into 14 languages – and this was still not sufficient to address the needs of the population it served. "Provincial fact sheets, media presentations and web sites were not uniformly accessible to persons who did not understand English, French or Chinese since materials were not readily available in other languages. While TPH had translated materials into 14 languages, co-ordination and exchange of translated materials did not occur till late in the outbreak. Persons who were hearing or visually impaired also had difficulty getting information suitable to their needs." Originally, the Ministry translated material into Cantonese and French. Only much later, during SARS 2, did the Ministry provide more comprehensive translation.

Hard-to-reach communities: At one stage in the outbreak, it was reported that a number of individuals under investigation were living in shelters or other short-term housing. Communications materials and vehicles may not have been sufficient to meet this population's needs, nor

was adequate planning in place to address broader issues such as quarantine support for this population.

Role of media: We have heard mixed feelings about the interaction with the media. Lead spokespeople encountered significant challenges in working with the press. An active media source was aggressively pursuing news stories throughout the emergency and continued to approach individuals throughout the health sector for comment. While several submissions indicated that they felt that the press conferences, while useful in conveying information over time, lost focus and may have contributed to overall panic, the Panel recognizes that at the time, this was a necessary component of sharing information with the public. Other submissions expressed concern that a greater focus was placed on preparing for the media response, without equivalent time and resources dedicated to getting information out directly to healthcare providers. "The public needs information but it needs to be presented carefully to prevent unnecessary panic. The perception was that once there were financial/political implications, the message to the public changed somewhat to decrease the severity of the situation."

Overall, while most respondents acknowledge the role of the media conferences in getting information out to providers, two specific criticisms were raised. Firstly, the broad spectrum of experts who rotated through the media conferences to answer various technical questions became confusing and reduced the consistency in the messages getting out. Secondly, the media conferences – especially after the World Health Organization put its travel advisory in place – ended up blending political and technical themes too frequently. While the press conferences were effective in getting information out to the pubic, the Panel encourages the Ministry to examine more effective ways to communicate to healthcare providers.

Given the challenges in getting up-to-date information into the hands of frontline providers, it is not surprising that the media was relied upon to a great extent.

[But]..."There were instances when media announcements were made before information [was] officially communicated to other facilities...[That] created a lot of angst and concerns from staff."

Given the challenges in getting up-to-date information into the hands of frontline providers, it is not surprising that the media was relied upon to a great extent. We can anticipate that in any emergency, the media will continue to play a central role, both reporting and conveying vital information to the public. The

Panel heard that many health care practitioners obtained information from the media during SARS, as opposed to other sources. "There were instances when media announcements were made before information [was] officially communicated to other facilities. We learned things from the news. [That] created a lot of angst and concerns from staff."

Although the media was relied on to inform the public and in some cases healthcare providers, there remains much anger among nurses and other healthcare practitioners surrounding the specific attention that the media paid to the nurse who travelled by GO Train and was portrayed to be a risk to the spread of SARS. This is a specific example whereby the media hindered morale and created considerable emotional trauma, for the nurse herself and for healthcare professionals who were working tirelessly to contain SARS and to support SARS patients and their families during the outbreak. As shared by the RNAO in their video *SARS Unmasked*, "This is the hardest time of your life and people are scared of you. ... It was lonely. Day after day they've gone in. They followed the precautions. These are responsible registered staff who have gone in even though they were afraid. Family pressure I'm sure ... wearing this oppressive gear....then to read in the newspaper an innuendo that somebody had done something "wrong" Tremendously resentful. Anger. Because people really did go the distance."

In addition, portraying the outbreak in Toronto juxtaposed with pictures of individuals of Asian origin, the media was seen by some as contributing to cultural stereotypes. The Panel also learned about filming that occurred in hospitals during the outbreak; this filming was perceived as disruptive to healthcare practitioners during this stressful time and an invasion of patient privacy.

We recognize the important role that the media can and will continue to play in any health emergency. Therefore, we encourage the Ministry to work with the media to ensure that they play a constructive role in supporting the timely dissemination of critical and relevant and information during an emergency.

Risk Communications

During the SARS crisis, the Ministry's communications approach was guided by the crisis communication strategy originally developed in 1999 and last revised in November 2003. What has clearly emerged from Ontario's experience during SARS is the recognition that the province needs to develop a strong provincial public health risk communications strategy as distinct from but clearly complementary to the Ministry's crisis

communications strategy. This approach also requires that clear and distinct skills set unique to public health risk communications be in place.

This first Report of the Panel shares the perspective of groups and individuals about various aspects of the province's general approach to communications. It does not analyze this input based on risk communications theory and practice. However, the Panel recognizes the importance that risk communications must play in any future preparedness and response to a health emergency.

Risk communications is evolving to address a fundamental dilemma in the dialogue between government and industry with the public. "The risks that kill people and the risks that alarm them are often completely different. There is virtually no correlation between the ranking of hazards according to statistics on expected annual mortality and the ranking of the same hazards by how upsetting they are. There are many risks that make people furious even though they cause little harm – and others that kill many, but without making anybody mad." Risk communications has emerged to address some of the many challenges that need to be overcome when communicating with the public; challenges such as inconsistency, confusing risk messages, and lack of trust in information sources.[2]

Many strong emotions are evoked during a health emergency that involves risk. These may include fear, anxiety, and frustration. The key perspective that risk communications brings is the need to share practical information about the nature of risk. In a manner that allows for the relative risk to be contextualized and understood in a balanced manner by the general public, there is much valuable existing and emerging literature and practical assistance in this field upon which the Ministry could draw. The Panel, in making the recommendations below, would urge examination of approaches that have proven successful with both Health Canada and the CDC. Additional efforts will be required to effectively address public health risk communications and to ensure that the approaches developed are wholly integrated with the Ministry's overall communications strategy. The Panel will explore this further in our final report.

Recommendations

30. By February 15, 2004, the Ministry should ensure that a health sector communications infrastructure is in place to reach all key stakeholders in a health emergency. This infrastructure should enable use of e-mail, facsimile, Internet and other technologically advanced modalities. It should be two-way, multi-functional and enable the Ministry to reach healthcare practitioners, healthcare organizations and institutions, support staff, educational institutions, emergency medical services, professional associations, licensing bodies and unions. This infrastructure should be tested and evaluated by March 31st, 2004.

    a. This infrastructure should facilitate the development of a formal Public Health Alert Network (PHAN), to provide communications concerning infectious disease outbreaks and public health threats to all healthcare providers.
    b. As critical to enabling this infrastructure, electronic literacy should be established as a basic standard of practice for all newly graduated healthcare practitioners within two years. Methods of ensuring electronic competency of existing healthcare providers should be explored in collaboration with professional regulatory colleges within three years.

31. By January 15, 2004 the Ministry should review and update provincial crisis communications protocols to support the dissemination of information during a health emergency. These protocols should ensure:

    a. Early designation of a credible and consistent source of spokesperson(s) at the provincial level so as to deliver uniform and clear messages.
    b. Mechanisms are in place for two-way communications, which allow recipients to ask questions and receive clarification.
    c. Key personnel have specific communications training.
    d. Communications approaches are rapidly available in diverse languages and formats.

32. By March 1, 2004, the Ministry should develop a provincial public health risk communications strategy as part of overall contingency planning for a health emergency. This strategy should be based upon international best practices in risk communications, and should be shared with local and federal governments, and healthcare organizations to aid in the coordination of efforts and understanding of respective roles. The basis of this communications strategy should:

a. Build on and upgrade the use of proven effective communications vehicles, such as the use of web-based systems during SARS.
b. Include targeted approaches and tools for different audiences, such as healthcare providers and patients.
c. Be based upon strong links with Public Health Units
d. Encourage and build upon public health risk communications networks.
e. Clearly identify provincial spokeperson(s) in a health emergency, building on trust and credibility.
f. Ensure that communications methods used during a health emergency are practical in nature. If directed to healthcare workers, communications should include proper techniques and best practices.
g. Incorporate effective means of educating the public about necessary screening measures, changes to visitor policies, and temporary restrictions of healthcare services. This should include the production of standardized material and notices to distribute to patients.
h. Make provisions for briefing sessions between the Ministry and healthcare providers, in the form of a webcast or other real-time communication mechanism, *shortly before* any public broadcast on urgent matters of public health.
i. Clarify, update and streamline policies and procedures regarding the use of the media in an emergency. This should include the continued use of effective media buying services to deliver public service messages.
j. Optimize use of health information hotlines for the public as part of overall contingency planning.
k. Include mechanisms to evaluate performance.

33. The Ministry should continue to liaise with Health Canada to ensure consistency and to clearly designate points of contact regarding risk communications plans. Formal memoranda of understanding should be reviewed and updated by March 1, 2004 so that they clearly outline roles and responsibilities. The Ministry should commit to review and update such agreements on a regular basis. Such reviews should include appropriate public health expertise and representation from the Office of Health Emergency Preparedness (OHEP).

34. The Ministry should immediately ensure that any written communication to healthcare providers during a health emergency, is:

    a. clear, concise, and operationally viable
    b. based upon scientific evidence
    c. supported by mechanisms for rapid, two-way communications and clarification.

35. By March 1, 2004, the Ministry should develop an enhanced plan to educate the public about possible or actual threats to public health and appropriate infection control measures. Healthcare organizations and professional associations should be engaged in developing and implementing this plan to ensure coordination of effort and to identify the most effective tools for healthcare providers to use in communicating with the public.

References

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