

## **Summary**

The true test of an organization is if they emerge from a challenging situation stronger than before. Duke University Health System faced this challenge in February 2003.

Duke University Health System is an extensive network made up three hospitals, a School of Medicine, a School of Nursing, a biomedical research enterprise, and several large physician practices. With 16,000 employees, it is the largest employer in Durham County, N.C. and the third-largest employer in the state.

The Duke Health system's public relations effort consists of an internal relations department and an external communications operation, known as the Duke University Health System New Office. Ten employees, led by director Jeffrey Molter, staff the news office. According to Molter, the team maintains a "very proactive relationship with the media" (Calabro, 2003, p.1)

Because of the nature of the work performed at Duke, the office has learned to expect the unexpected. "When you're dealing with cutting edge medicine, as Duke does, some times things don't always go the way you want," Molter says. "A lot of high risk operations go on, where the outcomes can draw a great deal of media scrutiny"(Calabro, 2003, p. 1).

But no one could have expected and planned for the crisis that would strike Duke in February 2003.

Jesica Santillan, a Mexican immigrant, came to the United States with her parents with the hope of receiving an organ transplant that would save her life. Without a transplant, Jesica's doctors expected her to die within six months. She was listed for a

transplant at Duke University Hospital. But due to the shortage of donor organs and the rarity of her O-type blood, her prospects for receiving organs were grim.

To everyone's surprise, The New England Organ Bank contacted Carolina Donor Services, offering a heart and lungs for Jessica. The organs were then flown to Duke to be used in surgery. On February 7, Jessica's own lungs and heart were removed and the new organs were transplanted.

As soon as the surgery ended, doctors learned that they had made a fatal mistake; the organs given for Jessica's transplant were the incorrect type. Jessica's body immediately began to reject the new heart and lungs. After undergoing another unsuccessful surgery on February 20, Jessica died two days later.

During the first week of the crisis, Duke's communications team reached an agreement with the Santillan family not to disclose any information about the mismatch. "One of the most important principles in our business is to adhere to the family's wishes" says Molter, "Jessica's parents didn't want the mismatch to be made public because they wanted attention focused on getting her a second set of organs" (Calabro, 2003, p. 2). The news office helped train the family to deal with the media in order to discuss the situation without revealing the information about the mismatch. During this week, Duke also contacted the PR firm of Burson-Marsteller for advice on forming a crisis communications plan to deal with the present situation.

But on February 14<sup>th</sup>, to Duke's shock, the Santillan family spoke to the media and revealed that their daughter had indeed been the victim of a medical mistake. The following Monday, February 17<sup>th</sup>, the communications team met with Duke Hospital's CEO, Dr. William Fulkerson, to form a communications plan to publicly address the

mistake. But the spark lit by the Santillan family had already ignited a firestorm of controversy in the media.

### **Analysis**

The crisis situation reached its climax when the failure of the second transplant surgery resulted in Jessica's death. Up to that point, Duke had refused to comment on the transplant mistake. However, the increasing media scrutiny and the presence of a mourning and angry family demanded that Duke face the reality of its error and provide people with answers.

The hospital already had a long-standing crisis policy in place, according to Molter. He stated that its main objective was to "maintain control of the message to internal and external audiences, [and] make sure one message is being used" (Molter interview, 2003). Even in this particular tragedy, Duke stood by this plan.

Because of the prestige of the medical center, the crisis threatened its esteemed reputation. As a result, Duke resolved to get information out to every important public: the media, the Santillan family, the medical community, current patients and the general public. According to the plan, the media were to play a key role in distributing Duke's message.

Three weeks later, CBS aired "Anatomy of a Mistake" on its news program *60 Minutes*. During this news special, Duke officials opened up about the Santillan tragedy, offering a sincere admission of guilt. Many doctors involved in the procedure were interviewed, including Duke health chief Ralph Synderman and Dr. James Jagers, who had performed the botched transplant.

This proved to be a positive step in Duke's communication plan – the hospital had aligned itself with a respected national medium and admitted that it was at fault.

Throughout the aftermath of the crisis, Duke continued to manage its relationships with the media and provide them with answers.

Molter said that even after the crisis had settled, he visited local papers personally and “mended fences”(Molter interview, 2003). This gave him the opportunity to explain why Duke had “kept quiet” in the beginning and not been totally open with the press (Molter interview, 2003).

The hospital did not neglect to enhance its transplant protocol system. Soon after Jessica's first operation, Duke took measures to create a new system, which required thorough examinations and re-examinations of both medical and transplant data. PDA technology will soon make patient information immediately available to transplant surgeons. Additionally, careful monitoring of “close calls”, or “mistakes that don't harm patients but could”, allow physicians to prepare for and protect against potential dangers (Comarow, 2003, p.10,11)

Additionally, the communications team developed an outreach program with the goal of obtaining feedback about the hospital's crisis policy. Officials gathered input from news media and medical professionals regarding Duke's management of the Santillan case and what could be improved upon in the future.

In an effort to maintain a positive relationship with the community, Duke set up a \$4 million fund in Jessica's name. According to a Duke press release, the fund “will honor the memory of Jessica Santillan by providing additional support services for Latino

pediatric patients and their families receiving treatment at Duke” (Molter, May 8, 2003, p.1).

In the end, Duke’s public relations campaign was successful. The relationships the hospital had cultivated with the media before the crisis resulted in a lot of positive coverage. After the crisis, a report from *CNN Financial*, CNN's financial department, titled “Being Media Savvy,” offered Duke as an example of an organization with superior media skills. Articles in *Forbes* and *US News & World Report* also discussed the Santillan case and pointed out that Duke had upheld its reputation as a responsible medical institution. Although it was at the center of a healthcare nightmare, Duke proved that it was still an accountable and dependable organization.

A major benefit to Duke during the crisis was that it already had a generic crisis communications plan in place. Molter stated after the crisis that the plan “held up well” (Molter interview, 2003). However, he mentioned some weaknesses in the plan that should be worked out. For example, the Santillan case was a layered problem with many elements converging into a larger crisis. At the time, the generic communications plan was not designed to deal with the large number of elements playing into the crisis. Molter also said that Duke discovered the need for more spokespeople during the crisis. Because Duke handles crisis and potential crisis situations everyday, the organization should conduct “what if” situations, including situations where a number of elements are going wrong, so that the organization can be better prepared to deal with a multi-layered crisis. As part of these “what if” situations, the communications department should train its spokespeople to handle any kind of situation. Conducting mock press conferences with these representatives would further prepare the spokespeople to handle the press.

As mentioned above, Molter's main concern was communicating his message to external media. Because the press allowed Duke to send its message to the general public, maintaining a positive relationship was very important. However, because of privacy laws, Duke had to limit the information about the transplant that it sent out. Just after the transplant, Duke could only give a one word report on Jessica's condition, e.g. "Critical" or "Serious." (Fass, 2003, p.1). Although Duke is required by law to protect the privacy of its patients in this situation, the organization could have benefited from providing the press with more information. For example, organization representatives could have given the press an estimated time on when more information would be given. Immediately after Santillan's death, Duke realized the need to provide the press with more information. This was evident when Dr. James Jagers, the surgeon who performed the surgery, released a video statement to the press accepting responsibility for the mistakes that were made. However, by strictly limiting its initial message, the organization appeared to be concealing information from the press.

In an effort to strengthen two-way communication between the Hospital and the press, Molter visited local journalists and explained to them the reasons behind Duke's initial response to the crisis. By visiting local journalists, Molter was able to tell his side of the story and show members of the press that Duke Hospital does care about and value their opinions. This step in the plan can also be easily evaluated.

Because of the importance of rebuilding Duke's reputation in the aftermath of the transplant, it was vital that Duke make changes to ensure the public that mistakes, like those made in the Santillan case, would not happen again. Duke achieved this objective through its implementation of new transplant protocols. By immediately preparing a new

transplant system, Duke showed the public it would not tolerate having a flawed system and was able to guard the organization's reputation. The system evaluation at Duke influenced other hospital's decisions to make changes to transplant protocols, such as Saint Barnabas Health Care System in New Jersey. However, Duke could do more to explain the changes to key publics. Because the previous transplant system may not have been well known, Duke could send an information sheet explaining the new changes and how the new changes improve the system. The sheets would go to interested publics such as, former and future patients and their families, the media and other departments within the Hospital. The information sheet would provide the Hospital with a means of measuring the effectiveness of its new transplant protocol. Duke pr practitioners could document the number of information sheets sent to its publics to allow them to estimate how many people are familiar with its new protocol.

To evaluate its pr campaign after the crisis, Duke need only look at the number of media who have applauded the efforts of the organization. The Hospital's labors to balance the Santillan family's privacy with its need to report the transplant mistakes to the press can be summed up in a quote from Molter. During the crisis he would tell the press, "We are a hospital, and we need to be right all the time."(Molter interview, 2003). Duke's efforts "to be right" have paid off. The organization has suffered only minimal reputation damage if any at all and the Medical Center was ranked number 6 in *US News & World Report's* "America's Best Hospitals 2003" ("Best," 2003, p. 1).

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