Medicine and the Media

Disaster planning: managing the media

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During several recent disasters hospital routines have been severely disrupted as a result of invasions by representatives of the media. Reporters, photographers, and crews from television and radio stations have all vied with each other to be the first with detailed reports, pictures, and exclusive interviews. The problems arising from the "clamour for information from relatives, press, television, and radio" were recognised in 1977 by the Department of Health and Social Security when it issued the most recent health circular dealing with major accidents,¹ and general requirements for dealing with representatives of the media have since been outlined.²

The role of the media is to obtain information of interest to its listeners, viewers, or readers and to produce this information as rapidly as possible. While this is an essential part of a free society, the sudden arrival of a large number of reporters can be an unwelcome burden for a hospital trying to cope with the victims of a disaster. The problem can, however, be reduced to manageable proportions if the requirements of the media are understood and effective measures taken to meet them.

These objectives can be achieved by including in the disaster plan facilities for accommodating the press and by developing good liaison with the media through a press officer. This officer might be a designated senior member of staff at the hospital who assumes the role during a disaster. Professional help is available, however, from the press and public relations department of each regional health authority. The regional public relations officer and his staff will advise hospital managers and, if necessary, go to the hospital to take on the responsibility for the media, working with and for the hospital staff.

We prepared the following guidelines after analysing the lessons learnt from a disaster exercise held at Queen Mary's Hospital, Sidcup, and from the bomb explosion at the Grand Hotel, Brighton.

Theory and practice

A disaster exercise held at Queen Mary's Hospital in March 1984 was designed to include harassment by the media in the form of enthusiastic participation by reporters from the *Kentish Times* and members of the South East Thames Regional Health Authority's public relations department, several of whom had been professional reporters. The exercise simulated a train crash at Sidcup station and resulted in 76 "casualties" being admitted to the hospital over one and a half hours. In addition, 150 people playing the parts of relatives and volunteers presented themselves at various entrances to the hospital. The main aim of the exercise was to test the hospital's systems of communication, information, and command.

Although the hospital's disaster plan included the appointment of a senior administrator as press officer, this post was not filled during the exercise, and

the duty administrator was too busy to undertake this role herself. Despite many requests from reporters to talk to a senior member of the staff at the hospital, this facility was not provided during the exercise, and so reporters sought information by repeatedly entering the accident and emergency department, visiting many other parts of the hospital in the process. By failing to provide a reliable source of information from the outset the hospital lost central control of the release of information.

The Brighton experience

The explosion of a bomb at the Grand Hotel, Brighton, in the early hours of Friday 12 October was one of the biggest news stories of 1984.³ Many leading members of the Conservative party, including the Prime Minister and her colleagues in the Cabinet, were staying at the hotel for the party's annual conference when the building was split in two by a large explosion.

Brighton Health Authority has always adopted a policy of cooperating with the media, and this proved its worth after the bombing, when 30 casualties, including two Cabinet ministers with serious injuries, were taken to Brighton's Royal Sussex County Hospital. The hospital called in two press officers from the South East Thames Regional Health Authority's public relations department to advise the hospital on management of the media and to liaise directly with the press, answering their questions and acting as points of contact for the release and clarification of information. The press officers stayed at the hospital for three days after the bombing, when the number of pressmen was greatest, and continued to liaise with and advise the senior staff at the hospital until the last victim had been discharged. Media management of the incident was judged to have been a success by the hospital and the press. Crucial to this success was the commitment shown by senior doctors, nurses, and administrators, coupled with a clear system of liaison with the police and ambulance service.

The greatest single problem was caused by numbers. For most of Friday 12 October more than 70 reporters and photographers based themselves at the Royal Sussex County Hospital. A press room and press waiting area were set up close to the accident and emergency department (the focal point of all the activity) and the administrative control point. This enabled the hospital to control the release of information and, because the press were on the spot, eased the internal security problems that would have arisen had the press room been located anywhere else. The main difficulty arose when journalists sought interviews with some of the victims of the bombing. They found it impossible to agree among themselves to a "pool" system (see Guidelines for managing media), and so casualties had to be interviewed by groups of up to 15 reporters at a time. This put such a strain on the victims that the interviews had to be cancelled after the first half hour and were not resumed until the next morning. The press officers were unable to convince the representatives of the media that pooling would have been to their advantage.

The controlled release of information is a major problem in all disasters. It is tempting to make the press officer responsible for all announcements, but the scale of the Brighton bombing and the resulting media interest made this impractical. In the event, statements about the condition of inpatients were drafted from information received from the administrative control room and cleared with the duty administrator, senior police officer on duty, medical and nursing staff, and, when appropriate, Conservative party officers who were present at the hospital. Copies of the agreed statements were issued by the regional health authority's press officers and the duty administrator at press briefings and repeated as necessary over the telephone or to individual inquirers between briefings. The press officers acted as contacts for the press and were always available to elaborate on the information if necessary. As it was not possible to install a blackboard or wallchart in the press room details

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given at press conferences were summarised and copies handed to the journalists. This information was typed whenever possible, but at times of intense pressure notes made in clear handwriting were photocopied for distribution.

Finally, the Brighton experience confirmed the need for a flexible approach to management of the media based on an understanding of their needs. The decision to site the press room near the accident and emergency department was, in fact, a departure from the official plan. Press conferences were held fairly frequently and were dictated not by any preset timetable but by the demands of the situation within the hospital and the changing needs of the media. The press officers, while nominally in charge of management of the media, never fronted formal press briefings, which were always conducted by the senior hospital administrator on duty at the time. An inflexible approach would have resulted in friction between the hospital and the media, which in turn could have destroyed the atmosphere of mutual trust and confidence that in retrospect was one of the hallmarks of the three days during which the press room remained open.

Understanding the requirements of the media

In any media organisation the key figure is the news editor. It is on his decision that teams of reporters, photographers, and, in the case of television or radio, camera and sound crews go to the scene of any potentially newsworthy incident.

News of a disaster rapidly reaches the media through their regular monitoring of emergency service radios and through telephone calls from members of the general public and occasionally hospital employees. At this early stage the information tends to be incomplete and is sometimes inaccurate. Before authorising the printing or broadcasting of any information the news editor must establish whether this initial information is accurate. Reporters will therefore be dispatched immediately to the scene of the incident and the hospital as much to assess the scale of events as to collect information. Their immediate need is basic information such as the total number of casualties admitted, the number with serious injuries, the number dead, and the number undergoing emergency surgery. Later they require more specific information such as the names and addresses of casualties, with details of their injuries; the number admitted to and discharged from hospital; the number of doctors operating on emergency cases; and the names and cause of death of those who have died. If an authoritative source does not provide this information reporters will talk to anyone and may receive unreliable information from which they, not surprisingly, make erroneous deductions. It is in the interests of the hospital, therefore, to release accurate information in a responsible way.

Guidelines for managing the media

The key figure in the management of the media is the press officer, who is a member of the highest level of hospital management during a disaster.⁴ His duties can be analysed in three stages (appendix 1).

For the first hour or so after a disaster representatives of the media are often excluded from the hospital for security reasons while a press room is prepared. They usually congregate in an easily recognised group outside the emergency entrance of the accident and emergency department. During this time the press officer should liaise with the senior police officer at the hospital, the police documentation team, and any specialist police units such as the bomb squad, antiterrorist unit, or special protection unit. The press officer (whether called in from a regional health authority's public relations department or someone from the hospital itself) should make contact with the representatives of the media at the earliest opportunity to assure them that their questions will be answered and facilities for them are being prepared. This will help to establish an atmosphere of mutual trust that will pay dividends later. As soon as possible, and certainly by the end of the first hour, the press officer should give a short briefing for the press, if necessary in the grounds of the hospital, and be prepared to repeat this statement several times for various reporters (appendix 2).

The second phase begins with the opening of the press room, which should be established quickly and sited as close to the centre of clinical activity as possible. This is partly so that the representatives of the media can be controlled on the spot (they will in any case feel less inclined to wander about the hospital), and also because it enables senior medical and nursing staff to be reached quickly to

give short interviews without disrupting their work. The press room should have several telephone lines bypassing the hospital switchboard, tables and chairs, and a large blackboard or wallchart on which basic information can be displayed and updated as the disaster progresses. The provision of spare typewriters and paper is always appreciated. Regular press briefings should be held in the press room as necessary, even if only to confirm existing information, and the time of the next briefing should be clearly announced and displayed on the information board. These briefings give the hospital the opportunity to present information in a structured way and lessen the chance of rumours spreading through the press corps. They give the journalists the chance to ask specific questions, which if not answered at once can be researched and the answers prepared between briefings. The briefing can also be used to introduce individual members of staff, who can talk and answer questions about their own experience. It would be wise for senior staff in all disciplines to receive training in media relations so that they can respond to requests for interviews at the briefings.

Care should be taken to ensure that these conferences and any associated press releases or statements are given at times that take into account the deadlines for radio and television news bulletins and the printing times of evening and daily papers. A note of these deadlines should be recorded by the press officer on his action card no later than the first press conference.

The hospital must always balance the right of the public to be kept informed against the need to protect the privacy and professional confidences of individual patients. During a disaster the decision as to how much information to release can often be difficult.⁵ The press officer must agree with the administrator and disaster coordinator (and senior police officer if appropriate) how many details may be released about the incident and the identity and clinical condition of individual casualties. Information should not be withheld unreasonably, especially when its release could help prevent the publication of rumours and errors.

Each conference starts with confirmation of any information already given that is unchanged. Ideally, it should then include casualties' names, addresses, and ages; details of the extent of injuries; and an outline of treatment being given. Great care must be taken to ensure that details of any seriously injured people are not released to the media before next of kin have been informed and that, if there is any suspicion of terrorist activity, all press statements are cleared with the police. Names and addresses of dead victims may be given once the police have confirmed that next of kin have been informed. Details of those undergoing emergency surgery and casualties in intensive care units will be required, together with the number discharged from hospital. Each press conference ends with a statement of the time of the next briefing.

Talking to victims

The third stage begins when the first flood of requests has subsided and lasts until the incident loses its news value. Reporters will then be looking for stories with human interest and will wish to interview survivors to hear and record their experiences at first hand. Not only will national press, radio, and television make demands on the hospital but local papers and radio stations will wish to talk to victims of the disaster from their own areas. If the hospital is placed under great pressure by these requests it is worth making special arrangements to deal with them simultaneously. This can be done by designating a press hour during which casualties who are willing and medically fit to be interviewed can meet the press. As with the earlier press conferences this facility should be provided at a time that meets as many of the journalists' deadline times as possible. The media need about 30 minutes' warning of the press hour to give them time to liaise with their news editors and (in the case of television) prepare their equipment. It is not necessary to give more notice if the media are already at the hospital.

If the incident is the object of national attention the press officer should establish whether reporters are present from BBC television and radio, independent television and radio, any national newspapers, and the Press Association. If they are not already at the

hospital they should be telephoned and informed of the press hour (which should be retimed, if necessary, so that they can attend). The press officer should also ensure that the local newspapers and radio and television stations for the area are invited.

To avoid too much confusion and stress to patients the hour should be organised so that the media representatives enter in groups: first the newspaper photographers, then newspaper reporters and radio reporters, and, finally, television crews. After this hour the media should not need any further access to victims. Some casualties who wish to talk to the media may not be strong enough to face a series of interviews by all the attending newspaper, radio, and television reporters. In these circumstances journalists may agree to "pool"—that is, to send a small representative group to conduct the interview, who will share their notes and radio tape or television film with the rest of the press corps. Pooling should be suggested only for medical reasons and never as a matter of administrative convenience to the hospital.

Reporters should never be granted exclusive interviews with patients or members of staff. The rest of the press corps will demand equal treatment and will become difficult to manage if this demand is not met. There may, however, be some requests that, because of their highly specialised nature, are not of interest to the entire press corps. When the main interest starts to diminish it might be possible to provide special facilities for individual reporters with such requests, who might perhaps be a local reporter researching a feature article or a reporter from a medical or nursing journal whose article will not be of interest to the rest of the media.

We thank the following for their advice in the preparation of this paper: Pam Lelliott, press officer, South East Thames Regional Health Authority public relations department; Michael Forrer, unit administrator, Royal Sussex County Hospital, Brighton; and the public relations department, North West Thames Regional Health Authority.

References

1 Department of Health and Social Security. *Health service arrangements for dealing with major accidents*. London: DHSS, 1977. (HC(77)1.)
2 Savage PEA. *Disasters—hospital planning*. Oxford: Pergamon, 1979.
3 Lelliott P, Partington A. How Brighton stayed unrocked. *Health and Social Service Journal* 1984;**94**:1286-7.

What treatment is advised for a woman in her 50s with sarcoidosis who had an "atrophied kidney" removed a year ago. What is the prognosis and is there any danger to her children?

Much more information is required before anything can be said about treatment or prognosis in this case. Since sarcoidosis presents in a wide variety of ways, with widely different prognosis and indications for treatment, no useful statement may be made about an individual case without knowledge of history, clinical features, and investigations. Patients with some of the commoner syndromes—for instance, bilateral hilar lymph node enlargement either asymptomatic or accompanying erythema nodosum—may be expected to follow a benign course to resolution and to require no, or only symptomatic, treatment. In others persistent changes in lungs and occasionally in other organs, or the secondary effects of the hypercalcaemia that occurs in a few cases, may lead to disability and possibly to death. In these suppression of active manifestations by corticosteroids may be advisable. Similarly, the cause of the atrophy of the kidney is obviously relevant. Since the affected kidney was removed, information about both clinical features and histology should be available, and this should show whether the changes in the kidney could be related to sarcoidosis.

On the evidence available, this seems unlikely. The commonest cause of renal damage in sarcoidosis is hypercalcaemia, leading to a well recognised nephropathy, possibly with nephrolithiasis, likely to be obvious clinically; sarcoid infiltration of the kidney sufficient to produce clinical features is excessively rare and when it occurs is generally bilateral. Thus the renal condition and the sarcoidosis must probably be considered separately, both therapeutically and prognostically. In relation to the patient's concern about her children, she may be reassured. Although a few instances of families with

4 Savage PEA. Planning without panic. *Health and Social Service Journal* 1984;**94**:170-2.
5 Silver R. *Health service public relations: a guide to good practice*. London: King's Fund (in press).

(Accepted 20 May 1985)

Appendix 1: Press officer's disaster action card

- (1) Put on identifying tabard bearing the words "Press Officer."
- (2) Go to control centre and liaise with disaster coordinator and administrator.
- (3) Liaise with hospital information officer, police liaison officer, and police documentation teams. Record name of senior police officer.
- (4) Liaise with media, recording times of deadlines of press, radio, and television.
- (5) Supervise setting up of press room.
- (6) Prepare early press statement in consultation with hospital administrator and police and be prepared to make this statement to reporters outside hospital.
- (7) Prepare regular press statements.
- (8) Supervise activity of media.
- (9) If required liaise with medical, nursing, and administrative staff and with police to arrange a press hour for interviews with casualties.

Appendix 2: Draft press release

PRESS RELEASE

..... Hospital
..... (date) (time)
..... (description of incident)

Details of admissions

..... casualties have been received at
hospital, of whom have been admitted. Casualties have also been
admitted tohospital. casualties are seriously ill and
are undergoing emergency surgery. casualties are being treated
for minor injuries, most of whom are likely to return home.

The emergency work of the hospital is being coordinated by
(administrator), (nursing director), and (medical
director).

A further press statement will be made at am/pm.
..... (signed) Press officer

several cases of sarcoidosis have been reported, these are exceptional, and it is difficult to think of a possible cause of unilateral renal atrophy detected at the age of 50 which has familial implications.—J G SCADDING, honorary consulting physician, London.

I understand that terfenadine (Triludan) 60 mg twice daily has been approved by the Royal Air Force for use as a non-sedating antihistamine in aircrew. Have any trials been performed with this preparation under hyperbaric conditions? Is it a safe preparation to prescribe for divers and other workers in compressed air environments?

It is doubly important that an antihistamine used under hyperbaric conditions such as are experienced when diving should be non-sedating, since the nitrogen component of the compressed air acts as an anaesthetic under pressure—the so called "rapture of the depths" described by Cousteau. If the diver has already taken a sedative drug, such as many of the older antihistamines, an additive effect will occur and incapacitating narcosis may occur at unexpectedly shallow depths. This factor does not operate in the helium-oxygen environment used in deep commercial diving since helium appears to have little narcotic effect under pressure but, because of the hazardous nature of the environment, mental alertness is at a premium. Terfenadine, because of its lack of sedation, is thus particularly valuable in diving, and I have been advising its use when indicated for some time. So far I have not heard of any unexpected side effects. There do not appear to have been any formal trials of terfenadine in a hyperbaric environment, but where such a requirement exists, terfenadine would appear to be the drug of choice.—J C BETTS, authorised examiner for professional divers, London.