



Crisis management checklist: lessons learned from the SARS-CoV-2 pandemic

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Abstract

“Everyone has a plan until they get punched in the mouth.” Never has this quote, uttered in response to a challenger’s reported plan to take the title away from heavyweight champion Mike Tyson, rang truer than in the past 20 months as the global population wrestles with the fallout on the SARS-CoV-2 pandemic. While countless lives were disrupted both directly and indirectly during this time, members of the medical community bore the brunt of this fallout in their personal lives while being asked to perform above capacity in their professional lives simultaneously. Compounding this experience was the fact that injuries, illness, and death from other causes did not halt leaving many in the medical community, and community at large, to face personal tragedies in addition to the pandemic. Our goal is to create a series of discussions using the perspective of our surgical department that faced not only the fallout of the pandemic, but also the unexpected death of an influential mentor/physician and close family member to the department. Unfortunately, this pandemic is not the only time tragedy has struck a surgical department. For example, Louisiana State University and Hurricane Katrina in 2007, and a plane crash killing members of the University of Michigan transplant team. However, the pandemic is certainly the most globally widespread, relevant and recent. We leverage crisis-management strategies from other fields, responses from an internal survey, and thoughts from our surgical team on what worked during these crises, what did not, and how we can begin to create a strategic response for those unexpected moments where you get “punched in the mouth.”

Keywords Crisis management · Residency · Leadership · Checklist

Objective

To create a checklist blueprint for preparation of future crises using experiences from the current SARS-CoV-2 pandemic, as well as other acute stressors experienced by a surgical department.

Introduction

“Everyone has a plan until they get punched in the mouth.” Never has this quote, uttered in response to a challenger’s reported plan to take the title away from heavyweight champion Mike Tyson, rang truer than in the past 20 months as the global population wrestles with the fallout on the SARS-CoV-2 pandemic [1]. While countless lives were disrupted both directly and indirectly during this time, members of the medical community bore the brunt of this fallout in their personal lives while being asked to perform above capacity in their professional lives simultaneously. Compounding this experience was the fact that injuries, illness, and death from other causes did not halt leaving many in the medical community, and community at large, to face personal tragedies in addition to the pandemic. Our goal is to create a series of discussions using the perspective of our surgical department that faced not only the fallout of the pandemic, but also the unexpected death of an influential mentor-physician and close family member to the department. Unfortunately, this

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pandemic is not the only time tragedy has struck a surgical department. For example, Louisiana State University and Hurricane Katrina in 2007, and a plane crash killing members of the University of Michigan transplant team. However, the pandemic is certainly the most globally widespread, relevant and recent. We leverage crisis-management strategies from other fields, responses from an internal survey, and thoughts from our surgical team on what worked during these crises, what did not, and how we can begin to create a strategic response for those unexpected moments where you get “punched in the mouth.”

The crisis management checklist

As alluded to earlier we hope this article can spur discussions in the medical community to begin to create structure for crisis-management in a space where there is no precedent. Although one can never fully PREPARE for the unexpected, we propose a few tenets that can provide structure to a response at a time when people need it the most. We call these tenets the “*AEIOUs*” of crisis management (Table 1). The following sections review what we have learned from research within our department, and our suggestions for utilizing this structure in the future.

Act with urgency

It is basic human nature, especially in situations of uncertainty, to wait for more information and more clarity. It emanates from the fear of mis-stepping. However, indecision in and of itself is a decision to avoid making a move. The company Deloitte, in a manuscript on resiliency in leadership state “Aim for speed over elegance” [2], while McKinsey Quarterly calls for “turbocharging decision making” [3]. Two important examples of this are the decision of National Basketball Association’s (NBA) commissioner, Adam Silver, to suspend games for the remaining season, and the Prime Minister of New Zealand, Jacinda Arden’s decision to create and publicize a four-alarm system, and subsequently enact those alarms [4, 5]. Both of those decisions came in early March, well before or at the same time the World Health Organization (WHO) designated SARS-CoV-2 a pandemic. At that time these leaders acted with urgency when not all

of the information was available and there was uncertainty. Their decisions are widely credited with having many downstream life-saving effects—from the closing of other major sports organization events sparing exposure to thousands of spectators, staff, and players, to providing a framework that many countries mimicked as the pandemic became more widespread and elicited more of a government response [4]. These leaders acted with urgency, displayed bravery in actions that could have been criticized retrospectively, but ultimately saved numerous lives. While we acknowledge that it is easier said than done, we recommend that instead of minimizing the crisis and waiting for clarifying information, organizations should enact safe, widespread guidelines that protect healthcare workers and patients as soon as possible. At the minimum we encourage realizing that waiting for more information can be more dangerous than enacting safe regulations early and having to curtail them.

Empower previously trained leaders

The American Psychological Association’s (APA) comments on leadership during crises recognizes the all too often crisis dictum—“we did not have enough preparation time to respond effectively” [6]. However, they also point out that by nature there is never time to prepare for the unexpected, so this explanation is inadequate. They appropriately call for specific crisis leadership training. These leaders should be selected as individuals who would perform well in high stress, uncertain situations, instead of standard targeted training meant to elevate workers identified as at risk of underperforming. These individuals often make leadership personal and embody the idea of “leaders eat last.” They often do so even when times are not at crisis level and this characteristic should be recognized and nurtured [7]. With this preparatory, prophylactic training, leaders can be empowered immediately at times of crises to carry out the necessary tasks and members of the community know who to turn to. Put another way, by frontline physician Dr. Amy Federman, “invest in leadership” [8]. McKinsey Quarterly summarizes this as “treat[ing] talent as your scarcest resource” [3]. Dr. Derienzo describes these leaders as “latent talent” in need of discovery [9]. Her comments call for development of leadership early by identifying physicians who lead by example, are authentic, and who naturally, in times of calm, are looked up to and whose opinion is sought [8]. These are the physicians most in need during times of panic.

Initiate in place mental health resources

One of the most commonly cited factors for burnout in healthcare, regardless of whether a crisis exists, is the feeling that one’s organization lacked understanding of emotional

Table 1 *AEIOUs* of crisis management checklist

1. Act with urgency
2. Empower previously trained leaders
3. Initiate transparent communication
4. Optimize mental health resources
5. Utilize flexibility and adaptability

needs of its health care workers [10]. We are familiar with various links sent out in emails offering resources for “those who feel they need to talk” and require voluntary enrollment. To elucidate opinions and effects of leadership in our own institution we distributed an anonymous internal survey to 167 faculty, advance practice providers (APPs), and residents within our department, with a 35% response rate. In the questions addressing awareness and utilization of mental health resources, 83% of respondents were aware of professional support available, but only 13% utilized them. This represents a huge underutilization and begs the question of what can we do better. We suggest starting the process of mental health evaluation and relationship-building with therapists well in advance of any crisis. This will create an avenue of support which providers can take when the extra stresses of a crisis require mental health treatment. If there is an established relationship with a mentor or therapist, the utility rate will likely be much higher. This has shown to be associated with decreased burnout and increased workplace satisfaction and efficiency [10]. Instead of relying entirely on voluntary involvement, Baxi et al. recommends “deploying regular risk assessments for all students and staff... embedding mental health and resiliency training throughout education” [11]. We agree with both recommendations and support the idea that there should be regular required evaluations by a professional for every healthcare provider. In addition, we think “training” for times which require resiliency should start well before a crisis presents itself.

Offer communication with transparency

Similar to acting with urgency, it is often within our nature to try and carefully construct the perfect email, the perfect phrasing and, thus, we wait for as much verified information as possible. This, in turn, delays communication or forces us to use vague language to avoid misinformation. While misinformation avoidance is important, we often fail to recognize that knowing what is not known is just as important as being informed of the known facts. There is a perception that hearing leadership say they do not know something will create chaos and anxiety. However we point out that receiving vague or delayed information is often worse as put succinctly in Stanford Graduate School of Business’ Crisis Playbook, “Communicate clearly-don’t guess” [12]. The APA recommends communicating with transparency, honesty, and empathy [6]. Dr. Chris Derienzo states that effective transparent communication is when “there’s no wondering, ‘well, why did they do this instead of that’” [9]. Part of this transparency also involves method of communication, frequency of communication, and amount of information distributed. Our internal survey showed a variation in the preferred medium to receive that information (41% Zoom v 48% email) and frequency with which communication is desired

(15% daily, 31% QOD, 41% weekly emails). However, there was an agreement that multiple emails from different department leaders/hospital leadership was confusing, redundant, and created a fatigue resulting in indifference. This causes participants to start to ignore communications which could result in missing vital information. Instead of working parallel, we recommend one, centralized messaging system with input from pre-determined communication leadership that is completely transparent about the information currently available and, perhaps more importantly, about what is still being explored and investigated. As Dr. Federman states “kill fear with authenticity” [8]. Deloitte recommends this as “centralizing decision-making” [2]. Again, we turn to the example of Prime Minister Arden whose messaging and national addresses were clear, concise, honest, and widely praised within the country and in the global community [4, 5]. Much as we look to leaders within the government, the healthcare community looks for leaders to communicate within the system.

Utilize flexibility and adaptability

As each aforementioned section emphasizes, there is no one size fits all response to any particular crisis. Perhaps the most important, and possibly the most difficult, is utilization of flexibility and adaptability. Some of our actions, leaders, responses, and communications will be wrong or miss the mark. This is inevitable and important to acknowledge from the outset. An equal or greater detrimental mistake is to adhere to a plan that is ineffective or failing to admit faults. People appreciate honesty and adaptability. Stanford’s crisis playbook says “Keep your finger on the pulse; don’t just announce. Engage” [12]. Deloitte describes this engagement as “collective agility,” which refers to the relative efficiency with which change can be enacted, even within the moment, with the buy-in of all stakeholders [13]. This highlights a leader’s greatest resource during a crisis, those affected by it—ask, listen, and re-imagine plans in light of the information you discern.

Conclusions

We attempt to provide topics for discussion of what we believe can be a checklist for dealing with crises moving forward. While it is not an exhaustive list by any means, implementing the components of this list can provide guidance and structure to our approach during these crises. No checklist or strategy can prepare us completely to be in a situation where the unexpected happens, where we get “punched in the face.” Deloitte describes a crisis based on the following three time periods: response, recover, and thrive [14]. Response involves immediate reactions to the

new situation (what we can improve), recover involves the steady process of learning from mistakes and re-distributing efforts (what we hope to contribute to with this text), and thrive involves how a community is bolstered following times of crisis (what we hope comes next) [14]. Ironically, the English word crisis comes from the Greek word “krisis” which means “decision.” In our recent experiences, it is at these times when we find decision making the most difficult, but also the most crucial. We hope to provide some guidance in these situations because while it is our deepest hope that no tragedy like the SARS-CoV-2 pandemic ever occurs again, we want to be as prepared as possible for the next crisis that awaits us in the future.

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Declarations

Conflict of interest None of the authors have any conflicts of interest of financial disclosures to report.

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