Crisis, Communication, and Canadian Hospitals: An Analysis and Evaluation of Risk Preparedness and Crisis Communication Efforts of Ontario Hospitals

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ABSTRACT

Background *While hospitals are complex and unique organizations, they are not often the subjects of crisis communication research.*

Analysis *Through an analysis of each stage of the crisis communication process (preparedness, execution, and post-crisis), this study seeks to analyze and evaluate the crisis response of Canadian hospitals from a strategic communication perspective.*

Conclusions and implications *This study reflects the findings of similar research in the field, confirming that hospitals in Ontario are indeed more prepared to face issues and crises that they have faced in the past. This study also demonstrates how integration between crisis communication and operational crisis management helps to foster a robust crisis preparedness strategy and a unified crisis response.*

Keywords *Crisis communication; Crisis management; Healthcare communication; Reputation management*

RÉSUMÉ

Contexte *Bien que les hôpitaux soient des organisations complexes et uniques, elles ne font pas souvent l'objet de recherches en communication de crise.*

Analyse *En examinant chaque étape de la communication de crise (préparation, exécution, bilan), cette étude cherche à analyser et évaluer, par l'entremise de la communication stratégique, comment les hôpitaux canadiens répondent aux crises.*

Conclusion et implications *Cette étude, à l'instar d'études comparables menées dans le domaine, confirme que les hôpitaux en Ontario sont mieux préparés pour gérer des problèmes et des crises qu'ils one déjà eus à gérer. L'étude démontre en outre qu'en associant la communication de crise et la gestion de crise opérationnelle, on peut développer une meilleure stratégie de préparation aux crises et assurer une gestion mieux coordonnée de celles-ci quand elles surviennent.*

Mots clés *Communication de crise; Gestion de crise; Communication en santé; Gestion de réputation*

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Introduction

In order to function successfully and address the needs of a variety of publics and stakeholders, hospitals rely on the expertise of numerous professionals, including physicians, nurses, pharmacists, and administrators (Golden, 2006). According to Peter Drucker (1993), healthcare organizations, such as hospitals, are among the most complex organizations to manage effectively. The inherent complexity of hospital operations, combined with the fundamental obligations they have to a variety of stakeholders, creates unique and distinct organizational characteristics that separate hospitals from other types of corporate and organizational entities (Golden, 2006).

While there is an abundance of research that attempts to determine best practices in crisis communication and crisis management in corporate environments, a limited number of studies specifically examine these processes within hospitals. Crisis management researchers argue that hospitals are subject to significantly more crises than other types of organization while simultaneously being less prepared for crisis events (Canyon, Adhikari, Cordery, Giguere-Simmonds, Huang, Nguyen, Watson, & Yang, 2010b; Mostafa, Sheaff, Morris, & Ingham, 2004).

Due to the public nature of healthcare in Canada, hospitals—along with the healthcare system as a whole—have a certain sense of accountability to Canadian residents (Martin & Nordal, 2008). When combined with the multiplicity of crisis threats that hospitals face, this higher level of responsibility and responsiveness to crises results in a situation where crises have the potential to severely disrupt not only the successful operations of hospitals in Canada but also the trust established between hospitals and the general public (Canyon et al., 2010b; Coombs, 2007a; Golden, 2006).

This exploratory, qualitative research study draws upon data collected from 14 hospitals and health systems located in the province of Ontario in Canada with the aim of evaluating crisis communication efforts in a hospital context. By conducting in-depth interviews with senior communication professionals within Ontario hospitals, this study evaluates crisis preparedness, crisis recovery, and post-crisis review processes from a communication perspective. The study's findings are consistent with similar research in the field, while highlighting the importance of integration between crisis communication and management.

Literature review

Theoretical frameworks

Crisis communication and operational crisis management theory share several similarities. Both theoretical frameworks emerged near the dawn of the twenty-first century, particularly coming into a greater academic focus following the events of September 11, 2001 (Flynn, 2002; Roux-Dufort & Lalonde, 2013). Both types of theoretical frameworks acknowledge that human-caused crises often carry a higher reputational risk than crises caused by natural or environmental causes (Coombs, 2007a; Pearson & Mitroff, 1993). Theorists approaching the topic from both communication and operational perspectives also prioritize the importance of crisis management as an ongoing process enacted through proactive action, diligent preparation, and adherence to established processes (Benoit, 1997; Coombs, 2007a; Pearson & Mitroff, 1993).

Timothy Coombs's (2007b, 2014) comprehensive theoretical approach to crisis communication combines identifying the reputational threat of a crisis through the analysis of an organization's perceived responsibility, prior history, and prior reputation with crisis response strategies. Unlike prior crisis communication models, his theory directly links elements of the crisis situation itself with forms of responses (Coombs, 2007b). Matthew Seeger's (2006) best practices are often used in applied crisis communication research to evaluate crisis response. In analyzing prior crisis communication research, Seeger (2006) identifies a number of heuristics that communicators should follow for the optimal handling of crises. These include crisis preparedness and prevention concepts (such as developing policies and creating crisis plans) as well as crisis response concepts (such as building partnerships with the media, communicating with honesty, and remaining accessible to stakeholders).

Along with crisis communication theory, operational crisis management theory was developed to guide the practice of preventing crises from occurring and managing the ones that do. The work of Christine Pearson and Ian Mitroff provides theoretical frameworks for risk preparedness and highlights the importance of acting proactively to prevent potential crises. Pearson and Mitroff's (1993) five phases of crisis management model—signal detection, preparation/prevention, containment/damage limitation, recovery, and learning—provide guidance on how to structure crisis management efforts to detect, prevent, and prepare for a variety of crisis situations. By spanning the temporal dimension of crises from start to finish, this model demonstrates the need for process-driven crisis management that emphasizes prevention and learning from prior experiences.

In the context of this study, Pearson and Mitroff's (1993) five-phase model will be used alongside Seeger's (2006) best practices to evaluate crisis communication processes as well as the integration between crisis communication and operational crisis management.

Crisis communication and management in healthcare

As previously mentioned, research focusing on crisis communication and management that is specific to hospitals is quite limited in scope when compared to other foci present within the field. As the practice and implementation of healthcare differs globally due to varying funding and governance structures, it is difficult to create a set of comprehensive guidelines for crisis management or communication within the healthcare setting, which is further complicated by the differing range of functions that hospitals perform. While some hospitals are community-based organizations, others are teaching hospitals that are affiliated with higher education institutions and others serve as regional centres for a variety of specialized forms of medicine.

While there does not appear to be any academic literature focusing specifically on crisis communication and management within the context of hospitals in Canada, a limited number of studies analyzing crisis management efforts in healthcare institutions in other countries have been published. A series of research studies have analyzed risk preparedness and crisis management efforts among Australian healthcare institutions (Canyon, 2012a, 2012b; Canyon, Adhikari, Cordery, Giguere-Simmonds, Nguyen, Huang, & Yang, 2011a; Canyon, Adhikari, Cordery, Giguere-Simmonds, Huang,

Nguyen, & Yang, 2011b). Deon Canyon and his team draw upon Pearson and Mitroff's (1993) work as well as other contingency and crisis management theorists to evaluate the risk preparedness and operational crisis management efforts of a variety of Australian healthcare organizations.

Despite the danger that hospitals face from organizational crises, Canyon's (2012a) research demonstrates that hospitals are often less prepared for risk and crisis than other types of organizations. Consistent with Pearson and Mitroff's (1993) model, Canyon (2012b) purports that early warning signals precede crises and if these warning signals can be sufficiently detected and monitored, the threat of a crisis can be reduced and inevitable crises can be anticipated. Canyon's (2012a, 2012b; Canyon et al., 2011a) research reveals how Australian hospitals employ outdated and poor forms of risk prevention, which are potentially caused by inadequate and inexistent detection mechanisms.

Other studies conducted by Canyon and his research team have also found points of distinction between hospitals and other healthcare institutions from a crisis management perspective. Hospitals were found to be susceptible to more forms of crises than other types of healthcare institutions, such as chiropractic clinics, dental practices, and geriatric facilities (Canyon et al., 2010b). The research group also analyzed current and future budgetary allocations, which suggest that hospitals have a higher level of support from executive leadership for crisis preparedness and crisis management initiatives than other healthcare institutions (Canyon et al., 2011b).

Lastly, hospitals surveyed by Canyon's team demonstrated higher capabilities for crisis preparedness, as crisis planning processes were less common and less sophisticated in other healthcare institutions than they were in hospitals (Canyon et al., 2010b). It is important to note that the researchers found that all types of healthcare institutions had poor or limited levels of crisis preparedness capacity in three specific areas: product tampering, employee sabotage, and reputational damage (Canyon et al., 2010b). While the research does not directly comment on communication processes in hospitals in their work, Canyon and his team point toward a need for a greater preparedness capacity in this area.

Other researchers have also studied crisis management processes in hospitals, although not matching the breadth and depth of research performed by Canyon and his team. An early crisis management study conducted by Gregg Beatty (1987) strives to lay the groundwork and foundation for a hospital-wide crisis management response by citing the importance of preparedness and crisis management teams when the field was in its infancy. Mohamed Mostafa, Rod Sheaff, Michael Morris, and Valerie Ingram's (2004) evaluation of risk preparedness in Egyptian hospitals uses a similar approach to Canyon et al. (2010a) to deduce that a positive correlation exists between hospitals with a long-term strategic outlook and strategic crisis preparedness efforts. In their analysis of rural mass casualty crises in the United States, Kristin Viswanathan, Theresa Wizemann, and Bruce Altevogt (2011) note the challenges hospitals face in delivering care to rural communities during a crisis situation. This highlights the unique crisis environment that hospitals are situated within, as they need to adapt and react to a range of high-risk, low-probability crisis scenarios that can occur in a variety of situations. On the other hand, Andrew Stronach (2008) takes a different approach by con-

ducting a case study of crisis communication practices in one British hospital. The conclusions of Stronach's (2008) case study emphasize the need for building trust and communicating with transparency—aligning with the facets of successful crisis communication outlined by theorists such as Coombs (2007b) and Seeger (2006).

Some contemporary research evaluating crisis communication efforts related to healthcare takes a tactical approach to evaluating specific actions and determining optimal approaches. In analyzing interviews with communication professionals from hospitals across the United States, Brooke Liu, Brooke Fowler, Holly Roberts, and Emina Herovic (2018) identify a number of heuristics designed to improve crisis response, including segmenting communication by audience group, prioritizing face-to-face communication, and managing media representatives. By gauging survey responses to mock Facebook posts, Marcia DiStaso, Michail Vafeiadis, and Chelsea Amaral (2015) note that sympathetic approaches are received worse than informative or apologetic ones for crises that affect the reputation of hospitals. Building upon Seeger's (2006) best practices, these studies provide practical guidance for communication professionals faced with crises in a hospital environment.

Effects of social media on crisis communication and management

Whereas most crisis communication literature focuses on the effectiveness of crisis communication efforts themselves in protecting reputation and brand identity, a more recent approach taken by scholars is the analysis of the role of social media in the crisis communication process itself. However, this approach seems to be in its infancy due to a lack of integration with crisis communication theory and a tendency to focus on the functions of social media rather than their strategic effectiveness. Within the context of hospitals and other public institutions, social media use in crisis communication reflects the organizations' adaptability to emerging technologies that become increasingly adopted by their stakeholders. Connie White's (2011) approach focuses mainly on explanations of social media platforms and how various social media platforms can be used effectively to conduct crisis communication, rather than on evaluating the effectiveness of social media platforms as a whole. Ira Helsloot and Jelle Groenendaal's (2013) case study on social media usage by public institutions presents a contrarian view that challenges the effectiveness of social media usage for crisis communication.

However, the dominant view found within crisis communication literature argues that social media has changed crisis communication practices by providing an opportunity for greater dialogue between stakeholders and organizations (du Plessis, 2018; Schultz, Utz, & Göritz, 2011; Stephens & Malone, 2009). Charmaine Du Plessis (2018) notes that social media can be a powerful tool in relationship building not only during crises but also afterward. Friederike Schultz, Sonja Utz, and Anja Göritz (2011) draw upon Marshall McLuhan's (1964) theory that "the medium is the message" to encapsulate the core of their study: organizations that simply engaged in dialogue using social media were more successful in containing crises than organizations that did not, regardless of the specific messaging being disseminated. Keri Stephens and Patty Malone (2009) note how the dialogue created by social media is particularly significant during crises, as it can satisfy stakeholders' need for information by directly answering questions. Lastly, crisis communication researchers have asserted that the appropriate

use of social media supports best practices in crisis communication by also allowing for a greater monitoring of threats and crisis detection signals by tapping into existing dialogue between social media users (Veil, Buehner, & Palenchar, 2011).

Methodology

Research design

As healthcare in Canada falls primarily under the jurisdiction of provincial bodies, this case study sought to evaluate crises in hospitals within Ontario. Even though healthcare is funded at the provincial level in Canada, the healthcare system is fairly uniform across the country (Commonwealth Fund, 2012). Therefore, it is expected that findings of this study will contribute to a larger discussion of the ability of hospitals in Canada to remain transparent, accountable, and authentic in times of crisis.

An exploratory, qualitative study design was chosen as the optimal choice to evaluate crisis preparedness, crisis communication, and crisis management efforts within healthcare institutions in Ontario. Qualitative interviewing allows for a deep analysis into past events and future plans, fitting well with the study's aim to analyze processes, mindsets, and past experiences with crisis communication in an in-depth fashion (Bryman, Bell, & Teevan, 2012).

Data collection

Fourteen semi-structured in-depth interviews were conducted with participants representing hospitals and health systems across Ontario. A range of senior communication practitioners from a range of institutions located within the province of Ontario in Canada were approached to take part in the study. Senior communication practitioners were recruited not only due to their experiences in responding to crises within their organization but also for the strategic input that they have in creating crisis communication infrastructure and liaising with executive leadership during crisis situations. Due to the nature of the positions held by the prospective participants, participants were enrolled by convenience sampling to ensure that a total of 14 people consented to participate in the study.

Participants were recruited starting with those in closest proximity to McMaster University located in Hamilton, Ontario. Data was collected from a variety of hospital structures, including community hospitals, teaching hospitals, and hospitals serving both urban cores and rural communities. Eight of the hospitals represented in the study were teaching hospitals, while the remaining six hospitals were community hospitals. For the purposes of this article, teaching hospitals will be defined as hospitals that also serve as academic health sciences centres through an affiliation with one or more higher education institutions.

In-depth interviews were held either in person or over telephone with the 14 participants enrolled in the study. The participants responded to 10 interview questions, which are outlined in the next section of this study. Interviews ranged between 20 and 50 minutes in duration based on the participants' responses, with an average length of approximately 30 minutes. All interviews were audio-recorded with the consent of the participants, and the recordings were manually transcribed following each interview. All transcribed interview notes were then compiled into a single 88-page docu-

ment that the findings of this study were based upon. The McMaster University Research Ethics Board approved this study.

Data analysis

The qualitative data collected was coded according to matching themes and sentiments across all 12 research questions. The data was then analyzed against theoretical crisis communication and crisis management frameworks to determine if the processes elucidated by the participants corresponded to established best practices in crisis communication. This analysis aims to determine the adherence to process and the level of detection, preparation, and learning that are part of the crisis communication processes of the hospitals studied. It can also determine the extent to which crisis communication is conducted on a proactive, ongoing, and routine basis.

While this study is firmly rooted in qualitative research methodology, a quantitative content analysis was performed to determine patterns between the organizations studied in the form of percentages (i.e., what percentage (x%) of healthcare institutions studied identified that they had established crisis management teams). The author served as the single coder and interpreter of findings for this study.

Research questions

This study aims to evaluate pre-crisis, crisis recovery, and post-crisis processes with the goals of addressing three research questions. The following research questions were used to develop an interview guide designed to collect relevant data from participants. The interview questions strove to utilize methodology developed by operational crisis management theorists in a slightly different context by focusing specifically on crisis communication.

> Research question 1: How and to what extent do the communication functions in Ontario hospitals prepare for and prevent against potential crisis situations?
>
> Research question 2: How and to what extent do the communication functions in Ontario hospitals respond to and manage crisis situations?
>
> Research question 3: How and to what extent do the communication functions in Ontario hospitals learn from previous crises in order to increase preparedness for future contingencies?

The interview questions used to answer these research questions included

> What forms of crisis threat/detection does your organization employ?
>
> Which types of crises does your organization actively monitor?
>
> Which types of crises does your organization explicitly prepare to prevent?
>
> Does your institution have a crisis management team?
>
> What stakeholders (internal and external) are explicitly considered in the formation and execution of crisis management and crisis communication plans and procedures?

> What are your organization's priorities in recovering from a crisis situation?
>
> Is your organization vulnerable to the types of crises that it has faced in the past? Why or why not?
>
> Does your organization use social media to conduct crisis communication? Does social media serve a primary or secondary role as a crisis communication channel?
>
> What was done well and what could have been done better in the management and communication of prior crises?
>
> How will your organization reduce the risk that it faces from future crises?
>
> Does your organization engage in a systematic review following crisis events in order to learn from these situations and, if necessary, modify future responses?

Results

The findings of this study have been presented as answers to each of the three research questions. While some responses given by participants at various points in the interview might have provided answers to either prior or future aspects of crisis communication, the sections below aggregate all comments and input from participants in chronological order according to the research questions. As participants originated from a variety of different hospital types with differing management structures, they were asked to comment on the areas of crisis communication and crisis management that they were either familiar with or directly responsible for in their respective institutions.

Research question 1

When participants were asked about crisis and threat detection, their responses were primarily focused in two areas: media monitoring and issues monitoring. As the detection of crises and threats from a communication standpoint is primarily performed through monitoring of some sort, the lines between detecting and monitoring appear to be blurred. While it is evident that some forms of issue monitoring are definitive examples of crisis detection (i.e., the notification of internal crisis triggers), other forms of crisis detection (i.e., reactive media monitoring) are also forms of crisis monitoring.

Proactive crisis detection and monitoring processes were evident through established systems and processes embedded within hospitals themselves. Four of 14 participants (21.4%) explicitly mentioned that enterprise risk management (ERM) systems helped communication teams to identify threats and detect crises. According to these participants, ERM systems helped to identify the risks inherent within their organizations, which then allowed communication departments to work on ways to ameliorate them. In discussing ERM, participant #001 noted the following:

> I think that the enterprise risk management structure is the way that we're going to do that. Really, it's creating a framework of all areas of risk that define those people that are at the subject matter of their zone—whether it's clinical, research, public affairs, volunteers, whatever it is—defining what they're measuring and monitoring. And then measuring, monitoring,

> and reporting that up to the board. I think you need to have that formalized structure in place that we haven't had in place in the past.

Three of four participants with embedded ERM systems represented teaching hospitals. Seven of 14 participants (50%) had explicitly mentioned the role of hospital emergency codes in aiding crisis detection. These participants elucidated how hospital emergency codes not only ensured that staff (including emergency responders) knew of issues and threats present internally, they also alerted communication departments to other threats (such as infrastructural issues) within their institution.

Seven of 14 of participants (50%) had also explicitly mentioned established patient-relations programs or processes that identified potential risks and crises emerging from patient complaints. It is certainly possible that more institutions surveyed had ERM systems, hospital emergency codes, and patient-relations practices in place. While all participants were asked this question, a deliberate decision was made not to provide examples or aid participants in their responses to this question in order to receive unaided responses. These unaided responses can then be used to analyze which crisis- and threat-detection platforms participants specifically valued from an operational crisis management perspective.

Ten of 14 of participants (71.4%) defined processes that were used to detect and monitor issues external to the organization. External issues monitoring was conducted primarily through the identification and monitoring of issues defined by government bodies (either the Ministry of Health or Local Health Integration Networks [LHINs]) or by identifying topics that could become issues in the media. Participants noted how media monitoring kept them aware of issues looming in healthcare—in Ontario, across Canada, and around the world. It is important to note that while the number of participants engaged in internal and external issues monitoring was 10 of 14, eight of 14 participants (57.1%) had both proactive internal and external issues monitoring processes in place that they reviewed.

While media monitoring was mentioned as a tool used to proactively monitor looming issues, it was also used in a reactive sense to detect crises that have already unfolded. As media coverage of a crisis typically follows the emergence of an issue into public awareness, such monitoring is limited in its ability to prepare for or prevent crises. The responses given by participants revealed the prevalence of media monitoring as a reactive crisis-monitoring tool. Twelve of 14 participants (85.7%) utilized some form of media monitoring as a form of crisis monitoring or detection. Nine of the 12 participants (64.3% of total) that utilized media monitoring explained that it was performed in a routinized, procedural fashion rather than as an ad hoc practice.

Eight of 14 participants (57.1%) utilized social media as a form of crisis monitoring, typically through notifications received from social media channels themselves or an aggregate media monitoring service that included social media. Participant #002 summarized the importance of using social media as a monitoring tool, stating, "24 hours is a lot of time for social media—depending on your hospital or organization. You can't just let things sit—you have to have alerts that alert you that day if anything on social media is starting to develop." Six of the eight participants that utilized social media as a form of crisis monitoring represented teaching hospitals.

When asked how they plan to prevent crises, 10 of 14 participants (71.4%) referred to a defined crisis communication planning document. Half of these participants (five of 14, or 35.7%) stated that they either had multiple, documented crisis communication plans for a variety of issues, or they had one defined crisis communication plan that explicitly addressed a number of different possible crisis scenarios. Three of four participants who did not refer to a defined crisis communication plan or explicitly mentioned that they did not have a plan developed represented community hospitals.

Two participants noted that their lack of crisis communication planning for various scenarios was a weakness of their institutions' abilities to effectively respond to crises. Two other participants also noted that crisis communication plans for specific situations were either unnecessary or sometimes needed to be abandoned as they constrained crisis response. Both of these participants stated that crisis communication plans exist to provide guidelines but were not necessarily observed in the execution of crisis communication efforts. Five of 14 participants (35.7%) noted that they regularly engage in crisis preparedness exercises, most commonly in the form of tabletop exercises held with staff and management. All five participants that engaged in crisis preparedness exercises represented teaching hospitals. Three of these participants stated that they performed mock disaster or evacuation situations, similar to fire drills, for other types of crisis scenarios.

When participants were asked which forms of crises they specifically prepared to prevent, four types of crises were primarily mentioned: clinical (e.g., pandemics, patient complaints, and inadequate care resulting in death), infrastructural (e.g., fires, floods, building damage), reputational (e.g., threats to the reputation and brand of the institution), and natural disasters. As participants were asked to discuss crisis from their perspective as communication practitioners, their explanations often accompanied examples of crises that their institutions have recovered from. Three of 14 participants (21.4%) also noted preparation from a communication standpoint for attack-related crises such as bomb threats. While some participants noted how "anything could happen," none of the study participants explicitly discussed crisis preparation for internal human-caused crises with malicious intent—such as employee sabotage, the theft of hospital supplies, or the theft of drugs.

When asked about crisis preparation and prevention, three of 14 participants (21.4%) discussed the importance of building goodwill among stakeholders as a preventative measure to protect reputation in times of crisis. All three of these participants represented community hospitals. In discussing the importance of proactive community engagement, participant #012 stated: "I think it's very, very important to keep your community informed and engaged. A lot of times when you're running well, you still need to maintain confidence. It's not a matter of how many crises you've had, you have to continue that ongoing." These participants noted the importance of building relationships with media organizations through media relations, as well as building relationships with communities through community engagement.

Research question 2

The majority of participants confirmed the existence of a designated team responsible for crisis management within their organization. Eleven of 14 participants (71.4%)

stated that their institutions had a crisis management team, and that communication was integrated into these teams in some way. One of the remaining participants noted that their institution had a crisis management team but communication was not a part of it; another remaining participant noted that their institution had a crisis communication team but not a crisis management team; and the other remaining participant noted that their institution did not have a crisis management team. Two of the three participants that did not have a crisis management team represented community hospitals.

Eight of 14 participants (57.1%) mentioned that their institutions had an incident management system (IMS) in place that integrated communication and crisis management in a standardized way. The IMS is an operational framework for emergency response established by the Government of Ontario to ensure that emergency response organizations respond to incidents and crises in a coordinated fashion. Five of eight participants that discussed IMS implementation represented teaching hospitals. In describing the effectiveness of the IMS in their institution, participant #011 noted the following:

> Since we've been able to test [the IMS], we've gotten very good at immediately putting it in place, not just when there is an actual crisis but when there's a threat of a crisis. We immediately form the IMS team and have the designated role—so then I always act as the communication officer, or my colleague—there's only two of us on the communication team here, we're not a big organization. We know what our role is, everybody knows what they need to do, and we can quickly take action.

As five of 14 participants (35.7%) did not know the exact name of their institution's crisis management team or had difficulties in explaining what the letters in the IMS acronym represented, it is possible that more than eight of the institutions surveyed were utilizing IMS.

As a collective, the participants surveyed were highly proficient in identifying internal and external stakeholders they had considered in the development of crisis communication plans and in the execution of crisis communication efforts. Internal stakeholders listed by participants included patients, visitors, staff of all varieties (e.g., physicians, nurses, allied health professionals, pharmacy staff, administrators, management, general staff, etc.), volunteers, boards of directors, and hospital foundations. External stakeholders listed by participants included the Ministry of Health, the Ministry of Long-Term Care, municipal governments, LHINs, community access to care centres, media organizations, community groups, and local publics. While participants were easily able to identify both internal and external stakeholders, nine of 14 participants (64.3%) did not regard patients as stakeholders.

In terms of their priorities in recovery, however, seven of 14 participants (42.6%) explicitly prioritized the interests of stakeholders as their most important priority in recovery-focused crisis communication efforts. These participants mentioned or alluded to the primary importance of using communication to ensure that patients are kept safe, operations within the hospital continue to serve patient care needs, and the community is kept aware of what has transpired. When asked about stakeholder pri-

ority, participant #003 shared a sentiment found among the participant group: "patients, families, and staff [come] first, because they are within the jurisdiction of our institution—we have the judiciary duty to protect their safety and health and privacy at all times, so they're number one."

Four of 14 participants (28.6%) listed their primary priorities as the technical areas of crisis communication that need to be handled from a logistical perspective. These participants discussed the importance of tasks such as ensuring that messaging is tailored to audience groups, keeping media informed of the status of crises, and responding to inquiries from the public using a variety of platforms. While none of these four participants explicitly discussed patient or stakeholder safety, the importance of executing the technical elements of crisis communication defined by these four participants was rooted in ensuring that their institution continued to operate without disruptions to patient care.[1]

The remaining three participants surveyed (21.4%) stated that their primary priority during crisis response communication was to protect the reputation of their institution. None of these participants regarded patients as stakeholders. These participants prioritized the importance of keeping internal and external governance bodies (such as boards of directors, the LHIN, the Ministry of Health, the Ministry of Long-Term Care, etc.) and external stakeholders (such as media organizations) informed during the crisis. Minimizing any reputational damage from the crisis and maintaining a positive reputation with governance bodies was prioritized over patient safety and accountability to their communities.

While the usage of social media as a platform for crisis monitoring was previously noted, all 14 participants surveyed discussed using or being prepared to use social media for crisis communication. Participants commonly noted that while social media platforms were only beginning to be used as crisis communication platforms, their organizations would have used these tools throughout prior crises if they had been available. Despite the prevalence of social media usage among the study sample, two of 14 participants (14.3%) noted that social media took a primary role in the recovery process. The remaining participants noted the significance and importance of social media as an additional tool to use in their crisis communication efforts but stated that they did not feel as though social media platforms could be used independent of other communication platforms during crisis recovery. Two of 14 participants (14.3%) noted that even though they use social media for crisis communication at the moment, they hope to use social media platforms more extensively during crisis recovery in the future.

The participants also discussed the detrimental aspects of social media in regards to crisis response. Four of 14 participants (28.6%) identified challenges with social media in the context of crisis communication. These participants raised concerns about how social media provides an outlet for stakeholders to voice concerns publicly, which becomes problematic for communication practitioners when combined with the expected immediacy of responses to social media complaints and inquiries from stakeholders. They also noted how social media platforms can also foster rumours and gossip, which can be interpreted as truth during a crisis. Participant #010 explained that "the challenge, of course, with social media is that the information gets out so

quickly now, even information that's inaccurate. There was a rumour going around social media … that was not true, but of course through social media spread so quickly."

Research question 3

When participants were asked if they felt as though their institutions were vulnerable to the types of crises they have faced in the past, 12 of 14 participants (85.8%) agreed that indeed they were. While most of these participants admitted that they were still vulnerable to crises faced previously, they discussed how their crisis preparation and planning had helped to make their institutions less vulnerable. However, these participants also generally noted the fact that crises cannot always be anticipated and prevented, and they discussed inherent vulnerabilities faced by hospitals to a plethora of internal and external risk factors not controlled by the hospital itself (e.g., patient suicide, natural disasters, pandemics). The remaining two participants, both representing community hospitals, avoided the question of vulnerability by bridging to a discussion of their institutions' strengths in preventing and preparing for crises. While both groups discussed practices in place to make their institutions less vulnerable to crises, these two participants did not explicitly acknowledge or answer the question of crisis vulnerability with regards to their own organization.

Almost all of the participants (13 of 14, or 92.9%) identified their organizations' strengths and weaknesses regarding crisis communication. Six participants (42.9%) noted infrastructural issues as primary weaknesses of their organizations' crisis communication efforts. Six participants (42.9%) also discussed a lack of resources and communication capacity as a factor that undermines successful crisis communication efforts. In discussing the challenges of crisis communication response using social media, these participants believed that a higher public relations resource capacity and more communication infrastructure would help to make decisions around messaging quicker and more effective. Participant #002 stated, "we don't get additional resources anymore. We get all of these new tools, like social media, to communicate with. They're great because it gives us a new way to communicate, but we don't have new resources to communicate with those things." Two participants specifically noted the issue of prioritizing instinct and urgency over process during crises, and believed that more crisis communication infrastructure and planning would help to prevent this. Two other participants (14.3%) noted a weakness in successfully reaching internal stakeholders due to a lack of effective internal communication channels. Other than these issues, individual participants noted the following range of organizational weaknesses: slower-than-desired crisis response times, lacklustre crisis identification, underdeveloped social media usage in crisis response, and lack of two-way communication.

Participants provided a wide range of strengths when asked about their past successes in crisis communication. Three of 14 participants (21.4%) listed the speed and nimbleness of their crisis communication in response to incidents as strengths. Three of 14 participants (21.4%) described authenticity and transparency to be strengths of their crisis communication efforts. Two of 14 participants (14.3%) explicitly listed the culture present within their organizations as strengths of not only crisis communication efforts but also of its ability to manage operations during a crisis. Other strengths identified by individual participants include: well-established communica-

tion channels, experienced executive teams, post-crisis measurement, and proactive crisis monitoring.

When asked how they plan to reduce the risks they face from future crises, most participants explained how they or their organizations will work to address their identified weaknesses, or how their organizations had committed resources and effort toward creating more permanent solutions to issues and crises previously experienced. Five of 14 participants (28.6%) noted an increased level of preparation and planning undertaken by either their department or their organizations' risk and crisis management efforts as being central to reducing future risk. Two of 14 participants (14.3%) discussed increasing community engagement as a preventative strategy to reduce the risk of future crises by building goodwill.

Almost all of the participants (13 of 14, or 92.3%) confirmed that they carry out a formalized review process following crisis events. Participants collectively mentioned that they enjoy the debrief process as it helps them to improve their efforts in the future. Four participants explicitly noted how their debrief processes emerge directly from their organization's incident management system. Describing the crisis review process in their institution, participant #008 noted that "a debrief is often a good educational opportunity not just to talk about what we did well and didn't do well but also to educate people that need various roles that communication can play in helping to manage these things as well. I think it's important to share the role and expertise that we bring to the table. We debrief all the time."

One participant indicated that a formalized and systematic process was currently not in place due to resource limitations but that their organization would like to implement such a process in the future. Another participant mentioned that while their organization conducts one collective debrief following a crisis, their communication team organizes several debriefs throughout to ensure that the communication process is optimized at several points during crisis recovery. Most participants discussed how reviews helped to change operations and communication efforts permanently, making future crises easier to anticipate and manage.

Discussion

Research question 1

In analyzing the responses to the first research question about examining crisis preparedness and prevention efforts, a few important patterns emerge. While the rudimentary quantitative data collected suggests a high level of proactive detection, preparation, and planning, analyzing the data qualitatively highlights certain issues that raise concerns regarding these optimistic results. The results above demonstrate that over half of the participants surveyed engage in some form of proactive crisis detection and monitoring, with the vast majority having documented crisis communication plans. However, as outlined by Coombs (2007a), much of the success of these processes depends on both the mindset of the communication practitioners and the manner in which these preparatory measures are executed.

As mentioned previously, the proactive detection and prevention of issues appeared to vary widely among communication practitioners present within the hospitals surveyed. While some participants did engage in standardized issue prevention

through ERM systems, hospital emergency codes, patient relations processes, and media analysis, other forms of issue management did not seem to occur in standardized ways. External issue management—while often conducted in a proactive way through media and policy analysis—was described by participants as taking place at their discretion. This places a lot of emphasis on communication staff themselves, as their mindset essentially serves as the key factor that determines whether an issue is a crisis or not.

This is further complicated by the participants' confusion over the definition of the term "crisis." Three of 14 participants (21.4%) specifically asked about the definition of crisis in a hospital context. It is possible that participants were curious if they were being asked to discuss specific types of crises or incidents. However, as participants were provided with a written and oral description of the study prior to the interview, it is also possible that they were unsure of how the formal literature on crisis communication defines a crisis or incident. The ways participants defined and viewed crises proved to be significant, as ad hoc crisis detection and monitoring processes hinges on what is deemed to be a crisis.

In describing the types of crises that they actively prepare to prevent, participants' responses converged around three primary areas: infrastructure, care delivery, and reputation. While Pearson and Mitroff's (1993) matrix of crisis types lists infrastructural, operational, and reputational risks, the vast majority of participants did not discuss preparatory measures for attack-related crises such as terrorism, extortion, theft, employee sabotage, lawsuits, loss of information, etc. This finding is consistent with other crisis management-focused research in the field; Canyon et al. (2010b) note that "32% of hospitals experience employee sabotage, but they have little capacity to address this" (p. 64). Therefore, it is possible that the lack of crisis detection and the lack of monitoring for attack-related crises is not only an issue faced by communicators but by Ontario hospitals as a whole.

Confusion around the definition of crisis combined with the lack of preparation for attack-related crises also confirms prior research suggesting how crisis preparedness and experience go hand-in-hand. Pearson and Mitroff (1993) discuss how organizations often experience a paradox of not understanding how to prepare for a crisis until they have been through one. The applied research of Canyon et al. (2010a) confirms this notion, stating: "health and allied health organizations have fallen into the pattern of preparing for what they have previously experienced or what they expect and not for what is possible" (p. 7). While certain crisis incidents have an extremely low probability of occurrence and are thus not prepared for, Canyon et al. (2010b) describe how this is not the case for certain attack-related crises, such as employee sabotage, which are experienced by a third of hospitals. It is therefore possible that hospitals are not only underprepared for crises that have an extremely low probability of occurring but also for crises that occur regularly but may not be on the radar of communication practitioners.

Ian Mitroff, Christine Pearson, and Katherine L. Harrington (1996) describe the effectiveness of simulations and exercises in crisis management, noting how they allow organizations to test and improve their crisis management strategies and tactics with-

out undergoing a crisis. This proactive testing of crisis management and crisis communication efforts provides communication practitioners with an intimate understanding of operational crisis management processes within their institutions. The five participants that engaged in tabletop simulations or mock crisis exercises tended to display a strong integration with the hospital's crisis management operations.

Research question 2

While participants' responses with regards to crisis detection, monitoring, prevention, and preparedness were varied, responses focusing on crisis response processes were more uniform. Most participants noted that their institutions had crisis management teams that integrated communication with senior management in other departments. The vast majority of participants provided lists of internal and external stakeholders. However, one point of differentiation between participants was their primary priorities during crisis recovery.

According to his seminal text defining Situational Crisis Communication Theory (SCCT), Coombs (2007b) notes: "[t]he first priority in any crisis is to protect stakeholders from harm, not to protect the reputation" (p. 165). Half of the participants surveyed explicitly mentioned a primary commitment to patient safety, providing continuous care, and keeping the community informed. This fits into two of Seeger's (2006) proposed best practices: creating partnerships with the public and listening to the public's concerns. The other half of participants focused either on the technical aspects of crisis communication or on reputation management as primary priorities. As mentioned previously, the nature of the interviews performed with participants focused on the technical aspects of crisis communication, which could potentially account for predominately technical crisis recovery priorities. However, as three of 14 participants (21.4%) focused exclusively on minimizing reputational damage and appeasing those stakeholders that had power—such as boards of directors or governmental bodies—it appears as though at least some hospitals in Ontario place their reputation above patient and community welfare.

The findings from studies done by Arjen Boin, Paul 't Hart, and Allen McConnell (2009); Judy Motion and Kay Weaver (2005); and Eva-Karin Olsson and Lars Nord (2015) apply to some of the sentiments expressed by some of the participants surveyed. Whether or not their crisis communication efforts indeed strive to protect stakeholders from harm as a primary priority, the data collected suggests that at least three participants expressed a primary desire to maintain the appearances of their institutions to governing bodies without an emphasis on stakeholder safety. Other participants mentioned (albeit rarely) how the public awareness of the cause of a crisis will change crisis response, especially with regards to taking responsibility for the crisis itself. While most participants expressed a desire for open, honest, and transparent crisis communication that serve to keep stakeholders safe and informed, more questionable intentions were also represented in the data. These sentiments, while uncommon in the sample size, are a point of concern as hospitals are publicly funded institutions that have a responsibility to the communities and regions they serve.

All participants noted that social media is used in some form to carry out crisis response communication. This reflects academic literature focusing on social media

usage for crisis communication, which claims that the appropriate use of social media platforms encourages greater dialogue and helps disseminate messages to audiences quickly (Schultz et al., 2011; Stephens & Malone, 2009; Veil et al., 2011). Participants discussed the nature of social media usage by hospitals, explaining that while the usage of social media has gone up in recent years, hospitals are still lagging behind the private sector in the total adoption of social media platforms. While only two participants identified social media as a primary tool for crisis response, most participants stated that they are exploring new ways to use social media and that they anticipate greater use of these platforms in the future.

Research question 3

Perhaps the strongest element of the crisis communication process identified in the data was a commitment to learning, review, and evaluation. The vast majority of participants explained how their institutions feature a formalized and systematic review process following crisis events to improve operational crisis management and crisis communication. The vast majority of participants were also able to identify the weaknesses in their organizations' crisis communication and crisis management approaches, and they were able to define how these weaknesses will be improved upon to address future crisis risks. Participants' descriptions of their review processes combined with their commitment to develop solutions for identified weaknesses fits with best practices regarding post-crisis audits identified by Mitroff, Pearson, and Harrington (1996).

One specific weakness noted by participants was a difficulty in reaching internal stakeholders. Recent crisis communication literature notes the value of internal crisis communication as internal stakeholders are often ignored yet highly invested in crises (due to their proximity to the organization in question), while also having the capability of serving as brand ambassadors during crisis situations (Coombs, 2014; Frandsen & Johansen, 2011). The ability of participants to respond to weaknesses in crisis communication that are emergent in academic literature, whether deliberate or not, speaks to the ability of the organizations in question to both exhibit self-reflection and take actions to improve faults.

Participants were asked about their organizations' crisis vulnerability to gauge their own crisis mindsets as well as the crisis mindsets of their organizations and their executive leadership. The vast majority of respondents discussed the uncertain nature of crises along with the need to remain vigilant to prevent and prepare for new and emerging threats. Mitroff, Pearson, and Harrington (1996) state that the belief that an organization is invulnerable to crises is a systemic factor that hinders proper crisis preparedness and crisis management. The ability to recognize and identify vulnerabilities is integral to proactively identifying risks and evaluating the effectiveness of existing crisis management efforts (Mitroff, Pearson, & Harrington, 1996). When this understanding of vulnerability is combined with the review efforts and risk-prevention plans of the participant group, it further emphasizes the strong crisis evaluation efforts of the participants' surveyed.

Teaching hospitals vs. community hospitals

Within the data collected, a few patterns emerge among the participants that point to

some trends observed by teaching hospitals as opposed to community hospitals. As a whole, the data shows that teaching hospitals are better prepared, more proactive, and have more crisis communication infrastructure than community hospitals. On one hand, the majority of participants that both explicitly mentioned their use of ERM systems and reported using social media to proactively monitor issues represented teaching hospitals. On the other hand, the majority of participants that did not have a defined crisis management plan or crisis management team and avoided a discussion of crisis vulnerability represented community hospitals. However, participants representing community hospitals did mention community engagement as a proactive risk management strategy to mitigate crises. While only two participants mentioned community engagement strategies, it is important to note as it presents an example of a crisis communication process that community hospitals utilized that was not present among teaching hospitals.

It is also important to note that these two participants cannot adequately represent crisis communication processes found in community hospitals across Ontario. As this study sampled participants from eight teaching hospitals and six community hospitals, additional research would need to be undertaken to determine significant points of distinction between teaching hospitals and community hospitals. The results of this study, however, do suggest that there is a degree of differentiation between teaching hospitals and community hospitals in Ontario, as teaching hospitals appear to have stronger crisis communication processes and systems in place than community hospitals.

The importance of integration

The results of this study also point toward the importance of integration between operational crisis management and crisis communication. Participants who described the strongest crisis preparedness, crisis response, and crisis review processes tended to have a higher level of integration with the rest of their hospitals' operations. Systems such as ERM and IMS enable communication practitioners to become intimately familiar with operational crisis management and emergency preparedness practices and protocols. Participants also noted how the integration of communication into these systems allows communication to be perceived as an integral component of crisis management by executive leadership.

The integration of crisis communication and operational crisis management also speaks to the role of public relations during a crisis. In general, participants who described their role during crisis situations as protecting reputation rather than ensuring patient and community safety were also participants who tended to act alone or with other communication staff during crises. By working together with staff and management in other departments of their hospitals, participants who represented hospitals with an integrated crisis management and crisis communication approach were able to ensure that stakeholders were protected during crisis situations.

Limitations

The design and scope of this study result in some clear limitations to the study's findings. First, while potential participants from almost all hospitals in the province of

Ontario were approached to participate in the study, only 14 participants consented to take part. A higher number of enrolled participants would likely result in more reliable study findings. It is important to note, however, that some participants represented health systems that are comprised of a number of hospitals within a municipality.

Second, the qualitative findings obtained cannot be appropriately generalized to a larger context. While the findings in this study may apply to other Canadian provinces or even other countries, the results cannot be effectively reproduced with other participants representing another region. A complementary quantitative research study would aid in strengthening the validity of the conclusions drawn in this article.

Conclusion

This study has strived to analyze and evaluate the risk preparedness and crisis communication efforts of Ontario hospitals at each stage of the crisis process. This study reflects the findings of other similar research in the field, confirming that hospitals in Ontario are indeed more prepared to face issues and crises that they have faced in the past. While certain types of crises might be extremely rare, their realization may lead to a crisis response that is not premeditated or prepared for. Strengthening attack-related crisis detection and prevention would serve to better prepare Ontario hospitals for these types of crisis events in the future.

In analyzing the ways in which hospitals in Ontario respond to crises from a communication perspective, this study has demonstrated the growing usage of social media for crisis communication efforts, as well as the need for integration between crisis communication and operational crisis management. As publics begin to adopt newer forms of communication, hospitals must continue to adapt to technological changes to continue to serve their diverse and wide-ranging stakeholder groups.

The growing integration between crisis communication and operational crisis management helps to foster a unified crisis response and a robust crisis preparedness strategy. While communication practitioners typically add value to their organizations by developing reputations and engaging with stakeholders, integration also ensures that communication practitioners offer value by helping management achieve broader objectives during crisis situations. The rationale explaining the successes of crisis management and crisis communication integration suggests that this approach can not only be applied to hospitals but other public and private institutions as well.

Note

1. This could potentially be explained by the nature of the study itself, as participants were invited to comment on the crisis communication processes and practices present within their institutions.

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