Crisis and Emergency Risk Communication

CENTERS FOR DISEASE CONTROL AND PREVENTION

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The purpose of this course is to introduce the reader to communication principles and tools as they relate to what we have called emergency risk communication. The principles in this course borrow from (1) font of classical rhetoricians, (2) wealth of modern crisis, issues management, communication and psychological theory and, (3) lessons learned form the real and often painful world of experience, old-fashioned trial and error.

Crisis and Emergency Risk Communication is an introductory course that addresses a number of topics critical to successful public, partner and stakeholder communication during an emergency situation. This is not an in depth course on risk communication, issues management, crisis or disaster communication. It is an amalgamation of all of these incorporating from their theory and practical applications. It draws on the work of many professionals in these fields including Dr. Peter Sandman and Dr.Vincent Covello. Therefore, no one module is a complete source for a specific discipline such as media relations or risk communication. In fact, they are an introduction to the basics of that discipline and meant to help those who are charged with these responsibilities, and who may not be steeped in these subjects, to manage the tasks of planning and implementing crisis and emergency risk communication. When possible, we have provided resource sites that offer more in depth materials on a particular subject.

Crisis and emergency risk communication is the attempt by science- or public health professionals to provide information that allows an individual, stakeholders, or an entire community to make the best possible decisions during a crisis emergency about their well being, and communicate those decisions, within nearly impossible time constraints, and ultimately, to accept the imperfect nature of choices as the situation evolves.

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Introduction to Crisis and Emergency Risk Communication

Communication during a public health crisis

Communication is a broad science and an imperfect art. Nowhere in this book is there an implied promise that a population or community faced with an emergency, crisis, or disaster will overcome its challenges solely through the application of the principles presented here. However, this book does offer the promise that an organization can compound its problems during an emergency if it has neglected sound crisis and emergency risk communication planning. The reader should expect to gain the following understanding:

Aristotle stated, "It is equally unreasonable to accept merely probable conclusions from a mathematician and to demand strict demonstration from an orator."

—Ethics, Book 1

- The reasons that organizations must integrate effective emergency risk and crisis communication planning and resources into overall emergency operational planning at the community, state, and federal levels
- Accepted definitions of emergency risk and crisis communication concepts
- Nuts and bolts of crisis communication planning and tools, including problem definition, analysis, implementation of intervention, evaluation, and feedback
- How emergency risk and crisis communication concepts apply to a possible or declared bioterrorism event
- The psychology of a public health emergency and what messages the public will need from their public health professionals
- How local, state, and federal emergency response and recovery operations (including governmental and nongovernmental organizations) should communicate among themselves, to the public, and to their stakeholders

Well-planned and well-executed crisis and emergency risk communication, fully integrated into every stage of the crisis response, can give the organization the critical boost necessary to ensure that limited resources are efficiently directed where truly needed.

Types of Crises

Table 1–1. Potential Crises

National Multistate Disease Outbreak Investigation or Environmental Crisis	Unknown Infectious Agent With Potential To Spread to the United States	Site-specific	Terrorism	
			Bio	Chemical
■ Foodborne ■ Airborne ■ Waterborne ■ Vectorborne ■ Unknown infectious agent ■ Chemical ■ Natural disaster ■ Toxic materials ■ Radiologic materials	■ Large-scale environmental crisis ■ War-related	■ Laboratory incident with release of material in community ■ Death of employee/contractor/ visitor while on campus ■ Hostage event with/by employee/contractor on campus ■ Bomb threat ■ Explosion/fire– destruction of property ■ Violent death of an employee/contractor or visitor on campus ■ Laboratory incident with laboratory worker	■ Suspected ■ Declared	

The Risk of Disaster

Disasters are the ultimate test of emergency response capability. The ability to deal effectively with disasters is becoming more relevant as the factors that tend to increase risk are also increasing. Some of these factors include the following (Auf, der Heide E. 1996):

- **Increasing Population Density.** As areas become more densely populated, there are more potential victims when a disaster strikes.

- **Increased Settlement in High-Risk Areas.** Another reason for rising disaster losses is that part of this increase in population density is occurring in disaster-prone areas. There is greater settlement in such high-risk areas as floodplains; earthquake faults; coastal hurricane areas; unstable hillsides; areas subject to wild land fires; and areas adjacent to hazardous waste landfills, airports, and nuclear power plants.

- **Increased Technological Risks.** New technology is adding to the list of disaster agents at an ever-increasing rate. One of these is the 4 billion tons of hazardous chemicals that are shipped annually in this country. Our society is also becoming more dependent on technology and specialization, making us more vulnerable to such disasters as a mass power outage.

- **Aging U.S. population.** The United States is on the brink of a longevity revolution. By 2030, the number of older Americans will have more than doubled to 70 million, or 1 in every 5 Americans. The growing number and proportion of older adults is placing increasing demands on the public health system and on medical and social services. More than 65 percent of Americans ages 65 years or older have some form of cardiovascular disease, and half of all men and two-thirds of women older than age 70 have arthritis. Of older adults not living in institutions in 1994, nearly 40 percent—12 million seniors—were limited by chronic conditions. Of these, 3 million were unable to perform the activities of daily living—such as bathing, shopping, dressing, or eating—placing caregiving demands on family and friends. A large body of evidence indicates that the health conditions and needs of older adults are different from other segments of the population. An aging population offers new challenges for disaster response.

- **Emerging infectious diseases and antimicrobial resistance.** Infectious diseases are a continuing danger to all people, no matter their age, gender, lifestyle, ethnic background, or economic status. They are still among the most common causes of suffering and death, and they impose an enormous financial burden on society. Because we do not know which new diseases will arise, we must always be prepared for the unexpected.

  Throughout history, humanity has fallen victim to pandemics of cholera, plague, influenza, typhoid, tuberculosis, and other infectious maladies so widespread that most people rarely survived into middle age.

  In the years following World War II, it was widely believed that humans were winning the centuries-long war against infectious microbes. Such life-threatening bacterial diseases as tuberculosis and typhoid fever could be treated by antibiotics. Dread diseases of childhood such as polio, whooping cough, and diphtheria, could be conquered through vaccination. Coupled with earlier improvements in urban sanitation and water quality, vaccines and antibiotics dramatically lowered the incidence of

infectious diseases. Thus, it became possible to imagine a world in which infectious pathogens would no longer prey upon humanity.

However, this optimism was premature. As early as the 1950s, penicillin began to lose its power to cure infections caused by *Staphylococcus aureus*, a common bacterium that can cause serious illness. In 1957 and 1968, new strains of influenza emerged in China and spread rapidly around the globe, and in the 1970s, there was a resurgence of sexually transmitted diseases. Also during the 1970s, several new diseases were identified in the United States and elsewhere, including Legionnaires' disease, Lyme disease, toxic shock syndrome, and Ebola hemorrhagic fever. Antibiotic-resistant bacteria are becoming more common in hospitals, among patients, and in communities.

Looming over the yearly routine of preparing for each flu season is the threat that a pandemic strain might emerge—a virulent new type of flu that can span the globe in months and decimate the world's population—the kind that killed more than 20 million people in 1918–1919. Such a lethal virus can sweep the world without warning. The recent avian influenza scare in Hong Kong in 1997 raised the specter of a possible global pandemic and jolted the world from any renewed complacency about infectious diseases.

- **Increased International Travel.** International travel and trade play a role in the development of microbial resistance. A microbe originating in Africa or Southeast Asia can arrive on North American shores within 24 hours. In the United States, published reports show that the majority of multidrug-resistant typhoid cases originated in six developing countries. The future will bring, by all indications, megacities. In the next 25 years, the world may have as many as 20 cities with populations above 20 million. Most of these cities will be in developing countries where poverty, population density, and lack of sanitation will allow microorganisms to incubate and spread rapidly. Add to that the speed of travel, and the global threat is obvious.

  The rapid geographic movement of products and populations, changes in lifestyles and behaviors, the emergence of new infectious diseases, and the deliberate use of microorganisms and toxins as terrorist weapons add to the current public health risks. In addition, unforeseen interactions, such as those that may allow disease agents to cross species' barriers, also add to the unpredictability of public health risk.

- **Increased Terrorism.** The threat from terrorism is real, it is immediate, and it is evolving. State-sponsored terrorism appears to have declined over the past 5 years, but transnational groups—with decentralized leadership that makes them harder to identify and disrupt—are emerging. The world is seeing fewer centrally controlled operations and more acts initiated and executed at lower levels.

  Terrorists are also becoming more operationally adept and more technically sophisticated in order to defeat counterterrorism measures. For example, as security around government and military facilities has been strenghtened, terrorists are seeking out "softer" targets that provide opportunities for mass casualties. Employing increasingly advanced devices and using such strategies as simultaneous attacks, the number of people killed or injured in international terrorist attacks rose dramatically in the 1990s, despite a general decline in the number of incidents. Approximately one-third of these incidents involved U.S. interests.

  An act of biological or chemical terrorism may range from the dissemination of aerosolized anthrax spores to food product contamination; predicting when and how such an attack may occur is

impossible. The probability of biological or chemical terrorism cannot be ignored, especially in light of the events of the past 10 years.

Auf der Heide, Erik: *Disaster Planning, Part II: Disaster problems, issues and challenges identified in the research literature*, Emerg. Med. Clin. N. Amer. 14(2):453–480, (May) 1996.

Emergency/crisis/risk communication definitions

Communication theorists today are apt to slice and dice their definitions quite finely. For the purposes of this course, we will define crisis communication, issues management communication, risk communication, and crisis and emergency risk communication in ways that should be acceptable to most communication theorists and still give the practitioner a firm foundation for discussing with others the differences and similarities among the fields of communication. Call it what you will, but the fact is that communication expertise that fulfills the needs of public health professionals responding to a public health emergency or crisis will borrow from many areas of communication study. This course calls this special combination "crisis and emergency risk communication."

Crisis Communication: Crisis communication can be defined in two ways and, therefore, can cause some confusion for a practitioner looking for expert training and counsel. Today, the term is most often used to describe an organization facing a crisis and the need to communicate about that crisis to stakeholders and the public. Typically, a crisis is an event that occurs unexpectedly, may not be in the organization's control, and may cause harm to the organization's good reputation or viability. An example of an organization facing a crisis is the occurrence of a mass shooting of employees by a disgruntled employee. In most instances, the organization is facing some legal or moral culpability for the crisis (unlike a disaster in which a tornado wipes out the production plant), and stakeholders and the public are judging the organization's response to the crisis.

A simple definition of crisis communication separates the judgment or reputation factors in the communication and deals primarily with factual communication by an involved organization to its stakeholders and the public. Crisis communication could simply be the effort by community leaders to inform the public that, by law, they must evacuate in advance of a hurricane. In this definition, the organization is not being overtly judged as a possible participant in the creation of the disaster, and the information is empirically sound, so the individual can judge its veracity without the help of an expert.

The underlying thread in crisis communication is that the communicating organization is experiencing an unexpected crisis and must respond. Crisis also implies lack of control by the involved organization in the timing of the crisis event.

Communicator: Participant
Time Pressure: Urgent and unexpected
Message Purpose: Explain and persuade

Issues Management Communication: Issues management communication is similar to crisis communication; however, the organization has the luxury of foreknowledge of the impending crisis and the opportunity, to some extent, to choose the timing of its revelation to stakeholders and the public and reveal the organization's plan to resolve the issue. Again, the organization is central to the event.

Communicator: Participant
Time Pressure: Anticipated; timing somewhat in control of the communicator
Message Purpose: Persuade and explain

Risk Communication: Risk communication is a field that has flourished in the area of environmental health. Through risk communication, the communicator hopes to provide the receiver with information about the expected type (good or bad) and magnitude (weak or strong) of an outcome from a behavior or exposure. Typically, it is a discussion about an adverse outcome and the probability of that outcome occurring. In some instances, risk communication has been employed to help an individual make a choice about whether or not to undergo a medical treatment, continue to live next to a nuclear power plant, pass on genetic risks, or elect to vaccinate a healthy baby against whooping cough. In some cases, risk communication is used to help individuals adjust to the knowledge that something that has already occurred, such as an exposure to harmful carcinogens, may put them at greater risk for a negative health outcome, such as cancer, in the future. Risk communication would prepare people for that possibility and, if warranted, give them appropriate steps to monitor for the health risk, such as regular cancer screening.

Communicator: Expert that did not participate in the event and is neutral regarding the outcome
Time Pressure: Anticipated communication with little or no time pressure
Message Purpose: Empower decisionmaking

Crisis and Emergency Risk Communication: Crisis and emergency risk communication encompasses the urgency of disaster communication with the need to communicate risks and benefits to stakeholders and the public. Crisis and emergency risk communication differs from crisis communication in that the communicator is not perceived as a participant in the crisis or disaster, except as an agent to resolve the crisis or emergency. Crisis and emergency risk communication is the effort by experts to provide information to allow an individual, stakeholder, or an entire community to make the best possible decisions about their well-being within nearly impossible time constraints and help people ultimately to accept the imperfect nature of choices during the crisis. This is the communication that goes on in emergency rooms, not doctors' offices. Crisis and emergency risk communication also differs from risk communication in that a decision must be made within a narrow time constraint, the decision may be irreversible, the outcome of the decision may be uncertain, and the decision may need to be made with imperfect or incomplete information. Crisis and emergency risk communication represents an expert opinion provided in the hope that it benefits its receivers and advances a behavior or an action that allows for rapid and efficient recovery from the event.

Communicator: Expert who is an post-event participant invested in the outcome
Time Pressure: Urgent and unexpected
Message Purpose: Explain, persuade, and empower decisionmaking

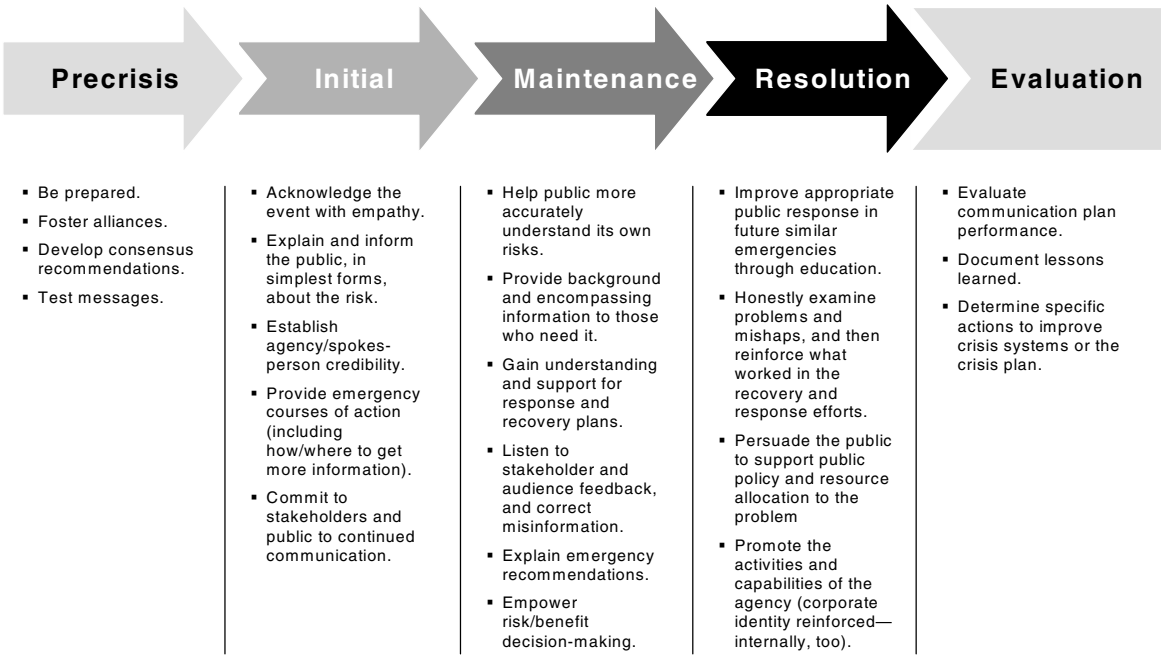
Emergencies, disasters, and crises

What do emergencies, disasters, and crises have in common? Simply, that something bad has happened or is happening. When something bad and/or unexpected happens, it may be called an emergency, a disaster, or a crisis depending on the magnitude of the event and the current phase of the event.

Crisis Communication Lifecycle

Understanding the pattern of a crisis can help communicators anticipate problems and respond effectively. For communicators, it's vital to know that every emergency, disaster, or crisis evolves in phases and that the communication must evolve in tandem. By dividing the crisis into the following phases, the communicator can anticipate the information needs of the media, stakeholders, and the general public. Each phase has its unique informational requirements.

Figure 1–1. Crisis Communication Life Cycle



The movement through each of the phases will vary according to the triggering event. Not all crises are created equally. The degree or intensity and longevity of a crisis will impact required resources and staff. In Module 4, an assessment for emergency communication response and a decision tree are provided.

Precrisis phase

Communication objectives during the precrisis phase are the following:

- Be prepared.
- Foster alliances.
- Develop consensus recommendations.
- Test messages.

This is where all the planning and most of the work should be done. Types of disasters that your organization may need to address can be anticipated. Reasonable questions can be anticipated, and preliminary answers can be sought. Initial communication can be drafted with blanks to be filled in later. Spokespersons, resources, and resource mechanisms can be identified. Training and refinements to plans and messages can be made. Alliances and partnerships can be fostered to ensure that experts are speaking with one voice.

Initial phase

Communication objectives during the initial phase are the following:

- Acknowledge the event with empathy.
- Explain and inform the public, in simplest terms, about the risk.
- Establish organizational/spokesperson credibility.
- Provide emergency courses of action (including how/where to get more information).
- Commit to stakeholders and public to continued communication.

Simplicity, credibility, verifiability, consistency, and speed count when communicating in the initial phases of an emergency.

The initial phase of a crisis is characterized by confusion and intense media interest. Information is usually incomplete, and the facts are disperse. It's important to recognize that information from the media, other organizations, and within your organization may not be accurate. Your role is to learn the facts about what happened, to determine your organization's response is to the problem, and to verify the true magnitude of the event as quickly as possible.

In the initial phase of a crisis, there is no second chance to get it right. Your organization's reputation depends on what you do and do not say and on when or whether you say it.

One of the best ways to limit public anxiety in a crisis is to provide useful information about the nature of the problem and what the public can do about it. During the initial phase of an event, establish your organization as a credible source of information. Even when there is little information to offer, you can still communicate how the organization is investigating the event and when more information will be available. At the very least, messages should demonstrate that your organization is addressing the issues head-on—that its approach is reasonable, caring, and timely.

Of course, the pressure to release information prematurely can be intense. Remember that all information must be approved by the appropriate managers before its release to the media.

In the initial phase of a crisis or emergency, people want information—*now*. They want timely and accurate facts about what happened, and where, and what is being done. They will question the magnitude of the crisis, the immediacy of the threat to them, the duration of the threat, and who is going to fix the problem. Communicators should be prepared to answer these questions as quickly, accurately, and fully as possible.

Crisis maintenance

Communication objectives during the crisis maintenance phase are as follows:

- Help people more accurately understand their own risks.
- Provide background and encompassing information to those who need it. (How could this happen? Has this happened before? How can I prevent this from happening again? Will I be all right in the long term—will I recover?)
- Gain understanding and support for response and recovery plans.
- Listen to stakeholder and audience feedback and correct misinformation.
- Explain emergency recommendations.
- Empower risk/benefit decisionmaking.

As the crisis evolves, anticipate sustained media interest and scrutiny. Unexpected developments, rumors, or misinformation may place further media demands on organization communicators. Experts, professionals, and others not associated with your organization will comment publicly on the issue and sometimes contradict or misinterpret your messages. Expect to be criticized about your handling of the situation.

Staying on top of the information flow and maintaining tight coordination are essential. Processes for tracking communication activities become increasingly important as the workload increases.

The crisis maintenance phase includes an ongoing assessment of the event and allocation of resources.

Resolution

Communication objectives for the resolution phase are as follows:

- Improve appropriate public response in future similar emergencies through education.
- Honestly examine problems and mishaps, and then reinforce what worked in the recovery and response efforts.
- Persuade the public to support public policy and resource allocation.
- Promote the activities and capabilities of the organization (corporate identity reinforced—internally, too).

As the crisis resolves, there is a return to stasis, with increased understanding about the crisis as complete recovery systems are put in place. This phase is characterized by a reduction in public/media interest. Once the crisis is resolved, you may need to respond to intense media scrutiny of how the event was handled. You may have an opportunity to reinforce public health messages while the issue is still current. A public education campaign or changes to a Web site may be necessary. Research has shown that a community is usually most responsive to risk avoidance and mitigation education directly after a disaster has occurred.

Evaluation

When the crisis is over, evaluate communication plan performance, document lessons learned, and determine specific actions to improve crisis systems or the crisis plan.

Role of Crisis and Emergency Risk Communication

Crises, emergencies, and disasters happen. One of the reasons disaster response is difficult to coordinate is that *disasters are different from routine daily emergencies.* The difference is more than just one of magnitude. Disasters generally cannot be adequately managed merely by mobilizing more personnel and material. During crisis situations, decision-makers are often unable to collect and process information in a timely manner and, thus, rely on established routines for situations that are, by definition, novel. Communication during a crisis cannot be managed solely by mobilizing more people and material—the communication itself must change because crises are inherently low-probability but high-impact events in which established frames of reference for understanding may breakdown. In major disasters, the incident is so shattering that both the sense of what is occurring and the means to rebuild that sense collapse simultaneously. Crisis and emergency risk communication is a vital component to help people cope and begin to rebuild a sense of order and understanding in their lives.

Communication during a crisis cannot be managed by mobilizing more people and material—the communication itself must change . . .

Crisis and emergency risk communication can work to counter some of the harmful human behaviors that are known to arise during a crisis. These potentially harmful individual, group, or community behaviors include:

- Demands for unneeded treatment
- Disorganized group behavior (stealing/looting)
- Bribery and fraud
- Reliance on special relationships
- Increased alcohol and tobacco use
- Increased multiple unexplained physical symptoms (MUPS)
- Unreasonable trade and travel restrictions.

Add bad communication practices to a crisis situation and the odds of a negative public response increase. Some of the bad communication practices that contribute to a poor public response that can be overcome with planning, coordination, research, and training include:

- Mixed messages from multiple experts
- Information released so late that events make the issue moot
- Messages that are over-reassuring
- Recommendations to the public without a reality check
- Leaving myths, rumors, and doomsayers unchallenged or corrected

Crisis and emergency risk communication can work to counter some of the harmful human behaviors that are known to arise during a crisis.

- Spokespersons who engage in improper behavior, exhibit a lack of affect, or use inappropriate humor
- Public power struggles and confusion.

The purpose of a public health response to a crisis is to efficiently and effectively reduce and prevent illness, injury, and death and return individuals and communities to normal. The possibilities of harmful human behaviors, combined with bad communication practices, can lead to overwhelming harmful public health outcomes during the crisis response. The following are some of the negative situations public health professionals could face:

The purpose of a public health response to a crisis is to efficiently and effectively reduce and prevent illness, injury, and death and return individuals and communities back to normal.

- Public demand for misallocation of limited emergency response resources
- Public mistrust or circumventing public health recommendations
- Opportunists who play on peoples' fear or uncertainties to provide fraudulent alternative treatments
- Increased disease and death
- Overreaction and wasted fiscal and medical resources during the emergency response.

Communication can reduce the tendencies of detrimental human behavior and prevent negative public health response outcomes by:

- Executing a solid crisis communication plan
- Being the first source for information
- Expressing empathy and caring
- Exhibiting competence and expertise
- Remaining honest and open
- Committing and remain dedicated to the response and recovery
- Applying emergency risk communication principles to the message.

The following chapters will map the way to good crisis and emergency risk communication and help your organization reserve limited resources, fulfill its mission, and maintain public trust.

Human Behavior in an Emergency: What Can Communication Address?

Effective communication is a "resource multiplier" during a crisis, disaster, or emergency. Many of the expected harmful individual and community behaviors can be mitigated with effective crisis and emergency risk communication. Each crisis will carry its own psychological baggage. The practitioner must anticipate what mental stresses the population will be experiencing and apply appropriate risk communication strategies to attempt to manage these stresses in the population. Risk communication is a fully legitimate tool of response and recovery just like any other resource applied to the disaster. It is not an attempt at mass mental therapy. It is a reasoned and mature communication approach to the selection of message, messenger, and method of delivery.

Contrary to what one may see in the movies, people seldom act completely irrationally or panic during a crisis. We do know that people have run into burning buildings, have refused to get out of a car stuck on the tracks with a train speeding close, and have gone into shock and become paralyzed to the point of helplessness. The overwhelming majority of people can and do act reasonably during an emergency. However, the following are some of the stresses and expected psychological manifestations that do occur during a crisis. These can be addressed through effective risk communication:

The overwhelming majority of people can and do act reasonably during an emergency.

- **Vicarious rehearsal.** Interestingly, experience has shown that people farther away (by distance or relationship) from the threat may actually exercise less reasonable reactions than those who are facing the real crisis. The communication age allows some people to vicariously participate in a crisis in which they are not in immediate danger of harm. These people will mentally rehearse the crisis as if they are experiencing it and "try on" the courses of action presented to them. Because these "arm chair" victims have the luxury of time to decide their chosen course of action, they may be much more critical about its value to them. In some cases, these people may reject the proposed course of action and choose another or insist that they too are at risk and need the recommended remedy themselves, such as a visit to an emergency room or a vaccination. In its most troublesome form, these "worried well" will heavily tax the recovery and response.

- **Denial.** Members of the community will experience denial.
  - Some people choose not to get warnings or action recommendations.
  - Some people may become confused by the warning.
  - Some people may not believe the threat is real.
  - Some people may not believe the threat is real to them.

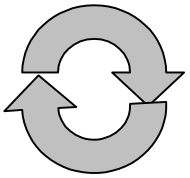
An individual experiencing denial may not take recommended steps to safeguard safety and life until the absolute last moments, and then, perhaps, when it's too late.

- **Stigmatization.** In some instances, victims may be stigmatized by their communities and refused services or public access. Fear and isolation of a group perceived to be contaminated or risky to associate with will hamper community recovery and affect evacuation and relocation efforts. In a disease outbreak, a community is more likely to separate from those perceived to be infected.

- **Fear and avoidance.** Fear is an important psychological consideration in the response to a crisis. The fear of the unknown or the fear of uncertainty may be the most debilitating of the psychological responses to disaster. With fear at the core, an individual may act in extreme and sometimes irrational ways to avoid the perceived or real threat.

- **Withdrawal, hopelessness, and helplessness.** Some people can accept that the threat is real, but the threat looms so large that they feel the situation is hopeless. They feel helpless to protect themselves and thus withdraw.

Figure 2–1. Stresses and Psychological Manifestations During a Crisis

Vicarious rehearsal	armchair victimization	**emotional physical**
Denial	refusal to take good advice	
Stigmatization	isolation of group	
Fear and avoidance	irrational behavior	
Withdrawal, hopelessness, helplessness	paralysis	**cognitive interpersonal**

Harmful actions instigated by crisis-related psychological issues

The negative emotions commonly experienced in a crisis or disaster—left without mitigating communication from a trusted source—may lead to harmful individual or group behaviors that can adversely affect the public's safety by hampering the speed, quality, and appropriateness of the crisis response and recovery. What's at stake are loss of life, health, safety, and property. This may be manifested when harmful actions lead to:

- Misallocation of treatments based on demand, not need

- Needless destruction of an industry or product through avoidance or boycotting

- Accusations of preferential treatment and bias in aid

- Unreasonable trade and travel restrictions

- Attempts at fraud

- Creation and propagation of damaging rumors and hoaxes directed at people or products
- Doomsayers that encourage distrust of government
- Attempts at bribery for scarce or rationed treatments and resources
- Dependence on special relationships to ensure special considerations based on desire, not need.

Self-destructive behaviors among adults as reactions to stress may include increased alcohol and tobacco use, inattention to family responsibilities, depression, anxiety, and compromised immune systems contributing to health complications.

- Research shows increased incidences of "multiple unexplained physical symptoms (MUPS)" among populations experiencing a crisis. (In emergencies involving a biological disease, these symptoms could confound the effort to identify those people who need immediate care versus those who need limited treatments or pharmaceuticals.)

Communication in a Crisis Is Different

The public must feel empowered to take action in the event of a crisis to reduce the likelihood of victimization and fear. Physical and mental preparation will relieve anxiety despite the expectation of potential injury or death. An "action message" can provide people with the feeling that they can take steps to improve a situation and not become passive victims of the threat.

How people absorb or act on information they receive during an emergency may be different from non-emergency situations. Research provides some clues about the receiver of information during an emergency. While it can be expected that normal communication psychology principles apply during a crisis, research has shown that in a dire emergency, people or groups may exaggerate their communication responses as they revert to more rudimentary or instinctual "flight or fight" reasoning, caused in part by the increase of adrenaline and cortisol in the blood system.

. . . in a dire emergency people or groups may exaggerate their communication responses as they revert to more rudimentary or instinctual "flight or fight" reasoning . . .

Studies show that the amount of media coverage of a traumatic event directly affects audience response. In some instances, information can hurt. The media affects segments of the population differently. The effects of television coverage of disasters on children can be especially troubling because the context of the disaster may not be understood. The 24-hour-a-day coverage following the Oklahoma City bombing gave local children the illusion that the entire town had been demolished. Most studies show that more information leads to decreased anxiety.

Decisionmaking

Decisionmaking is also affected during a crisis. The following behaviors are commonly exhibited:

1. **Simplify**
   Under intense stress and possible information overload, people will miss the nuances of messages or avoid the effort to juggle multiple facts by simplifying what they've heard. To cope, people may not attempt an analytical and reasoned approach to decisionmaking. Instead, they may rely on habit, long-held traditions, following the lead of others, and such stereotyping as classifying participants as "good" and "bad" guys.

2. **Maintain current beliefs**
   If your communication requires asking people to do something that seems counterintuitive (e.g., getting out of a safe car and lying in a ditch instead of outrunning a tornado), it may be difficult to change beliefs during a crisis or emergency. People are adept at maintaining faith in their current beliefs. People tend not to seek out contrary evidence. They also exploit the conflicting or contradictory information about a subject by interpreting it as consistent with existing beliefs. (e.g., "I believe that chocolate is good. Some studies say chocolate is bad for your health. Some studies say chocolate is good for your health. I choose to believe that no one knows for sure, and I'll continue to eat chocolate.")

3. **Believe assumed, incorrect, or conflicting information**
   People remember what they see. They tend to believe what they've experienced in their own lives; however, faced with new risks in an emergency, people must rely on experts. The concern today is that supposedly reputable experts may disagree regarding the level of threat, risks, and appropriate recommendations. The natural give and take among experts and their tendency to enjoy the peer process could leave the general public with increased uncertainty and fear. Research indicates that, often, the first message to reach the listener may be the accepted message even though more accurate information may follow.

   Simplicity, credibility, verifiability, consistency, and speed count when communicating in an emergency. An effective message must be repeated, come from a legitimate source, be specific to the emergency being experienced, and offer a positive course of action.

Perception of risk

The perception of risk is also vitally important in emergency communication. Not all risks are created equally. A wide body of research exists on issues surrounding risk communication, but the following emphasizes that some risks are more accepted than others.

- **Voluntary versus involuntary:** Voluntary risks are more readily accepted than imposed risks.
- **Personally controlled versus controlled by others:** Risks controlled by the individual or community are more readily accepted than risks outside the individual's or community's control.
- **Familiar versus exotic:** Familiar risks are more readily accepted than unfamiliar risks. Risks perceived as relatively unknown are perceived to be greater than risks that are well understood.
- **Natural origin versus manmade:** Risks generated by nature are better tolerated than risks generated by man or institution. Risks caused by human action are less well tolerated than risks generated by nature.
- **Reversible versus permanent:** Reversible risk is better tolerated than risk perceived to be irreversible.
- **Statistical versus anecdotal:** Statistical risks for populations are better tolerated than risks represented by individuals. An anecdote presented to a person or community, i.e., "one in a million," can be more damaging than a statistical risk of one in 10,000 presented as a number.
- **Endemic versus epidemic (catastrophic):** Illnesses, injuries, and deaths spread over time at a predictable rate are better tolerated than illnesses, injuries, and deaths grouped by time and location (e.g., U.S. car crash deaths versus airplane crashes).
- **Fairly distributed versus unfairly distributed:** Risks that do not single out a group, population, or individual are better tolerated than risks that are perceived to be targeted.
- **Generated by trusted institution versus mistrusted institution:** Risks generated by a trusted institution are better tolerated than risks that are generated by a mistrusted institution. Risks generated by a mistrusted institution will be perceived as greater than risks generated by a trusted institution.

- **Adults versus children:** Risks that affect adults are better tolerated than risks that affect children.
- **Understood benefit versus questionable benefit:** Risks with well-understood potential benefit and the reduction of well-understood harm are better tolerated than risks with little or no perceived benefit or reduction of harm.

The principles of risk communication are vital when developing messages during an emergency. If it's the first emergency of its type—manmade, imposed, or catastrophic—the communication challenges will increase.

Populations subjected to risks caused by human action and meant to destroy, hurt, and create terror will react with greater outrage. Unfairly distributed, unfamiliar, catastrophic, and immoral events create long-lasting mental health effects that lead to anger, frustration, helplessness, fear, and a desire for revenge.

If it's the first emergency of its type—manmade, imposed, or catastrophic—the communication challenges will increase.

In any discussion of risk, the scientist may perceive one risk in 10,000 as an acceptable risk when the listener may anecdotally be familiar with that one adverse outcome and believe that the risk is much greater to them. Perception of risk is not about numbers alone. These and other risk perceptions must be considered during a crisis.

Figure 2–2. The EPA's Seven Cardinal Rules of Risk Communication

Rule 1. Accept and involve the public as a legitimate partner.

Two basic tenets of risk communication in a democracy are generally understood and accepted. First, people and communities have a right to participate in decisions that affect their lives, their property, and the things they value. Second, the goal of risk communication should not be to diffuse public concerns or avoid action. The goal should be to produce an informed public that is involved, interested, reasonable, thoughtful, solution-oriented, and collaborative.

Guidelines: Demonstrate respect for the public by involving the community early, before important decisions are made. Clarify that decisions about risks will be based not only on the magnitude of the risk but on factors of concern to the public. Involve all parties that have an interest or a stake in the particular risk in question. Adhere to highest moral and ethical standards: recognize that people hold you accountable.

Rule 2. Listen to the audience.

People are often more concerned about issues such as trust, credibility, control, benefits, competence, voluntariness, fairness, empathy, caring, courtesy, and compassion than about mortality statistics and the details of quantitative risk assessment. If people feel or perceive that they are not being heard, they cannot be expected to listen. Effective risk communication is a two-way activity.

Guidelines: Do not make assumptions about what people know, think or want done about risks. Take the time to find out what people are thinking: use techniques such as interviews, facilitated discussion groups, advisory groups, toll-free numbers, and surveys. Let all parties that have an interest or a stake in the issue be heard. Identify with your audience and try to put yourself in their place. Recognize people's emotions. Let people

know that what they said has been understood, addressing their concerns as well as yours. Recognize the "hidden agendas," symbolic meanings, and broader social, cultural, economic or political considerations that often underlie and complicate the task of risk communication.

Rule 3. Be honest, frank, and open.

Before a risk communication can be accepted, the messenger must be perceived as trustworthy and credible. Therefore, the first goal of risk communication is to establish trust and credibility. Trust and credibility judgments are resistant to change once made. Short-term judgments of trust and credibility are based largely on verbal and nonverbal communications. Long term judgments of trust and credibility are based largely on actions and performance.

In communicating risk information, trust and credibility are a spokesperson's most precious assets. Trust and credibility are difficult to obtain. Once lost they are almost impossible to regain.

Guidelines: State credentials; but do not ask or expect to be trusted by the public. If an answer is unknown or uncertain, express willingness to get back to the questioner with answers.

Make corrections if errors are made. Disclose risk information as soon as possible (emphasizing appropriate reservations about reliability). Do not minimize or exaggerate the level of risk. Speculate only with great caution. If in doubt, lean toward sharing more information, not less—or people may think something significant is being hidden. Discuss data uncertainties, strengths and weaknesses—including the ones identified by other credible sources. Identify worst-case estimates as such, and cite ranges of risk estimates when appropriate.

Rule 4. Coordinate and collaborate with other credible sources

Allies can be effective in helping communicate risk information. Few things make risk communication more difficult than conflicts or public disagreements with other credible sources.

Guidelines: Take time to coordinate all inter-organizational and intra-organizational communications. Devote effort and resources to the slow, hard work of building bridges, partnerships, and alliances with other organizations. Use credible and authoritative intermediaries. Consult with others to determine who is best able to answer questions about risk. Try to issue communications jointly with other trustworthy sources such as credible university scientists, physicians, citizen advisory groups, trusted local officials, and national or local opinion leaders.

Rule 5. Meet the needs of the media.

The media are a prime transmitter of information on risks. They play a critical role in setting agendas and in determining outcomes. The media are generally more interested in politics than in risk; more interested in simplicity than in complexity; and more interested in wrongdoing, blame and danger than in safety.

Guidelines: Be open with and accessible to reporters. Respect their deadlines. Provide information tailored to the needs of each type of media, such as sound bites, graphics and other visual aids for television. Agree with the reporter in advance about the specific topic of the interview; stick to the topic in the interview. Prepare a limited number of positive key messages in advance and repeat the messages several times during the

interview. Provide background material on complex risk issues. Do not speculate. Say only those things that you are willing to have repeated: everything you say in an interview is on the record. Keep interviews short.

Follow up on stories with praise or criticism, as warranted. Try to establish long-term relationships of trust with specific editors and reporters.

Rule 6. Speak clearly and with compassion.

Technical language and jargon are useful as professional shorthand. But they are barriers to successful communication with the public. In low trust, high concern situations, empathy and caring often carry more weight than numbers and technical facts.

Guidelines: Use clear, nontechnical language. Be sensitive to local norms, such as speech and dress. Strive for brevity, but respect people's information needs and offer to provide more information. Use graphics and other pictorial material to clarify messages. Personalize risk data: use stories, examples, and anecdotes that make technical data come alive. Avoid distant, abstract, unfeeling language about deaths, injuries and illnesses. Acknowledge and respond (both in words and with actions) to emotions that people express, such as anxiety, fear, anger, outrage, and helplessness. Acknowledge and respond to the distinctions that the public views as important in evaluating risks. Use risk comparisons to help put risks in perspective; but avoid comparisons that ignore distinctions that people consider important. Always try to include a discussion of actions that are under way or can be taken. Promise only that which can be delivered, and follow through. Acknowledge, and say, that any illness, injury or death is a tragedy and to be avoided.

Rule 7. Plan carefully and evaluate performance.

Different goals, audiences, and media require different risk communication strategies. Risk communication will be successful only if carefully planned and evaluated.

Guidelines: Begin with clear, explicit objectives—such as providing information to the public, providing reassurance, encouraging protective action and behavior change, stimulating emergency response, or involving stakeholders in dialogue and joint problem solving. Evaluate technical information about risks and know its strengths and weaknesses. Identify important stakeholders and subgroups within the audience. Aim communications at specific stakeholders and subgroups in the audience. Recruit spokespersons with effective presentation and human interaction skills. Train staff—including technical staff—in communication skills: recognize and reward outstanding performance. Pretest messages. Carefully evaluate efforts and learn from mistakes.

EPA Document OPA-87-020, April 1988. Drafted by Vincent T. Covello and Frederick W. Allen

Resources:

Cohn, Victor. (1990). *Reporting on Risk*. Washington D.C.: The Media Institute

Covello, Vincent T., Ph.D., http://www.centerforriskcommunication.com/publication.htm

Covello, Vincent T., Ph.D., http://www.astho.org/about/productions/workbook.htm

Lum, Max R., Ed.D.; Tinker, Tim L. Dr.P.H., M.P.H. (1994) *A Primer on Health Risk Communication Principles and Practices*. Atlanta: Division of Health Education, Agency for Toxic Substances and Disease Registry.

Other Web sites:

http://excellent.com.utk.edu/~mmmiller/bib.html

http://www.nlm.nih.gov/pubs/cbm/health_risk_communication.html

http://www.naccho.org/files/documents/a-westnileArticle.pdf

http://www.atsdr.cdc.gov/HEC/evalp1.html

http://riskcenter.doe.gov/docs/cre/Training-Program.pdf

How To Communicate Effectively in a Crisis

by Peter Sandman, Ph.D.

Be careful with risk comparisons

The true risk and the perceived risk can be quite different. The source of the risk can be as troubling as the degree of risk. People do not like injustice. If they perceive that the risk has been imposed on them, that they have been unfairly singled out to experience the risk, or that a fellow human being deliberately put them in the position to be exposed to the risk, they are likely to perceive the risk with more concern or outrage. Be careful about risk comparisons. Explore both the true risk and the perception of that risk. "Hazard" is the seriousness of a risk from a technical perspective. "Outrage" is the seriousness of the risk in nontechnical terms. Experts view risk in terms of hazard; the rest of us view it in terms of outrage. The risks we overestimate are high-outrage and low-hazard. The risks we underestimate are high-hazard and low-outrage.

When technical people try to explain that a high-outrage, low-hazard risk isn't very serious, they normally compare it to a high-hazard, low-outrage risk. "This is less serious than that," the experts tell us, "so if you are comfortable with that, you ought to be comfortable with this." In hazard terms, the comparison is valid. But the audience is thinking in outrage terms—and viewed in outrage terms, the comparison is simply false. "This" is lower hazard than "that," but it is higher outrage.

Bioterrorism is high-outrage and (for most of us, so far) low-hazard. You can't effectively compare it to a low-outrage, high-hazard risk such as driving a car—which is voluntary, familiar, less dreaded, and mostly under our own control. Even naturally acquired anthrax fails to persuade as a basis for comparison. People are justifiably more angry and frightened about terrorist anthrax attacks than about natural outbreaks, even if the number of people attacked is low.

A volatile risk comparison can work if it is clear that you are trying to inform the public's judgment, not coerce it. If you're trying to inform the public about a risk, the natural thing to do would be to bracket the risk: bigger than X, smaller than Y. If you report only that it's smaller than Y, your audience can tell they're being coerced.

> Risks for comparison should be similar in their characteristics that would generate outrage. Here is a risk comparison that can work:
>
> Research indicates that, in Hawaii, a person is 10 times more likely to be killed by brain damage from a falling coconut than to be killed by a shark. In this case, the risks are both natural in origin, fairly distributed, exotic, and outside the control of the individual. Although being killed by a shark may cause greater terror or emotion, its comparison to being killed by a coconut helps the individual to see that he or she may be perceiving the risk as greater than it is. Most people have never considered their risk of dying by coconut.

Acknowledge to people the reasons that they are more worried about anthrax (which has been imposed on them) rather than, for example, auto accidents or flu deaths.

Don't over-reassure

If an emergency event is catastrophic, unexpected, dreaded, unfamiliar, in someone else's control, morally repugnant, and memorable, expect high outrage. Reassurance can backfire. Tell people how scary the situation is, even though the actual numbers are small, and watch them get calmer.

Reassurance can backfire . . . It is important to remember that an over-reassured public isn't your goal. You want people to be concerned, vigilant—even hypervigilant at first.

Even if over-reassurance worked, which it doesn't, it is important to remember that an over-reassured public isn't your goal. You want people to be concerned, vigilant—even hypervigilant at first. You want people to take all available precautions; feel the fear, misery, and other emotions that the situation justifies; follow the crisis without obsessing over it; and still manage to live fairly normally. Over-reassurance is not the way to inspire that calm concern.

If you have to amend the estimate of damage or victims, it's better to amend it down, not up.

If you have to amend the estimate of damage or victims, it's better to amend it down, not up. The public tolerates "It's less serious than we thought" better than "It's more serious than we thought."

Sensitive syntax: put the good news in subordinate clauses

You should, of course, give people reassuring information. But don't emphasize it. Especially don't emphasize that it is reassuring, or you will trigger your audience's ambivalence.

One very good approach is to put the good news in subordinate clauses, with the more alarmist side of the situation in the main clause. "It's too soon to say we're out of the woods, even though we haven't seen a new anthrax case in X days." The main clause indicates that you are taking the situation seriously, how aggressively you are responding to every false alarm. Make sure that people have the data they need to put the risk in context and to judge how unlikely they are to get anthrax, but never put yourself in the position of minimizing the risk or urging them not to worry.

One very good approach is to put the good news in subordinate clauses, with the more alarmist side of the ambivalence in the main clause. "It's too soon to say we're out of the woods yet, even though we haven't seen a new anthrax case in X days."

Acknowledge uncertainty

Professionals are taught to sound confident even when they are not. We imagine that this inspires trust. And when people are feeling extremely dependent, it does. But when something goes wrong—and things always go wrong—the overconfidence backfires badly. On an individual level, doctors who share their uncertainty (in tone as well as content), who make the patient a collaborator, and who work against inflated expectations are less likely to be on the receiving end of malpractice suits. The same is true of public experts in all fields.

Acknowledging uncertainty is most effective when the communicator both shows his or her distress and acknowledges the audience's distress: "How I wish I could give you a definite answer on that . . ."; "It must be awful for people to hear how tentative and qualified we have to be because there is still so much we don't know . . ."

Acknowledging uncertainty is most effective when the communicator both shows his or her distress and acknowledges the audience's distress: "How I wish I could give you a definite answer on that . . ."

Give people things to do

In an emergency, some suggested actions are directed to victims, persons exposed, or persons who may be exposed. However, those who do not need to take immediate action will be engaging in "vicarious rehearsal" of those recommendations and may need substitute actions of their own to ensure that they do not prematurely act on recommendations not meant for them. In an emergency, simple tasks will give people back a sense of control and will help to keep them motivated to stay tuned to what is happening (versus denial, where they refuse to acknowledge the possible danger to themselves and others) and prepare them to take action when directed to do so. When giving people something to do, give them a choice of actions matched to their level of concern. Offer a range of responses—a minimum response, a maximum response, and a recommended middle response.

Simple tasks in an emergency will give people back a sense of control.

Example:
To make drinking water safe:
(1) Use chlorine drops if safety is uncertain, (2) boil water for 2 minutes or, (3) buy bottled water.
We recommend boiling water.

Stop trying to allay panic

Panic is much less common than we imagine. The literature on disaster communication is replete with unfulfilled expectations of panicking "publics." It turns out that people nearly always behave extremely well in crisis. Recall the behavior of people in lower Manhattan on the morning of September 11! In the face of awful events, people become simultaneously resourceful and responsive. If told what to do by those in authority, we tend to do it; if no one is in charge, we figure it out for ourselves. When the crisis is over, we may feel anxiety, fear, even delayed panic attacks now that the time to panic is past. During the crisis, people may well take calm, self-protective actions that seem rational and appropriate to them, even if authorities recommend otherwise. Whether wise or unwise, securing a personal stockpile of antibiotics is not a sign of panic.

The condition most conducive to panic isn't bad news; it is conflicting messages from those in authority. People are the likeliest to panic . . . when they feel that they can't trust what those in authority are telling them or when they feel misled or abandoned in dangerous territory.

The condition most conducive to panic isn't bad news; it is conflicting messages from those in authority. People are the likeliest to panic (though still not all that likely) when they feel that they can't trust what those in authority are telling them or when they feel misled or abandoned in dangerous territory. When authorities

start hedging or hiding bad news in order to prevent panic, they are likely to exacerbate the risk of panic in the process.

Anyone involved in responding to the public during an emergency may feel that they've witnessed plenty of panic. Experience shows that in a true emergency, when life and death are at play, people respond exceptionally well. However, it also seems that the inverse is true—the more removed people are from the real danger (in place and time), the more likely they are to allow their emotions full range. This vicarious rehearsal (How would I feel in an emergency? What would I do? Does this advice work for me?) can be overwhelming in an emergency. Therefore, the communicator must recognize the differences among his or her audiences. The person anticipating the high risk is much more likely to respond inappropriately than the person in the heat of the battle who is primed to act on the information and doesn't have the time to mull it over.

. . . the communicator must recognize the differences among its audiences. The person anticipating the "bad risk" is much more likely to respond inappropriately than the person in the "heat of the battle" who is primed to act on the information . . .

Acknowledge people's fears

What should you do with people who are vicariously rehearsing their responses? When people are afraid, the worst thing to do is pretend that they're not; second worst is to tell them they shouldn't be. Both responses leave people alone with their fears. (Mishandling people's fears goes hand in hand with over-reassurance, but it's conceptually different: "Everything is under control" versus "Don't worry.")

When people are afraid, the worst thing to do is pretend they're not; second worst is to tell them they shouldn't be.

Even when the fear is totally unjustified, it doesn't respond well to being ignored—nor does it respond well to criticism, mockery, or statistics. These approaches are less effective even when the fear is warranted. Instead, you can acknowledge fears even while giving people the information they need to put those fears into context. Giving people permission to be excessively alarmed about a bioterrorist threat (but while still telling them why they needn't worry) makes it far likelier they will *actually* be reassured.

Even when the fear is totally unjustified, it doesn't respond well to being ignored—nor does it respond well to criticism, mockery, or statistics.

All risks are not accepted equally by the audience

The number of people killed in a plane crash is the same as the number of people who die each week due to cancer or heart disease. Both causes of fatality are preventable, and yet, public outrage in response to these tragedies is vastly different. Whether or not a crisis personally affects an individual or group impacts their response to the crisis.

As your organization develops a plan for responding to the public during a crisis, it's important to consider the point of risk associated with your key target audiences. Depending on the type and extent of crisis, the key messages your organization communicates to a national audience may be different from the key messages your organization will need to communicate to local constituents. Your emergency risk communication plan needs to address strategies and tactics for all degrees of affected audiences.

Crisis and Emergency Risk Communication During Different Stages of Crisis

The principles of emergency risk communication should be considered during each phase of a crisis. These tenets are grouped below according to their importance during the precrisis, initial, maintenance, and resolution phases of the crisis:

Precrisis phase

- **Stop trying to allay panic.** Panic stems from confusion, uncertainty, and lack of consistency. During the precrisis phase, information should be developed that anticipates and consistently answers the questions. In the precrisis phase, messages can be audience tested to ensure they are culturally and demographically valid. This effort allows the responders to speak with one voice. Don't patronize people before a crisis by telling them they have nothing to worry about *or* scare them by telling them they do—especially when there's little action that can be taken by an individual in anticipation of a crisis.

- **Emphasize that there is a process in place.** Define the process, describe the roles and responsibilities for response, and outline the solution.

Initial phase

During the stage of acute danger, the priority for all is basic safety and survival. Most people respond appropriately to protect their lives and the lives of others. However, some may behave in a disorganized way and may not be able to respond appropriately.

The more the following stressors are experienced in a crisis, the more impact the crisis will have on the individual:

- Threat to life and encounter with death
- Feelings of powerlessness
- Loss (e.g., loved one, home, livelihood, possessions)
- Dislocation (e.g., separated from loved one or home)
- Feeling responsible (e.g., should be doing more)
- Inescapable horror (e.g., trapped, unable to escape, threat unseen)
- Human malevolence (e.g., deliberate evil to cause harm).

During the initial phase, violating the following emergency risk communication principles can spell immediate trouble. An inappropriate tone now will damage credibility.

- **Don't over-reassure.** The objective is not to placate, but to elicit accurate, calm concern.
- **Acknowledge uncertainty.** Offer only what you know. Show your distress and acknowledge your audience's distress about the uncertainty of the situation—"It must be awful to hear we can't answer that question right now . . ."
- **Emphasize that a process is in place** to learn more. "We have a system (plan, process) to help us respond (find answers, etc)."
- **Stop trying to allay panic.** Provide a consistent message that is qualified by the aspects of a changing situation. Alert the public that the message, recommendation, etc. may change as more information becomes available. Be sure that all responsible participants and any third-party validators are immediately aware when the message does change.

Maintenance phase

During this phase the sense of the crisis magnitude, the concept of personal risk, and the initial steps toward recovery and resolution have begun. Emotional reactions will vary and will depend a great deal on perceptions about the risk and the stressors people face or may anticipate. During the early part of this phase, people may be perceived as elated—despite surrounding destruction or death—because of relief over their own survival. However, as the maintenance phase evolves, people may experience:

- Numbness
- Denial
- Flashbacks
- Grief
- Anger
- Despair
- Sadness
- Hopelessness.

The longer that individuals or communities are not allowed to return to "normal," the greater these reactions will be, as a sense of disillusionment may set in. Once the needs for basic survival are met, other needs for emotional balance and self-control emerge and people typically become frustrated and unfulfilled. The early altruistic response to the emergency may fall away to negative emotions and greater difficulty in recovering.

Therefore, the following emergency risk communication principles should be incorporated in messages:

- **Acknowledge fears**. Don't tell people they shouldn't be afraid. They are afraid, and they have a right to their fears. Don't disparage them for their misplaced fear. Acknowledge that it's normal and human to be frightened.

- **Express wishes.** "I wish we knew more." "I wish our answers were more definitive."

- **Give people things to do.** In an emergency, some suggested actions are directed to victims, persons exposed, or persons who may be potential to be exposed. However, those who do not need to take immediate action will be engaging in "vicarious rehearsal" of those recommendations and may need substitute actions of their own to ensure they do not prematurely act on recommendations not meant for them. In an emergency, simple tasks will give people back a sense of control and will help to keep them motivated to stay tuned to what is happening (versus denial, where they refuse to acknowledge the possible danger to themselves and others) and prepare them to take action when directed to do so. When giving people something to do, give them a choice of actions matched to their level of concern. Offer a range of responses—a minimum response, a maximum response, and a recommended middle response.

- **Acknowledge the shared misery**. Some people will be less frightened than they are miserable, feeling hopeless and defeated. Acknowledge the misery of a catastrophic event then help move people toward hope for the future through the actions of your organization and through actions that they, too, can take.

- **Give anticipatory guidance.** If you are aware of future negative outcomes, let people know what to expect (e.g., side effects of antibiotics). If it's going to be bad, tell them.

- **At some point, be willing to address the "what if" questions**. These are the questions everyone is thinking about and wants answered by experts. Although it's often impractical to fuel "what ifs" when the crisis is contained and not likely to affect large numbers of people, it is reasonable to answer "what ifs" if they could happen and people need to be emotionally prepared for them. After all, if you do not answer the "what if" questions, someone with much less at risk regarding the response's outcome will answer them for you. If you are not prepared to address "what ifs," you lose credibility and the opportunity to frame the "what if" questions with reason and valid recommendations.

- **Be a role model and ask more of people.** Many trauma experts agree that the psychological outcome of a community as a whole will be resilience. Perhaps the most important role of the spokesperson is to ask people to bear the risk with you. People can tolerate considerable risk, especially voluntary risk. If you acknowledge the risk, its severity, and complexity and acknowledge fears, you can then ask them, to bear the risk during the emergency and work toward solutions. As a spokesperson, especially one who may be on site and at some personal risk, you can model the appropriate behavior—not false happiness, but true willingness to go on with life as much as possible and to make reasonable choices for yourself and your family. Don't be glib, but be stalwart. Your determination to see it through will help others who are looking for role models to face risk. Americans have great heart, a sense of selflessness, and a natural competitiveness. Sparking those inherent attributes will help people cope with uncertainty, fear, and misery.

Resolution phase

At the time when the emergency is no longer on the front page, those who have been most severely affected will have significant emotional needs. Emotional symptoms may present as physical health symptoms such as sleep disturbance, indigestion, or fatigue as well as difficulties with interpersonal relationships at home and

work. Organized support starts to erode and the realities of loss, bureaucratic constraints, and permanent life changes come crashing in.

To truly maintain trust and credibility at this point, the expressed commitments from the initial phases must be followed through.

- **Be regretful, not defensive**. Say "We are sorry . . ." or "We feel terrible that . . ." when acknowledging misdeeds or failures. Don't use "regret," which sounds like you're preparing for a lawsuit.

- **Express wishes.** Say, "I wish we all could have been spared this tragedy, incident, etc." or "I wish our answers were more definitive, but we will continue to investigate and monitor this problem and we will keep you posted on our developments."

Figure 2–3. Principles of Emergency Risk Communication and Their Importance to Crisis Phases

When the following communication recommendations are most effective:	Crisis Phase			
Principles of Emergency Risk Communication	Precrisis	Initial	Maintenance	Resolution
Stop trying to allay panic	■	■		
Emphasize that there's a process in place	■	■		
Don't over-reassure		■		
Acknowledge uncertainty		■		
Acknowledge people's fears			■	
Express wishes			■	
Give people things to do			■	
Acknowledge the shared misery			■	
Give anticipatory guidance			■	
Address dreaded "what if" questions			■	
Be a role model and ask more of people			■	
Be regretful				■

Resource:

CDC Crisis Communication Draft Plan (1999).

Cooper, Lane. (1932). *The Rhetoric of Aristotle.* Englewood Cliffs, NJ: Prentice Hall, Inc.

Sandman, Peter, Ph.D. www.psandman.com

Facts To Consider About Human Psychology During a Crisis

Negative effects of traumatic stress disorder in a disaster situation

- **Emotional effects:** Shock, terror, irritability, blame, anger, guilt, grief or sadness, emotional numbing, helplessness, loss of pleasure derived from familiar activities, difficulty experiencing loving feelings.
- **Cognitive effects:** Impaired concentration, impaired decisionmaking, memory impairment, disbelief, confusion, nightmares, decreased self-esteem, decreased self-efficacy, self-blame, intrusive thoughts/memories, worry, dissociation (e.g., tunnel vision, dreamlike "spacey" feeling).
- **Physical effects:** Fatigue, insomnia, cardiovascular strain, startled response, hyperarousal, increased physical pain, reduced immune response, headaches, gastrointestinal upset, decreased appetite, decreased libido, vulnerability to illness.
- **Interpersonal effects:** Increased relational conflict, social withdrawal, reduced relational intimacy, alienation, impaired work performance, impaired school performance, decreased satisfaction, distrust, externalization of blame, externalization of vulnerability, feeling abandoned and rejected, overprotectiveness.

Positive responses following a disaster

These include resilience and coping, altruism, relief and elation at surviving the disaster, sense of excitement and greater self-worth, changes in the way the future is viewed, and feelings of strength and growth from the experience.

Posttraumatic stress disorder (PTSD)

PTSD is a mental disorder resulting from exposure to an extreme traumatic stressor. Unique identifying features include the following:

- Exposure to a traumatic stressor
- Re-experiencing symptoms
- Avoidance and numbing symptoms
- Symptoms of increased arousal
- Duration of at least one month
- Significant distress or impairment of functioning.

PTSD sufferers tend to have abnormal levels of key hormones involved in response to stress. Some studies have shown that cortisol levels are lower than normal and epinephrine and norepinephrine are higher than normal. When people are in danger, they produce high levels of opiates, which can temporarily mask pain. Scientists have found that PTSD sufferers continue to produce those higher levels even after the danger has passed.

Most trauma survivors will be upset for several weeks following an event but recover to a variable degree without treatment. The majority of traumatized individuals do not develop PTSD. The frequency varies from about 4 to 30 percent.

The percentage of those who continue to have problems or develop PTSD depends on many factors, including the severity of trauma exposure:

- Natural disaster: 4–5 percent
- Bombing: 34 percent
- Plane crash into hotel: 29 percent
- Mass shooting: 28 percent.

Certain types of exposure place survivors at high risk for a range of postdisaster problems:

- Exposure to mass destruction or death
- Toxic contamination
- Sudden or violent death of a loved one
- Loss of home of community.

The rate of acute stress disorder (ASD) varies with higher rates reported for human-caused trauma:

- Typhoon: 7 percent
- Industrial accident: 6 percent
- Violent assault: 19 percent
- Motor-vehicle accident: 14 percent
- Assault: 13 percent.

Associated disorders from PTSD and ASD include:

- Depression
- Substance abuse
- Panic disorder

- Obsessive-compulsive disorder
- Sexual dysfunction
- Eating disorders.

Media coverage and PTSD

In a study of 85 adults seeking mental-health services 6 months after the Oklahoma City bombing, the number of hours of bombing-related television watched did not correlate with increased PTSD symptoms.

Children in the group who watched bombing-related television reported more PTSD symptoms 7 weeks after the bombing than children who did not watch as much.

In a second study, television exposure was directly related to PTSD only in children who did not see, hear, or feel the explosion and who did not know anyone who was killed or injured. These findings suggest that watching bombing-related television may have contributed to an increase in PTSD symptoms. However, only the most distressed children may have chosen to watch bombing-related television.

Other studies

In an Israeli study, 237 adults were divided into 2 groups. One group was exposed to television clips of terrorism and political violence; the other group was exposed to news clips unrelated to national threat. Individuals who watched the terrorism clips reported more anxiety than those who watched clips unrelated to terrorism.

A sample of adults who had an intimate friend or relative killed in the Mount Saint Helens explosion reported that the media were a hindrance to recovery. Adults who suffered property loss reported that the media were neither a help nor a hindrance.

Common experiences of those exposed to poisonous gas in a Japanese subway included anxiety, fear, nightmares, insomnia, depression, and fear of subways.

Understanding concepts of death, dying, and grief

In a catastrophic event in the United States, communities or the nation may face what experts call “death out of time.” The death of someone who is not advanced in age and sickly (e.g., the death of a child) can be much more difficult to cope with. People communicating to an individual or community experiencing the extreme pain and grief that accompanies loss through death must be especially aware of how this grief is suffered. Grief is experienced in a broad social context. The view of a particular society, culture, or subculture with its expectations of “appropriate grieving” influences the experience of loss and the “performance” of grief for those in that society.

Grief is a universal emotion, but no two people experience grief in exactly the same manner. Experts have given name to this process, which includes the following:

- **Bereavement** is the state that results from a significant loss and encompasses a wide range of reactions—emotional, cognitive, spiritual, behavioral, and physical. Bereavement is a normal, natural experience, although it is traumatic and emotionally disruptive.
- **Grief** refers to the intrapsychic process of regaining equilibrium after a loss. Manifestation includes emotional catharsis and obsessive thoughts of the deceased. Re-evaluating spiritual issues and experiencing physical symptoms may also be occurring.
- **Mourning** is the public expression or sharing of the feelings of grief. Such rituals as funeral services or the wearing of black are expressions of mourning.
- **Anticipatory** grief is an experience that occurs before the expected death of a loved one and is a projection of emotional pain and the life change that the loss will bring.

Growth should be the outcome of the grief process. The individual and the context of the death will affect the grief process.

The tasks of grief work include:

- Acceptance of the reality of the loss
- Experiencing the pain of grief
- Adjusting to an environment without the deceased
- Withdrawing emotional energy for the relationship with the deceased and investing it in new or existing relationships.

Several contexts have an influence on the grief process:

- The circumstances of the death
- The nature of the relationship with the deceased
- Has the individual experienced a prior loss?
- Are there secondary losses (e.g., no longer fits into social group, loss of dream)?

The types of grief reactions are:

- Normal or uncomplicated grief
- Abnormal or complicated grief
- Pathological grief.

Resources:

"Phases of Traumatic Stress Reaction in a Disaster": National Center for Post-Traumatic Stress Disorder, htttp:www.ncptsd.org/facts/disasters/fs_phases_disaster.html

Novac, Andrei, M.D. April 2001. "Traumatic Stress and Human Behavior," *Psychiatric Times*, website: http://www.mhsource.com.

DiGiovanni, C. (1999). "Domestic terrorism with chemical or biological agents: psychiatric aspects." *American Journal of Psychiatry*, 156, 1500–1505.

Everly, George S. Jr., Ph.D. 2001. "America Under Attack: The '10 Commandments' of Responding to Mass Terrorist Attacks" *International Journal of Emergency Mental Health*, 3(3), pp 133–135.

The Message—Content Counts in an Emergency

Consider your audiences

The receiver of your communication will be judging the content of the message, the messenger, and the method of delivery. Each of these aspects must be considered in planning for crisis and emergency risk communication. The public's awareness of government is heightened during a crisis. A lack of continuity, control, adequate resources, or full knowledge of the event can invoke fear and threaten social unity. Your audience's needs can be judged three ways: (1) their relationship to the incident, (2) their psychological differences, and (3) their demographic differences. In this chapter, we explore audiences and message content.

The receiver of your communication will be judging the content of the message, the messenger, and the method of delivery.

Possible audiences for your crisis and emergency risk communication:

1. **Public within the circle of disaster or emergency for whom action messages are intended**
   Concerns: Personal safety, family safety, pet safety, stigmatization, property protection

2. **Public immediately outside circle of disaster or emergency for whom action messages are not intended**
   Concerns: Personal safety, family safety, pet safety, interruption of normal life activities

3. **Emergency response and recovery workers, law enforcement involved in their response**
   Concerns: Resources to accomplish response and recovery, personal safety, family safety, pet safety

4. **Public health and medical professionals involved in the disaster response**
   Concerns: Resources adequate to respond, personal safety, family safety, pet safety

5. **Family members of victims and response workers**
   Concerns: Personal safety, safety of victims and response workers

6. **Health care professionals outside the response effort**
   Concerns: Vicarious rehearsal of treatment recommendations, ability to respond to patients with appropriate information, access to treatment supplies if needed/wanted

7. **Civic leaders, local, state, and national**
   Concerns: Response and recovery resources, liability, leadership, and quality of response and recovery planning and implementation; opportunities for expressions of concern; trade and international diplomatic relations

8. **Congress**
   Concerns: Informing constituents, review of statutes and laws for adequacy and adjustment needs, opportunities for expressions of concern

9. **Trade and industry**
   Concerns: Business issues (loss of revenue, liability, business interruption) and protection of employees

10. **National community**
    Concerns: Vicarious rehearsal, readiness efforts started

11. **International neighbors**
    Concerns: Vicarious rehearsal, readiness efforts started

12. **International community**
    Concerns: Vicarious rehearsal, exploration of readiness

13. **Stakeholders and partners specific to the emergency (discussed in a separate module)**
    Concerns: Included in decisionmaking and access to information

14. **Media**
    Concerns: Personal safety, access to information and spokespersons, deadlines

Figure 3–1. Audience Relationship to the Event

Each of these audiences will be looking for a specific message. Prioritize the development of messages for each audience based on their involvement.

Remember the basics when creating your messages. Audience segmentation and demographics are still relevant during a crisis. Always consider the following:

- Education
- Current subject knowledge and experience
- Age
- Language spoken/read
- Cultural norms
- Geographic location

See Template. *Message Development for Communication*, at the end of this section. It is a worksheet to help develop messages during a crisis.

How Audiences Judge Messages in a Crisis

Expect your audiences to immediately judge the content of your message in the following ways:

- **Speed of communication.** Was the message timely? Research indicates that the first message received on a subject sets the stage for comparison of all future messages on that subject. If the public hears that the world is flat, and then someone comes along and says "the world is round," that message may face some resistance because of preconceived ideas on the subject. Also, the speed with which you respond to the public can be an indicator of how prepared you are to respond to the emergency, that there is a system in place, and that needed action is being taken. If the public is not aware that you're responding to the problem, then you're not! The public may then lose confidence in the organization's ability to respond, and you will be attempting to catch up in convincing the public that the system for response is working.

  First impressions are lasting impressions. If you shoot out of the gate and fall flat, it won't matter much if you get back up and flawlessly jump all of the hurdles in record time. This doesn't necessarily mean having all the answers; it means having an early presence so the public knows that you are aware of the emergency and that there is a system in place to respond. A great message delivered after the audience has moved on to other issues is a message not delivered at all.

- **Factual content of the message.** The public will be listening for factual information, and some will be expecting to hear a recommendation for action. Get the facts right, repeat them consistently, avoid sketchy details early on, and ensure that all credible sources share the same facts. Speak with one voice. Again, preparation counts. Consistent messages are vital. Inconsistent messages will increase anxiety and will quickly torpedo credibility of experts.

During the mid-1990s, the U.S. Midwest was badly crippled by a number of floods. Response officials cautioned citizens to boil their water to make it safe for drinking. Most citizens sought out more specific information. Unfortunately, various response agencies offered different guidance about how long and to what temperature water should be boiled to make it safe for drinking. The public and media were quickly indignant about the response operation and the government=s ability to get the job done. Consistent messages are vital, especially when asking the public to perform an action or take a step that is unfamiliar.

- **Trust and credibility of the message.** Research shows that there are four basic elements to establishing trust and credibility through communication. You can't fake these. They must be truly present in the message. All messages, written or spoken, can incorporate these elements and should, especially when attempting to communicate during an emergency.

  – **Empathy and caring.** Empathy and caring should be expressed within the first 30 seconds. According to research, being perceived as empathetic and caring provides greater opportunity for your message to be received and acted upon. Acknowledge fear, pain, suffering, and uncertainty.

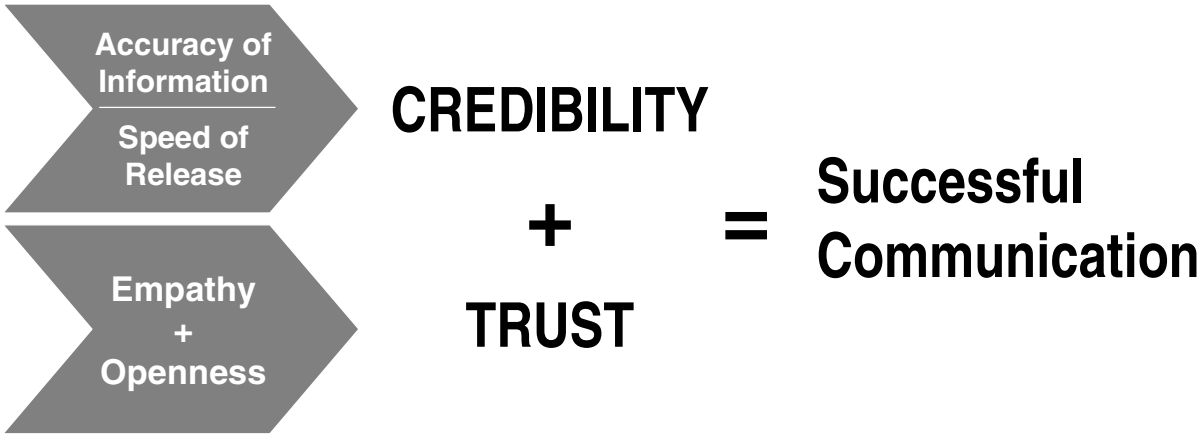
  – **Competence and expertise.** Obviously, education, position title, or organizational roles and missions are quick ways to indicate expertise. Previous experience and demonstrated abilities in the current situation enhance the perception of competence. Another useful means is to have established a relationship with your audiences in advance of the emergency. If that is not

possible, have a third party, who has the confidence of the audience, express his or her confidence in you or your organization.

– **Honesty and openness.** This does not mean releasing information prematurely, but it does mean facing the realities of the situation and responding accordingly. It means not being paternalistic in your communication but, instead, participatory—giving people choices and enough information to make appropriate decisions. Be realistic about your communication systems and procedures and, if they do not permit you to comment on something or reveal information, don't pretend you don't have the information; tell the public why the information isn't available for release at the time (e.g., verifying information, notifying your organization, not your information to release, etc.). It means allowing the public to observe the process while reminding them that this process is what drives the quality of the emergency response. Cut the professional jargon and euphemisms; they imply insecurity and lack of honesty.

– **Commitment and dedication.** State up front what your organization's objective is in this emergency response, and commit to reaching that objective. Show dedication by sharing in the sacrifices and discomforts of the emergency. Don't fake hardship for the cameras. Effective Governors know that they'd better walk the territory in which they're declaring a state disaster area. Dedication means not leaving the emergency until the community is recovered. This often means staying in touch with the community long after the media lose interest in the story. Resolution and followup should be committed to from the start and carried through to the end.

Figure 3–2. Elements of Successful Communication



Resources:

Andreasen, Alan R. (1995). *Marketing Social Change: Changing Behavior to Promote Health, Social Development, and the Environment*. San Francisco: Jossey-Bass Publishers.

Shewe, Charles D.; Smith, Reuben M. (1983). *Marketing Concepts and Applications*. New York: McGraw-Hill Book Company.

Graeff, Judith A., et. al. (1993). *Communication for Health and Behavior Change*. San Francisco: Jossey-Bass Publishers.

Lum, Max R., Ed.D.; Tinker, Tim L. Dr.P.H., M.P.H. (1994) *A Primer on Health Risk Communication Principles and Practices*. Atlanta: Division of Health Education, Agency for Toxic Substances and Disease Registry.

Cohn, Victor. (1990). *Reporting on Risk*. Washington D.C.: The Media Institute

How To Make the Facts Work in Your Message

Consider the following when creating your initial communication to your audiences:

- For the general public, **present a short, concise, and focused message** (6th-grade level). It's difficult in a heightened state of anxiety or fear to take in copious amounts of information. Get the bottom line out first. In time, the public will want more information.

- **Cut to the chase**—*relevant information only* at this time. Don't start with a lot of background information. Don't spend a lot of time establishing yourself or your organization. One sentence should be enough.

- **Give action steps in positives,** not negatives (e.g., "In case of fire, use stairs," "Stay calm," are positive messages. Negative messages are "Do not use elevator" and "Don't panic.") Use positives, not negatives.

- **Repeat the message**—repetition reflects credibility and durability. Correct information is correct each time you repeat it. Reach and frequency, common advertising concepts, tell us that your message is more apt to be received and acted upon as the number of people exposed to the message (reach) and the number of times each person hears the message (frequency) go up.

- **Create action steps in threes or rhyme, or create an acronym.** These are ways to make basic information easier to remember, such as "stop/drop and roll" or "KISS—keep it simple, stupid." Three is not a magic number, but in an emergency, you should expect someone to absorb three simple directions. Research indicates that somewhere between three and seven bits of information is the limit for people to memorize and recall. It makes sense in the stress of an emergency to ask you audience to remember fewer bits of information. (For example, Anthrax is a bacterium that is treated with antibiotics. Anthrax is not transmitted from person to person. Seek medical care if you believe you have symptoms of anthrax: fever, body aches, and breathing problems.)

- **Use personal pronouns for the organization.** "We are committed to . . ." or "We understand the need for . . ."

Avoid

- **Technical jargon**

  - Instead of saying "people may suffer morbidity and mortality," say, "people exposed may become sick or die."

  - Instead of "epidemic" or "pandemic," say "outbreak" or "widespread outbreak."

  - Instead of "deployed," say "sent" or "put in place."

  - Instead of "correlation" say "relationship" (avoid using "cause").

- **Unnecessary filler**—background information (save for other outlets/times)

- **Condescending or judgmental phrases**—(e.g., "You would have to be an idiot to try to outrun a tornado." "Only hypochondriacs would need to walk around with a prescription for Cipro.") Many of us are neither idiots nor hypochondriacs, and both ideas have crossed our minds. Don't insult your audience by word or tone. That doesn't mean condoning the behavior; instead, validate the impulse but offer a better alternative and the reasons why it's better.

- **Attacks**—Attack the problem, not the person or organization.

- **Promises/guarantees**—only what you can deliver. Otherwise, promise to remain committed throughout the emergency response.

- **Speculation**—Don't play "worst-case scenario." Stick to the known facts. If you don't know it's an outbreak of Ebola, then why talk about Ebola? If the facts are not known, don't fall into the "what ifs." Instead, concentrate on describing the steps in place to get the facts and help the audience deal with the uncertainty while that process goes on. Speculation weakens your credibility. Do you want to be the Ebola expert or the emergency response expert who knows how to get the answers and empower the public to make the best possible response? "What ifs" are usually topics for times when there are no emergencies.

- **Discussion of money**—In the initial phase, discussion of the magnitude of the problem should be in the context of the health and safety of the public or environment. Loss of property is secondary. Also, a discussion of the amount of money spent is not a surrogate for the level of concern and response from your organization (what does that money provide?).

- **Humor**—Seldom is humor a good idea. People seldom "get the joke" when they are feeling desperate. Humor is a great stress-reliever behind closed doors. Anyone who has responded to emergencies knows that sometimes-inappropriate humor creeps in as a coping mechanism. Be careful not to offend others responding to an emergency, even behind closed doors. Be especially sensitive when speaking to the public. One person's attempt at humor may be another's insult.

Resources:

Borman, Ernest G. (1975). *Discussion and Group Methods. Second Edition*. New York: Harper and Row Publishers, Inc.

Cohn, Victor. (1990). *Reporting on Risk*. Washington D.C.: The Media Institute

Cooper, Lane. (1932). *The Rhetoric of Aristotle.* Englewood Cliffs, NJ: Prentice Hall, Inc.

Fischer, Henry. W, III. (1998). *Response to Disaster.* Lanham, Md.: University Press of America.

Lum, Max R., Ed.D.; Tinker, Tim L. Dr.P.H., M.P.H. (1994) *A Primer on Health Risk Communication Principles and Practices*. Atlanta: Division of Health Education, Agency for Toxic Substances and Disease Registry.

Precrisis phase: Building consensus for actions

In the precrisis phase, when consensus on recommendations is being built and implementation planning is being developed, consider the following to make recommendations more appealing to the target audience:

- Increase the expected gains
- Decrease the expected costs
- Increase the present social pressure
- Improve the individual's ability to act
- Decrease the desirability of competitive alternative actions

For example, you want to encourage a community to prepare "family survival kits," so consider doing the following:

- **Increase expected gains**—give anecdotes about successful families who had kits and how they benefitted in earlier disasters; offer lots of possible expected uses for the kit.
- **Decrease the expected costs**—decrease the expectation of the monetary cost for a kit and explain its longevity as a safety product for the home.
- **Increase social pressure**—involve the community neighborhood watch program in promoting the concept. Ask neighbors to help each other develop kits specific to the community's anticipated needs. Saturate communication channels with information about the civic groups involved in the kit project.
- **Improve the individual's ability to act**—Make the list of kit items easy to use and widely available; encourage partner retailers to discount safety kit items during key times of the year.
- **Decrease competitive alternatives**—Explain how putting together your own kit need not cost much nor take much time, and that expensive prepackaged kits are less desirable because they are not customized to the individual family's needs.

Example two: You want a targeted population to remain indoors and not travel to the emergency room or hospital unnecessarily during an infectious disease outbreak:

- **Increase the expected gains**—Self-imposed isolation will protect people from unnecessary exposure. They can cut through the red tape and emergency room waiting time by first calling a community nurse hotline. A trained nurse will assess their risk immediately by phone and empower them to make the best decision about additional care during the crisis.
- **Decrease the expected costs**—If the nurse agrees that a doctor or hospital visit is needed, an e-mail of the hotline contact with the patient's name will be placed on a reservation list at the medical facility, giving the patient priority in the waiting room before those who have not gone through the screening process.

- **Increase the present social pressure**—Engage community and civic leaders and trusted health care professionals to present the individual benefits of using the hotline, and applaud the expected reduction of chaos at the medical facilities, so that dedicated health care workers can effectively treat those in dire need of care—who might someday be a family member.
- **Improve the individual's ability to act**—Publicize widely the toll-free number, ensure that contact is made with little or no waiting, and ensure that a "satisfaction" check is made before the call is ended.

Culture and the message

Culture is a complex amalgam of values, ideas, attitudes, and symbols that shape our behavior as they transmit from one generation to the next. People can belong to several cultural groups. The largest is our national heritage; we identify with the people of our nation. But people are also members of smaller groups within the larger society, such as where we live in the nation, our religion, or our ethnicity. Culture is adaptive. As the needs of a society change, its values change to meet those needs. Because cultural norms influence how people live and behave, culture has important implications to communication, including emergency communication. Reference groups influence individual behaviors. Of the reference groups, the family is the most influential.

Reality Check: Within a given group, individual behavior is never uniform, but some general observations can be made about the behaviors of different groups.

Getting to know your border neighbors

Canada

The Canadian cultural identity, despite all that we have in common, is different from the United States. Canadians know much more about the U.S. than we do about Canada. Naturally, Canadians resent being considered a pseudo U.S. annex (Turkington, 1999). The following are some points about Canada and its culture that may be important when building partnerships during the precrisis phase:

- Canada is the second-largest country in the world.
- It stretches for 3.8 million square miles, divided into provinces.
- Its government is a parliamentary democracy with two houses, the Senate and the House of Commons. The head of the government is the Prime Minister.
- Both French and English are spoken and provinces (e.g., Quebec) take their French identity very seriously. The law requires that all materials to be written in both languages.
- First names are not automatically used in business (as is the case so often in the U.S.).

Canadian holidays

- Jan. 1–2: New Year's Holidays
- Jan. 3: New Year's (Quebec only)
- Feb. 20: Family Day (Alberta only)
- May 20: Victoria Day

- June 26: St. Jean Baptiste Day (Quebec only)
- July 1: Canada Day
- Aug. 7: Civic holiday (most provinces)
- Sept. 4: Labor Day
- Oct 14: Thanksgiving Day
- Nov. 11: Remembrance Day
- Dec. 26: Boxing Day

Mexico

- Mexico is more than three times the size of Texas.
- Mexico has a federal republic led by a president who serves once for 6 years.
- Ruled by colonial Spain since 1521, Mexico achieved its independence in 1810.
- Though not an official religion, 90 percent of Mexicans are Roman Catholic.
- If you must speak English, first ask if anyone speaks English.
- Between 1 and 3 p.m., many places of business close down. Government offices typically open at 8 a.m. but close at 2:30 p.m., Monday through Friday.
- There is only one time zone in Mexico, and it's one hour behind EST.
- A person's dignity means a great deal in Mexico, no matter his or her social status. Be careful not to embarrass anyone and never publicly criticize (Turkington, 1999).

Mexican holidays

- Jan. 1: New Year's Day
- Feb. 5: Constitution Day
- March 21: Benito Juarez' birthday
- Late March: Spring Equinox
- May 1: Labor Day
- May 5: Cinco de Mayo (Victory at Puebla)
- Sept. 16: Independence Day

- Oct. 12: Columbus Day (Dia de la Raza)
- Nov. 20: 1910 Revolution Anniversary
- Dec. 12: The Day of the Virgin of Guadalupe
- Dec. 31: New Year's Eve

Organizing Information for Emergency Response Presentations

Public health emergencies can come in various sizes and durations. After the initial response occurs, health officials and emergency responders may need to present updates or background information to community leaders, Congress, or citizen forums. They may also have to explain certain recommendations made at each step of the recovery effort. Depending on the purpose of the presentation and any expected resistance to the message, the pattern in which you choose to present the information can help open your audience to receiving it. A careful arrangement of your key ideas goes a long way toward helping your audience understand your message.

If a message arouses exceptionally intense feelings of anxiety, people tend to ignore the further content of the message. People must be prepared for messages, especially those likely to evoke emotional responses. Give listeners a "preparatory set" to increase their recognition and attention level. Your introduction should prepare the audience for the subject, recognize its emotional impact and tell them that you will review the material as many times as necessary. Listeners will tune the speaker out if they suspect that his or her message will not confirm their beliefs or opinions. Look for those elements that you know you and your audience share and build on those elements.

Research indicates that you can "innoculate" your audience by providing a small dose of the counterargument, just as a person can be innoculated by a mild dose of a disease organism.

See Appendix B. *H5N1 Virus Outbreak Investigation, Hong Kong, 1997–1998* for a case study of how communication was handled during the H5N1 Virus Outbreak in Hong Kong in 1997–1998.

Sharing new information when facing little or no resistance

Consider first using the direct pattern which presents your main idea or conclusion. The idea is then developed with supporting information. Most busy decision-makers prefer not to be teased; they want the bottom line up front. If you save the big idea until last, you may increase expectations. At the end of your talk, when you say that you can decrease the spread of infection by 25 percent but the audience thought your proposal would stop all spread of the disease, they will be disappointed. Lower expectations by declaring the expected outcome first.

Persuasive presentations, however, benefit from an indirect pattern of presentation; building the argument with ancillary concepts until you offer your most potent ammunition. You could list each of the benefits of a public health policy and finish by saying, "it will save billions in the next 10 years while saving lives."

Progress reports

Often, progress reports are best organized chronologically. The same is true for step-by-step instructions. This helps the listener follow where you've been and where you're going. This technique can be overused, especially if these are frequent updates. It is a useful pattern if your listeners need to understand the ongoing development of your ideas. You may also wish to consider a priority order pattern for progress reports. In this

pattern, you present the most significant point first with other developments following in descending order of importance.

Problem-solving

If your presentation is meant to offer a solution to a problem, the criteria-application pattern is a strong approach. Early in the presentation, criteria or standards for evaluation are suggested. Then, solutions or choices are compared against those standards. This approach highlights your underlying reasoning and can be very convincing as long as the audience agrees with your decision criteria. The criteria should describe the best possible case, then explore the available alternatives.

Explain why something happened

A cause-effect pattern for your presentation can explain how something occurred or predict the consequences of an action. It's easy to confuse cause and effect, so apply this pattern carefully. Causality is not always clear. Be careful not to simplify your conclusions or make them too optimistic (e.g., "If only we had a training program for administrators, we wouldn't have such difficulty getting decisions finalized in an emergency.").

Teach a new concept or process

To teach, a speaker begins with something familiar or already known by the listeners and moves to the unknown or more complex. By using an increasing magnitude of difficulty pattern, you can help your audience take in complex information in a way they can "own" it.

Table 3–1. Arranging Main Points in a Presentation

Kind of presentation	Purpose of presentation	Recommended method of organization for
Persuasive	Have the audience accept ideas Get the audience to act	Inductive pattern: show several specific examples, lines of reasoning, that lead to a general conclusion Problem-solving pattern: Describe a problem vividly to create a "need," then offer a solution. Criteria-application pattern: Describe criteria which pose a "best possible case." Then compare alternatives against these. Your solution fits the best.
Informational	Inform or teach the audience	Deductive pattern: Present the conclusion first, then explain details. Chronological pattern: Show how several events developed over a period of time. Increasing difficulty pattern: Start with something known by the audience, then add more complex concepts.
Progress report	Inform or update knowledge of a familiar subject	Chronological pattern Deductive pattern Order of importance pattern: Start with most significant finding and arrange others in ascending or descending order.

Presentation flops that destroy credibility:

- The apologetic beginning such as "Unaccustomed as I am to public speaking," or "I'm here to bore you with a few more statistics."
- The offensive beginning. An off-color joke, sarcastic or ridiculing statement.
- The same opening regardless of audience or situation.
- The gimmicky beginning, such as writing the word "sex" on your overhead.

Receivers of behavior change messages

Communication is two-way. When the purpose of your communication is to make a call to action or change behavior, you must be especially aware of your target audience. "Who are they?", "What do they believe now?", "are you a credible source of information for them?", etc. In addition to knowing the audience specifically, there are a number of general aspects of audiences you should keep in mind when building your reasoned case for a recommendation of action.

- Audiences selectively receive and interpret messages based on their existing knowledge, attitudes, beliefs, and current needs.
- Listeners are more receptive to a message that is consistent with their attitudes and beliefs.
- Messages phrased in terms of the listener's interests and needs are more successful than if given from the speaker's perspective. A "you viewpoint" helps. Show benefits, with "What this means to you."
- Persons with high self-esteem are less readily influenced that those with low self-esteem.
- Those overtly hostile or excessively apathetic are not likely to be influenced by your message.
- Mental or verbal participation by listeners improves the chance that your message will influence them.

Group influences on the effects of your message

Social pressure involves the consideration that a person's intention to take a particular action will depend not only on his or her perceived perception of personal consequences, but also on the perception of others' wishes. Health care workers and physicians can be very important sources of social pressure. However, for someone to move to action, he or she must not only see personal benefit or accept the social pressure to take the action, but must also believe that the action can actually be accomplished. Perceived consequences of a behavior involves a tradeoff between positive and negative consequences.

- Listeners are influenced by beliefs shared by those around them. There is a tendency to conform.
- If the speaker's message is counter to the norms of the group, a listener's tendency to accept that message is inversely proportional to the value he or she places on group membership.

- Audience members will be searching for nonverbal cues from other audience members to confirm or refute the speaker's message.

Internally, your target population will be asking these questions:

- What will I gain if I undertake this proposed behavior?
- What will it cost me to do it?
- What do those who are important to me want me to do?
- Can I actually carry it out?

If you satisfactorily answer those questions with candor, the action may be more readily accepted. The more socially desirable and easily undertaken a recommended action is, the more likely that it will be accepted.

Communicating about death one-on-one

In a catastrophic event, many people are ill, dying, or in need of treatment and it may be your job to talk with individuals about what is happening. There is a great body of work about expressing empathy and empowering decisionmaking between the medical professional and the patient in a medical care setting. However, most of this work assumes the luxury of time that is non-existent in an emergency situation. Some people, who may not have much experience in this patient-professional dialogue, may be recruited for the first time to educate patients or groups during a crisis.

In addition, if an evolving disease outbreak in a community begins to involve members of your response teams or their families, supervisors and team leaders may find themselves attempting to engage in supportive conversations. The following are some basic thoughts about communication styles in an intimate but highly emotional health emergency situation:

Empathize with the patient and family.

- People indulge in serious, meaningful communication only for short spans.
- Chitchat is a treasure trove of meaningful "hints" about what a person is worried about.
- Privacy is an important requirement. Assure that information shared will be kept private.
- Allow communication free from interruptions (e.g., crying shouldn't be interrupted).
- Try not to answer questions outside your area of expertise. Get permission from the individual to refer him or her to an expert.

Listen carefully.

- Place the speaker's needs above your own.
- Use open and accepting body language (e.g., no crossed arms).

- Always be honest in responding.
- Try not to interrupt to give advice.
- Accept moments of silence.
- As much as 90 percent of communication is nonverbal.

Be careful.

- Don't miss the meaning of the words and the gestures.
- Value judgments hinder communication.
- Teasing belittles the individual.
- Blame cuts off communication.

Better communication:

- Use the person's name in the conversation.
- Ask a clarifying question: "Can you help me understand?"
- Allow the conversation to evolve—don't push it where you hope it will go.
- Allow time for silence.
- Be sensitive to a person's nationality, ethnicity, religion, age, and feelings.
- When possible, use the words the person uses.
- Self-disclosure may help the person expand on the topic.
- When responding to someone, say "you're crying" instead of "you're sad;" allow the person the opportunity to express the feeling behind the action.
- How something is said is often more important than what is said.

When speaking to grieving family members:

Your presence is more important than conversation. Family members may voice feelings with such strong emotion as "I don't know how I'm going to live without my husband," or "Why would God allow this to happen?" Short statements of condolence, such as "I'm so sorry," "This is a sad time," or "You're in my prayers," are enough of a response. If a persons tenses at your touch, withdraw.

Use "death" or "dying" not softer euphemisms. Many people feel patronized by words like "expired" or "received his heavenly reward." Use the same words as the grieving person to respect cultural differences.

Refrain from platitudes—"She lived a good life," or "She is no longer suffering." These statements can trivialize the family's loss.

Avoid sharing your personal experiences of death and grief so you can keep the focus on the family member.

Careful to avoid sending signals that you are distracted or need to do something else. Don't glance at papers, your watch, the elevator, the clock, or others in a conversation. Focus on the person and speak gently and without haste.

Offer support—don't wait to be asked.

Resources:

Lum, Max R., Ed.D.; Tinker, Tim L. Dr.P.H., M.P.H. (1994) *A Primer on Health Risk Communication Principles and Practices*. Atlanta: Division of Health Education, Agency for Toxic Substances and Disease Registry.

Hospice Handbook, United Hospice of Atlanta, 1999.

Timm, Paul, R. (1981). *Functional Business Presentations.* Englewood, NJ: Prentice Hall, Inc.

Audience Feedback

In pre-event planning, identify the mechanisms you will use to obtain and analyze feedback from target populations. In addition, state how this information will be used in reassessing your communication and response operations. The methods of obtaining feedback are straightforward. You will hear from your target populations either directly or through the media, community leaders and advocates, Congressional representatives, and lawyers. Be sure that there are open channels between the public and your organization and solicit public feedback.

Reality Check: In the heat of a public health emergency, public feedback could overwhelm your operation. It may be impossible to answer every person individually; however, it's not impossible to employ an automated system that says "we're interested in what you have to say," and offers a place where frequently asked questions (FAQs) can be found.

Toll-free public information lines, an e-mail address and a "snail mail" address for comments should be provided to the public before and during the emergency. The more public outrage the event generates the more opportunities people will need to vent. That venting can be valuable to you as a communicator. It will tell you what questions they want answers to, what upsets them, what needs more explanation and which recommendations are not working.

A citizen may begin with a question during a phone call, but will end with a concern. Be sure that your public response services can answer questions and detect trends in the public's comments. It's not just about pushing information out of your organization, it's also about taking it in.

Use common content or trend analyses to compile a report that will be useful to your public health emergency leadership. Tell them quickly when your analysis shows that something is or is not working. You may not be the most popular member of the team in this role, but it's vital that public input is taken into account.

In addition to monitoring direct feedback, you can also get a feel for the public's responses to the emergency through media and Internet monitoring. If a rumor takes flight on the Internet, you must know about it in order to respond. The media can reflect public reaction. Immediately after the Sept. 11, 2001 tragedy, CDC public response lines were indicating topic trends from the public before that information reached the media. It's possible that the questions you're getting directly from the public may clue you in to what the media will soon be asking. The predictive value of early feedback can help your communication team *manage* issues instead of simply *reacting* to issues.

Template 3–1. Message Development for Emergency Communication

First, consider the following:

Audience:	Purpose of Message:	Method of delivery:
❑ Relationship to event ❑ Demographics (age, language, education, culture) ❑ Level of outrage (based on risk principles)	❑ Give facts/update ❑ Rally to action ❑ Clarify event status ❑ Address rumors ❑ Satisfy media requests	❑ Print media release ❑ Web release ❑ Through spokesperson (TV or in-person appearance) ❑ Radio ❑ Other (e.g., recorded phone message

Six Basic Emergency Message Components:

1. **Expression of empathy:** _____

_____

2. **Clarifying facts/Call for Action:**

Who_____

What _____

Where _____

When_____

Why_____

How_____

3. **What we don=t know:** _____

4. **Process to get answers:** _____

5. **Statement of commitment**: _____

6. **Referrals:** _____

For more information _____

Next scheduled update _____

Finally, check your message for the following:

Positive action steps	Avoid jargon
Honest/open tone	Avoid judgmental phrases
Applied risk communication principles	Avoid humor
Test for clarity	Avoid extreme speculation
Use simple words, short sentences	

Case Study. H5N1 Virus Outbreak Investigation, Hong Kong, 1997–1998

In May 1997, a 3-year-old Hong Kong boy became ill with fever, dry cough, and a sore throat. He was hospitalized, continued a downward course, and died. Only influenza A virus was cultured from this child.

Scientists identified the virus as influenza A/(H5N1). This virus had never before been cultured from a human specimen. The subsequent investigation ruled out laboratory contamination, and concluded that the child's illness was consistent with influenza complicated by viral pneumonia. Investigators believed, based on laboratory evidence, that the virus was transmitted directly from an avian source to the child, possibly in the outdoor garden area of his school. This was the first reported case of an avian virus being transmitted directly to a human. During the August–September investigation, no other cases were found.

In late November, the Hong Kong Department of Health contacted CDC's Influenza Branch to report that a second H5N1 infection had been detected. CDC sent a team of medical epidemiologists and field investigators.

CDC and health organizations around the world engage in ongoing, active surveillance to attempt to quickly detect the possibility of a pandemic influenza virus spreading among humans. Influenza viruses mutate easily. Most often the mutation is slight and occurs over time, a process called "drift." Occasionally, an influenza virus will suddenly mutate significantly; this is called "shift." A virus that shifts is a potential pandemic strain. To qualify as a potential pandemic strain, the virus must meet 3 criteria: (1) it must be genetically novel, (2) it must be virulent, and (3) it must be efficiently transmitted between humans.

In late December, cases were accumulating and young healthy adults were dying of this viral infection. The H5N1 virus in this outbreak met 2 of the 3 criteria: it was novel and it was virulent. CDC, Hong Kong DOH and a number of collaborators began an intense investigation to determine whether this was the start of an influenza pandemic. Indeed, public health officials know, based on trend analysis, that a pandemic is overdue. Investigators concentrated on determining the virus' ability to transmit from person to person. An increase in person-to-person virus transmission would have suggested that the virus was adapting to humans, with the potential for epidemic spread.

In mid-December, a veterinarian virologist collaborating on the investigation held a telephone worldwide news conference and announced this was the "pandemic" strain that health officials were expecting. The immediate media uproar severely disturbed the investigators' attempts to collect information in Hong Kong. The Hong Kong DOH and the CDC field team requested that a CDC public information officer (PIO) join the team in Hong Kong, the first time CDC had assigned a PIO on an overseas field investigation. During the field assignment, the CDC PIO represented CDC, DHHS and WHO on public information issues.

Communication Environment Analysis

Only months earlier, Hong Kong had reverted back to governmental control by China, no longer controlled by Great Britain. The Hong Kong government was being critically observed by both its national China counterparts and Hong Kong residents. Every step taken was under scrutiny, so trust and credibility surrounding the investigation were critical.

Case Study. H5N1 Virus Outbreak Investigation, Hong Kong, 1997–1998 (Continued)

- Hong Kong is a sophisticated, high-technology city with major international media outlets, including representatives from major U.S. media.
- The city is densely populated with a constant stream of international visitors.
- Cultural behaviors were found to play a part in the outbreak. Hong Kong residents buy live chickens that are killed, cleaned, and prepared for same-day meals. A means of choosing the best chicken included close contact between the face of the human and the body of the chicken, which increased the chance of transmission.
- Immigrant domestic workers were highly represented among the ill; they were most likely to do the shopping and meal preparation.
- Questions about transmission through prepared food, including the consumption of chicken bone marrow, were not readily answered.
- Imported live fowl were warehoused in unclean conditions—which increased cross-contamination among fowl species.
- Families, apartment buildings, schools, and hospitals were becoming stigmatized by association with the H5N1 outbreak.
- When health officials declared the need to slaughter 1.25 million chickens and other birds within 2–3 days, farmers and economic interests were at the center of the debate.
- Only days after the chicken slaughter, a major holiday that includes chicken dishes (like turkey at Thanksgiving) was to occur.
- Health care workers chose to wear simple face masks while in the health care setting, upsetting other employees and patients.
- Persons with influenza-like illness faced a crowd of media as they attempted to seek medical treatment.
- Media, including cameras, trailed CDC and other disease investigators to the point that the field investigation was becoming severely hampered. People did not want to open their doors with the media cameras running—fueling the stigmatization.
- The White House intern story was unfolding internationally at the same time.
- Documentary writers were clamoring for a seat at the table to document the "start of the pandemic."
- The influenza vaccine virus strain is normally grown in fertilized chicken eggs. The H5N1 killed chickens, so the H5N1 strain could not be used to prepare a vaccine.

Case Study. H5N1 Virus Outbreak Investigation, Hong Kong, 1997–1998 (Continued)

- Antivirals were known to mitigate influenza A illness if taken within approximately 24 hours of the appearance of symptoms. There were no stockpiled antivirals to effectively distribute to Hong Kong residents.
- Malaysia and other bordering countries forbade travelers from Hong Kong to enter the country.
- Fearing the decimation of its poultry industry, the United States placed restrictions on people who traveled from Hong Kong to the United States and visited a poultry farm.
- The Hong Kong DOH was dealing with an unrelated legal issue that threatened its credibility with some residents.

Crisis and emergency risk communication steps taken by the joint CDC/Hong Kong DOH information center:

- The official collaborators agreed to speak with one voice and present a united and agreeable face to the public and the media. This involved co-creation and clearance of public materials provided through the World Health Organization (WHO), Hong Kong and DHHS/CDC.
- Core messages about the investigation process, public health measures, commitment to find answers, and efforts to work collaboratively, were imbedded in all materials released.
- CDC and HK DOH committed to and followed through on joint (multilanguage) news conferences at critical points in the investigation.
- Both also committed to remaining open and sharing information quickly during the investigation. This was accomplished through a streamlined approval process for both HHS/CDC and HK DOH.
- At the end of the Hong Kong business day, a one-sheet update of the investigation, including cases and deaths, was distributed to the media and posted on the HK DOH Web site. The information was also sent to CDC for posting and dissemination to media operating in the United States.
- Partners and stakeholders were identified and provided separate channels of information. Scientific conference calls kept health care professionals from around the world informed.
- The CDC and HK PIOs agreed to triage media calls together, select spokespersons as appropriate, and co-train spokespersons whenever possible.
- Both HK and CDC monitored the media and provided analysis to detect topic trends in the English and Chinese press.
- CDC's Office of Communication coordinated with the CDC field PIO regarding media requests and posting of new materials. (Note: Hong Kong time is 13 hours ahead of Atlanta time). It was truly a 24-hour operation.
- The CDC field team and CDC HQ team held daily conference calls that included media updates.

Case Study. H5N1 Virus Outbreak Investigation, Hong Kong, 1997–1998 (Continued)

- Support resources were provided to the CDC field PIO by the U.S. Consulate and the HK DOH.
- The HK PIO acted as an important source of culture-specific information for the CDC PIO.
- All materials were developed and released in English and Chinese.
- Rumors and misinformation were challenged immediately in both languages and by both PIOs.

Outbreak issues supported by communication (resource multiplier):

- Nations soon relaxed their travel restrictions against Hong Kong.
- Residents of Hong Kong and other areas did not inappropriately seek out antiviral medication.
- Farmers accepted the destruction of their poultry when promised reasonable compensation.
- People continued to go to work and school.
- Residents accepted the shortage of chickens for the holiday.
- Residents began to change their behaviors regarding live poultry.
- Honk Kong civil service workers volunteered to conduct the poultry destruction.
- CDC investigators were able to complete their studies without interruption by media.
- Health workers stopped wearing masks.

Communication outcomes:

- International populations (including the United States) did not overreact to events unfolding in Hong Kong, and, in turn, the tone of media coverage became reasonable and much less a "worst-case scenario."
- Criticism about the investigation, and decisions made based on the investigation, were few and relatively contained to Hong Kong.
- No collaborator interests regarding future resources were put above the public safety issues.
- Rumors were countered and none took hold.
- Media adapted to the rules set by CDC/HK PIOs quickly, considering the timing and methods of information releases.

Case Study. H5N1 Virus Outbreak Investigation, Hong Kong, 1997–1998 (Continued)

Field investigators were freed from the constant media presence when CDC/HK PIOs explained that the investigation was being hampered and that requests for interviews and new information would come through the PIOs. (CDC investigators were given the CDC PIO's locally produced business cards to redirect media to the PIO. The CDC team leader, in 6 weeks, participated in 3 press conferences and 12 individual media interviews. Because a PIO was onsite, the teamleader was able to do his job and still meet critical media demands.)

The first national emerging infectious disease conference, held in Atlanta in 1998, included a panel of U.S. media representatives who discussed the H5N1 outbreak. They unanimously praised CDC's management of the media/public information operation and especially noted that information at all levels (HK, CDC, DHHS, WHO) provided consistent information which increased their trust in the information and made their jobs easier.

PIO Lessons Learned

- Have a "go-kit" ready. Technological support for communication during the approximately 2 months of the field operation was poor. The CDC PIO relied on a bulky, old 8mm camera and a 35mm camera on loan from the U.S. consulate to document the investigation. Although the PIO's pager worked, the cell phone did not. Consider a digital camera—a lot of money was spent buying and developing film.
- Have potential field PIOs vaccinated in advance—it's not fun to fly 18–24 hours with a sore arm and slight fever.
- Have field PIO roles and lines of authority outlined ahead of the deployment and included in EIS training. The PIO had to integrate into a field team that never before included a PIO. Although it went exceptionally well, personalities may not always be so compatible.
- Consider institutionalizing the deployment of a PIO on a field investigation team to ensure that the PIO is deployed early enough to help avoid some of the communication problems that arose for the CDC field team during the early days of the H5N1 outbreak investigation.
- Prepared materials, readily available about the disease, the epidemiological investigations, and the roles of the organization in an outbreak investigation are critical. Most of these products were developed onsite by the CDC PIO during the H5N1 outbreak.
- Partnerships are vitally important. The ability to work as a team with diverse groups that don't all share the same mission or concerns is tough work—whenever possible, the partnership should be started before it's needed.
- Be sure to have adequate PIO human resources and relief available. The CDC PIO worked a 24-hour news cycle (between Hong Kong and the United States) attempting to catch sleep with catnaps. A prolonged 24-hour news cycle requires more than 1 or 2 people.

Case Study. H5N1 Virus Outbreak Investigation, Hong Kong, 1997–1998 (Continued)

- Keep a media contact log.
- Media monitoring is critical to the success of a public information operation. Give it appropriate resources.

Correcting a media mistake

Not all media representatives get it right every time. A major issue in the media during the H5N1 outbreak concerned the origin of the virus' introduction into Hong Kong (from China or elsewhere) and whether additional unreported human cases of H5N1 disease may be occurring in China. A national U.S. news magazine reported that CDC's lead investigator in Hong Kong said that China was the source and may have cases not being reported to WHO. This occurred at a time when critical negotiations regarding whether or not a high-level CDC influenza expert would be allowed to meet with Chinese health officials in China were ongoing. Hong Kong and U.S. officials were mortified by the news magazine report. The CDC field PIO could document that the CDC lead investigator was never interviewed by the magazine. In fact, no reporter from that magazine contacted CDC, either at the HQ or in the field, to verify the quote.

The CDC PIO contacted the magazine's Hong Kong bureau and explained the concern. When an immediate offer of a printed correction was not made by the bureau, the CDC PIO contacted the U.S. bureau and asked for an immediate correction. The magazine investigated and determined that the source was a Chinese-language newspaper that attributed the statement to the CDC lead doctor, who happened to have a name similar to the doctor (not in any way involved in the investigation) who did make the statement. The magazine offered a correction. The CDC PIO insisted on a boxed correction. In addition, the CDC immediately posted the correction and notice of an impending correction by the magazine on its Web site. The HK PIO corrected the Chinese newspaper that had made the original mistake. The magazine printed the correction in a large box on the index page of the next issue. The CDC flu expert was permitted to visit China. Ultimately, the investigation documented human-to-human transmission of the H5N1 virus among the Hong Kong population, but found that the virus was inefficient in that type of transmission. The virus continues to be monitored to see whether it adapts to human transmission.

Overview—Crisis Communication Phases and the Crisis Communication Plan

Understanding the pattern of a crisis can help communicators anticipate problems and respond effectively. For communicators, it's vital to know that every emergency, disaster, or crisis evolves in phases and that the communication must evolve along with it. By dividing the crisis into the following phases, the communicator can anticipate the information needs of the media, stakeholders, and the general public. Each phase has its own unique informational requirements.

For communication purposes, the phases of an emergency, disaster, or crisis include:

- Precrisis
- Initial
- Maintenance
- Resolution
- Evaluation

The movement through each of the phases will vary according to the triggering event. Not all crises are created equally. The degree or intensity and longevity of a crisis will impact required resources and manpower.

Precrisis phase

Communication objectives during the precrisis phase:

- Be prepared
- Foster alliances
- Develop consensus recommendations
- Test messages

This is where all of the planning and most of the work should be done. You can usually predict the types of disasters that your organization is likely to encounter. Reasonable questions can be anticipated and preliminary answers sought. Initial communication can be drafted with blanks to be filled in. Spokespersons and resources, and resource mechanisms, can be identified. Training and refinements of plans and messages can be made. Alliances and partnerships can be fostered to ensure that experts are speaking with one voice.

Conduct an emergency public health communication needs assessment. (See needs assessment checklist at the end of this module.)

Initial phase

The initial phase of a crisis is characterized by confusion and intense media interest. Information is usually incomplete and the facts scattered. It's important to recognize that information from the media, other organizations and within your organization might not be accurate. Your role is to learn the facts about what happened, to determine what your organization's response is to the problem, and to verify the true magnitude of the event as quickly as possible.

There is no second chance to get it right in the initial phase of a crisis. Your organization's entire reputation is on the line, based on what you say and what you don't say; based on when you say it or that you never say it.

There is no second chance to get it right in the initial phase of a crisis.

Communication objectives during the initial phase:

- Acknowledge event with empathy
- Explain and inform the public, in simplest forms, about the risk
- Establish organization/spokesperson credibility
- Provide emergency courses of action (including how/where to get more information)
- Commit to stakeholders and public to continued communication

Simplicity, credibility, verifiability, consistency, and speed count when communicating in the initial phases of an emergency.

One of the best ways to limit public anxiety in a crisis is to provide useful information about the nature of the problem, and what the public can do about it. Hence, during the initial phase of an event, seek to establish your organization as a credible source of information. Even when there is little information to offer, you can still communicate how the organization is investigating the event and when more information will be available. At the very least, messages should demonstrate that your organization is addressing the issues head-on—that its approach is reasonable, caring, and timely.

Of course, the pressure to release information prematurely can be intense. Remember, the appropriate managers must approve all information before release to the media.

In the initial phase of a crisis or emergency, the public wants to know what they want to know *now*. They want timely and accurate facts about what happened and where and what is being done. They will question the magnitude of the crisis, the immediacy of the threat to them, the duration of the threat to them, and who is going to fix the problem. Communicators should be prepared to answer these questions as quickly, accurately, and fully as possible.

Crisis maintenance

Communication objectives during the crisis maintenance phase:

- Help the public more accurately understand its own risks.
- Provide background and encompassing information to those who need it (How could this happen? Has this happened before? How can we keep this from happening again? Will I be all right in the long term—will I recover?)
- Gain understanding and support for response and recovery plans
- Listen to stakeholder and audience feedback and correct misinformation
- Explain emergency recommendations
- Empower risk/benefit decisionmaking

As the crisis evolves, anticipate sustained media interest and scrutiny. Unexpected developments, rumors, or misinformation may place further media demands on organization communicators. Experts, professionals, and others not associated with your organization will comment publicly on the issue, and sometimes contradict or misinterpret your messages. Expect to be criticized about your handling of the situation.

Staying on top of the information flow and maintaining tight coordination is essential. Processes for tracking communication activities become increasingly important as the workload increases.

The crisis maintenance phase includes an ongoing assessment of the event and allocation of resources.

Resolution

Communication objectives for the resolution phase:

- Improve appropriate public response in future similar emergencies through education.
- Honestly examine problems and mishaps and then reinforce what worked in the recovery and response efforts
- Persuade the public to support public policy and resource allocation to the problem
- Promote the activities and capabilities of the organization (corporate identity reinforced—internally too)

As the crisis resolves, there is a return to stasis with increased understanding about the crisis. Complete recovery systems are in place. This phase is characterized by a reduction in public/media interest. Once the crisis is resolved, you may need to respond to intense media scrutiny about how the event was handled. You may have an opportunity to reinforce public health messages while the issue is still current. A public education campaign or changes to a Web site may be necessary. Research has shown that a community is

most responsive to risk avoidance and mitigation education usually directly after a disaster has occurred because they have been sensitized.

Evaluation

When the crisis is over, evaluate communication plan performance, document lessons learned, and determine specific actions to improve crisis systems or the crisis plan.

Finding public information and risk communication a "seat at the table"

A critical element in your crisis communication plan is its integration into the overall emergency response plans for your organization. After all, a "perfect" media and public information plan that can't be executed because of resistance or lack of understanding by the response leadership is a failed plan.

The following are some thoughts about "getting a permanent seat at the table."

1. In FY 2002, DHHS leadership insisted that a new and distinct "focus area," of the bioterrorism and emergency public health response cooperative agreements between the Department and the 62 project areas, include separate plans and funding for public information and risk communication. This new "Focus Area F" garnered about $46 million in initial funding for states, cities and territories to plan crisis communication responses.

Reality Check: The fact is that communicators are great at their jobs but less than enthusiastic about written documentation. The linear thinkers who lead emergency response are looking for something on paper that describes what communicators "do" during an emergency. Writing the plan goes a long way toward increasing your credibility.

2. Be ambassadors of communication. Every element of your organization involved in emergency planning and response should know you by first name AND face. Meet the planners informally and ask them how they think better communication to the public, partners, and stakeholders would help them accomplish their mission.

3. Engage the leadership with straightforward objectives for communication in a crisis. (Note: most emergency operations planners think "two-way radio" when they hear the word "communication." It might be a good idea to stick with public information, to distinguish what you do.)

4. Tell leadership how the overall response and recovery operation benefits through an investment in public information activities. Following are a few key concepts to stimulate proactive thinking:

Role of crisis and emergency risk communication:

- Customer focus
  - Acquire necessary facts.
  - Empower decisionmaking.

  - Be an involved participant, not a spectator.
  - Provide feedback to responders.
  - Watchguard resource allocation.
  - Recover or preserve well-being and normalcy.
- Organizational focus
  - Execute response and recovery efforts.
  - Gain support for crisis management plans.
  - Avoid misallocation of limited resources.
  - Ensure that decisions-makers are well informed.
  - Reduce rumors.
  - Decrease illness, injury, and deaths.
  - Avoid wasting of abundant resources.

You will go a long way toward getting a seat at the table if your leadership understands the following:

- Contributors to a poor public response to recovery plans
  - Mixed messages from multiple experts
  - Tardy release of information
  - Paternalistic attitudes
  - No reality check on recommendations
  - Not immediately countering rumors and myths
  - Public power struggles and confusion
- Formula to meet customer and organization goals
  - Execute a solid communication plan.
  - Be the first source of information.
  - Express empathy early.
  - Show competence and expertise.

- Remain honest and open.
- Remain dedicated to customer.
- Apply emergency risk communication principles.

Any worries about "not being heard" at the table during a crisis event must be addressed in the precrisis planning. Don't be a wallflower—get in and get talking *now* with EOC planners and leaders. Recent national events give you plenty of examples (both good and bad) to help decision-makers in your organization "get it." Your participation, education, and credible execution during the planning phases will help to ensure your seat at the table when a crisis hits.

Develop an Emergency/Crisis Communication Plan

The crisis communication plan must be planned with the worst case scenario in mind. An organization's crisis communication plan should be fully integrated into the overall emergency response plan for the organization and the local, state, or national response plan. A true public health emergency will involve a number of agencies and departments, and a good plan will reflect that coordination. An important benefit is the opportunity to mobilize shared resources; for example, a city-wide telephone number to respond to public concerns.

An emergency risk and crisis communication plan should include the following elements:

- Signed endorsement from your director
- Designated line and staff responsibilities for the public information teams
- Internal information verification and clearance/approval procedures
- Agreements on information release authorities (who releases what/when/how)
- Regional and local media contact list (including after-hours news desks)
- Procedures to coordinate with the public health organization response teams
- Designated spokespersons for public health issues and third-party validators in an emergency
- Your organizations emergency response team after-hours contact numbers
- Contact numbers for emergency response information partners (e.g., Governor's public affairs officer, local FBI public information special agent in charge, local or regional department of agriculture or veterinarian public information officers, Red Cross, and other nongovernment organizations)
- Agreements/procedures to join the joint information center of the emergency operations center (if activated)
- Procedures to secure needed resources (space, equipment, people) to operate the public information and media operation during a public health emergency 24 hours a day/7 days a week, if needed
- Identified vehicles of information dissemination to public, stakeholders, partners (e.g., e-mail listservs, broadcast fax, door-to-door leaflets, press releases) during a crisis.

The plan is not a step-by-step "how to." It is the bones of your work. It should systematically address all of the roles, lines of responsibility, and resources you are sure to encounter as you provide information to the public, media and partners during a public health emergency. More than anything, your crisis communication plan is a resource of information—the "go to" place for must-have information. Many communication professionals keep media contact numbers jotted in phone books, or

More than anything, your crisis communication plan is a resource of information—the "go to" place for must-have information.

their directors' home telephone number on the scrap of paper it was originally written on during a quick Friday afternoon planning session from a previous "crisis." These must be collected, organized, and updated.

The single most important responsibility that can be assigned to someone in your organization is the duty to keep the plan alive. Update the plan regularly—all of the elements. Schedule the review; don't just wait for so many changes to occur that the plan is useless when you take it off the shelf.

The single most important responsibility that can be assigned to someone in your organization is the duty to keep the plan alive. Update the plan regularly—all of the elements.

Longer is not better. Again, the plan will be the bones of your work. It does not have to spell out every required task. It must be the reference that will keep everyone on track and enable the tasks to get done with a minimum of scrambling. Emergencies are chaotic enough without the disorganization of a planless office. You don't build lines of authority and relationships with your response partners during the crisis. Too often, the initial confusion and mixed messages that cripple an organization's credibility come from a lack of clear role and responsibility definition, and undefined lines of authority.

Reality Check: Don't be surprised if agreements made in the sunshine of business as usual are changed suddenly during the bleak realities of a crisis. Keep your plan simple and remain flexible. Get done what's in your control and try to move your important public health messages forward in a way that reaches the public and your partners as quickly and accurately as possible.

1. Signed endorsement from your director

This is a must. Your director should know that you've thought through the process, that you've coordinated your response planning, and that he or she has an important role in the ownership of this plan. Keep it to a couple of simple paragraphs that endorse the plan. Have it signed and dated. Get it re-signed and re-dated to keep the plan fresh. It also helps keep you accountable for getting it updated. Here's an example of an introduction for a crisis communication plan from a director at CDC:

"CDC comes together during a crisis to help protect the health and safety of Americans. We also need to calm public fears during a crisis by communicating credible information and by promoting appropriate health actions.

Experts agree that most crises take an organization by surprise. Appropriate and timely communication allows CDC to work effectively with partners, engender public trust in its scientifically based health recommendations, and perform its public health mission.

Crisis communication planning helps CDC deal effectively with those unexpected disasters or emergencies. This framework of action incorporates the ethical, professional, and guiding principles needed by CDC during a crisis to communicate to the media and public with confidence and credibility. We cannot predict or always avoid future crises, but we can do our part to be prepared."

2. Designated line and staff responsibilities for the media, public, and partner information teams

Someone must be in charge of the release of information to the media, public and partners. This is information not moving through official command channels as part of the emergency response. This is information to keep partners and the public up to date on the process, response outcomes, and any public health recommendations. It is also the information needed to respond to the public and partners based on their feedback to the organization. Whether you have teams of people to attend to these tasks or single individuals, the work must be done. If your organization is incapable of meeting the likely media, partner, and public information needs during a public health emergency internally, ensure that your plan identifies from where this response support will come, including your role as part of the city's or state's emergency operations center. Regardless of who does it, the work must be done, and it's your responsibility to ensure that appropriate public health information is reaching the public and partners, either through the media or through a direct communication channel, such as a town hall meeting.

Here are some of the responsibilities that must be planned for as part of the emergency response:

Command and control:

- Directs the work related to the release of information to the media, public, and partners
- Activates the plan based on careful assessment of the situation and the expected demands for information by media, partners, and the public
- Coordinates with horizontal communication partners as outlined in the plan to ensure that messages are consistent and within the scope of the organization's responsibility
- Provides updates to organization's director, EOC command and higher headquarters, as determined in the plan
- Advises the director and chain of command regarding information to be released, based on the organization's role in the response
- Ensures that risk communication principles are employed in all contact with media, public, and partner information release efforts
- Knows incident-specific policy, science, and situation
- Reviews and approves materials for release to media, public, and partners
- Obtains required clearance of materials for release to media on policy or sensitive topic-related information not previously cleared
- Determines the operational hours/days, and reassesses these throughout the emergency response
- Ensures that resources are available (human, technical, and mechanical supplies)

Direct Media:

- Assesses media needs and organizes mechanisms to fulfill those needs during the crisis (e.g., daily briefings in person, versus a Web site update)
- Triages the response to media requests and inquiries
- Ensures that media inquiries are addressed as appropriate
- Supports spokespersons
- Develops and maintains media contact lists and call logs
- Produces and distributes media advisories and press releases
- Produces and distributes materials (e.g., factsheets, B-roll)
- Oversees media monitoring systems and reports (e.g., analyzing environment and trends to determine needed messages, determining what misinformation needs to be corrected, identifying concerns, interests, and needs arising from the crisis and the response)
- Ensures that risk communication principles to build trust and credibility are incorporated into all public messages delivered through the media
- Acts as a member of the joint information center or field site team for media relations
- Serves as a liaison from your organization to the Joint Information Center (JIC)

Direct public information:

- Manages the mechanisms to respond to the public who request information directly from the organization by telephone, in writing, or by e-mail.
- Oversees public information monitoring systems and reports (e.g., analyzing environment and trends to determine needed messages, determining what misinformation needs to be corrected, identifying concerns, interests, and needs arising from the crisis and the response)
- Activates or participates in the telephone information line
- Activates or participates in the public e-mail response system
- Activates or participates in the public correspondence response system
- Organizes and manages emergency response Web site and Web pages
- Establishes and maintains links to other emergency response Web sites

Direct Partner/Stakeholder information:

- Establishes communication protocols based on prearranged agreements with identified partners and stakeholders
- Arranges regular partner briefings and updates
- Solicits feedback and responds to partner information requests and inquiries
- Oversees partner/stakeholder monitoring systems and reports (e.g., analyzing environment and trends to determine needed messages, determining what misinformation needs to be corrected, identifying concerns, interests, and needs arising from the crisis and the response)
- Helps organize and facilitate official meetings to provide information and receive input from partners or stakeholders
- Develops and maintains lists and call logs of legislators and special interest groups
- Responds to legislators, special interest group requests, and inquiries

Content and material for public health emergencies:

- Develops and establishes mechanisms to rapidly receive information from the EOC regarding the public health emergency
- Translates EOC situation reports and meeting notes into information appropriate for public and partner needs
- Works with subject matter experts to create situation-specific factsheets, Q/As, and updates
- Compiles information on possible public health emergency topics for release when needed
- Tests messages and materials for cultural and language requirements of special populations
- Receives input from other communication team members regarding content and message needs
- Uses analysis from media, public, and partner monitoring systems and reports to adopt messages
- Identifies additional content requirements and material development

3. Information verification and clearance/approval procedures

- Who absolutely *must* review a new piece of information before it's released from your organization or incorporated into an overall release from a higher authority?
  - The quickest way to publicly fall flat on your face as an organization is to be unable to quickly release accurate information. Prioritize what information is need to know versus want to know and get moving on what must be answered first. If an answer to a "need to know" question is not

formulated, give the media and the public information about the process or system to get that answer.

The quickest way to publicly fall flat on your face as an organization is to not be able to release accurate information quickly.

– Three people should officially clear a document before it's released from the organization: the communication director responsible for your organization's reputation, the director whose job is on the line if the information is wrong or counter to policy, and a subject matter expert who is fast and infallible on the subject. Keep legal out of it, unless the subject to be cleared has a legal implication. This doesn't mean that others can't review and comment on the product; they just can't delay its release. Also, don't forget to get clearance from your higher authority as required. As a courtesy, ensure that response partners know which new information you're planning to release. Have the mechanism in place to give a courtesy check to those response agencies with a stake in your release.

– Clear all information simultaneously and in person, whenever possible. Unless you can get the primary clearance authorities in one room with the door closed and no phone on the hook, make three copies; take one to each person and stand there while they review and approve the document. Point out any part of the document you believe needs their careful consideration. Ask if they would be comfortable seeing this as the headline of the next day's local paper. Reinforce that the information you've compiled and are attempting to get cleared answers important questions from the public, media, or partners *or* are in response to troubling trends from your own analysis of where the subject is headed.

Clear all information simultaneously and in person, whenever possible.

– It's difficult to delegate clearance. As the communication director, be realistic about the time it will take and build that time into your duties. If the director has designated a surrogate for clearance, go with it. Educate everyone involved in the development and release of information about the steps to clear a document and the expectation for time from development to release. Help responsible authorities understand that no release is worse than an incomplete release. Get "need to know" information out the door fast. Get "want to know" released as soon as possible without straining relationships with authorities who must clear new information.

– The key to this area of emergency response is to have as much information on a topic prepared and pre-cleared as is possible. However, make sure that pre-developed information is sensitive to a crisis situation. When people are sick and dying, the words you choose will naturally have to be more careful—choose them that way from the start.

The key to this area of emergency response is to have as much information on a topic prepared and pre-cleared as is possible.

4. Agreements on information release authorities (who releases what/when/how)

This is the preplanning that saves your job. Get agreements down on paper. Expect them to change. Try to respect everyone in the process. Seldom does an organization truly own a piece of information exclusively. Typically, many levels of a response command could release information. Learn to work collaboratively. Does it really matter who releases it? What matters is to get information out quickly and accurately. Also, once it's released, you can incorporate the information into products for the public and partners, and meet your audiences' needs.

5. Regional and local media contact list (including after-hours news desks)

Don't rely on scraps of paper. Write the list down. Include e-mail addresses and fax numbers. Because we know that emergencies happen during nonduty hours, learn the back-door entries to news directors and editors ahead of time. It shouldn't be difficult to get that information. Test the e-mail addresses or fax numbers periodically (but not too often to be aggravating) to see what happens. The fail rate can be astronomical after only a year. Try to have contacts for all major media outlets. *If I had only one thing ready to go in my crisis plan, this would be the first item I'd work on.*

Because we know emergencies happen during nonduty hours, learn the backdoor entries to news directors and editors ahead of time.

6. Procedures to coordinate with the public health organization response teams

- No man's an island. In a crisis, no communications team goes it alone. Find out how your organization works during a crisis. Become part of the response team. Have a formal, recognized role. Include an organizational chart in your plan, so you can find people you need quickly. If you don't operate out of an emergency operation center, find out who is on call. Make sure they know to call you immediately. Let them know that, in some cases, you may be the first person to hear about a public health emergency, often from the media. Make sure that your telephone numbers and after-hours contact information is included in the first emergency notification list. Communication can't afford to be an afterthought. Make sure you respond when you get a call.

- Don't stop with your organization. Make sure that other response organizations or partners include your contact information in their communication plans. Swap names, numbers, after-duty numbers, and expected roles and responsibilities. Obtain public health organization emergency response team after-hours contact numbers.

7. Designated spokespersons for public health issues and third party validators in an emergency

Know who your public health emergency spokespersons will be and designate backups. Don't name someone solely based on his or her position in the organization. Select people according to their ability and availability.

Keep them trained. Spokespersons can get rusty. Understand that even if the Governor will be speaking at the daily press conference, there's plenty of media work or public meeting work to go around. Make a list of names. Be prepared to offer your trained spokespersons to higher authorities if they need them. Know how to reach the designated spokespersons from your organization. Line up subject matter experts outside your organization who can perform some of these duties and keep them informed. Media and civic groups will appreciate the offer of an alternative if you're unable to meet their needs.

8. Agreements/procedures to join the joint information center of the emergency operations center (if activated)

You don't want multiple EOCs operating within a local region. Get plugged in now. Make sure the EOC commander's plan includes a role for your organization and its communication team. Don't surrender to the EOC's JIC. You will have a considerable amount of work outside the JIC. Agree ahead of time on your future presence in the JIC, and honor that agreement when the time comes. If you can't operate 24 hours a day from your organization, a JIC will be a blessing not to be underestimated. Keep contact numbers for emergency response information partners (e.g., Governor's public affairs officer, local FBI public information special agent in charge, local or regional department of agriculture or veterinarian public information officers, Red Cross and other nongovernment organizations).

9. Procedures to secure needed resources (space, equipment, people) to operate the public information operation during a public health emergency 24 hours a day/7 days a week, if needed

At the local level, a JIC may be the answer to your resource needs. However, some public health emergencies that can tax your organization may not trigger the operation of an EOC and a JIC. Obtain agreements with other local or nongovernment organizations for support to your operation if a JIC is not activated.

Most public information officers are accustomed to working with little or no budget. During a crisis, you must be able to get supplies, people, equipment, and space as needed. Based on your needs assessment, identify your needs and the procurement mechanisms. Try to connect with a part of your organization that has logistical savvy. Take the time to learn to get resources. Put that information in your plan. Don't wait for the emergency to start telling emergency response commanders what you need. Integrate that information into the planning. Make sure that the EOC plans indicate your space, people, telephone lines, etc. needs. Over-plan in this area.

Here are some suggestions to consider about resources

Space:

- You need space to operate your communication teams outside the EOC. You need a place to bring media on site (separate from the EOC).
- You need a quiet space to quickly train spokespersons.
- You need space for team meetings.
- You need space for equipment exclusive for your use. You cannot stand in line for the copier when media deadlines loom.

People:

- You need people designated and trained at a level to either operate a 24/7 public and media information center or the people needed to support a JIC as part of a local EOC.
- Identity people qualified to take phone inquiries; consider staff from throughout the health department as well as in partner organizations.
- Consider recruiting volunteers from the medical community to help with phones, especially infectious disease specialists.
- You can never have too many support staff. They will save you from your worst mistakes—always! Train them, give them respectful titles, and reward them.

Contracts and memoranda of agreement:

- Consider a contract with a media newswire.
- Consider a contract with a radio newswire.
- Consider contracts with writers or public relations persons who can augment your staff.
- Consider a contract for administrative support.
- Consider a phone system/contractor that can supply a phone menu that directs the type of caller and level of information desired:
  - General information about the threat
  - Tip line listing particular actions people can take to protect themselves
  - Reassurance/counseling
  - Referral information for health care/medical facility workers

- Referral information for epidemiologists or others needing to report cases
- Lab/treatment protocols
- Managers looking for policy statements for employees

Establish an emergency operations center

During an emergency situation, it is imperative that organizations not only manage the crisis, but also maintain normal, daily operations. Establishing an Emergency Operations Center always proves useful in managing crises, and was very helpful to those individuals investigating and managing the anthrax case in Palm Beach, Florida. The Emergency Operations Center there was equipped with the resources that were necessary for maintaining a unified and centralized approach to managing the crisis, including: a broadcast studio, computers, workstations, telephones, and other equipment for effectively investigating the situation and reporting information to the media and the public. This Emergency Operations Center was instrumental in allowing those involved in the crisis to focus on the situation in an environment solely dedicated to crisis management and resolution.

Equipment:

You can't wait for a contractor to show up with an extra fax machine. Equipment to support communication to media and partners must be obtained before the crisis. Determine what you may need to augment this equipment if a crisis persists.

- Fax machine (number that's preprogrammed for broadcast fax releases to media and partners)
- Web site capability 24/7. Attempt to post information within 2 hours—some say within 10 minutes.
- Computers (on LAN with e-mail listservs designated for partners and media)
- Laptop computers
- Printers for every computer
- Copier machine (and backup)
- Tables—lots of tables
- Cell phones/pagers
- Visible calendars, flow charts, bulletin boards, easels
- Designated personal message board
- Small refrigerator
- Paper
- Color copier
- A/V equipment

- Portable microphones
- Podium
- TVs with cable hookup
- VHS VCR
- CD–ROM
- Paper shredder

Supplies:

Keep these on hand as "emergency only" to ensure they are there when you need them.

- Copier toner (it always goes out)
- Printer ink
- Paper
- Pens
- Markers
- Highlighters
- Erasable markers
- FedEx and mail supplies
- Sticky notes
- Notebooks
- Poster board
- Standard press kit folders
- Organized B-roll in beta format (keep VHS copies for meetings)
- Formatted computer disks
- Color-coded everything (folders, inks, etc.)
- Baskets (to contain items that you're not ready to throw away)
- Organizers to support your clearance and release system
- Expandable folders (with alphabet or days of the month)

- Staplers (lots of them)
- Paper punch
- Three-ring binders
- Organization's press kit or its logo on a sticker
- Colored copier paper (for door-to-door flyers)
- Paper clips (all sizes)
- Tape (be creative)

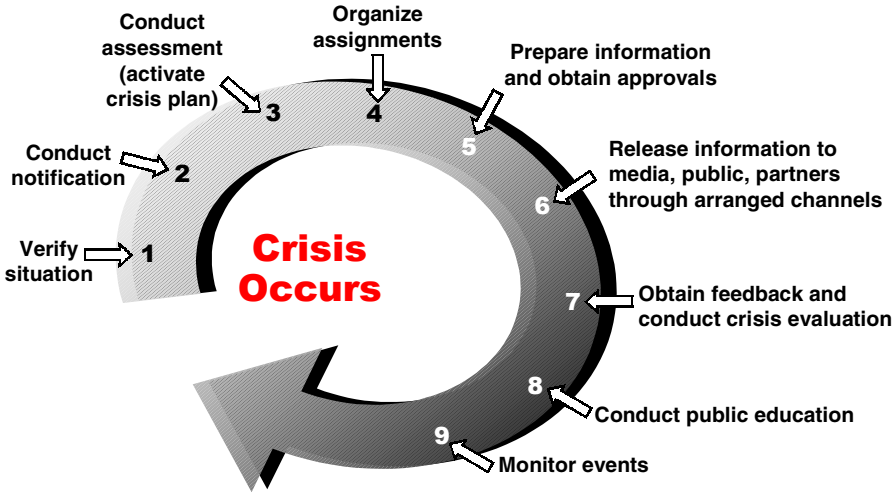
Identified vehicles of crisis information dissemination to media, public, stakeholders, partners (e.g., e-mail listservs, broadcast fax, door-to-door leaflets, press releases)

Different mechanisms are appropriate at different times and for audiences. The vehicles that can be used to communicate with media, public, and partner are:

- Phone (including hotlines)
- Fax (including broadcast pre-programmed fax)
- E-mail (including listserv)
- Partner or other emergency response vehicles (use someone else's mailing list)
- Mail (including special delivery)
- Face-to-face (including town hall meetings or press briefings)
- Partner association to its members
- Web sites
- Contracted press releases wires
- Media—radio, print, Web, TV

Nine Steps of Crisis Response

Figure 4–1. Nine Steps of Crisis Response



Step 1. Verify situation

- Get the facts.
- Obtain information from additional sources to put the event in perspective.
- Ascertain information origination and determine credibility.
- Did the information come from a formal source, such as HHS or Epi-Aid?
- Did the information come from an informal channel, such as a nongovernment partner?
- Is this a rumor (e.g., an e-mail chain)?
- Review and critically judge all information.
- Determine whether the information is consistent with other sources.
- Determine whether the characterization of the event is plausible.
- Clarify information through subject matter experts.
- Attempt to verify the event magnitude.
- Begin to identify staffing and resource needs to meet the expected media and public interest.
- Determine who should be notified of this potential crisis.

Step 2. Conduct notifications

Mandatory notification and coordination

It is essential for you to carefully think through who should be notified in your chain of command, up to what appropriate level, and within the scope of your organization.

Notification and coordination

Notification procedures vary by state and local jurisdictions. Know what procedures govern your area of responsibility.

Table 4–1. General Guidelines for Notification

Local agencies	Law enforcement Public health organization EMS Hospitals Fire department Medical examiner Local general services organization
State agencies	State public health State emergency management Law enforcement EMS State fire service National Guard
Federal agencies*	Office of Homeland Security FEMA FBI CDC U.S. Public Health Service Department of Defense

* At the time of writing, the development of new procedures for federal coordination were in development. Visit www.whitehouse.gov/homeland for updated information on this critical information.

Step 3. Conduct crisis assessment (activate crisis plan)

Throughout the event, continue to gather information; try to determine the severity of the situation and the potential impact on communication operations, resources, and staffing. This requires swift and active research.

- Determine the organization/office/individual in charge of managing the crisis. Ensure direct and frequent contact with the office in charge is possible.

- Continue to gather and check the facts. What happened? What was done to keep this situation from happening? What can be done to keep it from getting worse?
- Determine what your organization is doing to end this crisis. Is there an investigation? Who's involved in the investigation?
- Determine what other agencies/organizations are doing to solve this crisis.
- Determine who is being affected by this crisis. What are their perceptions? What do they want and need to know?
- Determine what the public should be doing.
- Activate media monitoring.
- Activate internet monitoring.
- Determine what's being said about the event. Is the information accurate?

Step 4. Organize assignments

Initial organizational issues

- Determine who is managing the event programmatically/scientifically.
- How should communication interface with the program staff in charge of managing the crisis? Are there meetings that communication staff should attend?
- Are all crisis communication teams operational (media, public, partner, stakeholder, support)?
- What are our current priorities?
- What resources are needed? Is staffing sufficient?
- Who is the organization's spokesperson for this event?
- Do we need subject matter experts (SMEs) as additional spokespersons?
- Should communication operate 10, 12, 20 or 24 hours a day?
- Should communication operate 5, 6, or 7 days a week?
- Will communication staff be expected to travel?
- Supplemental funds needed?
- Contractor support needed?
- Determine consistency of information across sources.

Ongoing organizational issues

- What do investigators say about the potential for the crisis getting worse?
- Could events result in more intense public/media interest?
- What rumors or points of conflict have been identified?
- How should the organization respond to these issues? Is our response working?
- Should the organization continue to be a source of information to the media about this crisis, or would some issues be more appropriately addressed by other government entities?
- Are the teams operating with approximately equal intensity? How could we improve efficiency? Would reassignments help?
- Are resources sufficient?
- Should the organization reset times for daily updates to media (e.g., set a time for a media update via Web and broadcast fax) or cancel the regular updates?
- Are daily/weekly SME briefings appropriate to reduce the demand for one-on-one interviews with SMEs?
- Should detailed persons be extended or returned to normal duties?
- Should hours of operation be increased or reduced?
- Are supplemental funds needed to meet public/media demand for information?
- What is the organization learning from the public and media that could be useful to outbreak investigators and policy managers?

Partner involvement

- Are partner organizations concerned about their own reputations?
- Which partners are or should be involved in this crisis?
- How do partners wish to get involved in the organization's response?
- Have traditional partners been given updates?
- Who are your traditional partners?
  - Other organizations
  - Volunteer organizations

- Associations
- Private sector

Step 5. Prepare information and obtain approvals

This function includes all message and materials development activities, the approval process, and the coordination of information within your organization.

Message development

- Who are our audiences? Who's been affected by this event? Who's upset or concerned? Who needs to be alerted to this situation?
- What are audiences' perceptions and information needs?
- What do media want to know?
- How should your organization show empathy?
- What are the facts? What happened?
- What is our policy on this issue?
- What is your organization doing about this issue? How are we solving the problem?
- What can your organization do to keep this from happening again?
- What other agencies or third parties are involved? What are they saying?
- What should the public be doing?
- What public information is available?
- When will more information be available?

Approval process

The approval process is unique to each organization. For discussion, see "3. Information verification and clearance/approval procedures," page 73.

Step 6. Release information to media, public, and partners through arranged channels

Likely media questions:

- Who's in charge?
- What are you doing for the people who got hurt?
- Is the situation under control?
- What can we expect?
- Why did this happen?
- Why wasn't this prevented?
- What else can go wrong?
- When did you begin working on this (were notified of this, determined this)?
- What do these data/information/results mean?
- What bad things aren't you telling us?

When talking to the media:

- Provide only information that has been approved by the appropriate managers. Don't speculate.
- Repeat the facts about the event.
- Describe the data collection and investigation process.
- Describe what your organization is doing about the crisis.
- Describe what other organizations are doing.
- Explain what the public should be doing.
- Describe how to obtain more information about the situation.

Step 7. Obtain feedback and conduct crisis evaluation

As soon as is feasible following a crisis, conduct an evaluation of the organization's response.

- Compile and analyze comments and criticisms from the customer base.
- Compile and analyze media coverage.

- Conduct a "hot wash" (an immediate review of what went right and what went wrong) to capture lessons learned.
- Develop a Strengths, Weaknesses, Opportunities, Threats report on the crisis communication operation.
- Report results of content analysis and Strengths, Weaknesses, Opportunities, Threats to leadership.
- Share results within your organization.
- Consider whether journal articles could be developed from the analyses.
- Determine need for changes to the crisis communication plan.
- Determine need to improve policies and processes.
- Institutionalize changes with appropriate training.
- Revise crisis plan policies and procedures based on lessons learned.

Step 8. Conduct public education

Once the crisis has subsided, the organization may need to carry out additional public education activities.

- Should the organization be educating the public about public health issues related to this crisis?
- What are the public's perceptions and information needs related to this crisis?
- Does the public understand the organization's health messages on this issue? Are they taking appropriate actions?
- Should we also consider audiences that were not involved in the crisis for public education?
- Should a public health message related to this crisis event be incorporated into other health communication activities (e.g., Public Health Week or National Infant Immunization Week)?
- Should we use this event to highlight any related public health messages?
- Should any Web sites be updated as a result of this crisis?
- Should any of the crisis materials be institutionalized?
- Would a series of postcrisis "canned" articles be useful in this situation?

Step 9. Monitor events

Crisis monitoring protocols include:

- Media monitoring

- Internet monitoring
- Ongoing exchanges of information with yours and other organizations, state health departments, etc.
- Ongoing communication with SMEs and partners
- Monitoring of public opinion data and other research.

Initial: Surviving the first 48 hours of an emergency: Be first, be right, be credible

The initial phase will be triggered either by your organization's identification of an unfolding event as a potential crisis or by intense media inquiry that is expected to be sustained for an indefinite amount of time. This phase is characterized by a need for quick assessment of the potential response level required, facts to be assembled, and actions to secure the necessary resources (persons and supplies) needed to meet the expected buildup of media and public information demand. All crisis communication planning must be designed to help manage the first 48 hours of an emergency that has garnered media and public scrutiny.

All crisis communication planning must be designed to help you manage the first 48 hours of an emergency that has garnered media and public scrutiny.

Critical tasks during the initial phase of the crisis include:

- Verification
- Notification/coordination
- Assessment
- Initial media response
- Assignments
- Resource allocation.

Tell the public what you know

It is important to quickly update the media and the public on the status of research, facts, and investigations when an event arises. When Mount St. Helens erupted, many local residents questioned the dangers of the volcanic ash and dust cloud. And although U.S. Geological Survey (USGS) scientists requested several weeks to have a panel review and evaluate the possible dangers, people needed answers—and quickly.

In a disaster situation, you have to provide people with the information you currently have and know to be true, and provide them with regular updates as you obtain additional information.

Verification

Early information shared with your organization about a possible crisis event, either from the media or from health care professionals, may be unintentionally slanted. You must critically judge the information, attempt to reasonably verify the magnitude of the event, and seek additional information to put the event in perspective regarding public/media interest.

- Where did the information originate? Formal channels of communication (e.g., HHS or Epi-Aid) versus informal (e.g., call from county health official), versus rumor (e.g., e-mail chain)
- How plausible is the characterization of the event?
- Is the information consistent with other sources?

Notification/Coordination

Once the event has been verified, notification should be the first consideration. Avenues of information into the communication office are varied. The more quickly you notify your chain of command and then open channels of coordination with partner organizations, the more smoothly and accurately the operation will be. Your communication plan should designate all of the people who must be notified.

Don't become part of a rumor mill. Make sure that your notification message contains only the information that you've verified. It may be useful, however, for you to characterize the event from a public/media perspective. If you anticipate, based on your risk matrix analysis, that the event will produce intense media and public interest, share your expert opinion with those you notify. After all, you know your community best. If you understand that the triggering event has potential to "grow legs" that may not be obvious, share it.

Coordination means notifying people who may not be in your formal chain of command for emergency response, but who may be your partners in the response (you may be coordinating with members of your own organization or with partners outside your organization). For example, you would notify your director of health if the media alerted you to an emergency. You would coordinate the emergency response with the communication representative of your local American Red Cross chapter.

Notification is formal, and comes first. Coordination is less formal, and is based on mutual respect and understanding of the organization's roles in your community. Your communication plan should identify those core people for notification and coordination who would work with your office during any public health emergency. The plan should also identify those people or organizations that should be notified or coordinated with according to the type of emergency that has occurred. For example, if the emergency involved animals, you would coordinate with your veterinary health representative.

Initial media response: If media are beating on the door

Assembling the facts is a priority. It is important that your organization not give in to pressure to confirm or release information before you have confirmation from your scientists, emergency operations center, etc. However, it may be necessary to release some information initially and be honest about the fact that your organization is still gathering information. One of the best ways to satisfy media (and, in some cases, the public) frenzy is to control the flow of information while establishing your organization as an information source. Note: Take the lead if you have the lead. If another organization is rightfully the lead, defer to them, continue to coordinate, and be as helpful as possible. The following are responses for the media which give you the necessary time to collect the facts. (See initial press release on page 98.)

- "We've just learned about the situation and are trying to get more complete information now."
- "All of our efforts are directed at bringing the situation under control, so I'm not going to speculate about the cause of the incident."
- "I'm not the authority on this subject. Let me have [name of authority] call you right back."
- "We're preparing a statement on that now. Can I fax it to you in about two hours?"

Get your information out early

It is important, particularly with regard to disasters, to give the public some idea of the kind of plans and procedures your organization is formulating to manage the crisis.

When documented cases of anthrax being sent through the U.S. mail were rampant, laboratories in Denver, CO, were unable to rule out the possibility of anthrax exposure in the case of a postal worker who was being treated for a suspicious respiratory illness. In turn, postal workers in Ft. Collins (who were not identified as being in direct threat of anthrax exposure) showed up at a clinic to receive antibiotics that were unnecessary.

In another situation, in 2000, before state and local officials had made a decision about how the public should respond to a hurricane, many people in Florida and Georgia self-evacuated based on their analysis of what they saw on The Weather Channel.

Assessment

During the initial phase, it's critical to do a quick assessment to help you predict the level of public information and media response that will be required. The attached risk matrix analysis can lead you to the answers for resource allocation and assignments.

Below are some of the questions you will be asked to consider in the risk matrix analysis:

- Is the event acute? The event occurred, is over, and your organization is faced with explaining the event and the aftermath (e.g., an accident in the BL4 lab or a chemical release).
- Is the event evolving? The event is uncertain and may become more or less serious (e.g., the identification of a novel influenza virus).
- Is the event a legitimate public health emergency requiring swift and widespread public education to prevent further morbidity and mortality (e.g., multistate *listerosis* outbreak)?
- Is this the first, worst, biggest, etc.?
- Is the interest generated because of the event's novelty versus a legitimate public health concern?
- Is the event occurring in a metropolitan area (with many media outlets) versus a sparsely populated area with fewer media?
- Is the event regional, national, or international?

- Does the event involve children or special populations?
- Is the human outcome of the disease uncertain (e.g., long-term health effects)?
- Is there a product, service, or industry potentially involved?
- Are there sensitive international trade or political relations involved?
- Is there/will there be an ongoing criminal investigation?

The following is a list of assessment questions that will help in the next critical task, assignments:

- Is this event within the scope of responsibility for your organization? Are we/should we be involved?
- Is or is not the state or city health department at the epicenter of the event well equipped and trained to manage a media response of this magnitude?
- How and by whom is the situation being managed programmatically/scientifically?

Based on your assessment, you must determine the following:

- Should initial media and public response hours of operation be: 10, 12, 20 or 24 hours a day?
- Should initial media and public response operate 5, 6, or 7 days a week?
- Will your staff be expected to travel?
- Will jurisdiction over the information to be released be shared?

Next media response step

If, by your assessment, the public health emergency belongs to you (at least in part), then you must release as many of the facts as possible to the media and the public. Credibility often relates to the speed at which you appear to be involved in the recovery and response; the accuracy of the information you provide; and your level of openness, empathy, and determination to see it through.

Those elements must be present in your first official statement or appearance with the media. It may, in fact, take some time to develop a solution to the crisis. By sharing with the media the process your organization is using to develop a reasonable and caring operation to resolve the crisis, you've garnered valuable time to put your communication operation in place. Take the opportunity to communicate early, but be careful not to speculate—stick to the facts and a commitment to a process to disseminate more information as you get it.

Before facing the media later as the crisis evolves, prepare answers to the following questions.

Individuals want your message to answer:

Are my family and I safe?

What have you found that will affect my family and me?

What can I do protect my family and me?

Who (what) caused this problem?

Can you fix it?

The media and communities want your message to answer:

Who is in charge here?

How are those who got hurt getting help?

Is this thing being contained?

What can we expect?

What should we do?

Why did this happen? (Don't speculate. Repeat the facts of the event, describe the data collection effort, and describe treatment from factsheets.)

Did you have forewarning this might happen?

Why wasn't this kept from happening (again)?

What else can go wrong?

When did you begin working on this (e.g., were notified of this, determined this . . .)?

What does this data/information/results mean?

What bad things aren't you telling us? (Don't forget the good.)

Assignments

Who is in charge of managing the crisis communication operations? Important areas of responsibility in a crisis communication operation include the following:

- Hands-on response to the media (messenger)
- Collection of accurate and timely public health information translated into lay language valid to media, public, stakeholders, and partners (message)

- Rapid execution of support tasks that keep the information flowing (delivery method)
- Environmental scanning and analysis to identify rumors, myths, errors, trends (message)
- And the continued operation of tasks not related to the crisis event.

Resource:

CSC Crisis Communication Plan Draft (1999)

Checklist 4–1. First 48 Hours

First 48 Hours

Critical First Steps After Verification:

Notification:

- ☐ Use your crisis plan's notification list to ensure that the chain of command is aware and know that you are involved.
- ☐ Ensure that your leadership is aware (especially if it comes from the media and not the EOC) of the emergency and that they know you are involved.
- ☐ Give leadership your first assessment of the emergency from a communication perspective and inform them of your next steps. *Remember: Be first, be right, be credible.*

Coordination:

- ☐ Contact local, state, federal partners now.
- ☐ If there is potential for criminal investigation, contact your FBI counterpart now.
- ☐ Secure a spokesperson as designated in the plan.
- ☐ Initiate alert notification and call in extra communication staff, per the plan.
- ☐ Connect with the EOC—make your presence known.

Media:

- ☐ Be first: Provide a statement that your agency is aware of the emergency and is involved in the response. (Use the CERC first statement.)
- ☐ Be right: Start monitoring media for misinformation that must be corrected.
- ☐ Be credible: Tell the media when and where to get updates from your agency.
- ☐ Give facts. Don't speculate. Ensure partners are saying the same thing.

The public:

- ☐ Trigger your public information toll-free number operation now if you anticipate that the public will seek reassurance or information directly from your organization. (You may adjust hours of operation and number of call managers as needed.)
- ☐ Use your initial media statement as your first message to the public.

- ☐ Ensure that your statement expresses empathy and acknowledges public concern about the uncertainty.
- ☐ Give the precleared facts you have and refer the public to other information sites as appropriate.
- ☐ Remind people that your agency has a process in place to mitigate the crisis.
- ☐ Start public call-monitoring to catch trends or rumors now.

Partners/Stakeholders:

- ☐ Send a basic statement to partners and stakeholders to let them know you are thinking about them.
- ☐ Use prearranged notification systems (preferably e-mail listservs).
- ☐ Engage leadership to make important first phone calls, based on your plan, to partners and key stakeholders to let them know that your agency is responding.
- ☐ Use the internal communication system (e-mail) to notify employees that their agencies are involved in the response and that updates will follow. Ask for their support.

Resources

- ☐ Conduct the crisis risk assessment and implement assignments and hours of operation accordingly. (Use the CERC assessment.)
- ☐ Stake out your pre-planned place in the EOC or adjoining area.

Template 4–1. Message Development for Emergency Communication

First, consider the following:

Audience:	Purpose of Message:	Method of delivery:
❑ Relationship to event ❑ Demographics (age, language, education, culture) ❑ Level of outrage (based on risk principles)	❑ Give facts/update ❑ Rally to action ❑ Clarify event status ❑ Address rumors ❑ Satisfy media requests	❑ Print media release ❑ Web release ❑ Through spokesperson (TV or in-person appearance) ❑ Radio ❑ Other (e.g., recorded phone message

Six Basic Emergency Message Components:

1. **Expression of empathy:** _____

_____

2. **Clarifying facts/Call for Action:**

Who_____

What _____

Where _____

When_____

Why_____

How_____

3. **What we don-t know:** _____

4. **Process to get answers:** _____

5. **Statement of commitment**: _____

6. **Referrals:** _____

For more information _____

Next scheduled update _____

Finally, check your message for the following:

Positive action steps	Avoid jargon
Honest/open tone	Avoid judgmental phrases
Applied risk communication principles	Avoid humor
Test for clarity	Avoid extreme speculation
Use simple words, short sentences	

Checklist 4–2. Notification Schedule

Emergency Risk Communication: Immediate Response to Inquiries

By phone to media:

- ❑ "We've just learned about the situation and are trying to get more complete information now. How can I reach you when I have more information?"
- ❑ "All our efforts are directed at bringing the situation under control, so I'm not going to speculate about the cause of the incident." How can I reach you when I have more information?"
- ❑ "I'm not the authority on this subject Let me have XXXX call you right back."
- ❑ "We're preparing a statement on that now. Can I fax it to you in about two hours?"
- ❑ "You may check our web site for background information and I will fax/e-mail you with the time of our next update."

At incident site or press availability:

Response to Inquiries (you are authorized to give out the following information)

Date: _____ Time: _____ Approved by: _____

This is an evolving emergency and I know that, just like we do, you want as much information as possible right now. While we work to get your questions answered as quickly as possible, I want to tell you what we can confirm right now:

At approximately, _____ (time), a (brief description of what happened)

_____

_____.

At this point, we do not know the number of (persons ill, persons exposed, injuries, deaths, etc.).

We have a system (plan, procedure, operation) in place for just such an emergency and we are being assisted by (police, FBI, EOC) as part of that plan.

The situation is (under)(not yet under) control and we are working with (local, State, Federal) authorities to (e.g., contain this situation, determine how this happened, determine what actions may be needed by individuals and the community to prevent this from happening again).

We will continue to gather information and release it to you as soon as possible. I will be back to you within (amount of time, 2 hours or less) to give you an update. As soon as we have more confirmed information, it will be provided. We ask for your patience as we respond to this emergency.

Source: CDC Public Health Training Network satellite and web broadcast *CDC Responds: Risk Communication and Bioterrorism* December 6, 2001, Barbara Reynolds, CDC Crisis Communication Plan, Draft 1999.

Checklist 4–3. Public Information Emergency Response Call Tracking

Time of call: _____ a.m. p.m.

Nature of call:

☐ Specific information contained in stock materials:
- ☐ Disease or illness-related
- ☐ Treatment-related
- ☐ Prevention-related
- ☐ Clarify recommendations
- ☐ Current status of the incident
- ☐ Hot topic 1_____
- ☐ Hot topic 2_____

☐ Request for referral:
- ☐ For more health information
- ☐ For medical attention
- ☐ Other _____

☐ Feedback to agency:
- ☐ Complaint about specific contact with agency
- ☐ Complaint about recommended actions
- ☐ Concern about ability to carry out recommended action
- ☐ Report possible cases or markers (e.g., dead birds for West Nile or increased absences from place of employment)
- ☐ Rumor or misinformation verification (briefly describe)

Outcome of call:

☐ Calmed caller based on scripted information

☐ Referred caller to:
- ☐ Health expert outside the department
- ☐ Personal doctor or health care professional
- ☐ Emergency room
- ☐ Red Cross or other nongovernment organization
- ☐ FEMA or state emergency management agency

Action needed:
- ☐ None
- ☐ Return call to:
- ☐ Caller=s name: _____Telephone number: _____Gender: M F
- ☐ Call urgency: Level A ___ Level B ___ Level C ___

Call taken by: _____ Date: _____

Checklist 4–4. Incident Media Call Triage Sheet

Deadline: ___ 2 hours ___ Today a.m. ___ Today p.m. ___ ASAP ___ Other

Media outlet:

- ☐ Local ___ TV ___ Daily/Wire ___ Radio ___ Magazine ___ Other
- ☐ Regional
- ☐ National

Caller's name: (print first and last) _____

Caller's contact information: Phone(s): _____

Fax: _____

E-mail: _____

Request:

- ☐ SME* questions
- ☐ Interview (by name request? _____)
- ☐ Background/B-roll
- ☐ Fact check
- ☐ Update
- ☐ Return call to press officer

Topic:

- ☐ Numbers _____
- ☐ Response/Investigation _____
- ☐ Health/disease issue/treatment _____
- ☐ Hot issue 1 _____
- ☐ Hot issue 2 _____
- ☐ Other _____

Action needed:

- ☐ Return call expected from press officer
- ☐ Return call expected from SME

Comments:

PA suggested triage priority:**

- ☐ Level A
- ☐ Level B
- ☐ Level C

No action needed; call closed by:

- ☐ PA answered question
- ☐ PA referred to Internet
- ☐ PA referred to CIO
- ☐ PA referred to outside CDC
- ☐ PA other _____

Taken by: _____

Time: a.m. _____ p.m. _____

Date: S M T W T F S _____

* SME = subject matter expert

** PA = press assistant

Risk Communication Assessment

- Initial assessment of the intensity of a crisis event is vital.
- First, turn to the event assessment checklist on the following page and check the boxes that are applicable to your event.
- Don't spend a lot of time considering whether or not to check a box—this matrix is meant to be a general guide.
- This is not a test and there are no right or wrong answers.
- The checklist is meant to take a only few minutes to complete.
- When you are done, turn back to this page, and compare the boxes you checked to those cited in the "Crisis Criteria" column in the table below to determine the level of crisis that you are dealing with and how you may want to respond.
- Reassessment is expected as more information about the event is gathered.

Table 4–2. Event Evaluation

Event Evaluation Factors			
Crisis Level	**Crisis Description**	**Crisis Criteria**	**Recommended Outcome***
A	**Highly intense in the initial phase.** The need to disseminate information rapidly to the public and media is critical. Life and limb will be at risk if the public is not notified about the risk and public health recommendations.	*First box must be checked. From among boxes 2, 3, and 4, at least two boxes must be checked.*	Operate 24 hours a day, 7 days a week for media and public response, with an expectation that relief and replacement staff will be needed. Per your plan, form or join a Joint Information Center (JIC).
B	**Intense.** The need to directly provide public health recommendations to the public and media to save life or limb is not immediate. The public and media, however, believe their health and safety are or could soon be at risk. There is a high and growing demand for more information.	*First box not checked, and third and fourth boxes checked.*	Operate 20 hours a day, 7 days a week during the initial phase. Set up routine times for media briefings, allow public to e-mail or leave phone messages during nonduty times, and move into maintenance phase when possible. Be prepared to face "initial phase" demands, depending on developments during the maintenance phase (maintenance phases with bumps). May need to form a JIC.
C	**Moderately intense.** Media frenzy develops. Interest is generated because of the event novelty versus a legitimate and widespread or immediate public health concern. Interest could die suddenly if a "real" crisis occurred.	*Third box checked, and boxes 1, 2 and 4 not checked. Three or more of the ++ boxes checked, and one or more of the +++ boxes checked.*	Operate 10–12 hours a day, 5–6 days a week and assign a single team member for after-hour purposes during the initial phase. Operate on weekend if event occurs on a weekend; otherwise use on-call staff only on weekends, not during full operation. Attempt to move the media and public to maintenance phases with prescribed times and outlets for updates. No need to form a JIC.
D	**Minimally intense.** Builds slowly and may continue for weeks, depending on the outcome of further investigation. Requires monitoring and reassessments.	*Boxes 1, 2, and 3 not checked. More + or ++ boxes checked than +++ boxes.*	Operate normally in the initial phase while preparing to move to 24 hours a day, 7 days a week, if needed. Notify relief and replacement staff that they may be called for duty depending on how the event develops. Do not "burn out" staff with long hours before the public and media demand escalates. Practice your crisis communication operations (during normal duty hours) to ensure the system works. Consider operating a JIC if information release is shared.

* Public and media emergency communication response recommendations, based on crisis level. Remember with reassessments an ongoing event may move from one level to another.

Checklist 4–5. Event Assessment

Directions: Check all that apply, based on current information.

Criteria Number	Check if applicable	Criteria Intensity (0–8)	Crisis Criteria
1	☐	++++++++	The initial event is clearly recognized as a public health emergency that requires immediate communication with the public to prevent further widespread illness or death.
2	☐	++++	Deaths are expected within a short window of time (catastrophic event). Diagnosis and/or treatment are uncertain.
3	☐	++++	The media and public perceive the event as the "first," "worst," or "biggest," etc.
4	☐	++++	Deaths are expected well above normal levels.
5	☐	+++	The event is occurring in a metropolitan area (with dense media outlets) versus a sparsely populated area (with fewer media outlets).
6	☐	+++	The event is sudden, is national in scope, or has the potential to have a national health impact.
7	☐	+++	The government is perceived as a cause of or responsible for the event.
8	☐	+++	The event predominantly impacts children or previously healthy adults.
9	☐	+++	The event is possibly "man-made" and/or deliberate.
10	☐	+++	Controlling the event may require a suspension of civil rights for a significant portion of the population.
11	☐	+++	Persons involved in the event must take active steps to protect their personal health and safety.
12	☐	+++	Responsibility for mitigating the event falls within the scope of your organization.
13	☐	++	The event has some "exotic" aspect.
14	☐	++	A well-known product, service, or industry is involved.
15	☐	++	Sensitive international trade or political relations are involved.
16	☐	++	A well-known "celebrity" is involved.
17	☐	++	An ongoing criminal investigation is involved.
18	☐	++	The disease or public health issue is not well understood by the general population, or the general population is misinformed about the situation.
19	☐	++	The event is "acute." The event occurred and your organization is faced with explaining the event and the aftermath (e.g., an accident in the laboratory or a chemical release).
20	☐	+	The long-term health effects for humans involved in the event are uncertain.
21	☐	+	The event is evolving. Its progression is uncertain and may become more or less serious (e.g., identification of a novel influenza virus).
22	☐	+	The event site does not have a well-equipped and resourced public information response capability.
23	☐	0	The event occurred internationally with little chance of affecting the U.S. population.
24	☐	0	Treatment or control of exposure is generally understood and within the person's control.

Checklist 4–6. Needs Assessment for Crisis and Emergency Risk Communication

Planning, research, training, and evaluation		
Yes	**No**	
❑	❑	Does your organization have an emergency response/crisis communication operational plan for public information and media, partner, and stakeholder relations?
Yes	**No**	**If yes, does the plan have the following elements:**
❑	❑	Designated line and staff responsibilities for the public information team
❑	❑	Information verification and clearance/approval procedures
❑	❑	Agreements on information release authorities (who releases what/when/how)
❑	❑	Regional and local media contact list (including after-hours news desks)
❑	❑	Procedures to coordinate with the public health organization response teams
❑	❑	Designated spokespersons for public health issues in an emergency
❑	❑	Public health organization emergency response team after-hours contact numbers
❑	❑	Contact numbers for emergency information partners (e.g., Governor's public affairs officer, local FBI public information special agent in charge, local or regional department of agriculture or veterinarian public information officers, Red Cross and other nongovernment organizations)
❑	❑	Agreements/procedures to join the joint information center of the emergency operations center (if activated)
❑	❑	Procedures to secure needed resources (space, equipment, people) to operate the public information operation during a public health emergency 24 hours a day/7 days a week, if needed
❑	❑	Identified vehicles of information dissemination during a crisis to public, stakeholders, partners (e.g., e-mail listservs, broadcast fax, door-to-door leaflets, press releases)
Yes	**No**	
❑	❑	Have you coordinated your planning with the community or state emergency operation center?
❑	❑	Have you coordinated your planning with other response organizations or competitors?
❑	❑	Have designated spokespersons received media training and risk communication training?
❑	❑	Do they understand emergency crisis/risk communication principles to build trust and credibility?

Message and audiences

The following are types of incidents (disasters) that could require intense public information and media and partner communication responses:

- ❑ Airborne infectious disease outbreak (e.g., pandemic influenza)
- ❑ Foodborne infectious disease outbreak (e.g., listeria)
- ❑ Waterborne (e.g., Cryptosporidiosis)
- ❑ Vectorborne (e.g., West Nile virus)
- ❑ Outbreak with potential to spread outside your region or to your region
- ❑ Unknown infectious agent
- ❑ Chemical or toxic material disaster
- ❑ Natural disasters
- ❑ Unknown infectious agent (international) with potential to spread to U.S.
- ❑ Known infectious agent (international) with potential to spread to U.S.
- ❑ Large-scale environmental crises
- ❑ Radiological event
- ❑ Terrorist event
  - ❑ Biological (suspected or declared)
  - ❑ Chemical

- ❑ Radiological
- ❑ Mass explosion

❑ Site-specific emergencies

- ❑ Laboratory incident with laboratory worker
- ❑ Laboratory incident/release of material in community
- ❑ Death of employee/contractor/visitor while on campus
- ❑ Hostage event with/by employee/contractor on campus
- ❑ Bomb threat
- ❑ Explosion/fire—destruction of property
- ❑ Violent death of an employee/contractor or visitor on campus

Yes	No	
❑	❑	Have you **identified special populations** (e.g., elderly, first language other than English, Tribal communities, border populations)? List any specific sub-populations that need to be targeted with specific messages during a public health emergency related to your organization (e.g., Tribal nations, persons with chronic respiratory illness, unvaccinated seniors)?
❑	❑	Have you **identified your organization's partners who should receive direct information and updates** (not solely through the media) from your organization during a public health emergency?
❑	❑	Have you **identified all stakeholder organizations** or populations (groups or organizations that your organization believes have an active interest in monitoring activities—to whom you are most directly accountable, other than official chain of command) who you believe should receive direct communication during a public health-related emergency?
❑	❑	Have you **planned ways to reach people according to their reactions** to the incident (fight or flight)? Are messages, messengers, and methods of delivery sensitive to all types of audiences in your area of responsibility?
❑	❑	Are there **mechanisms/resources in place to create messages** for the media and public under severe time constraints, including methods to clear these messages within the emergency response operations of your organization (include cross clearance)?
❑	❑	Identify how you will perform **media evaluation, content analysis, and public information call analysis in real time** during an emergency to ensure adequate audience feedback.

Have you developed **topic-specific precrisis materials** for identified public health emergency issues, or identified sources of these materials if needed?

Yes	No	
❑	❑	Topic factsheet (e.g., description of the disease, public health threat, treatment, etc.)
❑	❑	Public Q/As
❑	❑	Partner Q/As
❑	❑	Resource factsheet for media/public/partners to obtain additional information
❑	❑	Web access and links to information on the topic
❑	❑	Recommendations for affected populations
❑	❑	Background beta video (B-roll) for media use on the topic
❑	❑	List of subject matter experts outside your organization that would be effective validators to public/media regarding your activities during a public health emergency.

Messenger		
Yes	**No**	
❑	❑	Have you identified public health spokespersons for media and public appearances during an emergency? Identify persons to act as spokespersons for multiple audiences (e.g., media spokesperson, community meeting speaker, etc.) and formats about public health issues during an emergency and ensure that their communication roles and responsibilities are understood and incorporated into their expected duties during the crisis.
Methods of delivery (information dissemination) and resources		
Yes	**No**	
❑	❑	Does your organization have **go kits** for public information officers who may have to abandon their normal place of operation during a public health emergency or join a JIC? If yes, does the kit include:
❑	❑	A computer(s) capable of linking to the Internet/e-mail
❑	❑	A CD–ROM or disks containing the elements of the crisis communication plan (including media, public health, and organization contact lists, partner contact lists; information materials, etc.)
❑	❑	A cell phone or satellite phone, pager, wireless e-mail, etc.
❑	❑	A funding mechanism (credit card, etc.) that can be used to purchase operational resources as needed
❑	❑	Manuals and background information necessary to provide needed information to the public and media
❑	❑	Care and comfort items for the public information operations staff
❑	❑	Have you identified the mechanisms that are or should be in place to ensure **multiple channels of communication to multiple audiences** during a public health emergency? If yes, do they include:
❑	❑	Media channels (print, TV, radio, Web)
❑	❑	Web sites
❑	❑	Phone banks
❑	❑	Town hall meetings
❑	❑	Listserv e-mail
❑	❑	Broadcast fax
❑	❑	Letters by mail
❑	❑	Subscription newsletters
❑	❑	Submissions to partner newsletters
❑	❑	Regular or special partner conference calls
❑	❑	Door-to-door canvassing
❑	❑	Are **contracts/agreements** in place to post information to broadcast fax or e-mail systems?
❑	❑	Have **locations for press conferences** been designated and resourced?
Have you identified employees, contractors, fellows, interns currently working for you or available to you in an emergency, that have skills in the following areas:		
❑	❑	Public affairs specialist
❑	❑	Health communication specialist

❑	❑	Communication officer
❑	❑	Health education specialist
❑	❑	Training specialist
❑	❑	Writer/editor
❑	❑	Technical writer/editor
❑	❑	Audio/visual specialist
❑	❑	Internet/Web design specialist
❑	❑	Others who contribute to public/provider information

Personnel

Have you identified who will provide the following expertise or execute these activities during a public health emergency (including backup)?

Yes	No	
❑	❑	**Command and control:** ❑ Directs the work related to the release of information to the media, public, and partners ❑ Activates the plan, based on careful assessment of the situation and the expected demands for information by media, partners, and the public ❑ Coordinates with horizontal communication partners, as outlined in the plan, to ensure that messages are consistent and within the scope of the organization's responsibility ❑ Provides updates to organization's director, EOC command and higher headquarters, as determined in the plan ❑ Advises the director and chain of command regarding information to be released, based on the organization's role in the response ❑ Ensures that risk communication principles are employed in all contact with media, public, and partner information release efforts ❑ Advises incident-specific policy, science, and situation ❑ Reviews and approves materials for release to media, public, and partners ❑ Obtains required clearance of materials for release to media on policy or sensitive topic-related information not previously cleared ❑ Determines the operational hours/days, and reassesses throughout the emergency response ❑ Ensures resources are available (human, technical, and mechanical supplies)

Yes	No	
❑	❑	**Media:** ❑ Assesses media needs and organizes mechanisms to fulfill media needs during the crisis (e.g., daily briefings in person, versus a Web site update) ❑ Triages the response to media requests and inquiries ❑ Ensures that media inquiries are addressed as appropriate ❑ Supports spokespersons ❑ Develops and maintains media contact lists and call logs ❑ Produces and distributes media advisories and press releases ❑ Produces and distributes materials (e.g., factsheets, B-roll) ❑ Oversees media monitoring systems and reports (e.g., analyzing environment and trends to determine needed messages, determining what misinformation needs to be corrected, identifying concerns, interests, and needs arising from the crisis and the response) ❑ Ensures that risk communication principles to build trust and credibility are incorporated into all public messages delivered through the media ❑ Acts as member of the joint information center of the field site team for media relations ❑ Serves as liaison from the organization to the JIC and back

Yes	No	
❑	❑	**Direct public information:** ❑ Manages the mechanisms to respond to public requests for information directly from the organization by telephone, in writing or by e-mail ❑ Oversees public information monitoring systems and reports (e.g., analyzing environment and trends to determine needed messages, determining what misinformation needs to be corrected, identifying concerns, interests, and needs arising from the crisis and the response) ❑ Activates or participates in the telephone information line ❑ Activates or participates in the public e-mail response system ❑ Activates or participates in the public correspondence response system ❑ Organizes and manage emergency response Web sites and Web pages ❑ Establishes and maintain links to other emergency response Web sites
Yes	**No**	
❑	❑	**Partner/stakeholder information:** ❑ Establishes communication protocols based on prearranged agreements with identified partners and stakeholders ❑ Arranges regular partner briefings and updates ❑ Solicits feedback and responds to partner information requests and inquiries ❑ Oversees partner/stakeholder monitoring systems and reports (e.g., analyzing environment and trends to determine needed messages, determining what misinformation needs to be corrected, identifying concerns, interests, and needs arising from the crisis and the response) ❑ Helps organize and facilitate official meetings to provide information and receive input from partners or stakeholders ❑ Develops and maintain lists and call logs of legislators and special interest groups ❑ Responds to legislator/special interest groups requests and inquiries
Yes	**No**	
❑	❑	**Content and material for public health emergencies:** ❑ Develops and establishes mechanisms to rapidly receive information from the EOC regarding the public health emergency ❑ Translates EOC situation reports and meeting notes into information appropriate for public and partner needs ❑ Works with subject matter experts to create situation-specific factsheets, Q/As, and updates ❑ Compiles information on possible public health emergency topics for release when needed ❑ Tests messages and materials for cultural and language requirements of special populations ❑ Receives input from other communication team members regarding content and message needs ❑ Uses analysis from media, public and partner monitoring systems, and reports (e.g., environmental and trend analysis to determine needed messages, what misinformation need to be corrected, identify concerns, interests and needs arising from the crisis and the response) to identify additional content requirements and materials development ❑ Lists contracts/cooperative agreements/consultants currently available to support emergency public/private information dissemination
Suggestions to consider about resources		
Yes	**No**	
❑	❑	**Space:**
❑	❑	You need space to operate your communication teams outside the EOC. You need a place to bring media on site (separate from the EOC).
❑	❑	You need a quiet space to quickly train spokespersons.
❑	❑	You need space for team meetings.
❑	❑	You need space for equipment, exclusive for your use. You cannot stand in line for the copier when media deadlines loom.

Yes	No	
❑	❑	**Contracts and memoranda of agreement:**
❑	❑	Consider a contract with a media newswire.
❑	❑	Consider a contract with a radio newswire.
❑	❑	Consider a contract for writers or public relations personnel who can augment your staff.
❑	❑	Consider a contract for administrative support.
❑	❑	Consider a phone system/contractor to supply a phone menu that directs type of caller and level of information desired: ❑ General information about the threat ❑ Tip line, listing particular actions people can take to protect themselves ❑ Reassurance/counseling ❑ Referral information for health care/medical facility workers ❑ Referral information for epidemiologists or others to report cases ❑ Lab/treatment protocols ❑ Managers looking for policy statements for employees
Yes	**No**	
❑	❑	**Equipment:** ❑ Fax machine (number that's pre-programmed for broadcast fax releases to media and partners) ❑ Web site capability 24/7. Attempt to have new information posted within 2 hours (some say within 10 minutes). ❑ Computers (on LAN with e-mail listservs designated for partners and media) ❑ Laptop computers ❑ Printers for every computer ❑ Copier (and backup) ❑ Tables—lots of tables ❑ Cell phones/pagers/personal data devices and e-mail readers ❑ Visible calendars, flow charts, bulletin boards, easels ❑ Designated personal message board ❑ Small refrigerator ❑ Paper ❑ Color copier ❑ A/V equipment ❑ Portable microphones ❑ Podium ❑ TVs with cable hookup ❑ VHS VCR ❑ CD–ROM ❑ Paper shredder
Yes	**No**	
❑	❑	**Supplies** ❑ Copier toner ❑ Printer ink ❑ Paper ❑ Pens ❑ Markers ❑ Highlighters ❑ Erasable markers ❑ Overnight mail supplies

		❑ Sticky notes ❑ Tape (be creative) ❑ Notebooks ❑ Poster board ❑ Standard press kit folders ❑ Organized B-roll in beta format (keep VHS copies around for meetings) ❑ Formatted computer disks ❑ Color-coded everything (folders, inks, etc.) ❑ Baskets (to contain items you're not ready to throw away) ❑ Organizers to support your clearance and release system ❑ Expandable folders (with alphabet or days of the month) ❑ Staplers (lots of them) ❑ Paper punch ❑ Three-ring binders ❑ Organization's press kit or its logo on a sticker ❑ Colored copier paper (for door-to-door flyers) ❑ Paper clips (all sizes)

Spokesperson: Giving the Organization a Human Form

The spokesperson brings the organization to life. He or she literally embodies the organization and gives it its human identity. A spokesperson takes the organization from an "it" to a "we," and is the conduit to various audiences so the organization does not have to rely entirely on the written word.

In an ideal world, every organization would clone spokespersons who would all ooze charisma, caring, and confidence. In our world, we may have little choice about who ultimately speaks for our organization. The area of control that must be exerted by the organization's public information officer is to insist that spokespersons are trained, because we know that few are born. No person should represent the entire organization unless he or she has invested time and energy in developing the skills of an effective spokesperson. It's not about the color of a tie or scarf one wears on television, but the ability to *effectively* connect with the audience, either through the media or in person.

The role of the spokesperson in an emergency

Your job as a spokesperson in an emergency is to communicate information the public wants or needs to know to **reduce the incidence of illness and death**. Your job is also vital to reduce the likelihood that:

- Scarce public health and safety resources might be misallocated (through pressures brought forward based on incomplete or misinformation).
- Public health and safety recommendations are ignored or circumvented.
- Unneeded public health and safety response resources are committed (because of public or stakeholder demand based on faulty information or expectations).

Early in an emergency, expect to describe the following:

- The health and safety risks for individuals and communities—what is the risk?
- The incident and its magnitude (e.g., who, what, where, when, why, how)
- What's being done to respond to the incident?

The spokesperson is not solely responsible for the messages to be conveyed; however, he or she must be involved in the development of those messages to ensure that the spokesperson "owns" them. The words and the person must match. Spokespersons don't just read a statement; they *are* the statement. If the spokesperson doesn't fully understand the purpose behind the messages or recommendations, he or she will have difficulty assuming a stance of confidence and conveying believability and trust.

Spokespersons don't just read a statement; they *are* the statement.

Message development is covered extensively in a previous chapter; however, it's worth briefly repeating some of the principles of quality communication during a crisis. The following basic tenets help to build

confidence and trust in the facts and recommendations released. During an emergency, communication to the public is not business as usual. Before one can communicate the facts and recommendations for action, one must reduce the audience's psychological barriers by acknowledging their concerns.

Basic tenets of crisis and emergency risk communication include the following:

- **Don't over-reassure.** The objective is not to placate but to elicit accurate, calm concern.
- **Acknowledge uncertainty.** Offer only what you know. Show your distress and acknowledge your audience's distress. "It must be awful to hear that we can't answer that question right now . . ."
- **Emphasize that a process is in place** to learn more. Describe that process in simple terms.
- **Give anticipatory guidance.** If you are aware of future negative outcomes, let people know what to expect. (e.g., side effects of antibiotics).
- **Be regretful, not defensive.** Say, "We are sorry . . ." or "We feel terrible that . . ." when acknowledging misdeeds or failures from the organization. Don't use "regret," which sounds like you're preparing for a lawsuit.
- **Acknowledge people's fears.** Don't tell people they shouldn't be afraid. They *are* afraid and they have a right to their fears. Don't disparage fear; acknowledge that it's normal and human to be frightened, (even though . . .).
- **Acknowledge the shared misery.** Some people will be less frightened than they are miserable, feeling hopeless and defeated. Acknowledge the misery of a catastrophic event, then help move people toward the future through positive actions.
- **Express wishes.** Say, "I wish we knew more," or "I wish our answers were more definitive."
- **Panic is less common than imagined.** Panic doesn't come from bad news, but from mixed messages. If people are faced with conflicting recommendations and expert advice, they are left with no credible source to turn to for help. That level of abandonment opens the door to charlatans and poor judgment. Candor protects your credibility and reduces the possibility of panic, because your messages will ring true.
- **Be willing to address the "what if" questions.** These are the questions that everyone is thinking about and they want expert answers. Although it's often impractical to fuel "what ifs" when the crisis is contained and not likely to affect large numbers of people, it is reasonable to answer "what ifs" if the "what if" could happen and people need to be emotionally prepared for them. If you do not answer the "what if" questions, someone at much less risk regarding the outcome of the response will answer them for you. If you are not prepared to address "what ifs," you lose credibility and the opportunity to frame the "what if" questions with reason and valid recommendations.
- **Give people things to do.** In an emergency, some actions are directed at victims, and those exposed or have the potential to be exposed. However, those who do not need to take immediate action will be engaging in "vicarious rehearsal" regarding those recommendations and may need substitute actions to ensure that they do not prematurely act on recommendations not meant for them. Simple actions in an emergency will give people a sense of control and will help to motivate them to stay tuned to what

is happening (versus denial, where they refuse to acknowledge the possible danger to themselves and others) and will prepare them to take action when directed to do so. Give people a choice of actions matched to their level of concern. Give a range of responses: a minimum response, a maximum response, and a recommended middle response. Refer to Module 2 ♦ Psychology of a Crisis, page 13.

- **Ask more of people.** Perhaps the most important role of the spokesperson is to ask people to bear the risk and work toward solutions with you. People can tolerate considerable risk, especially voluntary risk. If you acknowledge the risk's severity and complexity, and recognize people's fears, you can then ask the best of them. A spokesperson, especially one who is on the ground and at personal risk, can model the appropriate behavior—not false happiness, but true willingness to go on with life as much as possible and to make reasonable choices. Don't be glib—be stalwart. Your determination to face risk will help others looking for role models. Americans have great heart, a sense of selflessness, and a natural competitiveness. Sparking those inherent attributes will help people cope with uncertainty, fear, and misery.

Resource:

Sandman, Peter, Ph.D. www.psandman.com

CDC Crisis Communication Plan, Draft 1999.

What makes a good spokesperson?

It's sometimes difficult to capture the qualities of a good spokesperson and pass them on to others. However, it's not at all difficult to identify the qualities of a poor spokesperson. This section is about what not to do.

Nearly all spokesperson training starts or ends with this statement: "Be yourself. Be natural." That may not always be the best advice. The audience can tell when the persona appears stilted or fake. But "be natural" doesn't mean forgetting the seriousness of your role. Perhaps better advice is "Be your organization. Act like your organization." Every organization has an identity. A spokesperson should try to embody that identity. For example, CDC exists solely to make people safer and healthier. CDC personnel have a history of placing themselves in harm's way to do the detective work needed to stop the spread of illness or death. CDC also is humble in its understanding that it goes where asked. It has partners and relationships that it values and will neither steal the show nor abandon the effort.

Every organization has an identity. A spokesperson should try to embody that identity.

Example:

As a spokesperson for CDC, you should express a desire to help, show courage in doing the job, and communicate the value of partners. A CDC spokesperson is committed but not flamboyant in communicating.

A spokesperson must be perceived as trustworthy and credible. Research indicates that being perceived as empathetic and caring provides greater opportunity for your message to be received and acted upon. Express empathy or caring within the first 30 seconds. Besides empathy, credibility is built on expressions of competence and expertise (truly

Be your organization, then be yourself.

"knowing your stuff"), honesty and openness, and commitment and dedication.

Work with your organization's public information officer to develop messages, gather facts, and determine what can be released at any given time. Also, be certain that you know when you will be available to the media or the public. Reassure them that you will be back to share updates with them.

General recommendations for spokespersons in all settings

- Know your organization's policies about the release of information.
- Stay within the scope of your responsibilities, unless you are authorized to speak for the entire organization or a higher headquarters.
- Don't answer questions that are not within the scope of your organizational responsibility.
- Tell the truth. Be as open as possible.
- Follow up on issues.
- Use visuals when possible.
- Illustrate a point through examples, stories, and analogies. Ensure that they help you make your point and do not minimize or exaggerate your message. Try the stories out on a small group first.

Pitfalls for spokespersons during an emergency

- **Remember that jargon obfuscates communication and implies arrogance.** If you have to use a technical term or acronym, define it. If you can define it, do you need to use it? Jargon and euphemisms are security blankets. Try to give yours up.
- **Use humor cautiously.** Humor is a minefield. Soft, self-deprecating humor may be disarming for a hostile audience, but be careful.
- **Refute negative allegations without repeating them**. Don't own the negative by repeating the accusation.
- When possible, **use positive or neutral terms.**
- **Don't assume you've made your point.** Ask whether you've made yourself clear.
- Ultimately, **money will become an issue.** During the early stage of an emergency, don't lead with messages about money.
- At all costs, **avoid one-liners, cliches, and off-the-cuff comments.** Any statement that trivializes the experience of the people involved by saying something such as "there are no guarantees in life" kills your credibility.
- **Discuss what you know, not what you think.**

- **Do not express personal opinions.**
- **Don't show off.** This is not the time to display an impressive vocabulary.

Resource:

Covello, Vincent. www.vincentcovello.

Lum, Max R., Ed.D.; Tinker, Tim L. Dr.P.H., M.P.H. (1994) *A Primer on Health Risk Communication Principles and Practices*. Atlanta: Division of Health Education, Agency for Toxic Substances and Disease Registry.

CDC Crisis Communication Plan, Draft 1999.

When emotions and accusations run high in an emergency public meeting

- **Don't show inappropriate hostility.** You can be angry at the organisms, chemicals, or natural disasters causing illness and death. In the case of bioterrorism, you can express outrage at the act and the perpetrators. But don't show outrage or become indignant toward your detractors. Those involved in public health and safety see themselves as the good guys. It hurts when our intentions, abilities, and expertise are criticized. Get over it! Outrage in such cases is natural for many people. As scientists and technical experts, we may be less emotional than others, and that can divide us from the audiences with which we are attempting to communicate. Don't dismiss emotions expressed about the situation or your organization as hysterical or inappropriate. Those emotions are normal for most people, whether or not they are normal for you. The first step in dealing with the criticism and outrage expressed by your audience is to acknowledge that it exists. Don't "own" their outrage, but don't dismiss it either.
- **Ask for ground rules and have them outlined by a neutral third party.** Acknowledge the anger up front and explain what you hope to accomplish. Refer back to your objectives when the communication deteriorates.
- **Don't react with temper when confronted with accusations.** It's helpful to visualize someone to whom you sincerely hope to communicate what you are doing and talk to that person (e.g., may be your parent, your child, someone you care about and who cares about you). This is a way to continue to reach important audiences by mentally bypassing the reporter or advocate who is trying to cause a negative response.
- **Practice self-management.** Calm yourself, breathe deeply, and remind yourself of your greater purpose. Display confidence and concentration. Visualize a verbal attack and mentally rehearse a temperate response. Don't be caught off guard. Anticipate the attack and practice not feeding the anger. Anger fizzles more quickly if it does not meet an obstruction. Let the person vent, without interruption, for a reasonable amount of time. Ask if he or she has had time to fully express feelings. Don't be insincere. If you can't say it, don't.
- **Engage in active listening.** Listening means being able to express the other person's point of view. Concentrate on what the person is saying. It's hard to do when you're also attempting to form your answer. It's not a race; take the time to listen and frame your response.

- **Don't say, "I know exactly how you feel."** Instead, acknowledge the feeling, and suggest an example of something you've found worked for you and may work for them.
- **Avoid interrupting, but set limits.** If a hostile speaker dominates, appeal to him or her that you want to address the concerns of others in the room.
- **Don't overreact to emotional words.** Remember, you're the professional. Others have a different investment in what's happening. Words that you interpret one way may mean another to others. Give them the benefit of the doubt.
- **Use open body language.** Sit or stand with your arms relaxed by your sides. Do not cross your arms or put your hands on your hips. Make eye contact when possible.
- **Modulate your voice.** Use a slightly lower tone and volume of voice than the angry individual.
- **Don't take personal abuse.** A certain amount of anger and negative emotion directed at you is understandable. If it becomes personal, however, you have a right to express the inappropriateness of that behavior and ask the person to join with you in getting back to the issues. You are your organization. You are not alone. You are not the true focus of the attack; it's more likely a result of frustration, fear, and a sense of lack of control. Attackers may feel marginalized and feel the need to have their positions validated. Give them the right to feel the way they feel. If you know that the audience will be hostile, bring along a neutral third party who can step in and defuse the situation.
- **State the problem, then the recommendation.** When explaining your position, state the problem before your answer. For example, rather than saying, "Exposed persons should take Cipro for 60 days," say, "To eliminate the risk of respiratory anthrax, CDC recommends that exposed persons take Cipro for 60 days."
- **Commit to a response.** Write down people's concerns and get back to them.
- **Don't promise what you can't deliver.** Explain the limitations of the situation and express that you are doing everything you can to keep the response on track.
- **Look forward, not back.** Acknowledge past mistakes: "I wish we had met with you sooner to hear your concerns." Then talk about where you want to go in resolving problems rather than where you have been. Avoid rehashing old issues.
- **Do not search for a single answer.** One size may not fit all. Consider many possible solutions and do not view a negotiation as an either/or proposition.

Identifying and training spokespeople

Spokespeople allow the public to put a face to the act of investigating and resolving a crisis or big event. How a spokesperson handles public and media inquiry, in addition to what he or she says, helps establish credibility for an organization and contributes to the public's transition from the crisis stage to resolution and recovery. An organization should choose carefully the individual(s) who will be charged with the role of spokesperson based not only on the individual's familiarity with the subject matter, but also on his or her ability to talk about it in a way that communicates confidence and is understandable.

Children are among the victims diagnosed with cancer in a town where the people believe a major corporation is linked to the town's prevalence of cancer there. During a public meeting, a mother, a doctor, and a scientist (who was leading the investigation into the link between the major corporation and the incidences of cancer in a similar town) were among the community spokespeople prepped to speak to the public about the issue. At one point during the meeting, in front of national media, a 9 year-old child with a jar of dirty water asks/demands assurance that the water she is drinking is safe. Fortunately, the CDC spokesperson who was present for the meeting was not only knowledgeable about the issue, but also trained to talk about it in an effective and consistent manner, and as a result, responded to this line of questioning extremely well.

If possible, have the crisis spokesperson appear in public often to help establish credibility for your organization. He or she should not be a new face. Throughout the duration of the Brentwood anthrax case, an EIS officer met with the Brentwood postal workers several times to discuss antibiotic prophylaxis. When the CDC recommended 30 days of therapy in addition to the anthrax vaccine, an activist in the crowd started shouting inflammatory comments. But because the EIS officer had established himself as a credible and trusted source of information, instead of rallying around the activist, the crowd told the guy to be quiet so they could hear what the EIS officer had to say.

What spokespersons should know when talking through the media

The media are important during the first hours or days of an emergency. They are the fastest and, in some cases, the only way reach the public during an emergency. Media professionals accept their community responsibilities; however, your job is not their job. Respect the differences and look for mutual goals.

- **Go into any media interview with a purpose.** Have a message to deliver. If you don't have a message, you don't have a reason to do the interview.
- **Make sure the reporter gets your name and title right.** Keep your title as short as possible. It's better to make it descriptive of what you do than to give an official position title. For example, medical epidemiologist is better than "acting chief of the XXXXXXXX, section of the XXXX branch," etc.

General media interview pitfalls

- **Don't let a reporter put words in your mouth.** The reporter may use inflammatory or emotionally laden words. Don't repeat them.
- **If the question contains leading or loaded language,** reframe the question to eliminate the language and then answer the questions.
- **Don't assume the reporter has it right** if he or she claims that someone has lodged an allegation. Don't react to new information a reporter gives you. Instead, say, "I have not heard that" or "I would have to verify that before I could respond." Don't let the reporter start a fight.

- **If a reporter leaves a microphone in your face** after you've answered the question, *stop*. *Do not answer the question again or add to your answer.* Instead, say, "That was my answer. Do you have another question for me to address?" Say it matter of factly, without sarcasm or annoyance.

- **There is no such thing as "off the record."** Background and deep background do not mean you won't be quoted. Do not say anything before, during, or at the conclusion of an interview that you are not prepared to see in print the next day. *The interview hasn't ended until the reporter and all equipment is out the door and long gone.*

- **Anticipate questions.** Work with your public information officer to anticipate as many expected questions as possible and draft the answers. Nuances count. A word change here or there may make the difference in how well your answer is received. Put the answer on paper (it will usually be too long to give in public) and then find the bottom line—what is the point you want to make? What rings true and doesn't sound evasive? That's your 30-second answer.

- **Make your point first.** Have prepared message points. Try to say it in 30 seconds and in fewer than 90 words.

- **Don't fake it.** If you don't know the answer, say so. If it's not in your area of expertise, say so. Commit to getting the answer.

- **Never speak disparagingly of anyone, not even in jest.** Your mother was right—it's not becoming. Don't assign blame or pass the buck. Stick to what you know and what your organization is doing. Don't fight your battle through the media. If you don't have something nice to say, don't say anything. Remind reporters that professionals can differ in opinion but that does not mean they should attack each other in the media. There is a peer-review process to discuss differences.

- **Don't buy in to hypothetical questions.** Reframe the question in a way that addresses legitimate concerns of the public without being sensational or "entertainment."

- **Record sensitive interviews.** Be sure the reporter knows you are doing it.

- **Do not ask reporters to review their articles or interviews.** Offer to clarify information for them as they prepare their piece. If a reporter shows you the piece, understand that he or she expects you to correct errors in fact—not viewpoints that may differ from yours.

- **Break down multiple-part questions** and answer each part separately.

- **Don't raise issues** you do not want to see in print or on the news.

- **Don't say "no comment"** to a reporter's question. Instead, state why you can't answer that question. Say that the matter is under investigation, the organization has not yet made a decision, or simply that you are not the appropriate person to answer that question.

Media opportunity or press conference tips

- Determine in advance who will answer questions about specific subject matters.

- Keep answers short and focused—no longer than 2 minutes.
- Assume every mic is live—all the time.

In-person interview tips:

- Know who will be conducting the interview.
- Know the subjects the reporter wants to cover and limit the interview to those subjects.
- Caution the reporter when you are not the right person to answer a question.
- Know the format and duration of the interview. You can set limits.
- Ask who else will be interviewed or has been interviewed.

Do not:

- Embarrass or argue with a reporter.
- Tell the news organization which reporter you prefer.
- Demand that your remarks not be edited.
- Insist that an adversary not be interviewed.
- Lie or cloud the truth.
- Demand that an answer you've given not be used.
- State that what you are about to say is off the record or not attributable to you.

Telephone interview tips

- Know who is on the other end of the line.
- Ask if you are being recorded.
- Ask when and where the information will be used.
- Obtain the reporter's phone number before the interview begins. You may need to call back if the call is interrupted or if you need to provide updated information.
- Spell out difficult names/technical terms/phrases.

At the outset, limit the time available for the interview. Give yourself an out, such as a pending meeting. You have an obligation to answer important questions from the media, but you do not have an obligation to explore every facet of the incident or to do reporters' homework. Send them to Web-based or print materials to save time. Be certain to ask reporters for feedback to ensure that they understand your points.

- Go to a quiet room.
- Don't allow distractions.
- Stand up. It strengthens your voice and makes you alert.
- Keep key messages at hand. Repeat them often so reporters know these are what you believe are important.

Counters to electronic media interview techniques

Reporters are not adversaries. They are also not your friends. Some reporters will use well-known techniques to attempt to get a reaction from you. Adjust your interview style accordingly.

- **Sensational or unrelated questions:** Answer the question in as few words as possible without repeating the sensational elements. Then return to your key messages. Here are a few recommended "bridges" back to what you want to say:
  - "What I think you are really asking is . . ."
  - "The overall issue is . . ."
  - "What's important to remember is . . ."
  - "It's our policy to not discuss this issue, but what I can tell you is . . ."
  - "What I'm really here to discuss . . ."
  - "Your readers/viewers need to know . . ."
- **Character attack:** Don't lock horns with an adversary during an interview. Do question the science, issues, or goals, but not someone's character. "I can't speak for Dr. X. You'll have to ask him or her, but what I can address is . . ."
- **Machine-gun questioning:** Reporter fires rapid questions at you. Pacing is quick. Reporter interrupts your response. You respond, "Please let me answer this question." Control the pace. Take time to think.
- **Mic feeding and pausing:** You've given a good answer on a controversial issue. The reporter pauses and the camera continues to roll. Stay on your agenda. Be aware of nonverbal cues (deer in the headlights look, fidgeting). Don't sweat. It's the reporter's job to fill the air time. Dead air doesn't make scintillating viewing—unless you're reacting nonverbally. Relax.
- **Hot mic.** It's always on. Always—including during "testing."
- **Sensational question with an A or B dilemma.** Use positive words, correct the inaccuracies without repeating the negative, and reject A or B if neither are valid. Explain, "There's actually another alternative you may not have considered," and give your message point.

- **Surprise prop.** The reporter attempts to hand you a report or supposedly contaminated item. *Don't take it.* If you take it, you own it. React by saying, "I'm familiar with that report, and what I can say is" or "I'm not familiar with that report, but what is important is," and then go to your key message.

Radio interview tips

A live interview is very different from a taped interview. Be sure you know whether it's live, live to tape, or taped. If the interview is live, determine whether callers will be permitted to ask questions. Try to avoid answering caller questions—seldom is that an effective means to provide information.

- Speak in normal tones.
- Watch out for "uh," "um," and "you know." You do not own the air time. It's not your responsibility to fill the space. Take the time you need to form your thoughts and answer.
- Use notes, but don't rustle your papers.
- Radio interviews will not be as in-depth as print. Get your key messages out quickly and succinctly.
- Don't offer lengthy scientific explanations. Remember that your audience has very little scientific background. Tell them what it means to them. Take on your audience's point of view.
- Reporters may ask the same question multiple times in an attempt to elicit a different answer from you *or* to get you to answer the question with fewer words.
- Be careful *not* to repeat the negatives in a reporter's question. Typically, radio interviews do not include the questions from the reporter. Therefore, if the reporter says, "Some say you blew it when you failed to . . .," do not respond: "We didn't blow it." Instead, start with what you *did* do and what you want the audience to know you did.
- Assume the mic is always live.

Television interview tips

Do not make broad unnatural gestures or move around in your chair. Ask for a chair that does not swivel.

- **Practice, practice, practice:** Spokespersons must take the time to prepare for an appearance. With the help of your public information officer, practice answering questions, especially aggressive, rapid-fire questions. Ideas, facts, and anecdotes must be part of your thinking so you can discuss them easily and naturally. Memorized answers might sound as if you are reciting the material by rote. Practice answering questions in 10–20 second phrases. If a question calls for a longer answer, pause every 20 seconds. This will make it easier for the host to break in for a commercial interruption. Practice stopping the minute you are directed to; hard breaks in mid-sentence at commercial look unprofessional and desperate.
- **Slow down.** Microphones tend to make people talk faster. Slow down and deliberately pause between sentences to appear in control.

- **Drive out monotone.** Practice raising and lowering the pitch of your voice, not the volume. Natural animation helps increase credibility. Monotone may be due to fear. The more practice, the less fear—and the greater the animation in the voice.
- **Don't look at yourself on the TV monitor.** It is distracting to the viewer.
- **Look at the reporter,** not the camera, unless directed otherwise.
- **Ensure that your earphone fits securely** and that you know what to do if it pops out of your ear. Ask the producer or sound/camera technician for help if needed.
- **Sit comfortably upright.** Do not slouch.
- **In taped interviews, ask to repeat your response** if you believe the first attempt was not your best. **In live interviews, correct misstatements** as quickly as possible.

What to wear on television

Wear clothes appropriate to the situation. If you're in a field situation, a suit may not be appropriate. Do not wear medical clothes or a lab coat unless you would be wearing them for your job.

Men

- Avoid patterned suits, stripes, and checks. The camera will make them wavy and distracting to the viewer.
- Button double-breasted suits. You may unbutton single-breasted suits. If possible, sit on your coattails, to avoid bunching around your neck and shoulders.
- White shirts are considered the most conservative. Also consider wearing light blue or grey. Bottom line: in an emergency, you should look conservative, not stylish or flashy.
- Neckties should be somber. Do not "advertise" a product or point of view on your tie.
- Wear knee-length socks darker than your suit. Your credibility can plummet if your socks end at your ankles and viewers get a "skin shot" when your pant legs creep up.
- Be clean-shaven.

Women

- Tailored clothes work best.
- Short skirts kill credibility as quickly as short socks on men.
- Neutral colors and muted patterns work best. Most set backdrops are blue or purple. Consider taking along a contrasting shawl or scarf to ensure that you do not blend into the background if your suit matches the set color.

- Wear dark shoes.
- Avoid distracting or shiny jewelry and any accessory that jangles or needs constant adjusting.
- Wear everyday makeup. Avoid loud fingernail color. Lipstick should be a neutral/natural shade; lip liner helps define the lips. Women who never wear makeup should consider color on the lips. The lighting for TV is not natural, and you'll look years older and less energetic without the lipstick color. Wear pink or coral or berry—red seldom looks good. Avoid the trend toward dramatic dark colors on the lips and eyes and heavy lip liner. You'll look ghoulish, not reassuring.

Men and Women

- Neat, trimmed hair is best.
- If your skin is shiny under the lights, ask for powder. Bald men should powder the tops of their heads.
- If you can take off the glasses without squinting, do so. Consider nonglare glasses if you must wear them. Never wear tinted lenses or sunglasses. If the light hurts your eyes, ask that it be adjusted.

Assessing your communication skills

In his book *The Art of Talking So That People Will Listen*, Paul W. Swets lists a number of causes of communication breakdown.

- **Fear:** Fear of being judged negatively, fear of appearing stupid, and fear of expressing or not controlling emotion can all cause roadblocks.
- **Assumptions:** We are often not aware that we select one meaning out of a number of possibilities when we make inferences. A study of the 500 most common English words produced an average of 28 dictionary definitions per word. We must be careful not to assume we know the meaning intended by the communicator.
- **Insensitivity:** Failing to care about the feelings of others may stem from preoccupation or an unwillingness to care about another.
- **Labeling:** Once we've assigned a negative label to another person or group, it is very difficult to overcome that belief and attempt empathy.
- **Uncertainty:** The uncertain person is often silent, tense, and afraid. Uncertainty is normal at times, but not all the time.
- **Resentment:** Resentment (a feeling of indignant displeasure for some perceived injustice) will cloud one's ability to perceive another's intent or gestures as sincere or neutral.
- **Egotism:** Egotism conveys lack of respect for another person and lack of genuine interest in hearing the other person's point of view. The listener will feel used as if the speaker's words serve only an ulterior motive.

Swets recommends the following communication-builders:

- **Self-awareness:** You can help develop self-awareness in a situation by asking yourself, "What do I really think about this issue and why do I hold that view?"
- **Understanding:** Repeat what you've heard and ask for clarification to correct misunderstandings and avoid wrong assumptions.
- **Care for others:** When people sense that a speaker does not really care about them, they stop listening. If you can empathize with your audience, they will listen.
- **Control of emotions:** Some believe that they are helpless against such emotions as anger, frustration, envy, resentment, and jealousy. These are, in fact, habits that we can choose to control. These are habits, but also a choice. We must believe we can control our emotions before we can motivate ourselves to change.

Assess your communication habits

- Write down the problems you can identify about your communication habits.
- Consider recording some of your conversations to look for negative communication patterns.
- Ask for feedback on the strengths or weaknesses in your communication patterns. Try not to be defensive.

Choose to listen

Research has found three barriers to effective listening:

- **Stress:** High stress, when our minds may be going in a million different directions, makes it very difficult to pay full attention to another person unless we make a choice to listen.
- **"Me syndrome."** Some social analysts call this the "new narcissism," in which our world view is centered on the self, with happiness and personal survival as its sole goal. A person affected by the "me syndrome" doesn't seem to care about others and can't see the legitimacy of any point of view but his or her own. He/she hears only what he/she wants to hear.
- **Brain speed.** While an average speech rate for many people is about 200 words per minute, most of us can think about 4 times that speed. With all that extra "think time," ineffective listeners let their minds wander.

Passive listening engages only part of the brain; in active listening, the brain is fully engaged. To actively listen, concentrate on what is being said and provide empathetic feedback. This encourages the speaker to continue. This is a language of acceptance, an unmistakable message that, regardless of whether you agree with what is said, the person is important and his or her thoughts matter.

Listen for ideas and feelings. Facts generally deal with external events. Thoughts represent our interpretation of events or facts. Feelings can be divided into two categories: feelings about external events and feelings about ourselves. Both types of feelings can be very intense.

As a listener you can:

- Refuse to evaluate or judge the speaker.
- Aim for understanding and cooperation, not manipulation and control. Openly clarify your motives.
- Don't be afraid of deep feelings. Feelings change, sometimes in a moment. The release of deep feelings is therapeutic and enables one to return to a truer representation of self.

Facial expressions

- **Positive:** smile, laughter, empathic face, head nod, eye contact
- **Negative:** frown, sneer, cry, glare, mocking laughter, smirk, angry face, disgust

Voice cues

- **Positive:** caring, warm, relieved, concerned, cheerful, laughing
- **Negative:** cold, tense, scared, impatient, hard, clipped, staccato, whining, blaming, sarcastic, angry, blaring, accusing, depressed

Body positions and movements

- **Positive:** touching, reduced distance, open arms, relaxation, forward lean
- **Negative:** neck or hand tension, rude gestures, raising hands in disgust, point, jab, inattention

Effective nonverbal communication:

- Maintain eye contact.
- Maintain an open posture.
- Do not retreat behind physical barriers such as podiums or tables.
- Do not frown or show anger or disbelief through facial expressions.
- Do not dress in a way that emphasizes the differences between you and your audience

Resources:

CDC Media Relations Training Slide Set, (1999)

CDC Crisis Communication Plan Draft, (1999)

Rodman, George. (1981). *Mass Media Issues: Analysis and Debate*. Chicago: Science Research Associates, Inc.

Yale, David, R. (1991). *The Publicity Handbook.* Chicago: NTC Business Books.

Swets, Paul, W. (1992). *The Art of Talking So That People Will Listen.* New York: Simon & Schuster.

Cooper, Lane. (1932). *The Rhetoric of Aristotle.* Englewood Cliffs, NJ: Prentice Hall, Inc.

Pocketcard 5–1. You're the Spokesperson—What You Need To Know

CRISIS EMERGENCY RISK COMMUNICATION

Build Trust and Credibility by Expressing:

+ Empathy and caring
+ Competence and expertise
+ Honesty and openness
+ Commitment and dedication

Top Tips

+ Don't over reassure.
+ Acknowledge uncertainty.
+ Express wishes ("I wish I had answers").
+ Explain the process in place to find answers.
+ Acknowledge people's fear.
+ Give people things to do.
+ Ask more of people (share risk).

As a Spokesman

+ Know your organization's policies.
+ Stay within the scope of responsibilities.
+ Tell the truth. Be transparent.
+ Embody your agency's identity.

CONSISTENT MESSAGES ARE VITAL

Prepare to Answer These Questions:

+ Are my family and I safe?
+ What can I do to protect myself and my family?
+ Who is in charge here?
+ What can we expect?
+ Why did this happen?
+ Were you forewarned?
+ Why wasn't this prevented?
+ What else can go wrong?
+ When did you begin working on this?
+ What does this information mean?

Stay on Message

+ "What's important is to remember…"
+ "I can't answer that question, but I can tell you…"
+ "Before I forget, I want to tell your viewers…"
+ "Let me put that in perspective…"

BE FIRST. BE RIGHT. BE CREDIBLE.

Working With the Media

Disasters are media events. Major public health emergencies will instantly engage the media, especially if they are exotic, catastrophic, or first of their kind. If the public health emergency involves the intentional release of infectious or chemical agents, the media spin into high gear because the inherent conflict created by a bioterrorism act is a guaranteed newsmaker—the public will be anxious to learn about the resolution of the health crisis and the criminal investigation. It may be natural for those responding to a public health emergency to think of the media as a bothersome gnat that should be brushed away. In reality, the media are more like a 20-ton elephant coming at you that can't possibly be ignored.

Today, the United States does not have a self-contained method to instantly communicate with its citizens, such as an emergency broadcast system that would reach everyone who may need important emergency information about what actions to take. The private media serve as an emergency broadcast system during a crisis and do it very well. If you ask someone where they go to get up-to-date information during an emergency, they will mention radio, TV, and, today, Web sites. Communities around the nation are served by professional media representatives that recognize their role in public safety.

The disconnect for public health and safety professionals about the media's role is that they would like to turn media demand on and off at whim. It doesn't work that way. The media are not an adjunct to public emergency response, they have their own place in a free society and their own obligations to the public. Public emergency planners should acknowledge the media's role in a crisis and plan to meet reasonable media requirements during the crisis. Few reporters, editors, directors, or producers will abandon their effort to obtain information and provide perspective on a crisis just because, as an emergency response person, you don't want them involved.

For reasons described in earlier chapters, it's imperative that emergency operation centers (EOCs) and all government and nongovernmental organizations involved in crisis response understand the legitimate needs of the media and how to fulfill those needs as an ongoing and well-thought-out part of the response plan.

To add a little perspective, emergency response would be considerably hampered if media were not involved—the absence of mass media would make it nearly impossible for EOC and public officials to communicate the nature of the crisis and the appropriate actions citizens should take to mitigate morbidity and mortality. Granted, in some disasters, response officials find themselves in trucks with bullhorns moving through neighborhoods telling people where to find shelter or not to drink the water from their faucets without purifying it. However, for most public health emergencies involving infectious diseases, including bioterrorism, the expectation is that the community infrastructure will be in place, electricity will continue to flow, buildings will stand, and roads will be clear. Therefore, the media will be an excellent vehicle to quickly communicate to the public. It is important to understand that the media will not allow you to spoon-feed them headlines. They will decide what to tell their viewers or listeners about what is occurring. Don't treat them like a member of your staff; suggest, do not dictate, and the relationship will move smoothly forward.

Reality Check: In easier times, you may begin to feel reporters are your friend or will report positive news about your organization. Don't bet on it if you and your organization are involved in an issue that has national significance. Reporters have a job to do and they will do it. Expect the relationship to become more serious and keep it that way. No favors should be expected from either side.

As the event unfolds, expect a widening gap between what you believe the media should be concentrating on (or not) and what they want to know. Also, remember that it's their job to look for alternate perspectives on what is happening. Make your points clearly and consistently, and you will have done your job. If incorrect factual information that could harm the public is presented by the media, it's imperative that you correct the facts. Expect only limited success in influencing, especially in the 24-hour news arena, that part of the crisis coverage devoted to debate, discussion, and speculation. Remember that what seems like facts to you may not seem so black and white to reporters and commentators.

Can't We All Just Get Along?

The quickest way to destroy your relationship with the media is to ignore the finite aspects of their job—they have space and time to fill and deadlines to meet. Know those deadlines and work to accommodate them. During a crisis, be available—if necessary, around the clock—to help reporters get the facts and get them right, before deadline. Attempt to give media a reasonable expectation of when new information will be provided and, as quickly as possible, establish a schedule for information releases. Everyone involved will appreciate some ground rules. Those ground rules will depend on the type and phase of the crisis.

Today, even print media face short deadlines because of their online Web editions. In the past, response to media could be prioritized by their deadlines. Today, everyone seems to have the same deadlines, and this requires a revamping of the way emergency information is provided to the media.

The most ethical way for a public agency to approach this responsibility is to provide all media with the same access at the same time. As technology progresses this becomes easier to do. Through the use of pre-agreed-upon e-mail addresses, fax numbers, and onsite media opportunities (including teleconferencing, so media away from the event can attend), you can be the pillar of fairness. In the first critical hours or days of an emergency, do not play favorites; equal access to information is imperative. If you have a message to communicate that is essential to the well-being or safety of the public, it's not up to you to decide where they get that information. Give the same information to all media all the time.

Reality Check: More than 70,000 media outlets operate news activities in the United States and many of them are interested in breaking news and health and medical news. It's impossible to have them all on your blast-fax system. Providing equal access to information may mean posting the information on a Web page within two hours of its release, rather than a day after. Equal access means not discriminating between the local network affiliates and local independent TV stations. Equal access means not leaving out newspapers or radio stations. Make a reasonable effort to include as many local media as possible in your media opportunities. Discuss precredentialing media to provide access to the media room at the EOC.

Think local media first

Don't ignore local media in favor of the national media and the well-known names. National media have contacts outside the local area to fill in much of what they need. They won't be shortchanged. Local media are counting on local response officials to work with them, and you should. If you are the public information official at the local level, think local media. If you are at the state level, think regional media or border media, and at the national level, think national media. The key is to have consistent information flowing back and forth between the official response levels. If the content of the message is consistent, we can begin to fulfill the needs of reporters at all levels. Following the H5N1 influenza outbreak in the late 1990s, national and local reporters on a panel at the first Emerging Infectious Disease Conference, held in Atlanta, praised the public information response because "everywhere we turned the facts were the same. When the Hong Kong Health Department released something, that same information appeared on the CDC Web site." Like the public, the media are looking for consistent information. Things change, no doubt, but as the information moves along it should be the same quality and content at all levels.

Reality Check: Americans have been exposed to various myths about harmful behavior following a disaster, including looting, price gouging, and scope-of-disaster estimates. Excessive media coverage of these negative incidents or the possibility of these incidents may lead the public to believe that these behaviors occur at a much higher rate than they truly do. Research shows, for a number of reasons, that local media can do a better job of covering disasters in a such a way as not to perpetuate these myths than can the national media. An analysis of coverage for Hurricane Gilbert found local print media the most accurate (Fisher, 1998).

What do reporters want?

An age-old question. They want answers to their questions, access to experts, and visuals to support their coverage. That stands true during an emergency, only they all want it NOW.

Questions at the top of the list in an emergency include the following:

- Who is in charge here?
- How are those who got hurt getting help?
- Is this thing being contained?
- What can we expect?
- What should we do?
- Why did this happen? (Don't speculate. Repeat the facts of the event, describe the data collection effort, and describe treatment from factsheets.)
- Did you have forewarning this might happen?
- Why wasn't this kept from happening (again)?
- What else can go wrong?
- When did you begin working on this (e.g., were notified of this, determined this . . .)?
- What does this data/information/results mean?
- What bad things aren't you telling us? (Don't forget the good.)

How to give reporters what they want

The more you can prepare to anticipate the needs of the media, the more completely you will accomplish your goals: inform the public, help the public understand public health actions or recommendations, and gain public acceptance for public health activities during the response and recovery of a major public health emergency. Background information—the information that will not change during a crisis—such as a description of the organism involved, its incubation period, methods of treatment, etc., should be in place as

soon as possible and easily retrievable. The CDC and other federal agencies work together to develop most of this background information. It will continue to be available to local and state public health officials through the CDC Web site. You may want to check there when faced with a infectious disease or chemical event.

Reality Check: The next recommendation may be difficult for public information officers who've taken their fair share of hard knocks from demanding or unreasonable reporters. But here it is: don't hold grudges. Help your leadership and spokespersons not to hold grudges either. That's easier said than done, but during an emergency emotions and tempers run high. If you are unhappy with the way a particular reporter is approaching coverage of the event, find a time when cooler heads prevail to discuss it. Don't shut the reporter out. Don't refuse to provide a subject matter expert to a reporter you're angry with if you're offering the expert to everyone else. Reporters have more ink and more air time than you do. Situations change quickly and it's your job to keep the communication lines open. Don't take it personally—take it professionally and follow the etiquette expected in the field when lodging a complaint or asking for a correction from a reporter and his or her outlet.

Media operations in a crisis

Just as a public health emergency is not business as usual for your agency, it's not for the media either. Media outlets have plans to cover major breaking news, and it's worthwhile to know what those plans are. During nonemergency times, EOC managers should invite local media into the operations center to explain how it will work, the agencies that will be involved in the response, and where media will be accommodated when the EOC is operating. There should be a designated media room, outside the command center but adjacent to it. This could be used for media opportunities and, when agreed to, to conduct individual interviews.

The media onslaught could start in a matter of minutes, depending on the type of public health emergency. The natural public curiosity feeds the media frenzy, along with pressure to fill 24-hour news outlets. Media are most apt to exert pressure en masse—they are all looking for answers to the same questions at the same time. It's imperative that the EOC or the public health department leading the response be ready for that pack of journalists. If official channels cannot meet the media's needs, experts and outside authorities on a subject will almost instantly be speculating to the media about what officials are or should be doing. This won't be "Monday morning quarterbacks" talking—the second-guessing will begin immediately.

During an unfolding emergency, media may not behave as they usually do, so you must expect the possibility of the following from media during the early moments of a crisis:

- **Diminished information verification.** Tentative information, sometimes incorrect, will be broadcast.
- **Diminished adversarial role** (media are people, too). They will have genuine concern about what is occurring and will want to help by providing important messages. Don't expect the media to be this accommodating throughout the entire crisis, but in the beginning, the "them" versus "us" ratio diminishes and media contribute in their way to public safety.
- **For major crises, expect the national media to dominate.** Most people will be getting their news from the national media. Local media will be feeding information to the national media that will be on the air, coordinating the coverage. Messages meant for local audiences will have to compete for

airtime with the national coverage. Respect local media deadlines and keep the information flowing to help disseminate local public health messages.

- **Media will expect an EOC**, where they can consolidate information to deliver to their viewers and listeners. Initially, the media will accept that much of their information must come from the command post. Within hours or days, depending on the crisis, media will be looking for other perspectives and other places from which to broadcast. If you want the media to use official releases of information, you'll have to ensure that the information is timely, fresh, and easy to access. Reporters have options about where to get information, and there are plenty of people inside and outside official channels who are willing to talk. A well-functioning media command center within the EOC that gives the most, the most accurate, and the freshest information will rule.

- **Inadequate scientific expertise.** The other reality during a public health emergency, especially those involving infectious disease issues, is that many media will not have the technical or scientific background to quickly grasp new information or the nuances of that information. Prepare to fill in the blanks, without being condescending. Remember not to assume that everyone knows the technical jargon. Talking plainly to the media is a good way to practice talking plainly to the public during the emergency. Some people do not understand the difference between bacteria and viruses. Start with the basics and bring your reporters along. They will appreciate not being made to feel stupid, and you'll appreciate that the reports are accurate.

Getting emergency information to the media

Media releases: In an emergency, print information must move electronically to the media or be given as handouts to media at the site of the incident. If it's important enough to put down on paper (the information will remain current for at least a 12-hour cycle), get it done.

Pluses:

- Ensures consistent information to all media.
- Provides an historical record.
- Allows for background information and direction to other sources of information.
- Gives media, who like paper, something in their hands from which to work.
- Releases that are fill-in-the-blank will guide you to answer the questions at the top of reporters' minds—keeps you organized in the early hours.
- Creates expectation for releases within the media and the public.
- Allows for the same releases to be posted on your own Web site.

Minuses:

- They take considerable time to write and information may be changing in that time.

- They may be difficult to clear through all layers of official command.
- If the release is not coming from the EOC (if it's involved), it could start a turf war.
- Reporters will expect more where that came from—be prepared to consistently release information this way.
- If the release of information is not organized through a command post, competing press releases could be frustrating for media, especially if press releases cover information that spans across response areas, and are unclear about who is responsible for collecting and releasing what information.

The press conference or media opportunity

A public health emergency is an appropriate time to consider holding a press conference. Though, in truth, the term press conference implies an event that is scheduled in advance, sometimes weeks, includes a press kit, and is designed to allow media to ask questions of the featured experts. A media opportunity is more appropriate for the early phases of a crisis. One can be arranged at the site of the crisis and allow for information to be released to all media, even without press kits or a question and answer opportunity.

Pluses:

- If media are at the site of an event, it's an effective way to conduct media interview requests in one shot and control their access to the site.
- It helps ensure consistency in the information released.
- It can introduce your spokesperson and subject matter experts (SMEs) to the public, allow them to express their feelings and begin to build their credibility with the public.
- It allows the response organizations to show very early on that there is a process in place to respond to the crisis and that, although the event is unfolding, someone is ready to help with response and recovery.
- Strict rules about questions from the media can be imposed.
- If information is changing rapidly or not enough is known to issue a press release, it fulfills the immediate need of electronic media to fill space and time.
- Elected officials have a forum to present a united front.

Minuses:

- It is sometimes difficult to get the right people in front of the media to give updates (planning helps).
- Information may be sketchy and response officials may balk at meeting with the media when they do not have the answers (training helps).

- If media cannot be at the site, they will not have the information they want or need.
- You can't do this just once—media will expect periodic opportunities.
- If coordination isn't solid, you could find competing media opportunities occurring. Local, state, and federal officials, and people across levels of other organizations, need to have a plan and agree to the timing of media opportunities.
- Early media intensity will push the limits of any rules set about the length of the availability and the no-questions policy. (There must be an escape route for speakers out of the media area).
- Media will want to follow up on individual interviews. Set the ground rules and be consistent.

Satellite media tours

At the national or regional level, or at the local level if media in other cities are pushing for access, a satellite media tour may be appropriate. Although a satellite media tour can be arranged in a matter of hours during a crisis, it may not be an efficient tool early in the emergency. It may be an effective tool for communities to talk to each other through the media—offering support, ideas, and lessons learned. Think creatively about these. Satellite media tours are usually conducted by a single spokesperson or SME and are meant to allow local media to interview the SME directly. To avoid confusion, be sure that the SME has a Teleprompter® identifying the speaker and the name and city of the reporter. Be alert for earphones that pop out. These interviews are typically live-to-tape. Correct misinformation on the spot. This concept will work well when the satellite trucks are parked outside your door, and it won't cost you a dime.

Pluses:

- Allows media unable to be onsite or are prevented by the nature of the public health emergency (e.g., the area becomes restricted) to be given access to the center of action and response officials
- Provides a way for local or regional media to speak in depth to SMEs and ask questions specific to the region or population
- Increases the chances that media in other local or regional areas get it right—right from the horse's mouth, so to speak, instead of translated through national media back to them at the local level

Minuses:

- Expensive
- Not easily arranged in a crisis, unless resources and agreements are in place in advance
- Limited reach, right for only very specific situations
- After a round-robin of similar interviews, spokespersons can burn out.
- Time-consuming

Telephone news conferences/Web casts

Computer and phone technology now allow the public information officer to set up a toll-free telephone number that media can call at a specified time and listen to updates from response officials. Participating spokespersons need not be co-located. It would be possible to conduct a local, state, or federal press opportunity by phone, even if spokespersons were working from many locations. In addition, the technology is interactive and can allow media to ask questions.

Pluses:

- Reaches far more media than just those at the site of the incident
- Multiple-community and national involvement give local and national media access to response officials
- Easy to arrange
- Moderate cost
- Allows for the number of telephone lines to be adjusted according to rising or falling interest from the media
- Officials are comfortable with this format
- Great flexibility in when and where
- Allows control by public information official about who has the toll-free number
- Can be regularly scheduled to mollify media by assuring them of regular updates
- Format allows for last-minute changes in spokesperson (e.g., a new development requires a new expert to appear or a spokesperson is called away for unavoidable reasons; it's easier to get a substitute)
- Allows time for questions and the questioner's name to be announced by the call moderator (phone operator)
- List of all participants, even those not asking a question, is provided by phone operator, making news monitoring and analysis easier
- Can be archived and made available to media after the fact
- Can be recorded so transcripts can be supplied on request

Minuses:

- Requires a funding source or advance contract
- Cost can add up over time

- Difficult to wean media from this format; regular calls should not be stopped abruptly
- Does not fulfill the visual needs of TV news; favors print and Web media

Commercial press release services

These services (e.g., PR Newswire, US Newswire, etc.) give organizations access to national, regional, or specialized media using media lists and fax numbers. Many of these services are available 24 hours a day.

Pluses:

- Eliminates the need to maintain up-to-date specialized media lists or those outside the local area
- Press releases move very rapidly to newsrooms
- A list of media outlets that received the release is available
- A way to reach media that may not be on your core media list but have an interest in what is occurring

Minuses:

- Funding source must be in place in advance.
- Releases through a newswire may appear less than official for some types of emergency information that, perhaps, should come directly from the response organization to the newsroom.
- It may not be necessary when media are actively engaged and could waste resources—appropriate at less intense times during the emergency response.

E-mail listservs and broadcast faxes

Many media are prepared to receive information from organizations through e-mail or by fax.

Pluses:

- You can almost instantly disseminate information to media on your e-mail listserv at an imperceptible cost.
- Corrections are easy to make.
- The organization gets credit for having contacted reporters or outlets by name.
- Provide an open channel that, until they yell “stop!” allows you to feed information to the media at will.

Minuses:

- Lists require regular updating and maintenance—media move around often.

- Provide a passive way to give the media information; some may not get to your e-mail or broadcast fax until it's too late for them or you.
- Not highly personal. They may still want a return phone call.
- Require cleared print information, which is time-intensive for the public information office and could slow information flow to the media.

Web sites/video streaming

Anyone who can afford the monthly cost can have a Web site. The Internet-connected public and media expect to go to the Web for information. Official Web sites can be a media-response tool.

Pluses:

- Serve as a rapid way to update all media simultaneously
- Become transparent since the public and media will see the same information on the site
- Organize the documents and creates a historical record for media and the organization
- Permit links to help media collect background information
- Allow rumors, myths, and misinformation to be addressed without drawing undue attention
- Allow official video or pictures to be available to media digitally
- Permit FAQs on the page to do double duty for media and public, providing a user-friendly way to educate both during a crisis
- An inexpensive communication tool

Minuses:

- Not available to all public or media.
- May frustrate media if too much information is provided or if the site's organization is not clear; they want it easy and immediate (you may have to walk some of them through the site the first time).
- Require the continual availability of a Web master who is willing to post updates on the Web within the 2-hour window that should be maintained between release of information and its appearance on the Web.
- Technology dependent—may be vulnerable to glitches or interruption by hackers, etc.

Response to media calls

The bread and butter of the relationship between public information officials and the media is the simple calls from media requesting specific information or an interview. In a public health emergency, the manner in

which an organization responds to these calls may make a difference in the way the organization's responsiveness or professionalism is portrayed to the public. The fact is that if the media don't believe you're responding well, they aren't going to believe that you're responding in good faith. Resources allocated to media response are well invested and will provide long-term returns. Every organization must establish a workable plan to respond to the surge of media calls. This aspect of working with the media is not an option, but a must. Training, planning, and coordination will make the difference. Media should know ahead of time how the flow of information will work, how to get their requests answered, and what you can or can't do. If your phone lines overload, what's your back up plan?

Pluses:

- Media can provide information you may not be aware of (e.g., a neighborhood leader who is complaining that the response resources are not being fairly distributed. It's a fact that some disgruntled people will call the media for resolution before they will call the responsible official organization).
- Media inquiries may reflect the public's level of interest. The number of calls and frequency of subjects raised can give the response community a sense of what is important to the public and where more information resources may need to be directed.
- One-on-one contact with the media allows opportunities to emphasize key message points, direct media to upcoming issues, and correct misinformation.

Minuses:

- Returning calls take a lot of time.
- Potential exists for inconsistent or premature release of information, unless press officers and spokespersons are well trained and the release is coordinated.
- Follow-up calls may be required if information changes before the media/reporter releases it—or you'll be guilty of not giving them the right information.
- Phone Tag is the name of the game.
- Massive prioritization is required, and the media will know if they're not at the top of the list.
- You can become the public library or return calls on subjects not in your area of responsibility unless the screening of calls is very well done.

Writing for the Media During a Crisis

The rules of journalism apply even during a crisis. The pressure, however, is to move the process along at a pace that reasonable media and people will perceive as responsive and credible. Research has shown that the public's belief that an emergency response was effective correlates with how much access to information they had during the crisis. The challenge is speed versus accuracy. Both are important. If information is accurate and released after the public has moved on to another issue, it has no value. If it's out fast but is inaccurate, the best-case scenario is to admit it and move on; the worst case is that the inaccuracy causes harm to the public.

Public information officials must stabilize that pendulum and push the responding officials toward releasing accurate but incomplete information as quickly as possible. It's like cooking a turkey when people are starving: if the wings are done, break them off and start chewing; keep cooking the turkey but don't let people starve waiting for it.

So what can you get on paper first? Start with what you can verify, and be careful to alert the media and the public that more will come as more becomes available. If decisions are not finalized, then explain that the process to reach decisions is ongoing. If laboratory tests are not completed, explain the testing process. You can keep the media and the public engaged and feeling involved and important even if you don't have the answers to the hard questions.

Prepare to provide basic background on issue to media

When ex-NBA star Magic Johnson announced that he was HIV positive, a lot of sports reporters, who had no understanding of the science of HIV, were suddenly interested in the issue. These reporters were trying to cover a breaking story that had obvious health implications, but were medical novices.

When your organization is putting together educational materials for the public about a crisis, it is worthwhile to think and communicate on a very basic level. When a health-related disaster or event occurs, reporters from the non-health/non-science arena will be assigned to cover it. At that point, you will find yourself dealing with people who need basic information about the issue *first*. Having this background information already developed and ready to share will also prove useful when the reporters begin developing their stories for the general public.

Back to the basics: What your media release should include

During the early phases of an emergency, you'll be writing standard press releases. As the crisis evolves, you may follow up with feature releases about individuals or units involved in the response or outcomes and their successes, or personal stories of those helped during the crisis.

An emergency press release should be limited to one page. Practice, and you'll be amazed how quickly you'll be able to determine what information belongs in the factsheet and what belongs in the press release. Think of press releases, from the very start, as press updates. The press release should answer, the who, what, when, where, why, and how of the ongoing event. Additional information should go into an attached factsheet or backgrounder. *This method will speed up the clearance process for the press release, reduce the opportunity to introduce errors into the release, and help the media quickly determine what is news and what is background.*

- At the top of the release, include the following information: your organization's name, address, and telephone number, and contact name(s).
- In an emergency, it's critical to give the media a 24-hour contact number.
- If you have a toll-free number for media, include that, too, and tell media it's for them, not for the public.
- Include the date or the date and time if more than one release is issued during a 24-hour period. Give your press release a headline; it's a way for media to identify quickly what they're calling back about. Create headlines in an active voice and summarize the core information in a few words. Never reuse a headline during the crisis.
- Some organizations employ a press release number. That's fine, but don't let it take the place of unique headlines.
- Put "for immediate release" at the top under your contact information—don't make reporters or editors guess.
- Write in the inverted pyramid style—most important information first.
- Press releases do not have strong concluding paragraphs.
- If you're providing a *new* telephone information number or Web site address, introduce it higher in the press release. Don't assume the editor will notice it in the last paragraph.
- Limit the length of sentences (rarely more than 20 words) and paragraphs. A one-sentence paragraph is acceptable in a press release.
- Remember, the more syllables per 100 words, the more difficult text is to understand.
- Explain scientific or technical terms. Don't assume your audience knows what you're talking about.
- Make every effort to eliminate adjectives or emotionally laden words.
- A well-written press release reads like a news story.
- Check your facts, especially after including revisions from subject matter experts.
- Do a security check—some information is classified.
- Do a privacy check—some information may violate the privacy of victims and their families. If names have unusual spellings, mark an OK note next to the name, so editors know that you've not made a mistake.
- If a name has an unusual pronunciation, include the phonetic pronunciation so radio and TV reporters will get it right. This is good for the reporter and good for the person being mentioned.

- If you detect an error in a press release that has already been distributed and there's time to fix it before it's used, make the effort to reach everyone who has it. Reporters don't like taking the blame for your mistake. Don't just correct it on your Web site and leave the media hanging. If it's too late, and it has appeared, apologize.

Reality Check: Some concessions to your journalistic tastes will be required to get the press release cleared through scientific and official response channels. Pick your battles or, better yet, write press releases in advance, with fill-in blanks, and get them cleared through channels or at least pre-reviewed to get officials with no media background used to the difference between a press release and a situation report. Do the best you can; we all understand that writing by committee won't likely be one of your greatest journalistic moments. Keep your eye on the prize: getting accurate and timely information from your organization to the media and public.

Press statements are not press releases

- Statements typically are not news; they may be an official position or perspective of the organization.
- They normally contain only a few paragraphs.
- They are usually attributed to a high-ranking official in the organization.
- They may be used to counter a contrary view about an *important* subject related to the emergency (e.g., why the organization is choosing one treatment recommendation over another).
- They should not be used to generate a peer-review debate.
- They are a means for an official to be quoted as having responded to an issue without the need for a media opportunity.
- They can be used to offer words of encouragement to victims, responders, and employees.
- They should be posed with press releases on the Web site.
- They need a contact number from the press office.
- Use them sparingly for best impact.
- Take the high road; no whining!
- Don't state the negative that's being countered; state the organization's position only—don't validate the contrary point of view.
- Get these cleared up, down, and sideways.

Media factsheets/backgrounders

- These should be attached to a one-page press release.
- Both can run for several pages.
- They should define scientific and technical terms.
- Factsheets should be in a bullet format with a logical progression from the broad to the specific about a single subject.
- Backgrounders may be in paragraph form and typically give historical information and information too in-depth for a bulleted factsheet.
- They are excellent sources of information for the media.
- FAQs can serve as both factsheets and backgrounders, but depending on the subject, may be annoying to seasoned reporters.
- Expect to see them on media Web sites, so get them right.
- Avoid including information in factsheets and backgrounders that will be changing. Press releases are the place for updates on the ongoing situation. Factsheets and backgrounders give just that—facts—and background or history.
- Don't include quotes from officials or SMEs.
- Both are official documents released from the organization or the EOC.
- Coordinate information to ensure that all parties agree on what's fact and what's background.
- Prepare these in advance, when no emergencies are in sight. Check in at state or local levels to see if the work has been done.

Visuals, video press releases, and B-roll

More people are getting their news information from TV or Web sites than ever before. News outlets are hungry for visuals to support their reporting—talking heads get boring. Digital technology makes it easier and less expensive for official response organizations to provide some visual support for the media covering the emergency.

- Consider 10–20-second sound bites from response officials and SMEs that can be edited into local newscasts.
- Get your key messages on tape.
- Video press releases (VNRs) quickly become dated and may be too time-consuming to produce in the early phases of an emergency.

- B-roll (silent, background video) is easier to produce, and news directors prefer it because they can build their own stories around it.
- Prepare B-roll in advance, if possible, and get a security check to ensure that classified information is not being released.
- Write the sound bites for your spokesperson. Spokespersons do not have time to pare points down to 20 seconds, so do it for them.
- Make sure each sound bite stands alone so it won't confuse a viewer who may see only one of five possible sound bites.
- Don't raise a subject in a B-roll if you do not want to promote it.
- Give the VNR or B-roll a paper and on-tape index of who is talking or what is being shown (e.g., SL2 bacterial lab technician preparing samples for testing).
- Determine your distribution methods: scheduled satellite feed following a media advisory or beta copies of the B-roll that can be picked up by media, dropped off for media, fed from a local network affiliate to national network satellite for feed to other locals, or via overnight mail, with the request that the hard copy be returned to you.
- VNRs and B-rolls must be professionally produced to fulfill the needs of media. Some in-house digital video can be used on your Web site.

Decide on a message daily

Be proactive and provide recommendations and information to the media and the public as early as possible to establish your organization as being accurate and credible. Doing so will facilitate stronger relationships with the media and the public.

In the case of the Ft. Collins postal worker, local and state health workers wanted to quell the concerns about the potential of anthrax exposure and quickly decided to distribute a press release announcing the closing of that post office and the availability of antibiotics to all the other workers in that facility.

FEMA Disaster Field Offices develop and distribute a "message of the day" to help establish credibility and a rapport with the public and the media—regardless of whether or not they are in the midst of a crisis.

Conducting a Successful Press Conference or Media Opportunity During a Public Health Emergency

Ask yourself one more time, "Is this the right way to release my information?" If you've coordinated with other responding organizations or you've been directed to hold a press conference, the answer may be an easy yes.

Where to hold the press conference

Press conferences are best held:

- On the site of the emergency, if it lends itself to a media event (e.g., it's safe for the media to be there, it won't interfere with recovery efforts, or would not violate the privacy of victims of the emergency)
- Hold the press conference at the EOC, if room has been set aside that is separate from the operations center. You don't want media moving in and out of the operations center. If the conference is held in a restricted building, try to streamline the media's screening and access to the site, even if it requires volunteer escorts for each reporter.
- At a separate official location, such as the town hall, the health department headquarters, or the governor's office.
- At a hotel meeting room convenient to the officials involved and the media who are likely to attend.
- Somewhere with sound equipment either available or in place, with electrical outlets (if not on the street) and other specialized equipment needed by media.

Whom to invite

Before you announce a media opportunity, guarantee that your spokespersons or officials are available. Have backups on standby.

- Invite print and electronic media, and don't forget radio stations. If the EOC is hosting a press room, be sure to post a notice in that room too.
- Attempt to limit the number of emergency response officials attending who will not have a speaking role. It's disconcerting to media to see a pack of people in the back of the room, possibly wearing response uniforms or credentials, who are never identified. Also, expect that anyone in the room from the response team could be approached by the media for comment, not to mention that information not yet ready for release could be the topic of conversation among the pack in the back of the room. "By invitation only" holds true for response personnel, too.

How and when to invite the media

- Give the media as much advance notice as possible, but not so early that the event is cancelled because it's overcome by events. An hour is the absolute least amount of time from notice to the event, unless media are all standing by waiting for a comment.
- If the emergency has gone on for some time, schedule a regular time for media opportunities and stick to it to eliminate the need to contact the media each time.
- If you have something really important to release and media may not be aware of what's coming, use the resources necessary to call reporters or their news directors/editors and tell them why they need to be there.

Send a brief media advisory about the opportunity. It should be only a-half page long and give the following information: the nature of the event (media opportunity or press conference—be aware of the differences); date, time, place, contact person, who is scheduled to appear (by name and title, or by position and subject matter expertise), and the topics that will be covered. Keep the advisory short—you'll get it cleared more quickly and have greater flexibility if you want to adjust messages or add topics. Be specific enough that the media understand the urgency (easy early in the emergency, but may be more difficult in later phases of the crisis).

How to conduct the media opportunity

Keep the speakers out of the room until the event begins—you don't want the negotiations about logistics and who speaks when being worked out in public. Do that in private. The instant that the principals are visible to the media, their demeanor and behavior is a matter of public record. It's natural to blow off a little steam, joke around, even during the heat of a crisis. Your officials need to be able to do that away from the cameras. Respect that need.

Whether the speakers sit or stand depends on the room, the length of the event, and whether they are all speaking and all taking questions. There are pluses and minuses to each. Remember, if they all stand, you get a "herd" effect that makes the group seem more active, as if there is more urgency to the situation. That's good if that's what you want to convey because you're about to ask the public to move immediately on the information you're about to release; it's bad if you're attempting to present a calm, reasoned response to an emergency.

You can choose to have a press officer moderate the event or allow the lead official to do so. Accommodate the preferences of the official but be available on the side if they decide to go it alone.

Unless the officials are nationally known faces and names, ask speakers to introduce themselves by name, title, and organization. They should repeat their names and organizations if they step forward to answer a late question.

It's appropriate to alert the media ahead of time whether questions will be addressed from the podium or if only statements of information from organization officials will be made. Caution: media do not like to be restricted from asking questions, but they'll accept it if the information is real news and they are given access

to the officials at other times to get answers. Taking questions means giving some control of the content over to the media. In the early phases, it may not be necessary to take questions.

If you plan to take questions, decide who will select reporters to ask questions (e.g., the lead official or a press officer moderating the event). Decide the time limit of the event, including questions and answers, and let the media know there will be a limit. If you're moderating controversial issues surrounding the emergency that should not be addressed by your officials, let the media know that questions should be limited to the topic at hand.

Reality Check: Media will ask whatever question they please, despite your directions. Be sure the officials know who will respond to controversial questions—the person who will toss the reporter back to the appropriate organization or SME. Get agreement from all of the officials involved—it's hard to have an answer and to restrain yourself from giving it because it doesn't fall within your scope of responsibility.

Have a backup plan for such glitches as the loss of sound equipment.

Tell the media, either before the officials enter the room if you're not moderating, or at the end of the event, how to get more information and answers to questions.

Decide ahead of time whether officials are going to do standup media interviews for individual reporters following the event. It's fine to do this if the official has the time, won't go off-message (because they've received good training in advance), and there's an exit plan to end the interview (e.g., official is pressed for time and has only 5 minutes before his car leaves for another appointment). Expect radio and print media to surround the TV reporter conducting the interview or vice versa. It's really like another small, informal press conference. Keep control of the officials and the media by assigning a press officer to each official. You need to know if something has been said to which you'll have to react. It happens.

Using visuals

It may be too much to ask of the officials to manage charts, PowerPoint presentations, or slides during the briefing. If there's a way to position a communications expert to manage the visuals, do that.

Media will want copies of any slides, graphs, or visuals you introduce. Caution: if an official waves a document or report or refers to it during the media opportunity, reporters will be asking for that, too. Try to agree on what will be mentioned and what will be available, and prepare the visuals ahead of time. You can reduce reporters' angst if you tell them ahead of time that they will get copies of what is being shown.

Watch a Department of Defense press conference to see how visuals can be used. (Don't forget security and privacy issues.)

Have paper copies of visuals in case the equipment fails.

Handouts

If possible, have copies of the presentations, useful fact sheets, and backgrounders available. Media like to use them to write their pieces, even if they have it all on tape.

Don't forget background information on you organization, simple mission statement, and facts.

If speakers are not well known, attempt to have brief biographies of the speakers. This helps build their credibility to reporters and the public who may read about them. You want your subject matter experts publicly accepted as such.

Reality Check: Record your press conference (at least on audio) if possible. It will help you with questions and answers after the fact and be a record of what was or was not said by your experts. Don't rely on your memory, especially during a crisis. Don't forget to arrange for media monitoring following the media opportunity or press conference to see if your messages were clearly reported. If not, prepare the materials you need to push those messages out as clearly and concisely as possible. If you limit the topics discussed during the media opportunity, the chances increase that the message you want communicated to the public will make the broadcast or the newspaper.

Following your press conference, immediately assess:

- Were key messages delivered?
- Were similar questions asked repeatedly?
- Spokesperson's delivery (e.g., tone, body language, clarity, etc.)?
- Any "next day" issues to prepare for?
- Any need to follow up with specific media, based on their questions, to clarify issues?
- What can you do next time to improve the media opportunity?

Responding to Media Regarding Egregious Errors, Myths, and Misperceptions

You're ready to throw your remote through your big-screen TV, or rip your daily paper to shreds—it must mean someone is reporting negative stories about your organization! If that is the case—what next?

"Declaring war on the press, tempting as it may sometimes be, is a game you can't win."
Stratford P. Sherman, *Fortune* magazine

Tip 1: First, calm down

Remember: when you talk to the media, you are speaking for your agency or organization. No matter how angry you are, you cannot react thoughtlessly and attack the reporter. Doing so will reflect negatively on you and your organization, and will detract from your mission to communicate accurate health information to the public. Some reporters believe that only sensational, negative stories are news. "If it's good news it's no news" and "if it bleeds it leads" are two quotes frequently uttered by this type of reporter. Also, reporters do not always have time to get all the facts before their deadline pressure becomes a job-retention factor. If they continue with research, a competing reporter may release the story first. Reporters are just trying to do their job, so don't take the negativity personally. Always try to think in terms of educating the media and, thereby, building bridges to promote accurate stories in the future. After all, the media are an important communication link to the audiences you are charged to serve. To do this, you need a strategy.

Tip 2: Analyze the situation

What is your relationship with this reporter and media outlet?

Is the publication, television, or radio program credible? Have you worked with the offending reporter previously? After a negative news report is not the best time to make a "cold call"—to speak to reporters or work with media outlets for the first time. Expressing your complaint to someone who knows you, and knows you are credible, is easier and more productive. If the media outlet is unwilling to hear your position, you may consider trying to get your point across to your audience through an alternative source. Try to understand the reporters' point of view, and that they do not serve as your public relations firm. Reporters have no obligation to report only positive stories for you—although they do have a responsibility to present their audience with accurate information. You can and should appeal to their sense of community service if the stories they are running are not in the public's best interest. Also, remember who you are trying to reach. You are not trying to win a contest with media representatives. You are trying to serve the public interest by disseminating accurate information to promote public health. No matter the response from reporters, keep your anger in check.

Did the article you read or the piece you saw/heard attempt to express both sides of the issue?

To reporters, a balanced piece is one that examines opposing sides of a story. Whether one point of view is an extreme position and the other generally accepted does not matter. As long as reporters attempt to present both sides, they consider this fair reporting.

Was there truly an inaccuracy, or did the reporter simply present the facts with a negative slant?

Correcting a factual error is relatively simple and straightforward. Reporters and media outlets want to do their jobs well, and, like you, no one wants to make a mistake. However, a difference of opinion about a subject is not as easy to counter. Statements you may perceive as biased, uninformed, or sensational reporting will not be viewed by reporters as an error on their part. You can still respond to the piece; however, your strategy will be different from that required to simply correct a factual error.

Is the piece basically true even though it is "bad news"?

Obviously, you would prefer that only positive stories about your mission appear in the media. That is not always possible. There will be times when you will not have a response to counter a bad news story. There is an old saying that in order to prevent the perception of covering up bad news, we must get the good news out fast, and get the bad news out faster. When there is bad news to report, your job is not to withhold or counter the information. It is to reassure the public that no matter what the issue, positive or negative, you are open and responsive to the public's need for accurate information. Remember, you are not attempting to win a contest with the media, or a popularity contest with the public. Your mission is to communicate accurate health information to the public. This event may be simply your time to "take it on the chin" to satisfy your critics who are also served by the media. If the facts are reasonably true, and any mistakes made by the reporter are minor, you may want to let the story run without comment. Quibbling with a reporter over a minor point when a news item is otherwise accurate will not help you build bridges for future positive stories. You may want to contact the reporter to establish a dialogue for future, more positive stories.

Tip 3: Know what to ask for

Once you have analyzed the situation and decided that action is necessary, know your options. There are only a few possibilities available for a reporter to respond to your complaint.

Decide ahead of time your ideal, as well as your minimal, solution. Think of this as a negotiation. Here are some actions you may request:

Ask for a retraction or correction

A retraction is reasonable when an egregious error has been made—if the facts are clearly on your side and you have supporting material to refute statements originally reported. Ask for a correction immediately, and request that it be run as prominently as the original piece. Although this is not likely to happen, you may be able to discourage the editor from burying the retraction.

Ask for another piece to air that presents your perspective on the issue

A followup response is a reasonable request if your point of view was completely ignored or misrepresented in the original report. The best way to get a report redone is to provide reporters another angle for the story. Reporters are not likely to present a followup piece that simply contradicts a story they have recently run. They will not want to lose credibility. If you give them a fresh perspective, a new angle, or supply some new information (and give them a way to maintain credibility), they are more likely to work with you.

Ask for an apology

Sometimes reporters make unintentional mistakes. If the errors are not endangering a person's life or reputation, perhaps an acknowledgment of the mistake over the phone by the reporter is enough. If this is the case, you may use this as an opportunity to establish yourself as a source for this reporter and develop rapport that could lead to accurate, more positive stories in the future. The reporter may call you to check the accuracy of a forthcoming story before running it. This would give you the opportunity to avert future inaccuracies in that reporter's stories and would provide forewarning if another bad news story is about to run.

Ask that a correction note be placed in the permanent record

Ask the reporter or editor to file a written correction with the original piece in the permanent record. If the mistake is a factual one, you do not want to see it repeated (even if a correction is made). Ask the reporter or editor to officially tie the correction to the original report. Reporters often go back to do research, and they may report the mistaken information again if they do not realize that a correction was made.

Ask that a letter to the editor or guest editorial be printed

If you have an important message concerning the issue reported, a letter to the editor may be the right choice. Letters to the editor are widely read, and publications are usually quite willing to print opposing views. Keep in mind that your message must be concise, or your opportunity to correct an error could be lost in editing. Make your strongest points early in the letter and keep the letter short and to the point. Editors who are rushing to meet a deadline tend to simply cut the end of written material when trying to fit text into a specific space. Be sure to seek concurrence from SMEs within your organization before releasing your letter. Be sure to coordinate with public affairs.

Tip 4. Know who to contact

Media outlets have a chain of command. Starting at the top is not usually the best approach. Follow the chain of command when contacting the media to respond to an article or broadcast piece.

Talk to the reporter first

Always give the reporter the first opportunity to respond to your concerns. Perhaps the reporter is frustrated because an editor changed a piece without the reporter's knowledge. Perhaps the producer who put together the nightly news teaser misunderstood the reporter's message, or sensationalized an originally balanced report. Let the reporter have an opportunity to respond and explain. Know the reporter's position before taking any action.

If the reporter can't be convinced . . .

Ask to speak to the news editor or producer. Keep moving up the chain until you are satisfied, or until you are convinced that you will not get satisfaction.

If you have doubts about the integrity of the media…

If the reporter or media outlet that presented the negative or inaccurate report is known to have no journalistic integrity, consider going to an alternative media outlet. Of course, go to them with a great story idea, not just a complaint about the other media outlet.

Consider reaching your public through alternative outlets

If all else fails in your efforts to set the record straight with the offending media outlet, redouble your efforts to get your message to the public through alternative means. For example, set up a public forum, make your presence known on the Internet, and invite partners to write letters or make phone calls. Offer articles for community newsletters. Work to establish contacts in competing media outlets.

Tip 5: Know what you want to communicate

When you decide to counter the bad news article, you must thoughtfully develop the message you want to communicate. Know your audience and the message you want your audience to receive.

- Develop your message and have it screened by advisors and SMEs. Remember, an organization should speak with one voice to maintain credibility. To do so, we must confer with interested parties within the organization to ensure that we are not working at cross purposes with colleagues who have more information or a different perspective.
- Make sure to frame the message in a positive way.
- Include a call to action, if appropriate.
- Focus on your audience—the public—and your purpose: to promote public health.
- Keep your anger at your critics or the media out of the message. The media are neither the message nor the audience.

If you want to convince a reporter or producer to give your message an airing, you must be prepared to communicate that message without delay.

Tip 6: Have a plan before you need it

If an objection is to be effectively heard, you must express it as soon as possible

You know the important issues within your organization and the basic arguments of your critics. Prepare messages on the various issues ahead of time, especially when an issue is controversial. Draft letters to the editor that could be altered slightly and submitted within hours of the appearance of the offending piece. You may wish to release articles on these issues before reporters have the opportunity to run inaccurate or negative stories.

Put the media on notice that you are paying attention

You are part of the media's audience. They have a stake in responding to your needs, too. Let them know you watch or read their stories. Maintain regular contact. You may call a reporter to praise a good story. Remember to build bridges with media at every opportunity. They are an important communication link to our public, as they can facilitate our efforts to promote public health.

Let the media know that you're a potential source for the future

Don't just ask for an immediate airing on the subject: invite reporters to call on you for interviews in the future. Make sure you are available to give credible and constructive interviews. You may also want to develop internal sources of interview candidates that you can offer to media when issues surface. Be willing to deal with tough subjects. Don't minimize the arguments of your critics. Remember to focus on getting your message to your audience.

Monitoring the media for public response to crisis management

When public health officials in Colorado were faced with the potential of public anthrax exposure, they decided to close down one of their postal facilities. When none of the tests for anthrax came back positive, public health officials began to monitor the editorial pages for public comment and criticism. They were concerned that the public would view them as having overreacted in shutting down the postal facilities and wanted to gauge how the public viewed their ability to manage the crisis.

HOW TO: Letter to the Editor

Newspapers take letters to the editor seriously. To increase the odds that your message appears with little or no editing, consider these guidelines:

- Always address your letter to Dear Editor or, whenever possible, use the actual name of the editor. Do not use the salutations, Dear Sir or To Whom It May Concern.
- Letters to the editor must be short—a maximum of 3 to 5 short paragraphs or 200–300 words should be sufficient.
- Focus the letter on the issue.
- Start with the name of your organization and the purpose of the message.
- Convey brief background material.
- State your opinion and tell the readers what you want them to know or do.
- If the letter is to correct an inaccuracy, briefly mention the misconception or inaccuracy, but do not give it much space (you don't want to introduce the negative point to an even wider audience).
- Then set the record straight in no uncertain terms. Back up your statements.
- In the last paragraph, draw a conclusion or ask for an action, such as calling a toll-free number for more information or visiting a Web site.
- Don't forget to provide your full name, address, and telephone number. The editor may want to check to be sure you are who you say you are or to clarify some point in the letter (include a nighttime phone number if your issue is urgent).

Resources:

CDC Crisis Communication Plan (Draft) 1999.

Yale, David, R. (1991). *The Publicity Handbook.* Chicago: NTC Business Books.

Ury, William. (1993). *Getting Past No: Negotiating your way from confrontation to cooperation*. New York: Bantam Books.

Fischer, Henry. W, III. (1998). *Response to Disaster.* Lanham, Md.: University Press of America.

Stakeholders/Partner Communication and Community Relations During an Emergency or Crisis

Stakeholders are people or organizations with a special connection to you and your involvement in the emergency. Anticipate and assess the incident from the stakeholders' perspective. They will be most interested in how the incident will affect them. Stakeholders are expecting something from you. It could be as simple as information released through the media or a Web site, or as complex as in-person meetings with key organization officials.

In crisis communication planning, the first step in responding to stakeholders is to identify them. Stakeholders may vary according to the emergency, but core stakeholders will be interested in every public health emergency your organization becomes involved in and will expect a response from your organization.

The following are the five most serious mistakes an organization can make in their communications with stakeholders:

- **Inadequate accessibility**
- **Lack of understandability**
- **Dullness, lack of energy in the response**
- **Problems with timeliness (too little, too late)**
- **Perceptions of arrogance (stakeholders are not valued)**

Not all stakeholders are supporters of your organization; nonetheless, it is critical to identify unsupportive stakeholders and be prepared to respond to them appropriately. In fact, stakeholders will fall into three categories based on their responses to you in a crisis: advocates, adversaries, and ambivalents. Your response to stakeholders will depend on which of the three groups to which a stakeholder belongs. The point is to anticipate stakeholders' reactions based on their affinity for the organization and the way that similar groups have reacted in the past when this type of crisis has occurred.

Why expend energy on stakeholders during an emergency? The effort secures input from people who have information you need. They represent points of view that are vital to understanding the perceptions of various groups of your organization's response to the incident. Involving stakeholders gives people a chance to tell you what they feel you need to know. It also ensures that everyone is aware that they are welcome to get involved and that they are valued.

An emergency or crisis may be an opportunity to strengthen your partner and stakeholder relationships as they see you in action. A positive response will enhance the organization's credibility. Don't forget to consider existing stakeholder controversies or concerns and how the ongoing relationship will color their attitude during this incident.

You must provide timely, accurate information to audiences and key stakeholders, both internal and external.

Following are the five most serious mistakes an organization can make in communicating with stakeholders:

- Inadequate accessibility
- Lack of understandability
- Dullness, lack of energy in the response
- Problems with timeliness (e.g., too little, too late)
- Perceptions of arrogance (e.g., stakeholders are not valued).

You must provide timely, accurate information to audiences and key stakeholders, both internal and external:

- Use audience assessment tools to ensure that appropriate messages are tailored to specific audiences.
- Concentrate on those stakeholders who can have the most impact on your ability to conduct public health business.
- Focus on the common concerns and reactions that will have to be addressed.

Develop strategies to minimize negative reactions by considering the following:

- **Emphasize factors that inspire trust,** such as expressing empathy, showing competence in the area of expertise needed to respond to the incident, encouraging stakeholder feedback, honesty and sincerity in your communication and actions, and committing to the long term by maintaining a visible presence even after the news cameras have left.

  Trust is usually endowed early in a crisis. However, that trust may quickly erode if information is inaccurate, inconsistent, or overly optimistic. If the estimate of risk turns out to be "more serious than we thought," your trustworthiness is greatly damaged. The damage is much less if you overestimated the degree of risk. People would much rather hear "the incident is much less serious than we thought."

- **Pay attention to organizational process** and, whenever possible, involve the affected community in determining recommendations for action.

- **Explain organizational procedures.** Be prepared to describe your organization's mission, the tools and methods used to provide its service, and the expected outcome—that which makes your response a success (e.g., fewer deaths, decreased infection rates, systems in place to detect secondary outbreaks).

- **Promise only what you can deliver, then follow through.** Under the pressure of scrutiny and the desire to "fix" problems, one may be tempted to guarantee outcomes. Don't. Make every effort to get back to people to ensure that the promises you make are being kept.

Be forthcoming with information; focus on building trust as well as providing good technical information. After identifying key stakeholders, determine their interests. Provide information that meets people's needs.

Try to gain trust and convey consistent themes and messages with empathy. Can you satisfy stakeholders' needs with blasts of e-mailed or faxed messages or will you need to make phone calls or hold special meetings to ensure continued understanding and support?

Before reaching out to stakeholders, be certain you've coordinated with other responding organizations to ensure that your message is consistent, you can accomplish what you intend to offer, and you don't send mixed messages. Remember, your stakeholder may also be a stakeholder of another responding organization. Power struggles or visible confusion among your organization and other organizations will reduce credibility of all of the players and further frustrate your stakeholders.

Methods to communicate to stakeholders include:

- Designated Web page for partners
- Telephone call from management or management representative
- Specific backgrounders and periodic updates.

Stakeholder Reaction Assessment

Define the advocates, adversaries, and ambivalents who are likely to be interested, and wish to be involved in this crisis.

- Note what will they want to know and likely reactions.
- Project the impact and/or financial effect of their reactions.
- Identify stakeholders whose reactions will have the greatest impact if the crisis escalates.
- Forecast the involvement of top management.
- Develop a reaction management strategy for key stakeholders' likely reactions.

These reactions will vary based on the disruption and how the perception affects them. Identify:

- Stakeholders who can have the greatest impact
- Common concerns and reactions to address
- Strategies to minimize negative reactions
- Actions and communication to inform and develop trust
- Consistent themes and messages to convey with empathy
- Preemptive communication strategies
- Concern for less important stakeholders
- Loyalty of your advocates, discouraging your adversaries, and keeping your ambivalents neutral.

Responding to stakeholders

Develop a reaction plan to determine the factors that would trigger the plan's implementation and to minimize disruptions from important stakeholder groups.

- Advocates—maintain their loyalty and support.
- Adversaries—discourage them from getting involved.
- Ambivalents—stay on the sidelines and/or provide tacit support.

Estimate the management time and resources based on what had to be done and who is responsible for each action item.

Stakeholders to consider

- Employees
- Families
- Retirees
- Board members
- External advisors
- Your organizations' clients/consumers
- Local residents
- Business and community leaders
- Elected officials
- Consumer action groups
- Union or labor organizations
- Competitors
- Legal advocates
- Media
- Public
- Others

Consider plans to provide advance notice to important audiences. Prioritize stakeholders according to the type of emergency.

Worksheet 7–1. Stakeholder Reaction Assessment

Stakeholder group_____ Importance to the success of public health communication (1–5) _____

Severity of likely reaction (1–5)____ Advocate ____ Adversary ____ Ambivalent ____

Importance of this stakeholder group? _____

_____

Likely initial reaction? _____

_____

Turning point? _____

_____

What would cause a change in position? _____

_____

Key messages: _____

_____

Key contacts: _____

_____

Opportunities for feedback: _____

_____

Strategies to inform/involve stakeholders: _____

_____

Strategies to help keep them from getting involved (satisfy needs early): _____

_____

Products to provide:_____

_____

Contact updates: _____

_____

Date, with whom, and how:_____

_____

Partnership Development

A partner may be defined as anyone with a role in aiding in the response. Partner relationships should be developed in advance of the crisis. One of the best methods of building partnerships is to start building relationships informally through community and social networks. Strong, collegial relationships can be very helpful when emergency coordination is required. Partnerships should be based on the partners' common purpose of serving the community.

Each potential partner should play a specific role during a crisis, and this role should be determined and agreed upon before a crisis situation occurs (or at the very least, in the first few hours of a crisis event). It is helpful to assess what each partner brings to the table, including strengths, weaknesses, and unique abilities.

The partner organization will most likely choose its representative. That representative should be someone who will be able to execute the partner's role and has the organization's authority to make decisions and speak on its behalf. Usually this person is not the head of the organization, but typically will keep the leader of the organization informed.

Tips for developing partnerships:

- Design a plan for building relationships *before* the crisis.
- Create a partner contact sheet with every available phone number and e-mail address (e.g., work, home, cell, etc.), Obtain permission to contact the people by any means necessary in an emergency.
- Draft a plan for partner communication during a crisis (e.g., e-mail alerts, twice-daily faxes, conference calls) to which everyone agrees.

Reality Check: Despite every good intention to allow partners a preview of a press statement or release, it may be impossible to do so. With some time-sensitive issues, you may have to consider the increased risk of leaks and choose not to share. If possible, consider telling partners to expect a release on a subject or ensure that they get the release and any supporting documents at the same time as the media.

Community relations

Research indicates that community leaders and institutions (e.g., schools, employers, community organizations, churches/religious institutions, and major employers) can be valuable partners in gaining support for public health actions, distributing information, or countering rumors surrounding an emergency event. These partners may be familiar, trusted, and influential with your target audience, and may be more likely than media alone to motivate the public to take recommended actions. Also, the partners can reach groups of people in a familiar setting.

In pre-event planning, make an effort to reach out to these groups. Consider memoranda of understanding with partners to engage them as information disseminators during a public health emergency. Consider supplying them with background information before or soon after an emergency occurs. Develop fast and reliable channels of communication directly to these community leaders so that they will have the facts when their constituencies begin to ask questions. Invite them to tour emergency facilities. Brief them on such issues as the national pharmaceutical stockpile or public health emergency laws.

Strategies to navigate a process for consensus building

Don't leave it to the media to negotiate public controversies during an emergency response effort. Instead, consider engaging a neutral party to speak for the diverse group of stakeholders to help resolve differences. The neutral party can speak to the media on behalf of all involved or facilitate a face-to-face meeting. The neutral party can express both consistent and inconsistent points of view from the entire group in an effort to find consensus.

Convening a citizens' forum

A professional facilitator, comfortable with the culture of the community, who is perceived by all sides as neutral, should convene the public forum. Conduct a needs assessment to determine the stakeholders in this issue. Representatives from all elements of the community must be considered, not just those from a vocal advocacy group.

Empower group decisionmaking with the following steps:

- Identify the options and discuss the pros and cons of each alternative.
- Analyze the costs and benefits, weaknesses and strengths of each.
- Present all known scientific or technical information about the alternatives.
- Choose the "must" versus "want" criteria for the decision.
- Be able to express why one alternative was chosen over the others (e.g., the highest number of people will be helped with a minimum disruption to self-reliance and community sovereignty).
- Reach a clear, justifiable decision.

Quality listening

Asking questions shows that you care. The first step in solving problems is to know what's really going on. Questions can do that. Good listeners are perceived as more intelligent. Listening actively reduces mistakes—like believing you understand what is being asked of you, only to discover later that you are mistaken.

- Listen for intent (feeling).
- Listen for content (facts).
- Listen for who is speaking.
  - Is this person qualified to give expert opinions on this subject?
  - Does this person have underlying motives?
  - Does this person have prejudices or beliefs that will compromise objectivity?

Dealing with an angry public

When risks are uncertain, because science has not reached an answer or a consensus answer, controversies will arise. Add the need to make decisions under the enormous time pressure of a crisis, and the uncertainty may seem unbearable to both response officials and the public. When science cannot lead to a clear path, decision-makers must make choices about what is and is not acceptable. In non-pressure environments, the public may turn to the courts to settle differences about the amount of acceptable or perceived risk.

In a crisis, as in the emergency room, where imperfect decisions must be made in minutes, not months, the fallout can be incredibly harsh, especially after the crisis is resolved and the decisions are reviewed with the omniscient power of hindsight. With the strongly held sense of self-determination among Americans, the struggle of imposing some risk on individuals or suspending some civil liberties to protect communities may be great. Great, unless, even in the crisis situation, response officials make an effort to empower the public.

At the community level, that may mean a face-to-face meeting. Involving stakeholders and building consensus is the most powerful way to advance compliance with public safety requirements before and during an emergency. Anything less will invite civil unrest and greater mistrust of the institutions or government responding to the crisis. These public forums sooth tempers and help the community to work toward a mutually agreeable solution to the common problem.

Communication experts and psychologists agree that anger is a defensive response to pain or the threat of pain. Experts identify three basic circumstances where anger is likely to arise:

- When people have been hurt
- When they feel threatened by risks not of their own making
- When they believe that their fundamental beliefs are being challenged.

The intensity of that anger can be confounded by related factors. For example, when people feel weak in the face of others who are more powerful, their anger is increased. When people feel that they have not been

treated fairly or with respect, their anger multiplies. If they have been manipulated, trivialized, ignored—or worse still, lied to—anger and a sense of unfairness will build. However, don't forget that displays of anger may be a form of manipulation by another party, especially in public, to bully others into accepting their demands. Of course, more than one anger-causing element can be involved in a single situation.

Don't make the error of defining anger as either rational or irrational. That's judgmental, counterproductive, and truly in the eye of the beholder. It's dangerous to label others as irrational because you may then feel justified in dismissing them, which will only heighten their sense of injustice.

Don't lecture! Let the audience discover the answer

No one willingly accepts a lecture, and seldom have lectures changed anyone's mind or behavior. Lecturing is easy—the lecturer gets to vent his or her emotions and doesn't have to take others' points of view into account. That which makes it easy also makes it ineffective. A lecture does not engage the audience. Telling is easy, asking is tougher. Asking questions is a deliberate action. It forces the process to slow down and forces everyone to stop and think before replying.

Instead of attempting to persuade an individual or community group to take an action, allow them to persuade themselves through a self-discovery process. *The key is to not give the solution, but help your audience to discover its own solution.*

How do you help an audience discover its own answers? By asking the right questions.

Using feedback as your tool, you can ask the audience questions that will create awareness about the situation in such a way as to empower them to make a difficult choice. As many therapists will attest, a person who comes up with his own answer and says something in his own voice will take ownership of that idea. It's better for you to ask a leading question than to make an interpretation. The right questions can help an audience to make the necessary connections. This strengthens the audience's tendency to claim ownership for the insight.

For example, were a severe communicable disease outbreak to occur, a challenge for officials in emergency response and public health is the possibility that civil rights may need to be temporarily suspended to control the spread of disease. A extreme case would be the need to quarantine individuals or communities. It makes sense that a population that understands the need to quarantine will be more likely to uphold the curfews or quarantine requirements.

Questions to help people persuade themselves

- Start with broad, open-ended questions.

Example: What challenges have (you or your community) faced that required consensus building to solve the problem? How did it go? What did you learn from those experiences? Were there difficult choices to make?

- Then, ask questions to discover the explicit wants, needs, and desires of your audience.

Example: What is most important to (you or your community) when faced with a problem to solve? Consensus building? Putting the greater good for the greater number first? Avoiding conflict? That the

solution is fair and equitably distributed? Ensuring that everyone has a voice and is heard? That reasonable alternatives are fully explored?

- Follow with questions that are more specific to the situation now being faced by the audience.

Example: What are the ramifications to (you, your family, your community, the nation) when faced with this current problem? What consequences are you hoping to avoid? What do you see as the worst outcome for (you or your community)? What courses of action do you believe could mitigate this outcome?

- Then, ask questions that encourage audience members to state the benefits they would like to see result from a course of action.

Example: What benefits would (you or your community) expect if this disease did not spread further? Since you've brought up quarantine, what benefits would (you or your community) expect if you accepted quarantine as a course of action to reduce spread of disease?

- Once the audience sees and expresses the benefits, it will be much easier to demonstrate how your strategy can solve the problem.

Example: "From what I understand, you are looking for a way to protect (yourself, family, community) from more illness or death? If I can go ahead and explain how quarantine will meet those needs, are you open to implementing it? If you think quarantine would work in this effort, how do you see the quarantine being explained to the entire community and implemented?"

Allowing people to persuade themselves is not an easy process. Done poorly, it can seem condescending or manipulative. It takes practice and a great deal of empathy. However, it's worth the effort, because it is truly the most effective way to gain acceptance in thought and behavior.

How to de-escalate the conflict?

Start by trying to agree on issues that may not be core to the conflict—not the hot button issue that no one is willing to concede. Agree whenever you can. It is hard to attack someone who agrees with you. You don't have to concede a thing. Find the elements that bring some agreement among both groups. Set up guidelines for interaction and make an effort to "humanize" each side for the other.

- At all times, seek common principles on which to base a common dialogue.
- Remain open to reason and allow yourself to consider that you might be wrong.
- Strive for fairness in the process, especially where a real or perceived inequity has occurred.
- Work to get input from *all* stakeholders.
- Leave the community or population better off than how you found it.
- Decision makers in the community should have access to open and complete scientific information.

Try to get as many "yeses" as you can. If someone says, "Your proposal is totally unrealistic," try this response: "Are you saying that you don't see how my proposal can (respect citizens' rights and stop the

spread of disease)?" When person says "yes," this transforms the relationship. Each question you offer that allows a "yes" answer from the other side further reduces the tension.

Don't say "but"—say "yes, and."

Typically, people express their differences by prefacing their responses with, "but." The other group will be more receptive if you first acknowledge their views with a "yes" and then preface your view with an "and." Example: "Yes, we want to protect people's rights and we want to keep them alive to enjoy those rights."

Resources:

Smith, Larry. (2001). *The ICM Crisis Management Certification Course*. Louisville, Kentucky: Institute for Crisis Management.

Leeds, Dorothy. (2000). *The 7 Powers of Questions*. New York: Berkley Publishing Group.

Borman, Ernest G. (1975). *Discussion and Group Methods. Second Edition*. New York: Harper and Row Publishers, Inc.

Ury, William. (1993). *Getting Past No: Negotiating your way from confrontation to cooperation*. New York: Bantam Books.

Selecting and Using Communication Channels during a Public Health Emergency

There are two major communication issues beyond working with the media that must be addressed in preparation for crises. First, at the community, state, and national level, the public expects access to its government during an emergency. One of the most effective ways to give them this access is through e-mail and toll-free information telephone lines. Second, as a public health crisis evolves beyond 24 to 48 hours, the demand for information outside traditional media channels—radio, TV, newspaper, and news Web sites—increases. The public information official must choose the right method of delivery to address various audiences. This module addresses both of these important issues.

Public telephone and e-mail services during an emergency

Consider the following when planning for toll-free number services (or building capacity inhouse).

- Decide between rapid expansion of an existing phone number or a "new" toll-free number generated specifically for the emergency.
- The service must be expandable in terms of number of calls managed per hour or day and the hours of operation.
- The toll-free number must be answered by trained people who can reassure callers, provide requested information, and/or refer callers as needed.
- Precleared materials on multiple subjects should be easily accessable during an emergency. The following are concerns about predeveloped materials:
  - Materials must be specific to the emergency and the community impact.
  - They must be easy to read and understand.
  - They must be available in multiple languages based on community needs.
  - They must be field tested for cultural sensitivity and preferences.
- Standards of performance and evaluation should be considered: customer satisfaction, response capacity, accuracy, etc.
- Call managers must be able to quickly integrate new information into their emergency responses.

These issues must be considered for your public e-mail response service. State up front how long it will be before the public gets a response to an e-mail (2 hours, 24 hours, same week) and provide a way to reach your organization if the need is more urgent. Be sure to advise people to seek out their health care providers or 911 for a personal medical emergency.

The CDC Public Response Service (PRS) began in October 2001, and is available free-of-charge to local and state health departments. PRS provides a rapid, turnkey toll-free hotline and interactive e-mail service that will provide both local information specific to the emergency (e.g., where to get shots in your community) and CDC-approved background health and medical information. This service is available to help a community or state manage its public information requirements during a public health emergency.

The service works with the general public, public health professionals, and emergency response teams. Service is available for Spanish and English speakers and the deaf and hearing impaired.

Why

Achieving effective communication with your audiences depends on selecting methods of communication that will reach them. This is especially important in health risk communication, where the audience participants can become disenfranchised quickly if they do not feel they are getting information.

Message delivery channels include:

- **Face-to-face** (e.g., health care professional to patient, or your organization's staff member to state partner organization or individuals in the community)
- **Group delivery** (e.g., small group or public meetings)
- **Organizational** (e.g., constituents of influential community organizations)
- **Mass media** (e.g., radio, television, newspaper, or direct mail)
- **Community** (e.g., employers, schools, malls, health groups, or local government agencies)
- **Combination of any or all of these** (i.e., most likely to work best).

Questions to ask

- Which channels are most appropriate for the health risk problem/issue and messages?
- Which channels will the target audience find credible and accessible?
- Which channels fit the program purpose (e.g., inform, influence, allay fears, influence attitudes, or change behavior)?
- Which channels and how many channels are feasible, considering your schedule and budget?

Identifying Specific Communication Tools

The tools you will use depend on your audience, how participants prefer to receive information, and the information you need to communicate. Possible tools include:

Briefings

A briefing is a session with key state and local officials, media representatives, and community leaders. Agency staff conduct sessions in person. Briefings help to notify key state and local officials, media representatives, and community leaders of developments at the site, such as results of studies or actions that should be taken to protect health. A briefing can be used to introduce your organization and explain its role and work process. Briefings are not usually open to the general public.

Conducting a briefing

- Schedule the briefing in a small public room, such as a hotel meeting room or a conference room.
- Hold the briefing in a neutral location, particularly when dealing with an antagonistic situation.
- Prepare a factsheet or question and answer sheet.
- Present a short, official statement about the agency's findings, health concerns, or recent developments.
- Use simple language.
- Avoid jargon, acronyms, and overly technical terms.
- Answer questions about the statement.
- Work with your organization to coordinate briefings.

Benefits of a briefing

- Allows state and local officials, the media, and citizens to question your organization directly about any activity before the public release of information
- Prepares officials and citizen leaders to answer questions from their constituents when the information becomes public
- Allows for the exchange of information and concerns.

Limitations of a briefing

- Although briefings can be effective, they could become the only means of communicating with site communities. Briefings should always be complemented by activities to inform the general public, such as small group or public meetings.
- Negative feelings or bad publicity could result if some people believe that they should be invited to the briefing and are not. Be sure not to exclude such persons or convey favoritism toward certain parties.

Community mailings

A community mailing sends information to key contacts and concerned or involved members of the community. It disseminates information quickly and easily in writing, and it is particularly useful when you have updates for the community.

If the updates are straightforward, noncontroversial, and easy to understand, the mailing can stand on its own. However, if the updates are more complicated and require discussion or further explanation, the mailing should augment a public meeting or small group meetings. The community mailing can announce upcoming meetings and provide advance information or serve as a followup for people who did not attend previous meetings.

Developing a community mailing

Compile a mailing list and include:

- State and local officials (check with city clerk for assistance)
- Community leaders (check with local chamber of commerce)
- Local residents of the site area (check with city clerk for assistance)
- Community members who have signed up to receive information.

Creating mailing materials

Include:

- A cover letter that introduces you, briefly explains the purpose of the mailing, and provides contact information for comments or questions
- A factsheet, newsletter, report, or other documents
- First-class postage to deliver the mailing quickly.

Benefits of a community mailing

- Enables you to deliver information quickly and may require less planning time than conducting a meeting

Limitations of a community mailing

- Allows no interaction or opportunity for community members to ask questions

Exhibits

Exhibits are visual displays of maps, charts, diagrams, or photographs, and can help illustrate health issues and proposed actions in a creative and informative display. Effective exhibits can make technical information accessible and understandable. Exhibits can be used during any phase of your site work.

Developing an exhibit

- Identify the target audience and the message.

  Possible audiences include:

  – General public

  – Concerned citizens

  – Media representatives

  – Public officials.

  Possible messages include:

  – Description of the health risk

  – Historical background information related to the issue

  – Community relations activities

  – Proposed remedies and actions to protect community health.

Creating an exhibit

- Determine where it will be placed, preferably in a highly visible location—a public library, convention hall, or shopping center—especially if your target audience is the citizens of the town.

- Set up a temporary exhibit at a public meeting if a segment of concerned community members is the target audience.

- Design it according to the message to be transmitted.

- Include photos or illustrations. Use text sparingly.
- Keep it simple and visual. A bulletin board could suffice, if appropriate.
- Staff the exhibit with someone to answer questions, guide people through complicated issues, and gain informal feedback.

Benefits of an exhibit

- Stimulates public interest and understanding
- Creates visual impact and leaves a lasting impression

Limitations of an exhibit

- Exhibits are a one-way communication tool and do not provide an opportunity for community feedback.

Flyers

A flyer is a brief report summarizing current or proposed activities. Flyers are appropriate whenever new information is available.

Flyers can be useful for:

- Introducing your organization and explaining its role
- Explaining associated health risks
- Guiding community members in precautionary health actions
- Announcing new findings
- Dissemination at public meetings or community gatherings.

Types of information in a flyer

- Explanation of the triggering event that caused the health risk situation
- Timetable for the proposed actions
- Description of the health issues or problems
- Description of the health actions necessary
- Description of public participation opportunities
- Name, address, and phone number of your organization's contact person who can provide additional information on request

Presenting the information

- Select a simple format.
- Be concise—avoid jargon, acronyms, or highly technical language.
- Provide written information (a press release summarizing your announcement, factsheets, copies of your prepared statement, and biographies of your speakers).
- Open the conference to questions for organization officials, local officials, and technical staff.

Benefits of a flyer

- Effective in briefly summarizing facts and issues
- Provides background for information discussed during a meeting

Limitations of a flyer

- Is a one-way communication tool
- Requires careful writing and coordination between making technical information easy to understand and message delivery

Newsletters

A newsletter is a publication that informs community members about activities, findings, health precautions, and other information concerning a health assessment.

Newsletter topic areas

- Overview of your organization and background of its involvement at the site
- Plans for your organization's onsite work and findings, if available
- Health guidelines, if applicable
- Upcoming activities and previous organization activities, if any, that have taken place in the community
- Frequently asked questions and answers
- Contact information for your organization

Newsletter design

- Use simple, understandable language with headlines, boxes, lines, type variations, and other effects to make the newsletter attractive and easy to read.

- Establish a 4-page limit (an 11-by-17-inch sheet of paper folded in half makes a good 4-page newsletter).
- Ask someone not involved in the project to test-read the newsletter and provide feedback on message clarity.
- Use two colors if resources allow.
- Photocopy or print the newsletter.

Mail the newsletter to your mailing list and/or distribute it at public or small group meetings. If there is a central gathering place in the community, ask to leave copies there for community members.

Benefits of a newsletter

- Explains your work and findings to the community
- Allows you to deliver a written document that community members can keep and refer to later

Limitations of a newsletter

- Can backfire if community members do not understand or are angered by what you have written
- Does not give community members the opportunity to ask questions. (Always include contact information in your newsletter so people have a way to ask questions.)

Open houses/availability sessions/poster sessions

An open house or availability session is an informal meeting where community members can talk to agency staff one-on-one. It is most appropriate when key milestones or major decisions have been reached.

Conducting an open house/availability session

- Determine community interest in the site before planning an open house.
- Select a date, time, and location for the open house. To encourage attendance, choose evening hours or weekends at an easily accessible building familiar to residents (e.g., a public library or local meeting room).
- Anticipate the number of attendees and plan accordingly. Consider holding two open houses if necessary to enable staff to greet and talk with each attendee. One staff member per 15–20 attendees generally fosters an informal atmosphere for conversation and avoids the situation where a staff member must speak to a crowd.
- Publicize the open house at least 2 weeks before the event. Send announcements to newspapers, television and radio stations, citizens on the mailing list, and any interested community organizations that publish newsletters.

- Create exhibits and factsheets to provide background information that enables citizens to ask more informed questions about the site during the open house.
- Include staff who are prepared to discuss technical information in an easy-to-understand manner.

Benefits of an open house

- Allows for one-on-one conversation
- Helps build trust and establishes a rapport between community members and agency staff

Limitations of an open house

- Can require significant staff time for planning and conducting an open house. A low turnout may not justify the effort.

Presentations

A presentation can be a speech to a club, civic or church organization, school class, or similar local audience. Presentations are more effective if they focus on such major milestones as research findings or health recommendations.

Developing a presentation

- Describe the health risk situation.
- Describe how the health risk affects the community.
- Discuss what your organization is doing to alleviate the health risk situation.
- Discuss how citizens can assist your organization and obtain additional information.
- Select materials to support the presentation, such as slides, graphics, and exhibits, that will hold the audience's attention.
- Conduct a trial presentation in front of colleagues and rehearse the presentation as much as possible.

Benefits of a presentation

- Offers the audience a chance to ask questions so the agency can gauge community concerns
- Reaches many people simultaneously, reducing individual inquiries

Limitations of a presentation

- If poorly presented, can distort community members' view of the situation.
- Can only address individual community concerns during a question-and-answer period following the rehearsed presentation; could try people's patience.
- The presenter may face difficult or argumentative questions from community members.

Public meetings

A public meeting is a large meeting open to the public, where experts present information and answer questions, and community members ask questions and offer comments.

Arranging a public meeting

- Create an agenda. Involve citizens in developing the agenda.
- Hold the meeting in a public, comfortable setting that is easily accessible, well lit, and has adequate parking and seating, especially for persons with disabilities.
- Be sensitive to special needs of community members. Consider translations for non-English speakers or sign language for hearing-impaired participants.
- Announce the meeting in local media 2 weeks in advance if possible. Distribute flyers to community members and groups interested in attending. Clarify that the meeting is not a formal public hearing, but rather, a place to exchange information and comments.
- Follow up with media closer to the meeting time to encourage them to attend. Send a "media alert," which contains brief information about the meeting date, time, and topic, and/or make phone calls to key contacts.

Conducting the meeting

- State the purpose of the meeting, then outline the agenda and the procedures for making statements.
- Present preliminary findings and proposed courses of action.
- Distribute materials, including factsheets and other materials, for participants to take home.
- Prepare a transcript of the meeting, make the transcript publicly available, and announce how it can be obtained.
- Allow time for citizens' comments. Include a question-and-answer session. Meetings should last from 1 to 3 hours.
- Consider audio- or videotaping the meeting as a record so you can refer to it to refresh your memory on community concerns, if necessary.

Benefits of a public meeting

- Allows the community to express concerns and the agency to present information

Limitations of a public meeting

- Can intensify conflicts rather than resolve controversies. If public meetings have failed in the past, use an alternative method (e.g., small group meetings or a formal public hearing) to transmit information and obtain feedback.

Small group (or focus group) meetings

At a small group meeting, agency staff share information with interested community members and state and local officials. It is especially useful for informing and keeping in touch with community concerns, answering questions, and clearing up any misconceptions or misunderstandings.

Preparing for a small group meeting

- Identify interested citizens and officials. Contact each citizen, group, or local organization that is directly affected by site activities. Offer to discuss health issues at a convenient time.
- Limit attendance to 5–20 people. If more community members and officials are interested, schedule additional small meetings.
- Decide whether to invite the media. Media presence may intimidate the community. You may want to hold a similar meeting for media only.
- Select a meeting place conducive to two-way interaction. Place chairs in a circle or other informal arrangement.
- Select a date and time that allows for maximum participation. Make sure that the date and time do not conflict with other public meetings, holidays, or other special occasions.

Conducting the meeting

- Ask people to provide contact information so you have a record of who attended.
- Begin with an overview of current and future health-related activities and findings.
- Encourage citizen participation.
- Distribute factsheets and other written information for attendees to take home.
- Follow up on major concerns. Stay in touch with the group and contact newly formed groups.

Benefits of a small group meeting

- Allows two-way interaction with the community

Limitations of a small group meeting

- May require a day or more of staff time to reach only a few citizens.
- May be perceived by community groups as an effort to limit attendance or a tactic to prevent large groups from exerting influence. (Hold additional small group meetings with organizations that express concern about being left out of the process.)
- Irate groups or individuals may accuse your organization's staff of giving different information to different groups. (Avoid criticism by inviting a cross-section of community representatives to each small group meeting and by keeping a written record.)

Telephone contacts

Telephone contacts are calls to state and local officials and concerned community members, informing them of your organization's activities, finding out who is involved, and gathering information about the event. After this initial contact is made, you may make calls to inform these individuals and monitor the extent of community concerns.

Calls also should be made periodically to inform key contacts of any major findings and the progress of activities. Telephone contacts are important to understand community concerns and gather information.

Making telephone contacts

Know exactly what information to request (e.g., additional references, site specifics, or background information) and tailor questions accordingly. Information to solicit from these contacts might include:

- Background on the problem and recovery process
- Recent government activities
- Nature and extent of citizen involvement
- Names, addresses, and telephone numbers of other possible contacts.

Always test your messages with a small group before public release to ensure that the meaning is clear.

Resources:

Chess C., Hance BJ. 1987. Communicating with the public. Piscataway (NJ): Rutgers University Press.

U.S. Environmental Protection Agency. 1992. Tipsheets. Adapted from Community relations in Superfund: A handbook. Washington (DC): U.S. Environmental Protection Agency.

Public Information Officers Face New Challenges

The ability of the United States government to prevent, deter, defeat, and respond decisively to terrorist attacks against our citizens is one of the most challenging priorities facing our nation today. The United States regards all terrorism as a potential threat to national security, as well as a violent criminal act. The United States vigorously pursues efforts to deter and preempt these crimes and to apprehend and prosecute directly—or assist other governments in prosecuting—individuals who perpetrate or plan terrorist attacks.

This focus on criminal investigations and prosecution may be a new concept for public information officers in the public health community to consider when responding to a public health crisis. It's imperative that public health communicators understand the information release challenges faced when responding to a terrorist event. First and foremost, the Federal Bureau of Investigation (FBI) must have final authority over the release of information about the incident. The Department of Justice (DOJ) and the FBI have committed to ensuring that health information regarding a terrorist or suspected terrorist incident will be immediately released to protect the public's health and safety. However, information that, in the normal course of a disease outbreak would be considered just "filler information," may be withheld to protect the integrity of the criminal investigation.

The response to a terrorist threat or incident within the United States will entail a highly coordinated, multiagency local, state, and federal response. The primary federal agencies that provide the core federal response are:

- DOJ/FBI
- Federal Emergency Management Agency (FEMA)
- Department of Defense (DoD)
- Department of Energy (DOE)
- Environmental Protection Agency (EPA)
- Department of Health and Human Services (DHHS).

The FBI is the lead agency for crisis management. FEMA is the lead agency for consequence management. As the lead agency for crisis management, the FBI will implement a federal crisis management response and designate a federal on-scene commander to ensure appropriate coordination of the overall response with federal, state, and local authorities. The Attorney General may, at some point, transfer the overall lead role to FEMA for consequence management, although both may be ongoing from the start.

DHHS serves as a support agency to the FBI for technical operations and to FEMA for consequence management. DHHS provides technical personnel and supporting equipment to the lead federal agency during all aspects of a terrorist incident. DHHS can also provide regulatory followup when an incident involves a

product regulated by the Food and Drug Administration (FDA). DHHS assistance supports threat assessment, epidemiological investigation, and technical advice. Technical assistance to the FBI may include identification of agents, sample collection and analysis, onsite safety and protection activities, and medical management planning. Operational support to FEMA may include mass immunization, mass prophylaxis, mass fatality management, pharmaceutical support operations (The National Pharmaceutical Stockpile [NPS]), contingency medical records, patient tracking, patient evacuation, and definitive medical care provided through the National Disaster Medical System.

What's different in a terrorism incident?

As in all incidents, weapons of mass destruction (WMD) incidents may involve mass casualties and damage to buildings or other types of property. There are, however, several factors in WMD incidents that are unlike any other type of incidents and must be taken into consideration when planning a response. First-responders' ability to identify aspects of the incident (e.g., signs and symptoms exhibited by victims) and report them accurately will be key to maximizing the use of critical local resources and for triggering a federal response.

- There will be a stronger public reaction to WMD incidents than to other types of incidents. The thought of exposure to a chemical or biological agent or radiation evokes terror in most people. The fear of the unknown also makes the public's response more severe.

- The situation may not be recognizable until there are multiple casualties. Most chemical and biological agents are not detectable by methods used for explosives and firearms. Most agents can be carried in containers that resemble everyday items.

- There may be multiple events (e.g., one event in an attempt to influence another event's outcome).

- Responders are at a higher risk of becoming casualties. Because chemical and biological agents are not readily identifiable, responders may become contaminated before recognizing the agent involved. First responders may, in addition, be targets for secondary releases or explosions.

- The location of the incident will be treated as a crime scene. As such, preservation and collection of evidence is critical. Therefore, it is important to ensure that on-scene actions are coordinated between response organizations to minimize any conflicts between law enforcement authorities, who view the incident as a crime scene, and other responders, who view it as a hazardous materials or disaster scene.

- Contamination of critical facilities and large geographic areas may result. Victims may unknowingly carry an agent to public transportation facilities, businesses, residences, doctors' offices, walk-in medical clinics, or emergency rooms because they don't realize that they are contaminated.

- First-responders may carry the agent to fire or precinct houses, hospitals, or to the locations of subsequent calls.

- Time works against responders. The incident can expand geometrically and very quickly. This may affect mutual aid jurisdictions.

- Airborne agents flow with the air current and may spread via ventilation systems, carrying the agents far from the initial source. In addition, the effects of some chemicals and biological agents worsen over time.
- Such support facilities as utility stations and 911 centers, along with critical infrastructures, are at risk as targets.
- Specialized state and local response capabilities may be overwhelmed.

Reality Check: By applying risk communication concepts, it's easy to see why a terrorism event can cause such strong emotions among the public. The event, after all, is outside the control of the individual, may be catastrophic or unfairly distributed, comes from a mistrusted source, is manmade, and exotic or unfamiliar. The uncertainty of the event may increase fear.

Terrorism and Public Information

The FBI is responsible for coordinating information dissemination to the White House, Congress, and other federal, state, and local government officials. In fulfilling this responsibility, the lead federal agency ensures that the release of public information is coordinated between crisis and consequence management response entities. The Joint Information Center (JIC) is established by the lead federal agency, under the operational control of the FBI or FEMA public information officer, as a focal point for the coordination and provision of information to the public and media about the federal response to the emergency. The JIC may be established at the same location as the FBI Joint Operations Center (JOC) or may be located at an on-scene location in coordination with state and local agencies.

Who should be operating in the JIC?

The following elements should be represented at the JIC:

- FBI public information officer and staff
- FEMA public information officer and staff
- Other federal agency public information officers, as needed
- State and local public information officers.

Working with state and local response agencies

Throughout the management of the terrorist incident, crisis and consequence management components will operate concurrently to ensure multiagency coordination and a tailored, time-phased deployment of specialized federal assets. It is critical that all participating federal, state, and local agencies interact seamlessly.

Once an incident has occurred, local government emergency response organizations will report to the incident scene and make appropriate notifications to local, state, and federal authorities. Control of this incident scene will be established by local response authorities (likely a senior fire or law enforcement official). Command and control of the incident scene is vested with the Incident Commander/Unified Command (IC/UC). Operational control of assets at the scene is retained by the designated officials representing the agency (local, state, or federal) providing the assets. These officials manage tactical operations at the scene in coordination with the UC as directed by agency counterparts at field-level operational centers, if used.

A biological terrorist event will unfold differently from a terrorist explosion or chemical release.

The United States is not immune to covert biological terrorist incidents. The traditional tools of public health officials would likely be the first to detect an infectious agent released to harm Americans. The role of public health is to recognize (detect), investigate, and work with responders to reduce the impact of a bioterrorist event. This is most important with biological agents, which, after a silent release, may first present as unidentified illnesses.

Expect a delay between the covert release of a biological agent in a public place and the onset of illness. Doctors or emergency rooms may be the first to identify the initial casualties. By then, the terrorist(s) may be far away. With some infectious diseases, only a short window of opportunity will exist between the time that the first cases are identified and the second wave of the population becomes ill. During that brief time, public health officials must determine that an attack has occurred, identify the organism, and prevent more casualties.

Early detection and response are crucial, and require a level of knowledge among medical caregivers about possible biological terrorist agents. These individuals must possess this knowledge because they are in the best position to report suspicious illnesses. Early detection requires access to a communication system between doctors and public health officials.

Preparing public health agencies for biological attacks

Disease detectives are being trained to detect and respond to biological attacks in order to speed detection and response. Increased laboratory capacity—well-trained lab workers and needed supplies—will speed diagnoses. The implementation of such secure, reliable, and swift communication channels as the national Health Alert Network (HAN) ensures early detection and rapid response.

Medical providers and public health officials are "going back to school" to become familiar with symptoms and signs of diseases rarely or never seen in the United States that could be used as biological weapons. The nation has strategically stockpiled drugs, medical supplies, and vaccines needed to supplement local supplies that could be quickly overburdened by a large-scale biological or chemical event.

Emerging infectious disease or bioterrorism?

Because the intentional release of a biological organism could mimic a naturally occurring outbreak, recognition and response to an undeclared terrorist use of an infectious disease agent will be much more difficult to detect than an announced biological release, a chemical release, or terrorist bombing.

Health investigators may not immediately recognize that an infectious disease outbreak is the result of an intentional release of germs. CDC has long recognized that the following selected illnesses may result from nature or from bioterrorism: encephalitis; hemorrhagic mediastinitis; pneumonia with abnormal liver function tests; papulopustular rash (e.g., as smallpox); hemorrhagic fever; descending paralysis; and nausea, vomiting, and diarrhea.

The following list of epidemiological attributes summarizes some characteristics of outbreaks that should suggest the possibility of intentional use of an infectious agent:

- Outbreak of a rare disease
- Outbreak of a disease in an area that normally does not experience the disease
- Occurrence of a seasonal disease at an inappropriate time of year
- Unusual age distribution of people involved in the outbreak

- Unusual epidemiologic features of an outbreak (e.g., a typical pathogen transmitted solely by food ingestion now found to be transmitted from person to person)
- Unusual clinical symptoms not typically seen with a known pathogen (especially respiratory symptoms)

In approximately the last 30 years, the CDC has been involved in the discovery of 30 emerging infectious diseases, either in the United States or around the world. Beware, however, that many past outbreaks, now known to be only nature at work, could have been mistaken for terrorism. The following are examples:

- **Legionnaires' Disease outbreak,** Philadelphia, 1976, was characterized by a severe pneumonia of unknown origin. The discovery of the cause of the pneumonia took many months.
- **Hantavirus Pulmonary Syndrome,** United States, 1993, consisted of an outbreak of severe pneumonia of unknown origin affecting healthy young adults. This virus had never before been recognized in the United States.
- **Food-borne crytosporidiosis,** Minnesota, 1995, investigators determined that a common organism previously associated with drinking contaminated recreational water, exposure to animals, or person-to-person contact, was, in this outbreak, found to be associated with contaminated chicken salad.
- **Antibiotic-resistant strain of plague,** Madagascar, 1995, could have been attributed to genetic engineering for bioterrorism purposes, although it was found to be a naturally occurring strain.
- **Ebola virus infection,** Zaire, 1995, was found to be a 99 percent genetic match to an Ebola virus that caused the 1976 outbreak. This finding raised the possibility of intentional reintroduction from a strain kept in a laboratory. (Most virus mutate over time, causing a greater gap in genetic matching to strains from previous outbreaks.)
- **Nipah virus encephalitis,** Malaysia and Singapore, 1998–1999, was an outbreak by a previously unrecognized virus that caused illness in pigs with transmission to humans. The outbreak raised questions about whether pigs were targeted to introduce a bioterrorism strain of virus to humans.

Whether epidemics result from terrorism or natural factors, the public health community must detect and quickly investigate outbreaks, here and around the world. Because new disease agents could simply be nature at work, however, the past is a cautionary tale that we should not prematurely assume that bioterrorism is the cause of an emerging infectious disease outbreak.

Is it bioterrorism?

In fall 1999, West Nile virus made its western hemisphere debut in the media capital of the world, New York City, and hasn't disappeared from headlines since. In the last 30 years, disease detectives from the CDC, have discovered—in places around the world—a new infectious disease in each of those 30 years. But the West Nile virus has rivaled such killers as plague, Ebola, and hantavirus for its continuing notoriety. Why?

Perhaps because this killer with a checkered past was now on a rampage in our own backyard. Unfortunately for public health communicators, the number of questions about when, where, and how it would strike was much greater than the answers about this unwelcome visitor.

Concerns about the "whys" and "hows" of this unusual infectious disease outbreak conflicted with media theories of domestic bioterrorism. Some experts believe that, if not for the mature emerging disease and bioterrorism plans and training of New York City public health and medical professionals, the initial cluster of illness may not have been brought to public health officials' attention as quickly as it was. Infectious disease experts are taught: "when you hear hoof beats think horses, not zebras." On the lookout for a bioterrorist act, they must think horses *and* zebras. That distinction is vital in early responses to disease outbreaks regardless of whether the virus is supplied by nature or by the hand of a human.

A *New Yorker* article released in October—after most of the first wave of questions about the new virus had been answered—led to a potential media frenzy about West Nile and bioterrorism. However, the day that advance news releases about the article went to national media, the CDC issued a statement reassuring New Yorkers that, as awful as West Nile was, it still appeared to be nature at work. Working closely with the CDC, local media officials also minimized the plausibility of bioterrorism theories. Within 24 hours of the CDC statement, the media frenzy waned and the investigation continued.

Consider this: Formulate your policy on commenting about bioterrorism aspects of your outbreak investigation now, because it's no longer "business as usual" in public health disease investigations. The increasing concern about bioterrorism and the likelihood that a bioterrorist act *could* be initially identified as a naturally occurring disease outbreak make law enforcement a real potential partner during a disease investigation. Since those of us involved in public health know firsthand that outbreaks often initially generate more questions than answers, the likelihood of the media raising the "bio-T question" is very high.

By stating officially to the media that West Nile was believed to be nothing more than nature at work, the CDC set a challenging precedent. For example, what if, in the course of the next outbreak, early suspicions about bioterrorism are raised? Do we confirm those suspicions? CDC experts can easily name 20 past outbreaks with characteristics that could have been believed at first to be the work of terrorists. Of course, none was. So plan your response before you're asked. CDC proposes that health officials give media the following response to the future "bio-T question" during the early stages of an ongoing infectious disease outbreak investigation:

"We're all understandably concerned about the uncertainty surrounding this outbreak and we wish we could easily answer that question today. For the sake of those who are ill or may become ill, our medical epidemiologists (professional disease detectives) are going to *first* try to answer the following critical questions: (1) who is becoming ill? (2) what organism is causing the illness? (3) how should it be treated? and, (4) how can it be controlled to stop it from spreading?

"A question that disease investigators routinely ask is: 'could this outbreak have been caused intentionally?' (Your organization name) must keep an open mind as data in this investigation are collected and analyzed.

"With public safety in mind, we should not speculate on the organism's route of introduction until we have enough data to formulate a theory. We must consider the possibility that we may never have the data to answer this important question, based on epidemiology alone.

"Any specific questions about the FBI's involvement in this outbreak investigation should be referred to them. However, the FBI and (your organization) have a strong partnership in the investigation of unusual disease outbreaks and have worked comfortably together in past parallel investigations."

(Don't forget to coordinate this answer with the FBI—whether or not they're currently involved.)

CDC media strategy during a possible undeclared bioterrorism event

During all infectious disease outbreak investigations, CDC will not comment to media about the possibility of an outbreak being a bioterrorist event, nor will it comment on the FBI's participation in an investigation, unless first confirmed by the FBI to the media. CDC will inform the media that all disease outbreak investigations routinely include questions about the possibility of an intentional act, and that it is CDC's policy not to speculate about this possibility during an outbreak investigation. All media will be referred to the FBI while an investigation is ongoing for comment about the possibility of bioterrorism and, at present, the FBI has not declared an outbreak a bioterrorist event.

CDC will provide factual information as requested and available on the Internet. CDC will not release information about an ongoing investigation unless first coordinated with the affected state; however, CDC can confirm that it has been invited by the state to assist in an investigation. CDC can release information about a multistate investigation after the state health departments (health officer and information officer) are notified.

CDC will not speculate to media or the public about the possibility of a bioterrorist act, nor will it respond to alarming "scenario" questions of a general nature during a suspected event. During an infectious disease outbreak investigation, the CDC will defer to the FBI any speculation about whether an event may be a bioterrorist event.

Reality Check: An outbreak could unfold such that an early and reasonable assumption of bioterrorism will be made simultaneously by the media and public and official responders, as with the anthrax letters in 2001. Remember, it's not officially bioterrorism until an official says it is. Respect the fact that the FBI should still publicly announce what is or is not deemed a bioterrorist act.

The following are federal authorities on terrorism response:

- Presidential Decision Directive 39, including the domestic guidelines
- Presidential Decision Directive 62
- Robert T. Stafford Disaster Relief and Emergency Assistance act
- Other plans and directives
- Federal Response Plan, including the Terrorism Incident annex
- Federal Radiological Emergency Response Plan
- National Oil and Hazardous Substances Pollution Contingency Plan
- DHHS Health and Medical Services Support Plan for the Federal Response to Assets of Chemical/Biological Terrorism
- Chairman of the Joint Chiefs of Staff CONPLAN 0300/0400
- DODD 3025.15 Military Assistance to Civil Authorities
- Other Department of Defense directives

Ten Healthy Psychological Responses to Terrorism

(Courtesy of the *International Journal of Emergency Mental Health*, Every American Under Attack)

1. Never lose sight of the fact that a terrorist act is intended to create feelings of psychological uncertainty, personal vulnerability, fear, and terror.

2. Once a terrorist act has occurred, the target population's state of mind and leadership serve to support or oppose the intent of the terrorist. Restoring a sense of community is critical.

3. Consider preincident psychological resiliency training, as well as ongoing psychological support for response personnel during and after the terrorist attack.

4. Collaborate with media to provide ongoing information to all involved and affected populations. Credible information contradicts the sense of chaos. Information combats destructive rumors.

5. Take whatever steps seem necessary to re-establish the public's sense of physical safety. Widely publicize these efforts to the degree that security considerations allow, and make special consideration for children, the elderly, and infirm.

6. Enlist the support of local political, educational, medical, business, and religious leaders to add to communication that calms fears, provides personal crisis intervention, and instills hope.

7. Re-establish normal communication, transportation, school, and work schedules as soon as possible.

8. Symbols (e.g., flags, bumper stickers, signs, and billboards) can help re-establish community cohesion.

9. Initiate rituals to honor the survivors, the rescuers, and the dead. Provide opportunities for others not directly affected to assist those who are directly affected, such as providing donations of blood, food, clothing, and money. Communicate to all the concept that an effective way to honor the dead is to carry on and succeed. To do otherwise is to allow the terrorists to succeed.

10. Be careful not to interfere prematurely with psychological support, which could undermine that support.

The National Pharmaceutical Stockpile Program

Managed by the Centers for Disease Control and Prevention (CDC), the National Pharmaceutical Stockpile (NPS) program is composed of skilled, highly motivated people and large quantities of medical materiel and equipment. NPS exists to help states and communities respond to the medical consequences of terrorist attacks, natural disasters, and technological accidents.

During an emergency, NPS ships drugs, vaccines, medical supplies, and medical equipment to states and communities—the first within 12 hours of the federal decision to deploy—and to continue to deliver materiel for as long as it is needed. NPS experts also will assist states and communities with receiving, storage, staging, distribution, and dispensing NPS materials.

NPS is not one package, but multiple, comprehensive packages of drugs, vaccines, medical supplies, and medical equipment that can be used to augment depleted state and local resources for responding to terrorist attacks and other emergencies. The packages are stored in strategic locations around the United States to ensure their rapid delivery anywhere in the country. The NPS typically will arrive by air or ground in two shipment phases. The first phase is called a 12-hour Push Package. "12-hour" refers to the package's transit time: 12 hours or less after the federal decision to deploy. "Push" is so named because a state need only ask for help—not for specific items—and NPS will "push" or ship virtually everything a state needs to respond to a broad range of threats in the early hours of an event, when people are sick or dying from an ill-defined threat.

Second-phase shipments normally begin within 24–36 hours after a state identifies a threat. These shipments contain large quantities of specific items designed to deal with a specific threat. These shipments are referred to as vendor managed inventory (VMI), because major pharmaceutical vendors will store this materiel until it's shipped.

A 12-hour Push Package typically will arrive in more than 100 specialized cargo containers via a wide-body jet (e.g., a 747 or 767) or on seven 48-foot tractor-trailers. The package weighs approximately 50 tons and occupies 5,000 square feet when offloaded. The 12-hour Push Package includes large quantities of medicines, antidotes, medical supplies, and medical equipment that states and communities will need in order to respond to such nerve agents as sarin; and biological agents, such as anthrax, plague, and tularemia. The package will enable state and local authorities to immediately treat thousands of symptomatic individuals and protect hundreds of thousands more who may have been exposed.

CDC scientists work closely with the intelligence community to assess the probability of different biological and chemical threats. Once the scientists identify the threats, they create protocols for therapeutic treatment and prophylaxis. The protocols determine which drugs and other supplies are in the NPS. Because threat assessments, treatment protocols, and other factors change over time, the items in the 12-hour Push Packages may also change.

Vital communication concerns about NPS for your community

In your crisis communication plan, special consideration should be taken regarding NPS issues. During a large-scale emergency, public fear and anxiety could impair your ability to distribute and dispense

prophylaxis to those who need it. An effective public information plan, using sound emergency risk communication principles that inform and reassure the public, will earn public confidence and cooperation.

Precrisis planning is critical. The plans should consider language barriers, cultural sensitivities, hearing and sight impairment, and the means by which population groups get their information (e.g., television, radio, church) to plan and create messages and information that effectively inform the public.

In your planning, consider the following:

- Are disease and drug information prepared in all of the languages spoken by your community members?
- Are messages and information threat- and incident-specific? Threat-specific messages give specific information about the disease, the protective drug regimens that public health agencies will provide, and the routine that people should expect at a dispensing site.
- Are processes in place to create incident-specific messages for people who are potentially exposed where they must go for prophylactic medications if they are well, and where they need to go if they are sick? The number of dispensing and treatment locations, for instance, will depend on the scale and type of threat.

A large-scale threat will require more dispensing sites, but if contagion is a concern, the number of treatment centers may be limited to avoid spreading the disease. Public information officers will need to know where the active dispensing and treatment locations are before they can effectively inform the public.

Public information officers also need to work with the media before an event to discuss the dissemination of information and messages. In addition to the important task of broadcasting health messages to the public, the media should be able to suggest ways to effectively present and deliver the information to target population groups.

Your plan should include the following:

- Multilanguage text of all documents used to inform the public during an emergency. These include television and radio public information announcements and the informational materials, forms, scripts, and videotapes that dispensing sites use to issue prophylaxis to the public
- Storage location of all informational material (including electronic versions)
- Methods for reproducing and disseminating informational materials during an emergency
- Specific communication channels, partnerships, and staffing pools that support public information release, reproduction, and dissemination. Dissemination channels should include volunteers or contract professionals to serve as onsite interpreters for people who do not speak English; are hearing impaired; and assist with public information campaigns, printing needs, and onsite public information assistance.

To determine how much NPS materiel and information you will need to provide to site locations, consider the following:

- Is the agent contagious?
- Who should be concerned about exposure?
- Who should seek preventive treatment at dispensing sites and who should seek symptomatic treatment at treatment centers?
- Directions to and information about dispensing and treatment locations. This information will affect the use of specific locations, the amount of NPS materiel, and the number of deliveries of that materiel that you make to specific locations. The information should answer these questions:
  - When will the dispensing operation start and what hours will it operate?
  - Where is the nearest dispensing site?
  - What is the best street access to each dispensing site?
  - If driving, where should the public park at each dispensing site?
  - What is the best transportation mode to the dispensing site (e.g., walk, use public transportation, drive)?
  - What is the dispensing process?
  - What form(s) of identification are needed?
  - What information must someone present when picking up medications for family members?
- Children: weight, age, health information, drug allergies, current medications.
- Adults: health information, drug allergies, current medications.

Information about the drugs the public must receive

The information should include the following:

- Reason(s) for using specific drugs or changing drug regimens. The cultural and ethnic sensitivity with which you provide the latter information is important to ensure that residents of a neighborhood do not think that others are getting preferential treatment because they receive different drugs. This information will affect the quantities of specific drugs that you provide to dispensing and treatment locations. It will also affect the public's acceptance of those drugs.
- Information about importance of taking the medication. This information must stress the importance of taking all of a prescribed regimen (e.g., 60 days of doxycycline for anthrax). This information affects the demand for NPS resources and minimizes the likelihood of additional people becoming symptomatic.

Reality Check: During anthrax attacks in one area during fall 2001, health authorities put at-risk individuals on ciprofloxacin until it was determined that doxycycline was also effective. After making that determination, the authorities put subsequent at-risk individuals on doxycycline to eliminate drug reaction problems arising from ciprofloxacin and to reduce cost. In their rush to protect all citizens, however, authorities failed to adequately explain their reasons for changing the drugs. The resultant outcry forced public health officials to spend valuable time dealing with public complaints rather than protecting the public.

Adherence is a well-known problem and will be especially challenging during an emergency if the treatment regimen is long, the prescribed drugs cause unpleasant side effects, and/or disease outbreaks stop before the public finishes the regimen.

After anthrax attacks in fall 2001, CDC surveyed those who received prophylactic drugs. Despite initial counseling and strong local appeals that encouraged individuals to finish the 60-day regimen, CDC found that only 45 percent adhered to the regimen. Reasons for sporadic or discontinued use included drug side effects and the perception that they were no longer at risk for anthrax.

Be aware of the danger of overmedicating. Focus on dispelling the erroneous notion that if 2 doses per day are good, 4 or 6 must be better. The goal is to reduce the demand for NPS materiel by discouraging individuals from acquiring drugs from multiple dispensing sites. A secondary goal is to minimize the possibility that some individuals will take more of a drug than is safe.

Recently, CDC awarded cooperative agreement funds to 62 project areas for bioterrorism response. Some of those funds support the improvement of health communication during emergencies. As a state or local public health communicator, you should contact the state official managing NPS planning under the cooperative agreement to coordinate health communication needs.

Checklist 9–1. National Pharmaceutical Stockpile Communication Needs Assessment

As a state or local public health communicator, you should contact the project area official managing NPS planning under the cooperative agreement to coordinate health communications needs.

Pre-event planning:

- ❑ Is the disease and drug information prepared in the multiple languages spoken by your community?
- ❑ Are processes in place to create incident-specific messages that tell people who are potentially exposed where they must go for prophylactic medications if they are well, and where they need to go if they are sick?
- ❑ Are processes in place to ensure that public information officers know which dispensing and treatment locations are *active*?
- ❑ Are media aware—before an event—of the need to disseminate NPS-related information and messages?

Your plan should include the following:

- ❑ Multilanguage text of all documents used to inform the public during an emergency
- ❑ Storage location(s) of all informational material (including electronic versions)
- ❑ Methods for reproducing and disseminating informational materials during an emergency
- ❑ Specific communication channels, partnerships, and staffing pools that support public information release, reproduction, and dissemination

To determine how much NPS-related information you will need to provide to site locations, consider the following:

- ❑ Is the agent contagious?
- ❑ Who should be concerned about exposure?
- ❑ Who should seek preventive treatment at dispensing sites and who should seek symptomatic treatment at treatment centers?
- ❑ Directions to and information about dispensing and treatment locations.
    - ❑ When will the dispensing operation start and what hours will it be open?
    - ❑ Where is the nearest dispensing site?
    - ❑ What is the best street access to each dispensing site?
    - ❑ Where should those who drive park at each dispensing site?

- ❑ What is the best way to get to the dispensing site (e.g., walk, use public transportation, drive)?
- ❑ What is the dispensing process?
- ❑ What forms of identification are needed?
- ❑ What information must someone have in order to pick up medications for family members? Children: weight, age, health information, drug allergies, current medications Adults: health information, drug allergies, current medications.

Information about the drugs the public must take

The information should include the following:

- ❑ Reasons for using specific drugs or changing drug regimens. Remember that cultural and ethnic sensitivities will affect the public-s acceptance of those drugs.
- ❑ The importance of taking the medication. This information must stress the importance of taking all of a prescribed drugs (e.g., 60 days of doxycycline for anthrax).
- ❑ Messages about the importance of adherence.
- ❑ Message to warn patients of the danger of overmedicating.

Model Emergency Health Powers Act

The U.S. public health system and primary health care providers must be prepared to address various biological agents, including pathogens that are rarely seen in the United States. High-priority agents include organisms that pose a risk to national security because they:

- Can be easily disseminated or transmitted from person to person
- Result in high mortality rates and present the potential for major public health impact
- May cause public panic and social disruption
- Require special action for public health preparedness.

The second highest priority agents include those that:

- Are moderately easy to disseminate
- Result in moderate morbidity rates and low mortality rates
- Require specific enhancements to CDCs diagnostic capacity and enhanced disease surveillance.

The third highest priority agents include emerging pathogens that could be engineered for mass dissemination in the future because of availability, ease of production and dissemination, and potential for high morbidity and mortality rates and major health impact.

"State of Emergency" communication

When dealing with communicable disease issues in an emergency, the public health response may be complicated by the need to protect civil liberties versus the need to stop the transmission of disease. Imposed quarantine, for example, has never been a popular response to a disease outbreak. And, in some cases, when a new disease emerged, clamor by a frightened public for quarantine began even before the true nature of the disease was clarified.

Therefore, who communicates what when your governor declares a public health state of emergency?

This an important question that must be answered in the pre-event planning. When a state of emergency is declared, public health officials may use law as a basis for emergency response activities. Your organization may or may not be the lead in this communication to the public. However, it's vital that you are involved in crafting messages to explain what the public health emergency law covers and why the law exists.

Most state public health emergency laws will charge the public health authority with informing its citizens when a state of emergency is declared and terminated, how people can protect themselves during a public health emergency, and the actions being taken to control the emergency. Most importantly, this information must be readily understood by citizens, regardless of their English-language skills. In preplanning, determine in what languages the information must be available and how to get that information to specific populations. Also consider the special needs of the elderly, institutionalized persons, and people with vision and hearing

impairments. These messages should be developed in template form (so you can fill in blanks about such specifics as curfew), translated, and tested to ensure that they are widely understood.

Most emergency public health laws do or will cover reporting of disease cases; quarantine; vaccination; protection of civil liberties; property issues; infectious waste disposal; control of health care supplies; access to medical records; and effective coordination with other state, local and federal agencies. These laws cover vaccination and quarantine because they are critical to stopping potentially devastating disease outbreaks. The vital medical goal is to keep an infected person from infecting others. This can be accomplished by vaccinating people who may have been exposed to the disease (if a vaccine exists) or by separating them from others during the incubation period of the disease.

A draft model law, developed at the request of CDC by the Center for Law and the Public's Health at Georgetown and Johns Hopkins universities, is serving as a basis for state and local officials to strengthen America's capacity and ability to respond to public health emergencies. *Finding the right balance between individual liberties and the common good requires effort.* A major part of the process in developing this draft model act has been to incorporate provisions that guarantee and strengthen civil liberty protections in state public health emergency laws. For example, the model law requires a court order to quarantine someone—although quarantine can be ordered without court permission if delay could pose an immediate threat to the public's health. In addition, a person in quarantine would have the legal right to a court hearing to contest the court order; the hearing must be held within 72 hours of receipt of the request. At the hearing, the public health authority must demonstrate that the quarantine is warranted. Quarantined people can also request a hearing regarding treatment and the conditions of quarantine. The draft law provides for court-appointed legal representation for those in, or recommended for, quarantine or isolation.

The materials developed to support your state public health emergency laws should stress the importance in finding the appropriate balance between individual liberties and the common good.

Pay Close Attention to the Well-being of Responders

People who respond to crises are typically extremely committed individuals who think of others before themselves. While it is precisely their generous outlook that calls them to this work, it is imperative that they—and those who care for them—be encouraged to pay close attention to *their* physical and emotional well-being. The strength of responders is the engine behind rescue and recovery.

Part of health and well-being is good preparation and planning so that people understand their roles and can maximize efficiency while minimizing unnecessary frustration. Crises bring enough unavoidable challenges without adding disorganization to the list.

Public health officials and the communication professionals who support them are responders who need to pay attention to their preparation, as well as their physical and emotional needs, as a crisis continues. The following describes important steps that should be taken to assure that they, like all who are serving the public good, can do so most effectively.

Precrisis planning for human resources

Provide training

Train communicators for designated emergency response jobs and refresh that training periodically (e.g., at minimum, require them to read and initial the crisis communication plan and discuss their roles).

Consider creating training drills (possibly unannounced) to see how quickly you can get your crisis communication operations up and running. Are phone numbers up to date in your plan? Do people respond within 45 minutes after being paged? Are backups ready if primary responders are away and out of reach? Can you assemble and make mock assignments within hours of the launch of the operation? Can your early skeletal staff produce, clear, and release a press update within 2 hours of obtaining information? Are the initial steps being considered (e.g., verification, notification, coordination, etc.)?

Acknowledge levels of experience

Develop an expertise ranking system and "promote" your team members as they gain more skills and experience in responding during an emergency. For example, the American Red Cross ranks responders, from technician to specialist to coordinator and then assistant officer and officer. They offer two tracks, one for subject matter expertise and another for leadership. Not everyone with specialized skills wants to lead, yet, their level of emergency response expertise should be recognized.

Maintain a registry of communication professionals

Identify your human assets, especially those who volunteer to participate at the headquarters or to be deployed as part of an emergency public health response. Keep a database and continually reach out to find and add

new volunteers within your organization. Make sure that their supervisors are in agreement and willing to sacrifice those staffers to the emergency response. Register communicators by specialty areas, level of experience and willingness to work in the headquarters, be deployed to a JIC, sent overseas, etc. The more "truly available" persons on your list, the more likely your operation can be maintained and, ultimately, go the distance. Ask people annually to recommit; this will ensure that you have a list representing a true inventory of your human assets.

Divide your registry according to the types of jobs that your organization's crisis communication plan has identified to be executed internally. If your plan indicates that your Web or 24-hour phone operations support will come from another organization, there's no need to keep those assignments active on your registry. Find out now if nonpaid, trained volunteers are permitted to augment your operations. Indicate on the registry who is eligible, based on your criteria, for management or leadership positions during an emergency response.

An event occurs: How many people will be needed to execute your crisis communication plan?

As an initial step in crisis response, you will be making decisions about your communication operations, especially about daily hours of operation the number of days per week, and, at some point, the expected duration of the response. Reassessments, of course, will be needed as the nature of the crisis is more clearly understood. Apply your risk assessment tools to help you make these decisions. Remember to stagger work hours to ensure continuity in your operation. You don't want an uninformed fresh crew to come in—at various times in the operational day, you'll want new workers to relieve members of a core group. For example, stagger shifts in a 24-hour period so that some are working 7 a.m. to 7 p.m., others come in at 4 p.m. and work until 4 a.m., and still others are arriving at noon and working until midnight.

Don't forget relief for leadership. Workers deserve clear and competent leadership—it's the duty of all involved to take occaisional breaks to keep them functioning at the high level required in an emergency.

The following are tried and true guidelines for establishing staff working hours during a crisis from the American Red Cross—an organization that has deployed millions of volunteers domestically and around the world for more than a hundred years. It's worth trying their formula.

Initial phase:

- Hours worked per person per day: reasonably 12, but never more than 16
- Days worked per person per week during a 3-week deployment: the first 7 to 10 days with no days off if the emergency is very intense

Maintenance phase:

If the emergency is less intense, staff should normally be directed to take one 24-hour period off after 7 days of work, with the expectation of 2 days off within 3 weeks. Typically, an assignment is for 3 weeks. However, if someone continues to be physically and mentally fit, the Red Cross may extend an assignment for another 3 weeks, with further reassessment for a final 3 weeks. However, the Red Cross expects that the volunteer, if deployed far from home, will return home for a brief stay before redeploying for each of the 3-week assignments.

Resolution phase:

Before volunteers return home or to their normal jobs, the American Red Cross either requires or encourages a visit to a mental health counselor. The organization also believes that there is value in debriefing participants. The Red Cross also provides support and educational materials to family members of persons deployed away from home.

What can be accomplished by a single person in public and media response?

How much can one communication "super-hero" accomplish in a day? There's a great deal of variation; however, there is reasonable consensus about the following rules:

Taking repetitive information calls from the public working from a script and requiring no analysis, a motivated worker may manage between 30 and 40 repetitive calls requesting information per hour. However, no one should be expected to do an 8-hour shift of this type of calltaking; 6 hours is more reasonable. Reduce that by two-thirds if calls require reassurance, referral, or recommendation. That degree of interaction would make for an overly intense 6-hour shift on the phones.

Reality Check: If the information requires regular updating or substantial script changes, don't expect your phone response workers to master the information immediately; plan for fewer calls to be managed in a day. This frontline work is incredibly intense and those responding directly to the public, no matter the job, must be monitored for emotional well-being and given needed support.

Media response needs:

Press assistants who take media calls can manage at least twice as many calls than can media information officers who provide more indepth assistance. However, the work of a press assistant can range from taking a message (not always an easy task), to directing the media representative to an alternate source. The people answering media calls provide your organizations' first impression—ensure that you assign enough people to this task. Also, make sure you have enough incoming phone lines, lest your press assistants endure a lot of grousing. When possible, create a frequently asked questions (FAQ) document containing all of the known facts that is available to reporters by fax, Web, and e-mail. This will reduce the amount of human power you'll need to get through the emergency operation.

Public information officers have been known to manage 100 calls in a day (but that could be a "fish" story) when the facts are straightforward. However, quantity must be tempered by quality. A tough day of media calls on a single but complex subject could mean between 40 and 50 for one press officer. Someone working with "issues" and not just providing information, won't be able to field as many calls. Someone acting as a spokesperson for the agency—doing radio or print interviews—will field even fewer calls. There's an obvious correlation between the intensity of the work and the amount of analysis and judgment needed in the response, and the reduction in the number of calls handled in a day.

Spokesperson assignments:

If the media interest is intense or enduring—what you'd expect in a crisis—stagger your spokespersons, too. Fatigue creates mistakes. Attempt to arrange interviews when your spokesperson is most fresh (e.g., not at the end of a shift). Reduce stress with lots of support from the public information officer.

Top leaders should expect no more 4 TV interviews in a day, along with 2 or 3 telephone interviews if they're not too indepth. That pace, however, can not be sustained day after day, and an organization director or hands-on leader of the response can't afford to do continuous interviews. Save the big guns for important moments when the public expects to hear from a real policy-maker or decisionmaker. If possible, substitute lower-level organization leaders or subject matter experts for more routine interview requests. The director should be reserved for the greatest possible reach and for pivotal moments. Overexposure of the top director may lead to accusations of grandstanding or perceived power struggles.

A spokesperson or subject matter expert assigned solely to provide media and public information response (a luxury rarely afforded) can keep pace with a top public information officer and should be able to do six or more short on-camera interviews, interspersed with print and radio interviews, each day. However, if that number of requests remains constant over time, be sure to capitalize on regular press availabilities and open more channels of communication to the public and media. The media would love unlimited access to exclusive in-person interviews. Use your assets wisely and save your human resources for the times that they're really needed.

Taking off the "superhero" cape! Emotional health issues for those responding to a crisis

According to the Red Cross, those who respond to a crisis have the potential to become "secondary victims," as they work long, intensive hours often under poor conditions. In some cases, physical dangers exist for responders. For those deployed away from home, personal support systems are left behind. Supervisory styles vary from person to person; and administrative organization and regulations often must change with little warning, adding additional stressors.

Most people who willingly respond to a crisis are dedicated individuals who also tend to be perfectionists. As such, they are at risk of pushing themselves too hard and of not being satisfied with what they have accomplished. With so much yet to do, they often fail to take credit for the amount of work completed and their contribution to the operation.

Frustration is common, and one's usual sense of humor is often stretched beyond its limits. Workers become exhausted, and anger easily surfaces. The anger of others—workers, victims, media—becomes difficult to deal with, and may be experienced as a personal attack on the worker rather than as a normal response to exhaustion. Survivor guilt may emerge as workers see what others have lost.

Coping

Remember that your response efforts are a gift of yourself—your time and your caring—that you couldn't give if you, too, were a victim.

Few of us have experience with mass death or destruction. Workers need to understand and appreciate the intensity of their emotions, and others talk about their feelings.

Although workers may function in superhuman ways during a disaster operation, the stress associated with this work takes its toll. Workers get tired, confused, hurt, and scared. It is critical for both the workers and those they are trying to help them understand the effects of stress and make an effort to deal with it.

Stress-relieving activities are not as difficult or time-consuming as we may think. A 15-minute walk, talking to someone, taking a "brain break" by going out to dinner or a movie, or just using deep breathing exercises, can significantly reduce stress.

During the operation, it's important to eat nutritional foods, avoid drinking large amounts of caffeine and alcohol, get some exercise whenever possible, and get as much sleep as possible.

Reality Check: Research indicates that after more than 24 hours without sleep, job performance is roughly equivalent to that of someone who's legally drunk!

Supervisors will attempt to juggle schedules so workers can have time off to sleep, read or sit in the sun. If workers need such time before they're scheduled, they should request it. If they need a change of assignment or setting, they should ask for that, too. And, as difficult as it may be to turn over duties to someone else, when a shift is over, workers must leave and take the time to recharge.

Personal coping

Think **RETALE**

- **R**ecognize that emotions will be high in this abnormal setting and talk about it.
- **E**at nutritious food (e.g., fruit versus donuts, or peanuts versus chips).
- **T**ake mental breaks.
- **A**void lots of caffeine or alcohol.
- **L**eave when your shift is over.
- **E**xercise.

Supervisors' support:

Think **RIMEREAD**

- **R**emind workers about the value of their effort.
- **I**nsist that scheduled meal breaks be taken.
- **M**ake nutritious foods and drinks available.
- **E**xpect high emotions and provide someone for workers to talk to.
- **R**espond to even timid requests for relief or reassignment.
- **E**ncourage exercise and personal grooming time.
- **A**ccept non-offensive "silliness" that some use to let off steam.
- **D**espite what they say, insist that workers take time to sleep.

Encouraging mental health and rejuvenation

While managing the anthrax crisis, the CDC offered a flexible schedule to their communications staff to prevent burnout. They created two staffs for their media relations efforts, and provided each team with alternating four days a week on, and three days off. It really worked well.

Coping with disasters for family members of workers

(sample wording for a brochure to families of deployed.) (Adapted from an American Red Cross brochure.)

Emotional Health Issues for Families of Deployed Emergency Response Workers

Someone very important to you and your family has just left on an emergency response assignment. It is natural for you to be worried about the experiences and potential hardships he or she may face on assignment.

Your family member has probably given you all of the information available at the time of the assignment. It may seem very scanty to you. That's because in the beginning stages of any operation, we don't really know much about where the need is greatest and where we will require your family member's particular skills. We often don't know that accommodations are available or even whether phone service is in place.

For the emergency response member, the beginning of any operation is a process of reporting as quickly as possible to a command center (which may change location), to perform a function that may change as the needs of the operation change. The staff member may be reassigned once or many times to different locations during the assignment. It is a time of great confusion and considerable frustration, as we begin to meet the needs of victims and affected communities. But we can guarantee that this is an opportunity unlike any other for emergency response workers to experience the satisfaction that accompanies helping others and stretching their own limits and potential.

We know that you will keep in touch with your deployed family member as often as possible, and continue to make him or her feel like part of the family. Friendships are quickly formed on assignments and workers look out for each other's welfare as if they had been lifelong friends. But even this sense of camaraderie is not a substitute for news and expressions of caring from home.

Deployed staff usually work long hours with little time off. They are constantly exposed to scenes of suffering, possible destruction, and the strong emotions of victims. The fast pace of the response operation is intended to quickly help the largest number of people to resume a normal, although changed, life.

When your family member returns home, he or she may need some additional time to adjust to the "normal" pace of everyday life, and may require a few days of rest before resuming previously normal responsibilities. It will be important for your family member to be able to talk to you about what happened and the emotions that accompanied the work. He or she may be proud, frustrated, angry, sad, tearful, and happy all at the same time. It will take some time to sort out these conflicting emotions.

He or she may seem preoccupied with the disaster experience, and may not seem to share your excitement, disappointment, or frustration about events at home. Be assured that what has happened at home is as important as it always was; your family member has been through an experience that tends to overshadow everyday events and puts them in a different perspective when viewed against the enormity of the situation he or she just left.

All emergency response workers return home with a conscious or unconscious need to reassure themselves of the safety of their environment. And virtually all workers feel that they left something undone on the operation. It is important that you greet your family member with the love and understanding that made you the type of family he or she could feel comfortable leaving in order to help others.

Deployed workers, even when they have served in a location that's not far from home, may have some difficulty readjusting to home life. This can create some conflicts and misunderstandings upon their return. We share this information with you in the hope that the family reunion will be joyful.

If you wish to talk to someone about your family member's assignment, please feel free to call *(designated phone number)* at any time of the day or night.

Example letter to accompany the brochure:

(Adapted from an American Red Cross letter.)

(On organizational letterhead)

To the family of our deployed emergency responder:

We at the *(your organization)* would like to offer our thanks and appreciation to you, the family whose loved one is serving on this emergency assignment.

It is not easy to be the ones who stay at home keeping life on track. We appreciate the sacrifices you have made while your family member is away for an extended period and recognize that the time may be difficult with increased family responsibilities, concern for the welfare of your loved one, and, perhaps, an increase in your personal stress.

It is also important for you to know that the person on assignment has been through a difficult experience. He/She may not be able to resume a normal schedule immediately. Your understanding of this is very important. For this reason, we have included with this letter a brochure to help your entire family when your loved one returns from assignment.

The *(organization name)* could not function without the families of our deployed workers. Thank you again for your support in this time of need.

Sincerely,

_____

Module 11 ♦ *Understanding Roles of Federal, State, and Local Health Partners*

Understanding the Environment

Understanding the communication roles and responsibilities of the federal government and its counterparts at the state and local levels during the planning for and reaction to emergency risk situations is a challenging task for several reasons:

- **Many players—**There are numerous agencies, organizations, and interagency partnerships—all responsible for different, and not necessarily distinct, components of different emergencies. Some of the key federal government agencies that may be involved include the Federal Emergency Management Agency (FEMA), Federal Bureau of Investigation (FBI), Department of Justice (DOJ), Department of Defense (DOD), Department of Energy (DOE), Department of Health and Human Services (DHHS), Environmental Protection Agency (EPA), Department of Agriculture (USDA), and the Nuclear Regulatory Commission (NRC). Within each of these agencies, separate programs or departments are in place to handle different components of a crisis, including planning, preparedness, training, on-scene assistance, consequence management, coordination, etc. The federal agencies primarily play a role in an emergency event during the first 48 hours following the onset of that event. The cities or states remain the first responders to an emergency incident until federal assistance can be coordinated and deployed.

- **Changing environment—**Administrations change. Threats change. New technological advancements arise. New or reemerging incidents occur. The way that those incidents are handled and the reactions to that handling will vary. All of these factors lead to a constantly changing environment within the roles and responsibilities arena. For example, during the writing of this section, President George W. Bush made a publicly televised announcement about his proposal to form the new Department of Homeland Security. If established, this new department would change how the federal government handles emergency risk situations (see below).

Proposed Department of Homeland Security

On June 6, 2002, President Bush announced a proposal for a new Department of Homeland Security. This department would be comprised of four divisions, responsible for controlling borders and keeping out terrorists and explosives; working with state and local authorities to prepare for emergencies; developing technologies to detect chemical, biological, and nuclear weapons and to treat those who are exposed; and analyzing intelligence and law enforcement information. The department would absorb a large portion of the executive branch, including the Coast Guard, Secret Service, Federal Emergency Management Agency, Immigration and Naturalization Service, and Customs Service, as well as the new agency in charge of airport security, the Transportation Security Administration.

The Federal Bureau of Investigation (FBI) and Central Intelligence Agency (CIA) would keep their current functions, but the department would have an "intelligence and threat analysis" unit to combine intelligence from those agencies and others to assess threats, take preventive action, and issue public warnings. The administration said that the department would take more than 169,000 employees and more than $37 billion from existing agencies. Only the Pentagon and the Department of Veterans Affairs (VA) would have more employees than the proposed Department of Homeland Security.

Therefore the environment in which you will be assigning roles and responsibilities while developing your communication plan is constantly changing. Federal agencies, states, counties, and cities all have to adapt to the changing environment, priorities, and budgets when it comes to planning for emergency risk situations. And while many organizations and agencies provide recommendations, sample plans, and training and assistance, there is no prescribed best way for departments of health to assign roles and responsibilities when generating their communication plans. However, there are recommendations and tools that can help to facilitate those decisions.

The remainder of this chapter is devoted to providing more details about the roles and responsibilities of the federal agencies as well as Internet resources that may be useful for developing emergency communication plans. Due to constant changes in the structures and staffing of these agencies, we have provided Web sites but not detailed contact information. We recommend that state officials use these resources as the basis for preparing their communication plans but supplement these resources by gathering additional contact information and state-specific resources.

Roles and Responsibilities

In the Roles/Responsibilities section below, we have compiled a list and summary of agencies, departments, and partnerships that may play a role in the planning and response to emergency risk situations. This list is by no means exhaustive and, as mentioned earlier, is constantly changing.

American Red Cross (http://www.redcross.org)

The American Red Cross provides relief to victims of disasters and helps people to prevent, prepare for, and respond to emergencies. When a disaster threatens or strikes, the Red Cross provides shelter, food, health, and mental health services. The Red Cross also feeds emergency workers, handles inquiries from concerned family members outside the disaster area, provides blood and blood products to disaster victims, and helps those affected by disaster to access other available resources. Although chartered by Congress to perform its disaster preparedness and relief mission, the American Red Cross is not a government agency and relies primarily on financial donations from the American people for support.

Agency for Toxic Substances and Disease Registry (ATSDR) (http://www.atsdr.cdc.gov/)

The mission of the Agency for Toxic Substances and Disease Registry (ATSDR), as an agency of the U.S. Department of Health and Human Services <http://www.hhs.gov/>, is to serve the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposures and disease related to toxic substances.

ATSDR is directed by congressional mandate </congress.html> to perform specific functions concerning the effect on public health of hazardous substances in the environment. These functions include public health assessments of waste sites, health consultations concerning specific hazardous substances, health surveillance and registries, response to emergency releases of hazardous substances, applied research in support of public health assessments, information development and dissemination, and education and training concerning hazardous substances.

Centers for Disease Control and Prevention (CDC) (http://www.cdc.gov)

The Centers for Disease Control and Prevention (CDC) is recognized as the lead federal agency for protecting the health and safety of people—at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

Central Intelligence Agency (CIA) (http://www.cia.gov)

The CIA provides evidence-based foreign intelligence related to national security, including information about the potential terrorist use of chemical, biological, radiological, and nuclear agents.

Department of Agriculture (USDA) (http://www.usda.gov)

USDA has the primary responsibility for protecting the safety of the nation's food supply. The agency has an overall biosecurity system designed to prevent the harmful introduction of plant and animal pathogens

into America's system of agriculture and food production. This system includes resources and response mechanisms in case an emergency should occur. USDA also closely coordinates with the states, industry, law enforcement, and such other federal agencies as the Food and Drug Administration (FDA), the CDC, and the U.S. Customs Service, on biosecurity issues.

Department of Defense (DoD) (http://www.dod.gov)

The armed service branches of DoD, including the Army, Air Force, Marines, Navy, and the National Guard, continue to be the frontline military defense against terrorist threats.

The DoD's **Defense Threat Reduction Agency** focuses specifically on safeguarding America from weapons of mass destruction (WMD) (e.g., chemical, biological, radiological, nuclear, and high explosives) by reducing the present threat and preparing for future threats. http://www.dtra.mil

In addition to their traditional military role, the DoD also supports the operations of other federal government agencies as well as state and local governments. The mission of the (**U.S. Army Soldier and Biological Chemical Command's (SBCCOM's) Homeland Defense Business Unit)** is to enhance the response capabilities of military, federal, state, and local emergency responders to terrorist incidents involving WMD. http://hld.sbccom.army.mil/about_us.htm

Department of Energy (DOE) (http://www.energy.gov)

One of the DOE's primary missions is to enhance national security in relation to nuclear energy. The **Emergency Operations** unit of the **National Nuclear Security Administration (NNSA)** directs DOE's and NNSA's emergency responses at DOE and NNSA facilities and field sites, and to nuclear and radiological emergencies within the United States and abroad. http://www.dp.doe.gov

The **Pacific Northwest National Laboratory's Chemical and Biological Defense Program's (PNNL's)** researchers focus on the entire spectrum of chemical, biological, and nuclear weapons. In addition to creating pathogen-detection systems, PNNL prepares military forces and emergency responders to recognize and respond to incidents involving WMD, with emphasis on chemical and biological threats. http://www.pnl.gov/chembio/index.htm

Department of Health and Human Services (DHHS) (http://www.hhs.gov)

DHHS is the primary agency for coordinating health, medical, and health-related social services under the Federal Response Plan. DHHS also provides medical teams to assist the FBI, Secret Service, and Department of State in the field.

The **DHHS National Disaster Medical System (NDMS)** is a federally coordinated system that augments the nation's emergency medical response capability. The overall purpose of the NDMS is to establish a single, integrated, national medical response capability for assisting state and local authorities in dealing with the medical and health effects of major peacetime disasters and providing support to the military and Veterans Health Administration medical systems in caring for casualties evacuated back to the United States from overseas armed conflicts. http://ndms.dhhs.gov

The **DHHS Office of Emergency Preparedness (OEP)** has departmental responsibility for managing and coordinating federal health, medical, and health-related social services, and recovery to major

emergencies and federally declared disasters, including natural disasters, technological disasters, major transportation accidents, and terrorism. Working in partnership with FEMA and the federal interagency community, OEP serves as the lead federal agency for health and medical services within the Federal Response Plan. OEP also directs and manages the National Disaster Medical System (see below). OEP is also responsible for federal health and medical response to terrorist acts involving WMD. http://ndms.dhhs.gov/index.html

Department of the Interior (DOI) (http://www.doi.gov)

The DOI's **Hazards and Facilities Team** of the **Office of Policy Management and Budget** works to ensure adequate capability to prepare for and respond to incidents caused by natural or human effects that impact federal lands, resources (including nationwide fish and wildlife resources, floodplains, wetlands, and cultural/historic resources), facilities, tenants, employees, visitors, and adjacent landowners. http://www.mrps.doi.gov/hft1.htm

Department of Justice, Office for Domestic Preparedness (http://www.ojp.usdoj.gov/odp/)

The Office for Domestic Preparedness (ODP), Office of Justice Programs (OJP), is the program office responsible for enhancing the capacity and preparedness of state and local jurisdictions to respond to WMD incidents of domestic terrorism. ODP's State and Local Domestic Preparedness Program accomplishes this through its training, exercises, equipment grants, and technical assistance programs.

Department of State (http://www.state.gov)

State Department activities related to emergency response include protecting and assisting U.S. citizens living or traveling abroad and keeping the public informed about U.S. foreign policy and relations with other countries.

The **Office of the Coordinator of Counterterrorism** coordinates all U.S. government efforts to improve counterterrorism cooperation with foreign governments and coordinates responses to major international terrorist incidents in progress. Another primary responsibility of the office is to develop, coordinate, and implement American counterterrorism policy. http://www.state.gov/s/ct

Department of Transportation (DOT) (http://www.dot.gov)

DOT contains several important agencies that deal with emergency situations. The **U.S. Coast Guard** responds to maritime emergencies and also may assist state and local officials in dealing with chemical incidents, particularly oil and hazardous materials spills. http://www.uscg.mil/uscg.shtm

Other DOT agencies that may be involved in emergency response are the **Federal Aviation Administration** (http://www.faa.gov) and the **Federal Railroad Administration** (http://www.fra.dot.gov), particularly its Hazardous Materials Division. http://www.fra.dot.gov/safety/hazmat.htm

Transportation Security Administration (TSA) (http://www.tsa.gov) The TSA is a new agency developed in 2001 in response to the events of September 11 to protect the nation's various transportation systems. Some of its duties include strengthening security systems at airports and coordinating transportation matters for the federal government in the event of a future terrorist incident.

Department of the Treasury (http://www.treasury.gov)

The primary divisions of the Department of the Treasury that are involved in emergency response are the **Bureau of Alcohol, Tobacco, and Firearms (ATF)** and the **U.S. Customs Service. ATF** supports federal, state, and local governments in responding to and investigating incidents caused by arson and/or explosives. Its national response teams are typically able to respond within 24 hours of an incident. http://www.atf.treas.gov/about/programs/response.htm

U.S. Customs Service guards the U.S. borders to prevent the entry of illegal substances that may be used for a terrorist attack. http://www.customs.treas.gov

Environmental Protection Agency (EPA), Chemical Emergency Preparedness and Prevention Office (CEPPO) (http://www.epa.gov/ceppo)

EPA's CEPPO provides leadership, advocacy, and assistance to (1) prevent and prepare for chemical emergencies, (2) respond to environmental crises, and (3) inform the public about chemical hazards in their communities. To protect human health and the environment, CEPPO develops, implements, and coordinates regulatory and nonregulatory programs. The Office carries out this work in partnership with regions, domestic and international organizations in the public and private sectors, and the general public.

Federal Bureau of Investigation (FBI) (http://www.fbi.gov)

The FBI serves as the lead agency for preventing acts of terrorism in the United States. The FBI Web site includes descriptions of major investigations under way as well as specific reports on terrorism.

The **Awareness of National Security Issues and Response (ANSIR) Program** is the FBI's national security awareness program. It is the FBI's public voice for espionage, counterintelligence, counterterrorism, economic espionage, cyber and physical infrastructure protection, and all national security issues. The program is designed to provide unclassified national security threat and warning information to U.S. corporate security directors and executives, law enforcement, and other government agencies. It also focuses on the "response" capability unique to the FBI's jurisdiction in both law enforcement and counterintelligence investigations. http://www.fbi.gov/hq/nsd/ansir/ansir.htm

Federal Emergency Management Agency (FEMA) (http://www.fema.gov)

FEMA is the federal agency that coordinates the response of federal agencies to disasters and the communication of information about disasters between federal agencies and the public, particularly within the first 48 hours following the event.

FEMA's Guide for All-Hazard Emergency Operations Planning State and Local Guide (101), Chapter 6, Attachment G - Terrorism, Tab B, April 2001, provides a detailed list of federal departments and agencies with counterterrorism-specific roles. Agencies mentioned include FEMA, DOJ, DoD, DOE, DHHS, EPA, DOA, and NRC. http://www.fema.gov/rrr/gaheop.shtm

National Domestic Preparedness Office (NDPO) (http://www.ndpo.gov)

The mission of this office is to coordinate and facilitate all federal WMD efforts to assist state and local emergency responders with planning, training, equipment, exercise, and health and medical issues necessary to respond to a WMD event. Program areas encompass planning, training, exercises,

equipment, information sharing, and public health and medical services. Federal partners include FEMA, FBI, DOE, EPA, DOJ, Office for State and Local Domestic Preparedness Support, DHHS, and the National Guard Bureau.

Nuclear Regulatory Commission (NRC) (http://www.nrc.gov)

NRC's Office of Nuclear Security and Incident Response (NSIR) is ready to respond to an event at an NRC-licensed facility that could threaten public health and safety or the environment. NRC's highest priority is to provide expert consultation, support, and assistance to state and local public safety officials responding to an event. Once the NRC incident response program is activated, teams of specialists obtain and evaluate event information to assess the potential impact of the event on public health and safety and the environment. http://www.nrc.gov/what-we-do/regulatory/emer-resp.html

Office of Homeland Security (http://www.whitehouse.gov/homeland)

The Office of Homeland Security and the Homeland Security Council have been established to develop and coordinate a comprehensive national strategy to strengthen federal, state, and local counterterrorism efforts. Resources include the Homeland Security State Contact List, which shows the homeland security contact for each state.

U.S. National Response Team (NRT) (http://www.nrt.org)

The NRT consists of 16 federal agencies with responsibilities, interests, and expertise in various aspects of emergency response to pollution incidents.

Tools and Resources

The following is a list of online resources and documents—or their relevant sections—that may be useful while developing this section of your communication plan. When appropriate, relevant excerpts are included.

Centers for Disease Control and Prevention (CDC) (http://www.cdc.gov)

The **CDC Public Health Emergency Preparedness and Response Program** is an Internet resource that provides information about chemical and biological agents, press releases, training, contacts, and other important information dealing with the public health aspects of bioterrorism preparedness and response. Section includes information on CDC bioterrorism funding for states. http://www.bt.cdc.gov/

The **CDC Interim Recommended Notification Procedures for Local and State Public Health Department Leaders in the Event of a Bioterrorist Incident, Public Health Emergency Preparedness and Response** is a Web resource that provides a flowchart of recommended notification procedures, beginning with a local health official either learning of or suspecting a bioterrorist threat or incident. http://www.bt.cdc.gov/EmContact/Protocols.asp

Department of Health and Human Services (DHHS) (http://www.hhs.gov)

The Department has produced a factsheet, *17 Critical Benchmarks for Bioterrorism Preparedness Planning*, to help states and cities prepare for possible bioterrorist attacks. http://www.hhs.gov/news/press/2002pres/20020606a.html

Department of Justice, Office for Domestic Preparedness (http://www.ojp.usdoj.gov/odp/)

This office operates the **State and Local Domestic Preparedness Support Helpline**.

The Helpline is a nonemergency resource available for use by emergency responders. It provides general information about all Office of Domestic Preparedness' programs and information on the characteristics and control of WMD materials, defense equipment, mitigation techniques, and available federal assets. The Helpline provides "customer intelligence" that will aid state and local jurisdictions in building capacity in their communities to respond to a WMD terrorism incident. The Helpline number is 1–800–368–6498 and is staffed weekdays from 9 a.m.–6 p.m. EST.

Federal Emergency Management Agency (FEMA) (http://www.fema.gov)

CONPLAN, U.S. Government Interagency Domestic Terrorism Concept of Operations Plan, January 2001—The CONPLAN outlines an organized and unified capability for a timely, coordinated response by federal agencies to a terrorist threat or act. It establishes conceptual guidance for assessing and monitoring a developing threat, notifying appropriate federal, state, and local agencies of the nature of the threat, and deploying the requisite advisory and technical resources to assist the lead federal agency (LFA) in facilitating interdepartmental coordination of crisis and consequence management activities. The CONPLAN outlines roles for the following agencies: FBI, FEMA, DoD, DOE, EPA, and DHHS. It is also meant to serve as a foundation for further development of detailed national, regional, state, and local operations plans and procedures, and illustrates which federal, state, and local agencies can most effectively unify and synchronize their response actions. http://www.fema.gov/rrr/conplan

Guide for All-Hazard Emergency Operations Planning State and Local Guide (101), Chapter 6, Attachment G—Terrorism, April 2001—This document aids state and local emergency planners in developing and maintaining a terrorist incident appendix to an emergency operations plan for incidents involving terrorist-initiated weapons of mass destruction. The planning guidance in Attachment G was prepared with the assistance of the DoD, DOE, USDA, DHHS, DOJ, Veterans Affairs (VA), EPA, NRC, the National Emergency Management Association, and the International Association of Emergency Managers. Tab B of this document provides a detailed list of federal departments and agencies with counterterrorism-specific roles. Agencies include FEMA, DOJ, DoD, DOE, DHHS, EPA, DOA and NRC. http://www.fema.gov/rrr/gaheop.shtm

Table 5. Responses to a WMD Incident and the Participants Involved, p.6-G-12.
http://www.fema.gov/doc/rrr/allhzpln.doc

Relevant excerpt

"State and local governments have primary responsibility in planning for and managing the consequences of a terrorist incident using available resources in the critical hours before federal assistance can arrive. State and local health departments, as well as local emergency first responders, are relied upon to identify unusual symptoms, patterns of symptom occurrence, and any additional cases of symptoms as the effects spread throughout the community and beyond. Local first responders will provide initial assessment or scene surveillance of a hazard. The proper local, state, and federal authorities capable of dealing with and containing the hazard should be alerted to a suspected WMD attack after state/local health departments recognize the occurrence of symptoms that are highly unusual or of an unknown cause. Consequently, state and local emergency responders must be able to assess the situation and request assistance as quickly as possible."

Guide for All-Hazard Emergency Operations Planning State and Local Guide (101), Linking Federal and State Emergency Response Operations, Chapter 7, September 1996—This document summarizes the response planning considerations that shape the content of the Federal Response Plan, regional response plans, and state emergency operations plans. It outlines the linkages between federal and state emergency response operations for planning purposes. http://www.fema.gov/pdf/rrr/7-ch.pdf

Guide for All-Hazard Emergency Operations Planning State and Local Guide (101), Chapter 5, Attachment D, Emergency Public Information, September 1996—This functional annex outlines the emergency public information (EPI) function of a jurisdictional organization and provides an outline for developing an EPI annex. The document provides information on interjurisdictional coordination and on organization and assignment of responsibilities. http://www.fema.gov/pdf/rrr/5-ch-d.pdf

Federal Response Plan, April 1999—The Federal Response Plan (FRP) establishes a process and structure for the systematic, coordinated, and effective delivery of federal assistance to address the consequences of any major disaster or emergency declared under the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The entire document can be found at http://www.fema.gov/rrr/frp.

Federal Response Plan, The Emergency Support Function (ESF) Annex #8—Health and Medical Services is a particularly relevant section that outlines how federal assistance is requested and coordinated specifically during public health and medical care needs following a major disaster or emergency, or during a developing potential medical situation. http://www.fema.gov/pdf/rrr/frp/frpesf8.pdf

Relevant excerpt

"Assistance provided under ESF #8 is directed by DHHS through its executive agent, the Assistant Secretary of Health. Resources are furnished when state and local resources are overwhelmed and public health and/or medical assistance is requested from the federal government."

Federal Response Plan, Public Affairs Support Annex—Provides guidance on carrying the public affairs function in support of the federal government's response to a major disaster or emergency. It discusses the organizational elements of a Joint Information Center (JIC), FEMA headquarters-level response structure, regional-level response structure, and the role of the FEMA director of emergency Information and media affairs. http://www.fema.gov/pdf/rrr/frp/frppa.pdf

Relevant excerpt

"According to the Federal Response Plan, FEMA is responsible for implementing federal public affairs activities after a major disaster or emergency. FEMA will develop strategic plans and policies, provide liaison with the directors of public affairs for other federal agencies and the White House press office, and determine the need for a Joint Information Center (JIC). A JIC is established as a central point for coordination of emergency public information, public affairs activities, and media access to information about the latest developments. A JIC may be established at both FEMA Headquarters and/or near the scene of the disaster. Release of information between the two will be well coordinated to the maximum extent possible. The chief spokesperson for FEMA in a headquarters JIC is the FEMA Director of Emergency Information and Media Affairs, or a designee, who fields inquiries from national news media."

Federal Response Plan, Terrorism Incident Annex—This annex describes crisis management and consequence management, and defines policies and structures to coordinate crisis management with consequence management. http://www.fema.gov/pdf/rrr/frp/frpterr.pdf

Relevant excerpts

"Responding to terrorism involves instruments that provide crisis management and consequence management. The federal government exercises primary authority to prevent, preempt, and terminate threats or acts of terrorism and to apprehend and prosecute the perpetrators. states and local governments provide assistance as required. Crisis management is predominantly a law enforcement response. Consequence management refers to measures to protect public health and safety, restore essential government services, and provide emergency relief to governments, businesses, and individuals affected by the consequences of terrorism. states and local governments exercise primary authority to respond to the consequences of terrorism; the federal government provides assistance as required.

"The DOJ is designated as the lead agency during threats or acts of terrorism within the U.S. territory. DOJ assigns lead responsibility for operational response to the FBI. Within that role, FBI operates as the on-scene manager for the federal government. FEMA is designated as the lead agency for consequence management within the U.S. territory."

Rapid Response Information System (RRIS)—The RRIS can be used as a reference guide, training aid, and an overall planning and training resource for response to a chemical, biological, and/or nuclear terrorist incident. The RRIS is comprised of several databases, consisting of chemical and biological agents' and

radiological materials' characteristics, first aid measures, federal response capabilities, help line, hotlines, and other federal information sources concerning potential WMDs. http://www.rris.fema.gov

Johns Hopkins Center for Civilian Biodefense Strategies (http://www.hopkins-biodefense.org)

This organization is a nonprofit center of Johns Hopkins University dedicated to informing policy decisions and promoting practices that help to prevent the development and use of biological weapons, and should prevention fail, lessen the death and suffering that would result. The Web site provides a wealth of information and resources, including factsheets, relevant publications, congressional testimonies, links to other resources, and its own publication, *Bioterrorism Quarterly*.

National Domestic Preparedness Office (NDPO) (http://www.ndpo.gov)

The Beacon is the National Domestic Preparedness Office's monthly newsletter. Each issue provides a forum for the federal government and the first-response community to provide insight into WMD issues, make announcements, and disseminate information. http://www.ndpo.gov/beacon.htm

Training Resources

Centers for Disease Control and Prevention (CDC) (http://www.cdc.gov)

The Response to Terrorism Series features four presentations that were originally given as a training program for clinical laboratory staff who may first encounter a potential bioterrorism agent. They are now available on the Internet so health care professionals can use them as needed. Topics include bioterrorism, clinical aspects of critical biological agents, agents of bioterrorism, and the Laboratory Response Network for Bioterrorism. http://www.bt.cdc.gov/roleofclinlab.asp

Federal Bureau of Investigation (FBI) (http://www.fbi.gov)

The **FBI's Counterterrorism/Weapons of Mass Destruction Training Links** were created in response to the recent demand for training pertaining to counterterrorism and WMDs. The training division of the FBI has compiled a list of Web sites that contain training opportunities available to federal, state, and local law enforcement and emergency response personnel. Many of these programs are federally funded and are offered free of charge or at minimal cost. http://www.fbi.gov/hq/td/academy/ctwork12.htm

Federal Emergency Management Agency, U.S. Fire Administration (USFA) (http://www.usfa.fema.gov)

The USFA offers a variety of counterterrorism training courses through the National Fire Academy. For example, the 2-day basic concepts course is designed to prepare first-responder personnel to take appropriate action at the scene of a potential terrorist incident. It provides students with a general understanding and recognition of terrorism, defensive considerations (biological, nuclear, incendiary, chemical, and explosive), and command and control issues associated with criminal incidents. When an incident occurs, the student will be able to recognize and implement self-protective measures; secure the scene; complete appropriate notifications to local, state, and federal authorities; and assist in completing a smooth transition from emergency to recovery and termination operations.
http://www.usfa.fema.gov/dhtml/fire-service/c-terror-train.cfm

Federal Emergency Management Agency, Rapid Response Information System (http://www.rris.fema.gov)

This site contains the U.S. Army Soldier and Biological Chemical Command's Compendium of Weapons of Mass Destruction courses, sponsored by the federal government (January 2000). This compendium was compiled to inform state and local agencies of available federal WMD training. These courses are available to state and local responders. http://www.rris.fema.gov/compendium_wmd_aug_2000.pdf

U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID) (http://www.usamriid.army.mil)

USAMRIID offers specialized training for military and civilian health care providers to enhance their capability to diagnose and treat casualties of biological warfare or terrorism. In addition to a quarterly inhouse course, an annual three-day satellite broadcast is offered for continuing medical education.
http://www.usamriid.army.mil/education/index.html

Freedom of Speech and Press

by Ralph Holsinger

The Constitution establishes the branches of U.S. government: the executive (headed by the President), the judicial (headed by the U.S. Supreme Court), and the legislative (Congress). The first 10 amendments, known as the Bill of Rights, were designed to protect natural or personal rights (Holsinger, 1991).

The First Amendment reads: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; of the right of the people peaceably to assemble, and to petition the government for a redress of grievances."

The First Amendment conveys no right to break the law to obtain or disseminate news.

Espionage law and the news media

The Espionage Act of 1917 is used to prosecute as spies people who pass military secrets to other countries. In 1985, the Act was used for the first time to prosecute and convict a government employee for disclosing information to the news media (as opposed to agents of a foreign government). The conviction was upheld on appeal and is seen as a warning to those who may be tempted to leak classified information to reporters, no matter the motives.

Law of defamation

A knowledge of libel law is important for those involved in any kind of public communication (Holsinger, 1991).

The Constitution recognizes the value of reputation—what others think of us—and under common law has permitted victims of harmful words to sue their detractors and recover sums of money for their loss of reputation. However, the First Amendment protects the media against libel actions brought by public officials, even when the official has been the victim of a lie. Officials cannot recover damages unless they can prove that the publisher knowingly published a lie or showed reckless disregard for the truth.

Any communicator who feels compelled to report, in tangible form or in a broadcast, that an identifiable person or business may be involved in illegal, unethical, immoral, or dishonest activity risks being sued for defamation.

Defamation is communication that:

- Exposes an individual (or organization) to hatred or contempt
- Lowers an individual in the esteem of others
- Causes an individual to be shunned, or
- Injures an individual in his business.

There are two forms of defamation:

- **Slander:** is spoken defamatory communication in the presence of others. Slander is not published or broadcast.
- **Libel:** is published or broadcast defamatory communication.

The following conditions must be met before a statement is held legally libelous:

- **Publication:** The defamatory statement must be published or broadcast.
- **Identification:** The communication must identify (by name or obvious suggestion) a person, persons, or entity.
- **Fault:** The plaintiff has to prove that the defendant was negligent or reckless (i.e., that the defendant was at fault).
- **Falsity:** The statement must be false. True statements cannot be considered libel. In addition, the lie must be stated as fact.
- **Injury:** The defamatory statement has to have potential to cause injury. Injury is often assumed to have occurred if the statement insinuated a crime, a loathsome disease, immorality, or caused harm to one's business or job performance.

Although any form of defamation is serious, libel is considered more serious than slander because libel is:

- **Intentional:** Libel is more intentional than slander because the forethought involved in writing and editing precedes the deliberate act of publishing or broadcasting.
- **Widespread:** Libel is more widespread than slander because it reaches a much larger audience through publication or broadcast.
- **Permanent:** Libel is more permanent than slander because printed publications and broadcast audiotapes and videotapes remain in existence, unlike the spontaneously spoken word.

Retractions

If you defame someone, one possible way to resolve the problem is to publish a retraction. Laws vary by state, but in many states retractions are a partial defense, provided the retraction appears with the same prominence as the original. Some states have time limits for requesting and printing retractions. Other states allow media outlets to run retractions to avoid paying certain damages.

Copyright

Copyright is the right of a writer, composer, artist, or photographer to own, control, and profit from the production of his or her work. Copyrighted material may not be republished without the copyright owner's permission. Often, you must pay to use the copyrighted work. Copyright law does not apply to facts, events, ideas, plans, methods, systems, blank forms, or titles.

Works created by federal employees as part of their employment are considered "works of the U.S. government." Copyright protection is not available for these works in the United States. The U.S. government may receive and hold copyrights transferred to it by assignment, bequest, or otherwise.

It is illegal for anyone to violate any of the rights provided the copyright owner by the copyright code. Only the author or those deriving their rights through the author can rightfully claim copyright.

The fact that copyrighted materials are located online does not allow use of those materials without the author's permission. Online materials retain their copyright protection. Users should assume that materials found online through the Internet or other online services are copyrighted unless they are clearly works of the U.S. government or otherwise noted to be in the public domain.

Generally, users may print or download one copy of copyrighted material for their personal use, unless different terms are specifically provided at the site or are provided in the online service license agreement. Any subsequent reproduction of downloaded or printed materials, whether in electronic or any other form, is governed by provisions of the Copyright Act.

Copyright limitations: fair use

In general, the owner of the copyright has exclusive rights to the copyrighted work. However, the act permits "fair use" for such certain purposes as teaching, scholarship, or research. Fair use permits one author, composer, or artist to borrow limited amounts of material from another without seeking permission.

Factors to be considered in determining what constitutes fair use include:

- The purpose and character of the use, including whether such use is of a commercial nature or is for nonprofit educational purposes
- The amount and substantiality of the portion used in relation to the copyrighted work as a whole
- The effect of the use upon the potential market for or value of the copyrighted work
- The nature of the copyrighted work, including whether the work is creative or factual.

Examples of fair use by the government include:

- Photocopying where copies are distributed to a discrete and limited audience within the government (as opposed to copies that are sold or distributed broadly outside the government)
- Copying that is done spontaneously for the purpose of facilitating an immediate and discrete objective (as opposed to the systematic archival copying of extensive materials for possible future use).

Making and using a photocopy or reproduction for purposes in excess of fair use may constitute copyright infringement. The U.S. government may be held liable for copyright infringement by its employees.

The Copyright Act protects collections of words or an artistic composition. Courts have held that no one can copyright individual words in common usage or even short collections of words or the kind likely to occur in common combinations.

Trademark

The Lanham Trade Act can be used to protect words or symbols that clearly identify a business and its products. These are called trademarks. Normally, they must be registered with the Patent and Trademark Office, and the owner must make an effort to prevent their unauthorized use.

Right to know versus need to know

When releasing information, elected officials and civil servants must weigh the public's right to know against the need for national security and individual privacy. Citizens expect to know how their money is being spent and how these resources are being used. They have a "right to know" about the government's activities.

The public's right to know is not strictly a legal concept supported by the Constitution or an act of Congress. Instead, it is a concept promoted by officials in all branches of our government as the proper approach to the disclosure of information because the government depends on the support of those it governs.

Keeping certain sensitive information secret is of paramount importance to the defense and operation of a government. The "need to know" concept is used to keep sensitive information in the hands of those whose duties require its use and away from potential enemies of the United States (Holsinger, 1991).

The following are CDC's principles of communication regarding the public's right to know:

CDC will make available timely and accurate information—through proactive news releases or in response to specific requests—so that the public, Congress, and the news media may assess and understand its scientifically based health information and programs.

- Final reports, information, and recommendations will be made fully and readily available.
- Communication will be open, honest, and based on sound science, conveying accurate information.
- Information will not be withheld solely to protect CDC or the government from criticism or embarrassment.
- Information will be released consistent with the Freedom of Information Act (FOIA).
- Prevention messages will be based on supportable scientific data and sound behavioral and communication research principles. At all times, health messages will remain scientifically valid and accurate. CDC will honor embargo agreements with standards of peer-reviewed periodicals in the scientific and medical communities.
- Targeted health messages will be sensitive to language and cultural differences and community norms.

Freedom of Information Act

A fundamental principle of democracy is that the citizens be informed about their government. FOIA ensures that the federal government provides the public with requested information to the maximum extent possible.

FOIA does *not* apply to state and local governments. These are covered by their own laws, which vary from state to state and city to city. The federal law does cover local branches of federal agencies.

FOIA cannot be used to obtain documentary information in the possession of the following:

- The President and his advisers
- Congress, its committees, and the few agencies under its direct control, principally the Library of Congress and the General Accounting Office
- The federal judicial system.

All records in a federal agency's possession that are not already in the public domain (e.g., in the library or available from a clearinghouse) are subject to FOIA. The Act requires that federal agencies make available for inspection and copying the decisions of administrative tribunals, policy statements, and staff manuals of instruction affecting the public.

No forms are necessary to request information under FOIA. Seekers need only write a letter with as much detail as possible about the records they want. However, to obtain someone's medical or personnel records, seekers must provide a consent form that names the person whose records are to be released, states that the federal agency is allowed to release the records requested, is signed and dated by the person whose records are requested (for adults), and is notarized (unless the request is from a law firm).

To request records on a minor (a person less than 18 years of age), the consent form must be signed by the minor's parent or guardian. The relationship between the minor and the person signing must be noted on the consent form. Several types of information are exempt from FOIA requirements and can be withheld. If you intend to withhold information, it must fall under at least one of the following nine exemptions (categories of records that an agency is allowed to or must withhold from release):

- Materials properly classified under executive order "to be kept secret in the interest of national defense or foreign policy." This includes information that could jeopardize national security; documents properly classified as Top Secret, Secret, or Confidential are not releasable. The designation "For Official Use Only" is not a national security classification and cannot be used as the sole basis for withholding information.
- "Internal personnel rules and practices of an agency." Reports related solely to the internal personnel rules and practices of an agency do not have to be released. This provision is designed to relieve the government of the burden of maintaining routine material for public inspection. Materials may include such issues as employee parking rules. Government agencies are not required to release this information, but they may choose to do so.
- Materials exempted from disclosure by a specific statute and information protected by other special directives. Secrecy is essential to the operation of certain organizations, such as the Central Intelligence Bureau or the Census Bureau. Such special directives as the CIA's charter or the Census Act protect this information and exempt it from FOIA, so that its release is not required.
- "Trade secrets and commercial or financial information obtained" with the assurance that it will be kept confidential. These are exempted because they could cause substantial competitive harm if disclosed. This information includes secret formulas, customer lists, and sensitive financial information.

- "Interagency or intraagency memorandums or letters" that would not ordinarily be available to outsiders except in connection with a lawsuit.
- Personnel and medical files and similar files that, if disclosed, could constitute a clearly unwarranted invasion of privacy.
- "Investigatory records compiled for law enforcement purposes." However, the law does require disclosure of records that will not interfere with an ongoing investigation, identify confidential sources or methods of gathering information, invade privacy, interfere with a fair trial, or endanger lives.
- Materials bearing on the operating conditions, regulation, or supervision of financial institutions.
- "Geological and geophysical information and data, including maps, concerning wells."

Records withheld by CDC/Agency for Toxic Substances and Disease Registry (ATSDR) usually fall into the following categories:

- Records whose release would result in a clearly unwarranted invasion of privacy
- Records containing confidential business information or inter- or intra-agency records of a predecisional nature, which typically contain the opinions, conclusions, or recommendations of the author(s) and are part of the decisionmaking or policy-making process of the agency
- Records whose release is prohibited by a law other than FOIA.

In response to FOIA requests, agencies may delete information that clearly would invade an individual's privacy, but they must explain such deletions in writing. The agency also may refuse to release information that it believes to be covered by one of the nine exemptions. However, even when documents are withheld, the agency is required to describe them in a general way and give its reasons for denying access to them. Such a report is called a "Vaughn index."

Requests for information do not have to be justified and must be disposed of within 10 working days. If the agency decides not to release information, the seeker is entitled to appeal to an agency review officer, and the appeal must be granted or denied within 20 working days. Thus, the maximum delay, if the law is observed, is limited to 30 working days, or 6 weeks. However, because some agencies have been overwhelmed with large numbers of requests or requests for huge volumes of documents, the law permits a 10-day extension. Agencies are permitted to charge fees to recover direct costs. If a request is deemed to be in the public interest, the agency can reduce, or even waive, its fee.

State and local decisionmaking

The open meeting laws now in effect in every state have been enacted in an effort to end the practice of conducting public business behind closed doors. Statutes in all states give reporters and the public access to most state and local records and to meetings of deliberative bodies, including such agencies as city and county councils, school boards, and the boards of trustees of state universities. Other kinds of records, such as birth and death certificates, complaints filed with police, accident reports, and welfare rolls may or may not be freely available for public inspection. Access depends on whether a law defines them as public records or

whether courts, applying common law, have defined them as such. Such laws require legislative and administrative bodies to meet in public, with closed meetings permitted only for limited purposes. Most such laws define a public agency in broad enough terms to include any agency spending public funds.

Legally, the media do not have special right of access to records and meetings. Public records laws define a right of access for all persons, including journalists. Reporters do not have any special legal right of access to meetings of government agencies; however, legal precedent supports the media's right to publish the nation's most highly guarded secrets, if they can be obtained. The same is true at the local level. For example, even when state laws prevent release of names of juvenile offenders, the Supreme Court has upheld that journalists can publish their names.

Privacy act of 1974

Do not disclose private facts about an individual without permission. Disclosure of an individual's private information that is offensive to a reasonable person's ordinary sensibilities, and not newsworthy, constitutes an invasion of privacy.

The Federal Privacy Act of 1974 is designed to prevent disclosure by government agencies of personal data about employees and others on whom files are kept. The Privacy Act of 1974 applies directly to FOIA. It limits access to personal files collected by government. Such files are defined as those that link an individual's name with "his education, financial transactions, medical history, and criminal or employment history."

The Privacy Act offers guidelines for providing required information without sacrificing a person's right to privacy. The following records concerning federal employees are a matter of public record and no further authorization is necessary for disclosure:

- Name and title of an individual
- Grade classification or equivalent and annual rate of salary
- Position description
- Location of duty station, including room number and telephone number
- Employee name in the case of accident or criminal charges, after next of kin has been notified
- In general, an individual's current city and state of residence
- Information on an individual's hospitalization or confinement while awaiting trial.

In most circumstances, you may not release the following information:

- Age or date of birth
- Marital status and dependents
- Street address or phone number

- Race
- Sex
- Legal proceedings.

The Privacy Act normally protects such personal information as medical records, pay records, age, race, sex, and family background. In some cases, media representatives may insist on obtaining information protected by the Privacy Act. In such cases, consult with your office of general counsel to seek guidance.

Sample Privacy Act Notification Statement

"The Centers for Disease Control and Prevention, an agency of the Department of Health and Human Services, is authorized to collect this information, including the Social Security number (if applicable), under provisions of the Public Health Service Act, Section 30l (42 U.S.C. 241). Supplying the information is voluntary and there is no penalty for not providing it. The data will be used to increase understanding of disease patterns, develop prevention and control programs, and communicate new knowledge to the health community. Data will become part of CDC Privacy Act System 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems" and may be disclosed: to appropriate state or local public health departments and cooperating medical authorities to deal with conditions of public health significance; to private contractors assisting CDC in analyzing and refining records; to researchers under certain limited circumstances to conduct further investigations; to organizations to carry out audits and reviews on behalf of HHS; to the Department of Justice for litigation purposes, and to a congressional office assisting individuals in obtaining their records. An accounting of the disclosures that have been made by CDC will be made available to the subject individual upon request. Except for these and other permissible disclosures expressly authorized by the Privacy Act, no other disclosure may be made without the subject individual's written consent."

In addition, the Privacy Act notification statement must also appear on CDC forms which are used by states, hospitals, or other third-party suppliers of individually identified data to CDC if full surname is present on the copy of the form that reaches CDC. The same prototype can be used if the last sentence is modified to read: "An accounting of such disclosures will be made available to the subject individual upon request."

Before deciding to release information on a given subject to the media, consider the following:

At some point an individual's asserted right to privacy limits the media's First Amendment right to inform the public. The law of privacy is of relatively recent origin and is not recognized as an actionable tort in all states. The law of privacy has not been federalized. The law of privacy is concerned primarily with exploitation or harassment of the individual by the news media, employers, bill collectors, advertisers, and public relations practitioners (Holsinger, 1999).

Today, nearly all states protect a right of privacy. The four kinds of invasion comprising the law of privacy include:

- **Intrusion upon the individual's physical and mental solitude or seclusion,** such as eavesdropping or entry without permission into another's private space.
- **Public disclosure of private facts.** A disclosure of private fact occurs when some medium of communication disseminates personal information that the individual involved did not want made public. The information must be of a nature that would be offensive to a person of ordinary sensibilities. Truth is not an absolute defense against disclosure. If the facts at issue are held to be

newsworthy, or are taken from public record of a court or other governmental agency, publication is not an invasion of privacy. Newsworthiness is information deemed to serve the public interest.

- **False light.** False light occurs if an individual is portrayed as something other than they are to the point of embarrassment. Knowledge of falsity or reckless disregard for the truth must be proven.
- **Appropriation.** Appropriation involves the unauthorized use of one person's name or likeness to benefit another.

As a public information officer, consider the following before releasing information to the media:

- **Ability.** Do you have the information on the subject? You must physically have the information before you release it.
- **Competency.** Are you qualified to discuss the topic with the news media? If you are not the expert, find out who the expert is and arrange to have him or her brief the media.
- **Authority.** Do you have jurisdiction over the issue? It's always advisable to stay in close contact to your higher headquarters to coordinate your response and get its view of "the big picture."
- **Security.** Is the information classified? The security limitation is most important because of the need to safeguard classified and operationally sensitive information.
- **Accuracy.** Is the information accurate? Public information officers have an obligation to provide accurate, factual information and to avoid speculation.
- **Propriety.** Is the information appropriate to the situation? Ensure that information released displays sensitivity and dignity. For example, do not release photographs of disease victims that could distress family members.
- **Policy.** Do the policies of your organization permit release of this information?

Resources:

Public information; agency rules, opinions, orders, records, and proceedings, 5U.S.C.552.

Records maintained on individuals, 5U.S.C.552a.

Privacy Act - Basic Regulations, HHS Chapter 45–10, General Administration Manual.

Management of Federal Information Resources, OMB Circular A–130.

Privacy Act Regulations, 45CFR Part 5b.

Freedom of Information Act, 45CFR Part 5.

Guidelines to Determine If a Project Is Covered by the Privacy Act.

White House New Comprehensive Privacy Action Plan For the 21st Century.

Privacy Act Management, On-Line Guidance, Management Analysis and Services.

Confidentiality Management, On-Line Guidance, Management Analysis and Services Office.

Information; publication restrictions, 42U.S.C.242m(d).

Protection of privacy of individuals who are research subjects, 42U.S.C. 241d.

Holsinger, Ralph L. (1991). *Media Law*. New York: McGraw Hill.

DoD Defense Information School—Public Affairs Officer Course

The Law and Public Health Agencies

by Babette Neuberger, J.D. and Tom Christoffel, J.D.

Public health authority at the state and local levels is typically exercised by boards of health and public health agencies. The jurisdiction and legal authority of these entities vary from state to state. The relationship between state agencies and local public health departments within each state is itself varied and complex.

All 50 states; the District of Columbia; and the territories of Guam, Puerto Rico, American Samoa, and the U.S. Virgin Islands have a state or territorial health agency (which we will call a state agency, for brevity). Each state health agency is directed by a health commissioner or a secretary of health. Each state also has a chief state health officer, who is the top public sector medical authority in the state. (The same person may fill both positions, or the chief state health officer may answer to the director of the state agency.)

A state health agency is generally organized as:

- An independent agency directly responsible to the governor or a state board of health (33 states)
- A division within a supra-agency.

As of 1982, 24 states had boards of health. In most of these states, the chief health officer reports to the board; in some states, the chief health officer is a member of the board. More than 90 percent of the state boards are appointed by the governor. The remainder are appointed by professional associations or by the state health agency director.

The general responsibilities of state boards of health are policy- and budget-related. For example, as the governing body of the Texas Department of Health, the Texas Board of Health adopts goals and rules to govern the department's activities. The six-member board is charged with the ultimate legal authority over most public health issues in the state.

There are about 2,900 local health departments in the United States. They are structured in one of the following ways:

- **Centralized at the state level.** About one-third of the states use this organizational structure, with the state agency operating whatever local health agency units exist within the state (1981 data).
- **Autonomous units.** Some local health agencies operate completely independently of the state health agency and receive only consultation and advice from the state.
- **Semicentralized.** In the majority of states, some programs are operated entirely by the state, some programs are shared with the local health department, and some programs have the state act merely as an adviser to the local health department. The extent of local health department jurisdiction also varies within states and across the nation. Some local health departments serve a single city or county, others serve a group of counties, and some serve a city-county combination.

Approximately 73 percent of local health departments serve a jurisdiction that has a local board of health. Eighty-eight percent of the local boards of health have statutory authority (under the concept of "home rule") to establish local health policy, fees, ordinances, regulations, etc. In addition, 61 percent of local boards of health have statutory authority to approve the local health department's budget.

Public Health Laws

Sources of authority

State governments (and, by delegation, their various subdivisions) possess the authority to enact and enforce public health laws under what is known as their "police power," a broad concept that encompasses the functions historically undertaken by governments in regulating society.

The term "police power" is not mentioned in the Constitution of the United States. Rather, police power is inferred from the powers traditionally possessed by governments and exercised to protect the health, safety, welfare, and general well-being of the citizenry.

Police power has been used to uphold a wide variety of actions by the states, many quite broad in their reach and impact. Generally, such laws will be upheld if it can be shown that the laws are reasonable attempts to protect and promote the public's health, safety, and general welfare and that the laws are not arbitrary or capricious attempts to accomplish such an end.

On the state level, all governmental authority (including expansive police power) resides with the state governments. The state governments, in turn, can and do authorize local governmental entities to exercise governmental authority on the local level. The establishment of local boards of health are authorized by state laws, which establish guidelines for their operation.

Public health functions may be divided among a number of governmental departments—health, environment, registration, etc. Often local boards of education have principal responsibility for conducting school health programs, and state departments of education have primary regulatory responsibility for school health services.

Local health departments carry out their activities under two types of authority:

- **Delegation of authority.** State legislatures commonly empower local health departments to carry out such administrative functions of the state as the enforcement of the state public health code.

- **Home rule authority.** To avoid the need for specific authorization each time a new need arises, most states—either through legislation or by constitutional amendment—have given local governmental units the right of local self-governance, that is, the right to make decisions concerning their own welfare.

Home rule allows local government to carry out public health and other functions without having to seek legislative authority anew for each specific activity. In Illinois, for example, home rule units "may exercise any power and perform any function pertaining to its government and affairs including, but not limited to, the power to regulate for the protection of the public health, safety, morals and welfare: to license; to tax; and to incur debt." Without constitutional or statutory home rule authority, city and town governments would not be empowered with their own rule-making functions.

Local public health authority, although generally not as broad or extensive as that authorized on the state level, is still considerable. For example, the New York City health code regulates virtually every phase of

human existence, requiring reports of nuisance or dead birds, ritual circumcisions, and deaths, and regulating the disposal of human remains and the location of cemeteries.

Also, general grants of authority can at times serve as the basis for enacting ordinances in circumstances not specifically contemplated by the state legislature. For example, on the basis of such general authorization, the courts upheld the New York City health department's authority to require window guards in high-rise residences. The courts also upheld the authority of the mayor of San Francisco to declare a "public health emergency" and authorize needle-exchange programs that were otherwise illegal under state law.

City councils commonly develop their own local public health ordinances or health codes. This autonomous exercise of power is limited by the rule that localities may not assign responsibilities that are in conflict with state laws and regulations to local health departments. Thus public health law is even more of a patchwork at the local level, where health departments are not only responsible for local public health ordinances but must also deal with enforcement authority, responsibility, and limitations established by state law.

The activities of the various levels of government are often interrelated. For example, a local health department may inspect local nursing home facilities and make enforcement recommendations to a state agency, which has final enforcement authority. At the same time, federal Medicare and Medicaid determinations may actually have the biggest governmental impact on the operations of these same regulated facilities.

In many instances, the federal government has the legal authority to preempt an area of public health regulation, thus denying regulatory authority to the states. Similarly, the states have authority to preempt all areas of public health regulation from local governments, denying county and municipal governments any regulatory authority. The governmental level with highest authority has several options. It may:

- Choose not to exercise its potential authority, leaving the lower levels of government the complete discretion to adopt legislation it deems appropriate
- Preempt the area, adopt legislation, and implement the program
- Preempt the area by adopting legislation and delegate the implementation of the program to a lower governmental unit to run.

Although the courts have interpreted the state police power broadly, governmental authorities do have limits placed on their powers. Limitations on state and federal powers are found in:

- The U.S. Constitution
- The constitutions of individual states
- Federal and state laws.

In the case of a federal law, the federal government has specifically enumerated powers, and if the subject matter of legislation does not fall within any of the enumerated areas of federal authority, then either the matter is one that is reserved to the states or it is a matter beyond the Constitutional reach of government altogether.

Public health laws are occasionally challenged as infringing upon constitutionally protected individual rights. These challenges require the courts to balance between the social needs of the community and the liberty of the individual.

Judicial determinations of individual rights are fluid; thus the elucidation of "constitutional rights" can and do vary with the times. The area of public health and safety laws, however, has historically been quite static, and the courts have traditionally been very hesitant to invalidate these laws, even for the sake of protecting individual rights.

In the 1905 case of *Jacobson* v. *Massachusetts*, the U.S. Supreme Court approved a broad grant of authority for the enactment of public health laws of all types. *Jacobson* tested the validity, under the U.S. Constitution, of a Massachusetts statute providing that "the board of health of a city or town, if, in its opinion, it is necessary for the public health or safety, shall require and enforce the vaccination and revaccination of all [its] inhabitants . . . ." [197 U.S. 11 (1905) at 26.] Those refusing to comply were to be fined $5.

Under the authority delegated by this statute, the Cambridge Board of Health, concerned with the spread of smallpox in the city, ordered the vaccination of all inhabitants not vaccinated against smallpox during the preceding 5 years. Jacobson refused to be vaccinated and refused to pay the $5 fine. The case went to the U.S. Supreme Court to determine whether the vaccination requirement was a reasonable exercise of the state's police power or whether such a requirement was unduly oppressive, going too far in restricting Jacobson's liberty under the Constitution. The Court balanced the competing interests involved—on the one hand, the state's responsibility to protect the public from infectious disease and, on the other, Jacobson's interest in making his own health decisions. The *Jacobson* opinion, upholding the validity of the vaccination law, provided a clearly stated and firm endorsement of the broad embrace of the police power. *Jacobson* is important for its affirmation of the police power and for the proposition that society can be "governed by certain laws for the common good" and that competing individual rights are no absolute.

Although a contagious disease—smallpox—was involved in *Jacobson*, the Supreme Court's decision did not hinge on the danger of contagion. In fact, in cases following *Jacobson*, the nation's courts have invoked the police power to uphold a variety of public health and safety measures, many of which did not involve any danger of contagion. For example, the police power justification outlined in *Jacobson* has been used to uphold laws requiring the fluoridation of public drinking water and mandating the use of seat belts by automobile occupants and helmets by motorcyclists.

Since the Supreme Court decided the *Jacobson* case in 1905, it has broadened its recognition of individual rights. For example, the Court first recognized the broad right to privacy more than half a century after its *Jacobson* decision, and the recognition of that right has since been important in several of its decisions on public health issues. This broadening of individual rights raises the question of whether *Jacobson* would be decided differently by today's Supreme Court. Although some health law scholars have suggested otherwise, it seems unlikely that it would.

Recently, the courts have been consistent in rejecting the claim that Constitutional rights to privacy and due process prevent government from mandating seatbelt use in motor vehicles, despite the absence of any threat of contagion (as in *Jacobson*). Similarly, compulsory examination, treatment, and quarantine have long been upheld by the nation's courts as legitimate governmental requirements, despite their highly intrusive nature.

Bill of Rights

The Bill of Rights was added to the U.S. Constitution to protect the individual from certain types of restrictive action by the federal government.

Many public health laws have been challenged on the basis that they interfere with the civil liberties guaranteed by the Bill of Rights and the Fourteenth Amendment to the U.S. Constitution.

A law that would force some individuals to abandon or violate important tenets of their religious faith could conflict with rights granted in the First Amendment to the U.S. Constitution, which provides that:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances.

For public health laws, the First Amendment's second clause is the most relevant: "Congress shall make no law . . . prohibiting the free exercise [of religion]." A literal interpretation of this provision would be fraught with serious problems. Would the First Amendment prevent the trial and punishment of someone who committed murder as part of a sincerely held belief in religion that called for human sacrifice? Are adherents of religions that condone or promote polygamy not subject to state laws outlawing this practice?

When conflict occurs between a legitimate, otherwise valid law and a religious practice, the courts will look at:

- The adherent's sincerity, not the validity of the particular underlying religious beliefs
- How central or essential the practice at issue is to the particular religion.

Where the court finds a real conflict between religious belief and an otherwise valid law, it must weigh the competing social and individual interests.

Public health concerns have been deemed to outweigh individual interests in the area of compulsory vaccination. As the U.S. Supreme Court stated, "The right to practice religion freely does not include liberty to expose the community . . . to communicable disease . . . " [*Prince* v. *Massachusetts*, 321 U.S. 158 (1943)]. It should be noted, however, that states sometimes choose to provide an exemption in their immunization laws for persons whose religious beliefs prohibit immunization.

Laws may also be invalidated because they conflict with that part of the First Amendment that protects the free communication of ideas:

> Congress shall make no law . . . abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances.

Laws can conflict with free expression and communication either directly or indirectly. For example, a law making it a crime to publicly criticize either of the two major political parties would be intentionally aimed directly at restricting communication and would be barred by the First Amendment. A law aimed at something other than communication itself but which restricts communication as a secondary or indirect

effect might also be barred. This argument is used by those who oppose limits on political campaign contributions and expenditures.

Under the Fifth Amendment's self-incrimination provision, people may refuse to answer official questions if the answers could be used as evidence against them in a criminal prosecution. This right applies not only to questioning by the federal government but also, through application of the Fourteenth Amendment, to questioning by state and local governmental agencies.

Self-incrimination may be an issue with records and reports required in public health and safety enforcements if they could conceivably lead to criminal prosecution. This potential conflict is sometimes avoided by making it a criminal offense to fail to maintain and report such records but forbidding use of their content for criminal prosecution. This is the approach taken by New York City, for example, in its self-inspection program for food establishments [N.Y.C. Health Code Sections 81.39 (a), 131.03(d), 131.05(b)]

Equal protection

The U.S. Supreme Court has also interpreted due process to mean that no person shall be denied equal protection of the laws. This guarantee is provided for explicitly in the Fourteenth Amendment, applicable to the states, and implicitly in the Fifth Amendment Due Process clause, applicable to the federal government.

Equal protection is an intricate concept that can be violated in two ways.

- The government may deny equality if its rules or programs make distinctions between persons who are actually similar in terms of any relevant criteria. For example, if a law restricted governmental job eligibility based on sex rather that training and ability, it would be denying equality in the application of law.

- The government may deny equality if it fails to distinguish between persons who are actually different in terms of relevant criteria. For example, a government program that provided free smoke detectors to the public would violate equal protection rights of persons with disabilities if it required them to appear personally at a government office to obtain one.

Equal protection does not require the same treatment in all instances. government often does classify people into groups and treat the groups differently. For example, some state governments apply more stringent driver's license requirements to persons over 75 years of age. And several states restrict the driving privileges of persons suffering from certain medical conditions. Yet these distinctions have not been held to be violations of equal protection.

The fact is that government can differentiate between individuals and groups if it has good reason to do so.

Rational basis

The rational basis standard applies in cases that do not involve a "suspect classification" or a "fundamental right." The standard is easily and routinely met. It simply requires that government offer some plausible basis for a law's unequal application.

Strict scrutiny

The strict scrutiny standard applies when the law involves a "suspect classification" such as race, sex, age, or national origin, or when the law affects a "fundamental right" such as the right of interstate travel, the right to vote, or the right to free speech. The strict scrutiny standard is very difficult to satisfy. Under this higher standard, the government must show:

- A compelling state interest in applying the law unequally
- That the law is tailored narrowly to achieve that purpose.

Taking of private property

The Fifth Amendment also provides that no private property shall be taken for public use without just compensation. The Fifth Amendment prohibition applies to both:

- Real property, defined as land, buildings and other real estate
- Personal property, defined as everything that is subject to ownership, that is not considered "real property."

Many public health laws prohibit, ban, or otherwise regulate the possession or use of hazardous agents, products, and real estate. The government does so to protect the public's health and safety. Such laws may substantially interfere with use and enjoyment of property. Does the Fifth Amendment require the government to compensate those persons whose private property rights are affected by the public health laws?

The general rule may be stated as follows:

> Government "takings" of private real and personal property to prevent harm generally do not require compensation, thus underscoring the broad authority the Constitution extends to government as the protector of public health and safety.

There are several possible explanations for the broader acceptance of the governmental taking of personal property without compensation:

- Society traditionally values real property more highly than personal property.
- Usually personal property is worth less than real property.
- Unlike hazardous real property, hazardous personal property usually cannot be used for a less hazardous purpose; thus the government usually has no alternative other than to ban the product outright.

Privacy rights

An argument frequently made against public health laws, such as immunization requirements, fluoridation, compulsory HIV testing, and helmet and seatbelt use laws, is that such laws infringe on individual rights. Opponents of such laws assert that they reach beyond the police powers of the states, deny due process, and

violate the Constitutional "right of privacy." But where does one look in the U.S. Constitution to find reference to a privacy right?

The right to privacy has been limited to intimate areas of life.

Public health officials responsibilities/liabilities

Public health authorities have broad legal authority that gives them the power to institute a wide variety of measures to protect the public's health and safety.

But what does the law say about those responsibilities? Are they discretionary or mandatory? Can you be forced to act? Can your actions or failure to act be the source of legal jeopardy? And what happens if your actions result in harm? Can you be sued for damages or threatened with criminal prosecution?

Responsibility

state statutes that authorize public health officials to protect and enhance the public's health and safety outline a variety of functions. These functions are classified as either mandatory or discretionary.

- **Mandatory functions** are those which an agency must undertake by legislative mandate. The statute leaves no room for an agency to determine whether to carry out the function. Examples of mandatory functions include:
  - Statutory requirements to maintain vital records
  - Legal mandates to develop toxic air pollutant regulations
  - Ordinances requiring agencies to hold "open or public meetings" and to make other information available to the public.
- **Discretionary functions** are defined as ones involving the exercise of judgment or discretion in connection with planning or policy-making. Discretionary activities may include:
  - Decisions to create a waste disposal site
  - Management of natural resources
  - Planning inspection and social service policies
  - Allocating funds for inspection of nursing homes and day care facilities.

Health departments have a legal responsibility to carry out mandatory functions but are allowed considerable latitude in how and when to carry out discretionary ones.

Liability

Conventional wisdom holds that Americans have become litigious, filing lawsuits whenever anything goes wrong or whenever they think they could collect money for damages. The concern over potential litigation has fallen heavily on health care professionals, particularly those who practice medicine. But there is a related

fear that anyone with responsibility for the well-being of others may be sued if that well-being is lost. Understanding the laws of liability will put such fears in their proper perspective.

Liability laws covering state and local health department agencies and employees vary considerably across the country.

Interstate quarantine

Public health law allows that whenever the Director of the Centers for Disease Control and Prevention determines that the measures taken by health authorities of any state or possession are insufficient to prevent the spread of any of the communicable diseases from one state to another state or possession, the director may take measures to prevent spread of the diseases. Measures may include inspection, fumigation, disinfection, sanitation, pest extermination, and destruction of animals or articles believed to be sources of infection.

In addition, a person who has a communicable disease in the communicable period can be restricted from traveling from one state or possession to another without a permit from the health officer of the state, possession, or locality of destination.

The person in charge of any conveyance (e.g., bus, ship, plane) engaged in interstate traffic on which a case or suspected case of a communicable disease develops is required, as soon as practicable, to notify the local health authority at the next port of call, station, or stop, and to take measures to prevent the spread of the disease as the local health authority directs.

Certain communicable diseases invoke special requirements. The following provisions are applicable with respect to any person who is in the communicable period of cholera, plague, smallpox, typhus, or yellow fever, or who, having been exposed to any such disease, is in the incubation period.

Without a written permit of the Surgeon General or authorized representative, the person cannot travel from one state or possession to another or on a conveyance engaged in interstate traffic. Persons given written permission will be required to present the permit to operators of the conveyances.

Apprehension and detention of persons with specific diseases for the purpose of preventing the introduction, transmission, or spread of the following diseases: anthrax, chancroid, cholera, dengue, diphtheria, granuloma inguinale, infectious encephalitis, favus, gonorrhea, leprosy, lymphogranuloma venereum, meningococcus meningitis, plague, poliomyelitis, psittacosis, relapsing fever, ringworm of the scalp, scarlet fever, streptococcic sore throat, smallpox, syphilis, trachoma, tuberculosis, typhoid fever, typhus, and yellow fever.

A parent, guardian, physician, nurse, or other such person should not transport, procure, or furnish transportation for any minor child or ward, patient, or other such person who is in the communicable period of a communicable disease, except in accordance with regulatory provisions.

Separate provisions exist for military personnel.

Foreign quarantine

U.S. public health law has made provisions to prevent the introduction, transmission, and spread of communicable disease from foreign countries into the states or possessions of the United States.

For ships destined for a U.S. port, ship masters are required to immediately report to the quarantine station at or nearest the port at which the ship will arrive, the occurrence on board of any death or any ill person among passengers or crew (including those who have disembarked or have been removed) during the 15-day period preceding the date of expected arrival or during the period since departure from a U.S. port (whichever period of time is shorter).

The commander of an aircraft destined for a U.S. airport is required to report immediately to the quarantine station at or nearest the airport at which the aircraft will arrive, the occurrence on board of any death or ill person among passengers or crew.

The master of a ship carrying 13 or more passengers must report by radio 24 hours before arrival the number of cases (including zero) of diarrhea in passengers and crew recorded in the ship's medical log during the current cruise. All cases of diarrhea that occur after the 24-hour report must also be reported not less than four hours before arrival.

The director of CDC may require detention of a carrier until the completion of the measures necessary to prevent the introduction or spread of a communicable disease. The director may issue a controlled free pratique to the carrier stipulating what measures are to be met, but such issuance does not prevent the periodic boarding of a carrier and the inspection of persons and records to verify that the conditions have been met for granting the pratique.

Persons, carriers, and things

Whenever the director of CDC has reason to believe that any arriving person is infected with or has been exposed to any of the following communicable diseases, the director may detain, isolate, or place the person under surveillance and may order disinfection or disinfestation as he or she considers necessary to prevent their introduction, transmission, or spread: cholera or suspected cholera, diphtheria, infectious tuberculosis, plague, suspected smallpox, yellow fever, or suspected viral hemorrhagic fevers (Lassa, Marburg, Ebola, Congo-Crimean, and others not yet isolated or named).

Whenever the director has reason to believe that any arriving carrier or article on board the carrier is or may be infected or contaminated with a communicable disease, he or she may require detention, disinsection, disinfection, disinfestation, fumigation, or other related measures as he or she considers necessary to prevent the introduction, transmission, or spread of communicable diseases.

Persons: isolation and surveillance

The director of CDC may require isolation of a person where surveillance is authorized whenever the director considers the risk of transmission of infection to be exceptionally serious.

By law every person who is placed under surveillance must during the period of surveillance:

- Give information relative to his or her health and his or her intended destination and report, in person or by telephone, to the local health officer having jurisdiction over the areas to be visited, and report for medical examinations as may be required
- Upon arrival at any address other than that stated as the intended destination when placed under surveillance, or prior to departure from the United States, inform, in person or by telephone, the health officer serving the health jurisdiction from which he or she is departing.

Liability of states and their political subdivisions

In most if not all states and localities, government officials are, by statute, granted immunity from lawsuits arising from the exercise of their governmental functions. Most may be held liable for torts arising from the exercise of proprietary functions.

State laws generally take on of two forms:

- Overall immunity is granted the state, subject to specified exceptions. In such states, immunity is the general rule and the limited circumstances under which the state agrees to be sued are specifically described.
- Immunity is the exception. state statutes following this model confer immunity on a limited basis as exceptions to a comprehensive scheme permitting governmental tort actions. In such states the doctrine of sovereign immunity is abolished, and immunities are restored on a limited basis as deemed appropriate by state legislators.

The rules for governmental tort immunities of counties and municipal corporations usually take one of three forms, the first of which is the most common:

- The state tort claims act governs the tort immunities of its counties and municipal corporations.
- The state tort claims act expressly excludes political subdivisions from coverage; more limited immunities are usually provided to them under a separate tort claims act.
- In a small minority of states, the rules governing immunity for counties and municipalities remain defined by common law principles.

Regardless of the form they take, virtually all state tort claims acts:

- Retain immunity for essentially governmental functions
- Waive immunity for negligence of governmental officers and employees acting within the scope of their employment
- Establish procedures for filing claims against the government
- Limit the amount of damages that may be recovered
- Authorize governmental entities to purchase liability insurance.

The term "negligence" means a failure to exercise reasonable care and caution. The standard by which the legal system judges "reasonable care" is often expressed as that which a "prudent" or careful person would do.

Liability for proprietary functions

Public health agencies are often involved in the provision of clinical services through public health clinics, school health programs, and the like. In such situations, the public health clinician has a legal responsibility to provide care that meets the same high professional standards expected of private clinicians. Failure to perform at this level of care and competency constitutes malpractice, that is, negligent performance by a professional that results in harm to the patient or client.

Like clinicians working in other public or private institutions, professionals who provide clinical services in health departments need malpractice insurance protection, which is usually provided by the employer (in this case, by the government).

There are other situations in which a public health agency may act in a proprietary role and could conceivably be sued for negligence. For example, the agency may operate an automobile child-restraint sale or loaner program and may worry about legal liability if a defective car seat results in harm to the user. Although this is an unlikely event, it must be dealt with before beginning any such program, either through insurance, waivers, or legal counsel's assurance of some relevant statutory immunity.

Liability for governmental functions

What about the public health professional's regulatory role? Certainly harm can result from the enforcement of public health laws. For example, a restaurant closed while an episode of food poisoning is being investigated will lose business, perhaps running into the tens of thousands of dollars. A nursing home that has its license restricted or suspended will suffer even greater damage. And any business or facility investigated by a local or state health department may find that rumors emanating from the investigation have driven business away, even if no problem is found to exist.

Can owners of these businesses sue the health department for compensation and win? No. Virtually all states provide immunity from tort actions arising out of the performance of essential governmental functions. In many jurisdictions this is called "the general duty doctrine." The doctrine says that a governmental body engaged in the inherently governmental tasks of enforcing laws and regulations ought not to be hampered in fulfilling its public duty by exposing it to tort liability should its actions (or failure to act) result in injuries to members of the public. Thus under the general duty doctrine, absent compelling circumstances discussed later in this module, the government cannot be held liable to private plaintiffs for the negligent exercise of its authority.

In most states the general rule is that governmental entities are immune from suit for torts committed by their officers and employees in performing basic governmental functions, unless liability is specifically permitted by statute, or the function, even though essentially governmental in nature, is ministerial rather than discretionary.

The extent of immunity varies among states.

A governmental entity will usually be held liable for failing to warn about hazards when it has notice of a dangerous condition which it created or had control over, and the danger is not readily apparent to the public. For example, a municipality would not be held liable for failing to place warning signs or otherwise protect persons using public beaches if an injury arose from natural conditions such as a strong undertow or steep drop-off, since the decision to warn is discretionary function. However, a city would be held liable to persons injured while driving in an unmarked area of a public beach where harm resulted from their striking an underwater concrete abutment placed there by the city. Because the city created the condition and the danger was not readily apparent to the public, the city has a special duty to warn divers of the hidden danger.

For the most part the courts are extremely reluctant to impede the important work of governmental agencies by expanding the scope of their liability. For this reason, they often go to great lengths to define functions to fall within the scope of a state's immunity rules.

Liability of individual health officers: qualified immunity

Thus far we have examined the liability of governmental entities at the state, county, and municipal levels. But what about the personal liability of individual public health officers? Injured persons who go to the time and expense of bringing a lawsuit will often name not only a governmental entity as a defendant but also the officers, agents, or employees who were involved in the incident. The latter may be sued in their official capacity as well as personally.

A suit against an individual in his official capacity means the plaintiff is seeking recovery from the governmental entity which employs the defendant; a suit against a person in his or her individual capacity means the plaintiff is seeking recovery directly from the person. Do immunity provisions protect them? The answer is a qualified yes.

As a general rule, when you perform your public health duties in good faith and in a reasonable fashion, you are not personally liable for damages that may result from your acts. Judges understand that if you are made too fearful of the legal consequences of your actions, you will be timid and ineffectual in carrying out your duties—not a desirable state of affairs. Thus, the courts have fashioned legal doctrines that afford public health practitioners broad immunity from lawsuits.

This is a qualified immunity, not an absolute one. It only applies under circumstances where you are acting in good faith within the scope of your authority. The principle would not hold in instances of gross and willful carelessness, malicious, corrupt or criminal actions, or acts that went beyond the authority vested in the public health agency or the scope of your employment. Clearly you would not engage in willful carelessness of corruption through mere inattention.

Going beyond an agency's appropriate authority may seem less clear cut. But in fact, this problem would arise not from taking legitimate authority to excess, but rather from going off into completely unauthorized or clearly invalid areas, for example, attempting to require participation in religious services by all nursing home residents.

Frank Grad lists the following questions that arise in determining whether an employee has exceeded an agency's authority:

- Was the employee authorized or required to do what was done?

- Was the employee authorized to use the means that were used?
- Were the employee's actions based on a mere error in the exercise of discretion or did the employee knowingly go beyond legal authority or knowingly use improper means?

Public health practitioners performing their duties in good faith and in a reasonable fashion are not personally liable for damages that may result from their acts.

Or, as a standard legal encyclopedia puts it:

> A health officer who by statute is authorized to take action for the prevention of the spread of disease is not liable for injuries resulting from such reasonable and customary measures as he may in good faith adopt or direct for that purpose with regard to persons or matters subject to his jurisdiction; and this rule has been applied to errors of judgment. However, health officers may be held personally responsible for gross and willful carelessness in the exercise of their powers, acts of corruption, unreasonable or arbitrary action, or acts in excess of their authority. (39 A C.J.S. Health & Environment, Sec. 54)

Variations on the general rule

State statutes vary widely in the amount of protection offered to individuals. In some jurisdictions health officials may be held liable for negligently performing ministerial, as apposed to discretionary, acts. For example, health officials may be personally liable for operating a motor vehicle in a negligent manner and for failing to provide appropriate social services.

To assure protection from civil and criminal legal difficulties, you should carefully document what you do, as you do it. Then, if you later need to demonstrate that appropriate agency procedures have been consistently followed, your work logs and records will provide key evidence that nothing untoward or improper occurred. Without such contemporaneous documentation, after-the-fact defenses become problematic.

While it is extremely unlikely that your work will ever result in civil or criminal legal repercussions, there are two practical lessons here:

- First of all, adhere to the standards and ethics of your profession and you will not run afoul of the legal system.
- Second, maintain complete records that will allow you to demonstrate that you in fact performed in a reasonable and defensible manner.

State and local programs financed in whole or in part by federal monies must attain compliance with federal regulations, which are often quite extensive in scope.

Americans with Disabilities Act of 1990

Under the Americans with Disabilities Act of 1990 (ADA), which prohibits public entities from discriminating on the basis of disability, health departments must assure that their services, policies and practices—essentially every aspect of their service delivery programs—meet extensive requirements. The regulations cover activities of the health department, whether provided directly or through contractual licensing or other arrangement. The ADA requires, among other things, that public entities:

- Provide qualified disabled individuals the opportunity to participate in the same services and programs of activities as others; separate and distinct programs are not acceptable.
- Operate each service, program and activity in locations that are readily accessible to and usable by individuals with disabilities.
- Take steps to ensure that communication with applicants, participants, and members of the public with disabilities are as effective as communication with others.

Civil Rights Act of 1964, Title VI

The Civil Rights Acts of 1964 prohibits discrimination based on race, color, or national origin. Section 601 of the act states:

> No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Recently health departments have been challenged for discrimination based on national origin and limited English proficiency. A complaint was filed with the U.S. Office of Civil Rights by an Illinois resident on behalf of himself and other non- and limited-English-speaking persons, alleging that an Illinois county health department discriminated against them based on national origin. The complaint specifically alleged that the county denied and/or delayed their receiving services, required them to provide their own interpreters, and treated them in a discriminatory manner. As evidence of the latter, the complainants asserted that county officials made negative comments, had a hostile attitude, and assigned them to Spanish-speaking clinics.

As a result of the complaint, the Illinois county worked with the complainants and the U.S. Office of Civil Rights to hire interpreters, conducted sensitivity training for its staff, and reorganized delivery services to prevent segregation of Spanish-speaking persons.

Resource:

Neuberger, Babette, J.D., M.P.H., Christoffel, Tom, J.D. “The Legal Basis of Public Health.” Public Health Training Network. http://www.cdc.gov.phtn.

Model State Emergency Health Powers Act

Laws are vital in protecting Americans from the potentially devastating impact of bioterrorism and other public health emergencies. As states enhance their preparedness for a bioterrorist event or other public health emergency, state officials are reviewing their states' laws to determine whether they have the authority needed to make quick decisions to save lives and prevent the spread of illness.

Individual states possess the principal legal powers to control epidemics, but have had little experience using the disease control laws in large-scale public health emergencies because the United States has been free of massive disease epidemics for decades. Existing laws were crafted, in many cases, to deal with the outbreaks typical of the early twentieth century.

As part of a broad effort to strengthen the country-s preparedness for bioterrorism and other public health emergencies, CDC requested that legal experts at Georgetown and Johns Hopkins develop a draft model law that states could compare with existing laws. The resulting draft Model State Emergency Health Powers Act is designed to facilitate and encourage communication among the various interested parties and stakeholders about the complex issues pertaining to the use of state emergency health powers. It is each state-s decision to adopt, modify, or reject the provisions contained in the draft. According to the Center for Law and the Public's Health at Georgetown and Johns Hopkins, as of August 16, 2002, 35 states and the District of Columbia have introduced bills or resolutions based in whole or in part on the model law.

The draft law covers the reporting of disease cases; quarantine; vaccination; protection of civil liberties; property issues; infectious waste disposal; control of health care supplies; access to medical records; and effective coordination with other state, local and federal agencies. The draft model law covers vaccination and quarantine because they are critical elements in stopping potentially devastating disease outbreaks. The vital medical goal is to prevent an infected person from infecting others. This can be accomplished by vaccinating those who may have been exposed to the disease (if a vaccine exists) or by isolating them from others during the incubation period of the disease.

The practice of quarantine, as we know it, began during the 14th century in an effort to protect coastal cities from plague epidemics. Ships arriving in Venice from infected ports were required to sit at anchor for 40 days before landing. This term "quarantine" was derived from the Latin word *quaresma*, meaning 40.

When the United States was first established, little was done to prevent the importation of infectious diseases. Protection against imported diseases was considered a local matter and handled by the colonies. While sporadic attempts were made to impose quarantine requirements, it was the continued yellow fever epidemics that led to the passage of federal quarantine legislation by Congress in 1878. This legislation, while not conflicting with states' rights, paved the way for federal involvement in quarantine activities. With the arrival of cholera from abroad in 1892, the law was reinterpreted to allow the federal government more authority in imposing quarantine requirements. In 1893, another act of Congress further clarified the federal role in quarantine activities. Local quarantine stations were gradually turned over to the government as local authorities came to realize the benefits of federal involvement. Additional facilities were built to provide better coverage, and quarantine was nationalized. By 1921, all quarantine stations were under federal control. In 1944, with codification of the Public Health Service Act, the federal government's quarantine authority was clearly established for the first time.

CDC assumed responsibility for quarantine in 1967. The Public Health Service Act gave the U.S. Public Health Service responsibility for preventing the introduction, transmission, and spread of communicable diseases from foreign countries into the United States. Under its delegated authority, the Division of Global Migration and Quarantine is empowered to detain, medically examine, or conditionally release individuals and wildlife suspected of carrying a communicable disease. The list of quarantinable diseases is contained in an Executive Order of the President and includes cholera; diphtheria; infectious tuberculosis; plague; smallpox; yellow fever; and such viral hemorrhagic fevers as Marburg, Ebola, and Congo-Crimean.

The speed of travel within and between nations, as well as the number of travelers, has accelerated the opportunity for the rapid dissemination of disease from one country or continent to another. In September 1994, India reported cases of plague for the first time in 28 years. CDC=s domestic response to the India plague outbreak involved 2 simultaneous components; (1) information dissemination and education, and (2) intensified active and passive surveillance to identify and treat suspected plague patients and their contacts.

During the plague epidemic, crews aboard all commercial aircraft originating in or continuing from India were reminded of the regulations requiring them to notify the quarantine officer of the destination airport of any ill passengers and were instructed to be especially alert for passengers with fever, cough, or chills. Before disembarking, a quarantine officer and physician examined passengers who reported illness to determine whether the illness warranted hospitalization and/or further evaluation. If deemed not likely to have contracted plague, the passenger was placed under surveillance and released with instructions. Had he or she been considered a patient with suspected plague, the passenger would have been placed in isolation at the airport until transported to a predetermined hospital. At the hospital, the passenger would have been placed in respiratory isolation. Other patients on the flight would have been informed that they were under surveillance, according to federal quarantine regulations. Persons identified, by proximity, with the sick passenger would have been provided antibiotic prophylaxis.

In order for this public health response to work, many agencies contributed at the federal, state, and local levels of public health; the Immigration and Naturalization Service, the U.S. Customs Service, commercial airlines, medical practitioners, hospital personnel, and the public played key roles.

Definitions and Processes

Detention is the temporary holding of a person; ship; aircraft; or other carrier, animal, or thing. The length and location of detention is determined by the CDC director.

Isolation is the separation of a person or group of persons from other persons except the health care staff on duty in such a manner as to prevent the spread of infection. This isolation is for the period of communicability of infected persons or animals from others in such placed and under such conditions as to prevent or limit the direct or indirect transmission of the infectious agent from those who are susceptible or those who may spread the agent to others.

Quarantine restricts the activities of well persons or animals exposed to communicable disease during its period of communicability in order to prevent disease transmission during the incubation, if infection should occur. There are two types of quarantine:

Absolute or complete quarantine limits the freedom of movement of those exposed to a communicable disease for a period of time not longer than the longest usual incubation period of that disease, in such a manner as to prevent effective contact with those not so exposed.

Modified quarantine is the selective, partial limitation of freedom of movement of contacts, commonly on the basis of known or presumed differences in susceptibility and related to the danger of disease transmission. This type is designed to meet such specific situations as the exclusion from school, exemption of those known to be immune, restriction of military to post, etc. This includes personal **surveillance** and **segregation**, defined as the following:

> **Surveillance** of a person is the temporary supervision of someone who may have or has been exposed to a communicable disease. It is the practice of close medical or other supervision of contacts in order to permit prompt recognition of infection or illness but without restricting their movements.
>
> A **surveillance order** is a notification delivered to a person who may have been exposed to a communicable disease, advising him or her of the potential exposure, the need for surveillance of the individual, the authority to perform the surveillance, and providing compliance instructions for the person being placed under surveillance. Instructions may include information about the symptoms, actions should symptoms occur, who to contact if the person relocates, time period of surveillance, penalty for noncompliance, etc.

Segregation is the separation of some part of a group, persons, or domestic animals from others for special consideration, control, or observation. Segregation includes removal of susceptible children to the homes of immune persons, or the establishment of a sanitary boundary (to protect the uninfected from infected portions of a population).

A *cordon sanitaire* is a Asanitary cord@ or line around a quarantined area guarded to prevent the spread of disease by restricting passage into or out of the area.

These concepts may be critical in the response to suspected or confirmed large-scale bioterrorist events. Questions about people with active cases of illness and those who may be incubating the disease and infectious agent would have to be considered to protect non-exposed healthy people.

The public health response, timing, and degree of the response would depend on the following aspects of the outbreak:

- Number of cases and exposed persons
- Associated illness and death from the disease (severity of the disease)
- Ease and rapidity of the spread of the disease (some spread so easily that these disease control measures may not be feasible).
- The degree of movement in and out of a community (how isolated the community may or may not be).
- Resources needed to separate sick or exposed people from well people
- Risk for public panic.

For individuals who are sick, the appropriate response may be isolation (home or congregate settings) and respiratory isolation. Sick people would need to be monitored to detect new cases and monitor disease treatment.

For individuals who were or may have been exposed but are not exhibiting symptoms of illness, the appropriate response may be quarantine, isolation, and/or surveillance to detect the disease and provide appropriate treatment to help prevent the onset of illness (e.g., a drug prescription).

At the community level, the response could follow four levels of activity such as the following:

Level 1

- Travel alerts and information
- Press releases
- Interagency partner notifications

Level 2

- All level 1 activities
- Travel advisories
- Recommendation against elective travel

Level 3

- Level 2 activities
- Restriction of movement and travel (e.g., air, rail, automobile, pedestrian)

Level 4

- Level 3 activities
- *Cordon sanitaire*
- Such community-wide interventions as mass treatment and mass prophylaxis

Recently, CDC researchers constructed a mathematical model to describe the spread of smallpox after a deliberate release of the virus. The model demonstrated, based on the assumption of 100 people initially infected and 3 people infected per infectious person, that it is theoretically possible to halt the spread of smallpox by quarantine only. The researchers noted that the level of quarantine needed and the speed at which public acceptance of the quarantine had to be achieved prove a quarantine impossible to enforce. The researchers concluded that a combination of vaccination and quarantine worked best, but that approximately 4,200 cases would still occur and that it would take a year to stop the outbreak. The researchers noted that successfully enforcing quarantine requires political will, public acceptance, and group discipline.

Bibliography

Andreasen, Alan R. (1995). *Marketing Social Change: Changing Behavior to Promote Health, Social Development, and the Environment*. San Francisco: Jossey-Bass Publishers.

Auf der Heide, Erik: *Disaster Planning, Part II: Disaster problems, issues and challenges identified in the research literature*, Emerg. Med. Clin. N. Amer. 14(2):453–480, (May) 1996.

Borman, Ernest G. (1975). *Discussion and Group Methods. Second Edition*. New York: Harper and Row Publishers, Inc.

Cohn, Victor. (1990). *Reporting on Risk*. Washington D.C.: The Media Institute

Cooper, Lane. (1932). *The Rhetoric of Aristotle.* Englewood Cliffs, NJ: Prentice Hall, Inc.

Covello, Vincent, Ph.D. (1989). *Effective Risk Communication: The Role and Responsibility of Governmental and Nongovernmental Organizations* (author and co-editor, with D. McCallum and M. Pavlova) New York: Plenum Publishing Co.

Covello, Vincent, Ph.D. (1987). "The Social and Cultural Construction of Risk," (co-author, with B. Johnson), in B. Johnson and V. Covello (eds.), *The Social and Cultural Construction of Risk*. Boston: Reidel.

Fischer, Henry. W, III. (1998). *Response to Disaster.* Lanham, Md.: University Press of America.

Graeff, Judith A., et. al. (1993). *Communication for Health and Behavior Change*. San Francisco: Jossey-Bass Publishers.

Hennekens, Charles H., Dr.P.H., et. al. (1987). *Epidemiology in Medicine*. Boston: Little, Brown and Company.

Hennekens, Charles, H., & Buring, Julie, E. (1987). *Epidemiology in Medicine.* Boston: Little, Brown and Company.

Hicks, Rick & Kathy. (1999). *Boomers, Xers, and Other Strangers.* Wheaton, IL: Tyndale House Publishers.

Holsinger, Ralph, L. (1991). *Media Law.* New York: McGraw Hill.

Johannesen, Richard L. (1971). *Contemporary Theories of Rhetoric*. New York: Harper & Row, Publishers

Leeds, Dorothy. (2000). *The 7 Powers of Questions*. New York: Berkley Publishing Group.

Lum, Max R., Ed.D.; Tinker, Tim L. Dr.P.H., M.P.H. (1994) *A Primer on Health Risk Communication Principles and Practices*. Atlanta: Division of Health Education, Agency for Toxic Substances and Disease Registry.

Neuberger, Babette, J.D., M.P.H., Christoffel, Tom, J.D. (1999). "The Legal Basis of Public Health." Public Health Training Network. http://www.cdc.gov.phtn.

Rodman, George. (1981). *Mass Media Issues: Analysis and Debate*. Chicago: Science Research Associates, Inc.

Sandman, Peter M., Ph.D. (1993). *Responding to Community Outrage: Strategies for Effective Risk Communication* (Fairfax, VA: American Industrial Hygiene Association).

Shewe, Charles D.; Smith, Reuben M. (1983). *Marketing Concepts and Applications*. New York: McGraw-Hill Book Company.

Smith, Larry. (2001). *The ICM Crisis Management Certification Course*. Louisville, Kentucky: Institute for Crisis Management.

Susskind, Lawrence, & Field, Patrick. (1996). *Dealing With an Angry Public.* New York: The Free Press.

Swets, Paul, W. (1992). *The Art of Talking So That People Will Listen.* New York: Simon & Schuster.

Timm, Paul, R. (1981). *Functional Business Presentations.* Englewood, NJ: Prentice Hall, Inc.

Turkington, Carol. (1999). *The Complete Idiot's Guide to Cultural Etiquette.* Indianapolis: Macmillan USA, Inc.

Ury, William. (1993). *Getting Past No: Negotiating your way from confrontation to cooperation*. New York: Bantam Books.

Yale, David, R. (1991). *The Publicity Handbook.* Chicago: NTC Business Books.

Acronyms

A

AATF	CDC Asian-Pacific American Task Force
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
APHL	Association of Public Health Laboratories
ASAP	As soon as possible
ASH	Assistant Secretary for Health
ASTHO	Association of State and Territorial Health Officers
ATSDR	Agency for Toxic Substances and Disease Registry

B

BIA	Bureau of Indian Affairs

C

CA	Cooperative agreement
CDC	Centers for Disease Control and Prevention
CERCLA	Comprehensive Environmental Response, Compensation, and Liability Act
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CIA	Central Intelligence Agency
CMS	Centers for Medicare & Medicaid Services
CSTE	Council of State and Territorial Epidemiologists

D

DAS	Deputy Assistant Secretary
DFO	Disaster field office
DHHS	Department of Health and Human Services
DLA	Defense Logistics Agency
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Response Team, National Disaster Medical System
DOC	Department of Commerce
DOD	Department of Defense
DOE	Department of Energy
DOEd	Department of Education
DOI	Department of the Interior
DOJ	Department of Justice
DOL	Department of Labor
DOS	Department of State
DOT	Department of Transportation
DVA	Department of Veterans Affairs

E

EEO	Equal employment opportunity
EIDJ	Emerging Infectious Disease Journal
EIS	Epidemic Intelligence Service
EMS	Emergency medical services

EO	Executive order
EOC	Emergency operations center
EPA	Environmental Protection Agency
EPO	Epidemiology Program Office
EPI	Emergency public information
ERC	Emergency response coordinator
ERCG	Emergency response coordination group
ERT	Emergency response team
ESF	Emergency support function
ESO	Engineering services office

F

FAA	Federal Aviation Administration
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCO	Federal coordinating officer
FDA	Food and Drug Administration
FECC	Federal emergency communications coordinator
FEMA	Federal Emergency Management Agency
FERC	FEMA emergency response capability
FESC	Federal emergency support coordinator
FHWA	Federal Highway Administration
FLSA	Fair Labor Standards Act
FOIA	Freedom of Information Act

FR	Federal Register
FRP	Federal Response Plan
FTS	Federal telecommunications systems
FY	Fiscal year
FYI	For your information

G

GAO	General Accounting Office
GPO	Government Printing Office
GS	General schedule
GSA	General Services Administration

H

HSAB	Health and Safety Advisory Board
HUD	Department of Housing and Urban Development
HQ	Headquarters

I

IAEA	International Atomic Energy Agency
IAG	Interagency agreement
IBC	Institutional biosafety committee
ICC	Interstate Commerce Commission
IG	Office of the Inspector General, Department of Health and Human Services
IHPO	International Health Programs Office
IHS	Indian Health Service

INPHO Information Network for Public Health Officials

IOM Institute of Medicine, National Academy of Sciences

J

JIC Joint Information Center

L

LAN Local area network

LIUNA Laborer International Union of North America

LFA Lead federal agency

M

MHPF Minority Health Professionals Foundation

MMWR Morbidity and Mortality Weekly Report

MOA Memorandum of agreement

MOU Memorandum of understanding

MRE Meals ready to eat

MSPB Merit Systems Protection Board

MUPS Multiple unexplained physical symptoms

N

N/A	Not applicable / available
NACCHO	National Association of County and City Health Officials
NALBOH	National Association of Local Boards of Health
NAPHSIS	National Association for Public Health Statistics and Information Systems
NARFE	National Association of Retired Federal Employees
NAS	National Academy of Sciences
NASA	National Aeronautics and Space Administration
NCEH	National Center for Environmental Health
NCHS	National Center for Health Statistics
NDMS	National Disaster Medical System
NECC	National Emergency Coordination Center (FEMA)
NEIS	National Earthquake Information Service
NEJM	New England Journal of Medicine
NIH	National Institutes of Health
NLM	National Library of Medicine
NLT	Not later than
NLTN	National Laboratory Training Network
NOAA	National Oceanic and Atmospheric Administration
NRC	Nuclear Regulatory Commission
NRT	National response team
NSF	National Science Foundation
NTE	Not to exceed

NVOAD	National voluntary organizations active in disaster
NVPO	National Vaccine Program Office
NWS	National Weather Service

O

ODP	Office for Domestic Preparedness
OEP	Office of Emergency Preparedness
OET	Office of Emergency Transportation
FDA	Office of U.S. Foreign Disaster Assistance
OSHA	Occupational Safety and Health Administration
OSTP	Office of Science Technology Policy

P

PAHO	Pan American Health Organization
PDR	Physicians' Desk Reference
PGO	Procurement and Grants Office
PHEP-NET	Public Health Education and Promotion Network
PHPPO	Public Health Practice Program Office
PHS	Public Health Service
PIO	Public information officer
PL	Public law

R

RETCO	Regional emergency transportation coordinator
RHA	Regional health dministrator (DHHS)
RSC	Radiation safety committee

S

SOP	Standard operating procedure

T

TDY	Temporay duty
TOD	Tour of duty
TREAS	Department of the Treasury
TVA	Tennessee Valley Authority

U

USACE	United States Army Corps of Engineers
USC	United States Code
USDA	United States Department of Agriculture
USGS	United States Geological Survey
USPHS	United States Public Health Service
USPS	United States Postal Service

W

WHO	World Health Organization
WYSIWYG	What you see is what you get

Y

YTD	Year to date

Epidemiology Terms

Airborne infection: A mechanism of transmission of an infectious agent by particle, dust or droplet nuclei suspended in the air.

Antibody: Protein molecule formed by exposure to a "foreign" or extraneous substance, e.g., invading microorganisms responsible for infection, or active immunization.

Antigen: A substance that is capable of inducing specific immune response. Introduction of an antigen may be by the invasion of infectious organisms, immunization, inhalation, ingestion, etc.

Association: The degree of statistical dependence between two or more events or variables. Events are said to be associated when they occur more frequently together than one would expect by chance.

Attack rate: Attack rate, or case rate, is a cumulative incident rate often used for particular groups, observed for limited periods and under special circumstances, as in an epidemic. The secondary attack rate expresses the number of cases among contacts occurring within the accepted incubation period following exposure to a primary case, in relation to the total of exposed contacts; the denominator may be restricted to susceptible contacts when determinable.

Behavioral epidemic: An epidemic originating in behavioral patterns (as opposed to invading microorganisms or physical agents).

Biological plausibility: The criterion that an observed, causal association fits previously existing biological or medical knowledge.

Carrier: A person or animal that harbors a specific infectious agent in the absence of discernible clinical disease and serves as a potential source of infection.

Case: A person in the population identified as having the particular disease, health disorder, or condition under investigation.

Case fatality rate: The proportion of persons contracting a disease who die of that disease.

Clustering: A closely grouped series of events or cases of a disease, or other health-related phenomena with well-defined distribution patterns, in relation to time or place or both.

Cohort: The component of the population born during a particular period and identified by that period so that its characteristics can be ascertained as it enters successive time and age periods.

Cohort study: The method of epidemiologic study in which subsets of a defined population can be identified who are, have been, or may or may not be exposed in different degrees in the future, to the probability of contracting a given disease.

Communicable disease: An illness due to a specific infectious agent or its toxic products that is transmitted from an infected person, animal, or reservoir to a susceptible host, either directly or indirectly.

Contact (of an infection): A person or animal that has been in physical association with an infected person or animal, or contaminated environment, allowing the opportunity to acquire the infection.

Contact, direct: A mode of infection transmission between an infected host and susceptible host.

Contact, indirect: A mode of infection transmission involving fomites or vectors.

Contact, primary: Person(s) in direct contact or associated with a communicable disease case.

Contact, secondary: Person(s) in contact or associated with a primary contact.

Contagion: The transmission of infection by direct contact, droplet spread, or contaminated fomites.

Contagious: Transmitted by contact

Contamination: The presence of an infectious agent on a body surface; also on clothes, bedding, surgical instruments, or other inanimate articles or substances.

Death rate: A rate expressing the proportion of a population that dies of a disease.

Disease, preclinical: Disease with no signs or symptoms, because they have not yet developed.

Disease, subclinical: A condition in which disease is detectable by special tests but does not reveal itself by signs or symptoms.

Disinfection: Killing of infectious agents outside of the body by direct exposure to chemical or physical agents.

Dose response relationship: A relationship in which a change in amount, intensity, or duration of exposure is associated with a change—either an increase or decrease in risk.

Epidemic: The occurrence in a community or region of cases of an illness or other health-related events clearly in excess of normal expectancy.

Epidemiologist: An investigator who studies the occurrence of disease or other health-related condition or events in a defined population. Also known as a disease detective.

Epidemiology: The study of the distribution and determinants of health-related states and events in populations, and the application of this study to the control of health problems.

Epizootic: An outbreak (epidemic) of disease in an animal population (often with the implication that it may also affect human population).

Eradication (of disease): Termination of all transmission of infection by extermination of the infectious agent through surveillance and containment.

False negative: Negative test result in a subject who possesses the attribute for which the test is conducted.

False positive: Positive test result in a subject who does not possess the attribute for which the test is conducted.

Fatality rate: The death rate observed in a designated series of persons affected by a simultaneous event.

Fomites: Articles that convey infection to others because they have been contaminated by pathogenic organisms. Examples include dishes, door handles, and toys.

Herd immunity: The immunity of a group or community. The resistance of a group to invasion and spread of an infectious agent, based on the resistance to infection of a high proportion of individual members of the group.

Host: A person or other living animal, including birds and arthropods, that affords subsistence to an infectious agent under natural conditions.

Household interview study: Collection of information from a sample of a civilian noninstitutionalized population by trained interviewers who go to the dwellings of the persons selected for interview.

Immunization: Protection of susceptible individuals from communicable disease by administration of a living modified agent (as in measles), a suspension of killed organisms (as in whooping cough) or an inactivated toxin (as in tetanus).

Incidence: The number of instances of illness during a given period in a specified population.

Incident rate: A measure of the rate at which new events occur in the population.

Incubation period: The time interval between invasion by an infectious agent and appearance of the first sign or symptom of the disease in question.

Index case: The first case in a family or other defined group to come to the attention of the investigator.

Infectiousness: A characteristic of the disease that concerns the relative ease with which it is transmitted to other hosts.

Monitoring: The performance and analysis of routine measurements, aimed at detecting changes in the environment or health status of populations.

Morbidity: Illness

Norm: Can be defined as what is usual or what is desirable.

Nosocomial infection: An infection originating in a medical facility.

Notifiable disease: A disease that, by statutory requirements, must be reported to the public health authority.

Numerator: The upper portion of a fraction used to calculate a rate or a ratio.

Occurrence: The frequency of a disease or other attribute or event in a population.

Outcomes: All of the possible results that may stem from exposure to a causal factor, or from preventive or treatment interventions.

Outliers: Observations differing widely from the rest of the data, suggesting that these values come from a different population.

Pandemic: An epidemic occurring over a very wide area and usually affecting a large proportion of the population.

Parasite: An animal or vegetable organism that lives on or in another and derives its nourishment therefrom.

Pathogen: Organism capable of causing disease.

Pathogenicity: The property of an organism that determines the extent to which overt disease is produced in an infected population, or the power of an organism to produce disease.

Population-based: Pertaining to a general population defined by geopolitical boundaries.

Prevalence: The number of instances of a given disease or other condition in a given population at a designated time.

Prevention: The goals of public health and medicine are to promote health, to preserve health, to restore health when it is impaired, and to minimize suffering and distress.

Primary case: The individual who introduces the disease into the family or group under study.

Quantitative data: Data in numerical quantities, such as continuous measurements or counts.

Quarantine:The limitation of freedom of movement of well persons or animals exposed to a communicable disease, for a period of time not longer than the longest usual incubation period of the disease.

Random: Occurs by chance.

Rate: Ratio whose essential characteristic is that time is an element of the denominator and in which there is a distinct relationship between numerator and denominator.

Relative risk: The ratio of the risk of disease or death among the exposed to the risk among the unexposed.

Reservoir: The natural habitat of the infectious agent.

Risk: A probability that an event will occur.

Risk factor: An attribute of exposure that is associated with an increased probability of a specified outcome, such as the occurrence of a disease.

Sample: A selected subset of a population.

Screening: The use of tests or examinations to identify unrecognized disease.

Seroepidemiology: Epidemiologic study or activity based on the detection on serological testing of characteristic change in the serum level of specific antibodies.

Statistical significance: Statistical methods allow an estimate to be made of the probability for the observed or greater degree of association between independent and dependent variables under the null hypothesis.

Surveillance: Ongoing scrutiny; generally, using methods distinguished by their practice—ability, uniformity, and, frequently, their rabidity, rather than by complete accuracy.

Surveillance of disease: The continuing scrutiny of all aspects of occurrence and spread of a disease that is pertinent to initiate investigative or control measures.

Survey: An investigation in which information is systematically collected not using the experimental method.

Transmission of infection: Transmission of infectious agents. Any mechanism by which an infectious agent is spread through the environment or to another person.

Validity: Expression of the degree to which a measurement measures what it purports to measure

Variable: Any quantity that varies. Any attribute or event that can have different values.

Virulence: The degree of pathogenicity.

Zoonosis: An infection or infectious disease transmissible under natural conditions from vertebrate animals to man.