Controlled management of public relations following a public health incident

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Summary

This paper describes the management of public relations following an outbreak of multidrug resistant TB at a London hospital. Eight patients were involved, all of the secondary cases occurred in HIV seropositive patients, and three cases died. The paper describes how the Incident Committee undertook to recall contacts of the cases for screening, inform the general practitioners of all of the contacts about their patients’ exposure, warn other organizations and professionals interested or involved in the management of HIV in the London area as to the nature of the incident, and establish a helpline, before informing a wider audience through the EPINET, Communicable Disease Report and national press.

Keywords: MDRTB, HIV, outbreak, public relations

The Incident Committee

An Incident Committee was established with representation from Genitourinary Medicine, Thoracic Medicine, Infection Control, Public Health Medicine, Occupational Health, Management and Public Relations. The aims of the Incident Committee were to limit the spread of infection, plan and coordinate the contact recall and screening process, and prevent future occurrence. The Incident Committee consulted with epidemiologists at the Communicable Disease Surveillance Centre (CDSC) and clinicians who had been involved in the management of a similar incident in the UK. The Incident Committee felt it of paramount importance to alert those patients requiring recall in a controlled and sensitive manner and to inform other health care professionals involved in the care of these patients so that they would be prepared if approached for advice.

A total of 1111 general medical patients were identified as having been in contact with the index case during their admission, of whom 226 were considered to require screening. This decision was taken by the Incident Committee on the basis of their geographical proximity to the index case and their medical condition. The ward has 22 beds, which are arranged as a series of open-plan bays. Patients admitted to certain bays were considered to be at higher risk because of the effects of the positive pressure ventilation from the isolation rooms. In addition, any immunosuppressed or immunocompromised
patient admitted to anywhere in the ward during the hospitalization period of the index case was also considered to be at risk. Patient contacts considered not to require screening were not informed of their possible exposure by the Trust, nor were their GPs.

A total of 476 HIV seropositive patients were identified as requiring screening, 68 of whom had been in-patients and exposed to the index case. The remaining 408 were considered to have been potentially exposed to case two in the HIV outpatient unit. A total of 792 members of staff had been exposed and required screening.

The Incident Committee agreed that screening of general medical patients would be undertaken by the Department of Thoracic Medicine, screening of HIV seropositive patients would be undertaken by the Department of Genitourinary Medicine and staff screening would be undertaken by the Department of Occupational Health.

Recalling contacts

Individual departments were responsible for drafting a personalized letter to each of their patients identified as a contact. The text of the letters was agreed by and the despatch of letters co-ordinated through the Incident Committee to ensure that all contacts received notification about the incident on the same day. Every effort was made to identify and exclude deceased patients in advance so as not to cause further upset to their families. This was undertaken through an extensive trawl of hospital records and consultation with the managing clinician.

Letters to contacts informed them of the occurrence of a number of cases of drug resistant tuberculosis at the hospital and of the need to attend for screening, giving instructions as to how they should arrange their screening appointment. Patients were also advised of action to take if they developed certain symptoms, and were given a helpline number. The letter made no reference to HIV.

Informing other health professionals and organizations

The recall letters were not sent out until contact had been made with patients’ GPs. Others contacted in advance by letter included local GPs with an interest in HIV and key individuals in seven of the larger centres treating patients with HIV in the London area. It was recognized that these individuals or the organization for which they worked might receive enquiries from HIV seropositive patients cared for at St Thomas’, or from HIV positive partners and acquaintances of these patients.

Two large HIV hospices, extensively used by the Trust, were contacted by telephone. The soundex code and date of birth of the patients with MDRTB were provided. This was to address concerns that these individuals could have attended these institutions at a time when they were potentially infectious, presenting a possible threat to other patients attending there, the majority of whom were extremely immunocompromised.

Twelve HIV charities and voluntary organizations were informed of the situation before patient recall. Two of these organizations had provided advocacy workers for the out-patient department who were therefore potentially at risk of MDRTB and required screening. Another was the Terence Higgins Trust. This organization has a high profile and receives a large number of calls following any news alert involving HIV.

The Communicable Disease Surveillance Centre and the Department of Health were informed. A message was sent by DoH via the EPINET to all consultants in communicable disease control on the same day as the press release. Additional details of the incident were disseminated in the Communicable Disease Report.

Staff working within the Trust who had contact with patients involved in the incident were briefed by the head of their unit. Information about TB and the signs and symptoms to look out for were presented to staff. It was explained that there had been a number of cases of TB within the Trust, which were likely to be linked. Given the expected public and media interest in this fact, staff were asked to refer all enquiries concerning the incident to the Public Relations Department.

Case notification

Patients with MDRTB or their next of kin received a personal visit from a consultant physician. This was intended to warn them of the potential media interest in their condition, to inform them that they had been part of this incident and explain to
them, in the light of the anticipated media interest, the true circumstances of the incident.

The helpline

Preparations for a free telephone helpline with 12 telephone lines were undertaken at the outset. Once established, volunteers were identified to staff it in the event of the news story breaking early. The helpline was staffed by members from the HIV unit at the Trust and volunteers from the Terence Higgins Trust. A rota was drawn up so that 12 volunteers would be available throughout the 24 hour period if required. All helpline staff were briefed in advance about tuberculosis. Each was provided with a fact sheet about tuberculosis and a flow chart of questions (Fig. 1) to help identify whether or not the caller was at risk. Use of the flow chart also ensured that confidential information about the incident was not divulged unnecessarily. The telephone helpline was initially planned to run 24 hours a day for 7 days with an undertaking to review this when the extent of demand had been assessed. In the event, because of the pattern of calls made to the helpline, with very few calls being made after midnight, an answerphone was used on the helpline overnight. This gave the opening times of the helpline and asked callers to call back during those times.

A total of 1142 calls were taken during the 5 days during which the helpline was operational. Ninety-five calls were received on day 1 (13 June), 544 calls on day 2, 339 calls on day 3, 104 calls on day 4, and 60 calls on day 5, after which the helpline was discontinued. The most significant peaks in callers occurred around the main evening and daytime news bulletins. Only on days 2 and 3 were all operators on duty all busy at once, and then only for short bursts of time. All of the calls which occurred between 11 p.m. and 1 a.m. took place on the first day of the helpline and followed extensive news coverage on the ITN News at Ten bulletin. Only six calls were received after midnight and this was following the day of the press release. In the light of these data, the incident team did not feel that there was a need for a 24 hour helpline.

Forty-six callers needed to be referred to the medical on-call cover. This cover was provided by the thoracic medicine consultant team and senior microbiologists. Very few calls were received from patients at risk.

The press statement

On the advice of the Public Relations Department it was decided that the Trust would release a press statement after patients, staff and other interested individuals and organizations had been notified. This would allow the information to be released by the Trust in a controlled fashion. However, a press statement was prepared from the outset to cover the possibility of the story breaking early. The text did not mention HIV or drug resistance. It focused on measures that were being undertaken by the Trust to limit the spread of TB and prevent recurrence of a similar incident. It was worded to reduce the possibility of sensationalism and to protect the identity of the cases.

The Trust Public Relations Department has very good relations with the press and has co-operated in the past over stories good and bad. With this in mind, the Trust actively contacted and informed the press that they would have a news story to give them, but that it was essential that patients affected received the information first.

All press enquiries at this time were managed by the Public Relations Department at the Trust and an increasing number of enquiries from journalists were received in the days leading up to the press release. However, journalists continued to appear sympathetic to the fact that the Trust was willing to acknowledge that there was a problem without divulging its nature, and sensitive to the Trust’s request that adequate time was allowed to make relevant investigations and contact affected individuals before the release of a press statement. In the event, the story was not published until after the press release and all subsequent press interviews were handled by one senior clinician.

Outcome

The Incident Committee was convened on four occasions in the 2 weeks between the decision to recall patients and the letters
being sent, and on several occasions over subsequent months to review the outcomes of the recall procedure. As a result of the exchange of ideas and information between individuals from different disciplines and the careful co-ordination of the various components of the recall procedure, the aims of the Incident Committee with regard to the recall procedure were achieved. Patients and the majority of staff were first made aware of the incident by a letter from the Trust, and not from any other source. Health care professionals and other professionals involved in the care of the patients received prior warning of the incident and were thus in a position to provide support and information to patients contacting them. The Trust received no complaints regarding communications or the management of the recall process from either patients or health professionals contacted because of the incident. The press coverage of the incident at the time was not unfavourable and the Trust was fortunate that other more important stories superseded the following day.

Lessons learnt

The management of public relations following serious incidents of this nature requires careful planning and a co-ordinated response from a range of professionals.

Recent guidance\(^5\) recommends that as a general principle it is preferable for patients to be contacted personally by a counsellor, health advisor or other relevant health professional before a press announcement is made. Notification by letter may not be the ideal, particularly if the patient is psychologically frail, has poor reading skills, limited English language or for whatever reason experiences delay in receipt of the letter. However, because of the scale of the incident and the large numbers of patients and staff identified for recall, the Incident Committee decided to inform contacts by letter. The Trust received no complaints from patients, staff or GPs about this approach.

The likelihood of ‘leaks’ was reduced by confining access of sensitive information to members of the Incident Team, although experience elsewhere shows that this does not necessarily prevent unplanned early publicity. Good relations with the press and the Trust actively contacting them and informing them about a news story that would be released to them after affected patients had been informed was felt to contribute to press co-operation in not breaking the story early. In addition, telephoned advance warning of the nature of the incident to other agencies involved in the care of people with HIV meant that when the story did break these agencies were thus in a position to provide support and information to patients contacting them. The Trust did not receive any complaints from patients contacting them after affected patients had been informed.

Telephone helplines are an effective way of dealing with health-related incidents in which large numbers of people need personal counselling or information for reassurance or case finding.\(^10\) The incident team was surprised that the demand for the helpline was not higher and that the operating hours could be reduced so rapidly. Keeping a ‘call log’ allowed informed decisions regarding the helpline operational hours and helped in anticipating staffing levels required. A systematic approach to assessing level of risk to callers was thought to be helpful in ensuring that confidential information was not divulged unnecessarily.

Health care professionals in all specialties who find themselves in the position of having to recall patients following a health alert may benefit from this account of the measures that were taken on this particular occasion.

Key points

The key points are as follows:

1. a multidisciplinary team;
2. a systematic approach to informing patients, contacts, associated health care professionals and voluntary organizations;
3. a helpline;
4. early preparation of a press statement;
5. press interviews given by one individual.

References

5 Midwife HIV positive. The Independent 2 May 1997.

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