

Chapter 63

Risk Management in a Pandemic Crisis at a Global Non Profit Health Care Organization

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ABSTRACT

This article categorizes the risks experienced and voiced by subject matter experts at a pandemic crises event which unfortunately claimed almost 800 lives before it could be controlled. The project was a case study design using multiple methods. Qualitative data was collected by interviewing 22 front-line multicultural crisis practitioners. The unit of analysis was the constructed meaning of the uncertainty and risk management processes experienced by the participants, while they were attempting to control the global pandemic crisis associated with the Severe Acute Respiratory Syndrome outbreak during 2003. Several guiding constructs were researched from the literature review. NVIVO was used to analyze the interview transcripts to build a thematic model of constructed meanings. The result was a best-practice model constructed by the practitioners which they felt improved risk control during a significant global pandemic crisis event considering the lead mitigation agency was a nonprofit health care organization.

INTRODUCTION

The meaning of uncertainty, contingency and risk management differ from one discipline to another and across cultures (Goodwin & Strang, 2012). Risk has generally been discussed in the management science disciplines, notably financial economics. It is rare to see risk analyzed

in the health care industry despite the obvious uncertainty and life threatening urgency of many projects. Pandemic health care is not the same as emergency room health care because the former may not have a known remedy whereas surgeons generally have the knowledge and facilities for performing life saving medical procedures. The “non-profit sectors are not immune to risk” (Goodwin & Strang, 2012, p. 9), therefore more research is needed in health care.

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A pandemic is an epidemic crisis triggered by the rapid spread of an infectious disease that is difficult to control, through human populations across a large region such as multiple continents or in some instances worldwide, as was the situation with smallpox and tuberculosis. Interestingly, when pandemic health care projects are encapsulated with life threatening uncertainty and when the participants involve practitioners whom have different cultures this creates a complex real life crisis itself. Health care practitioners need more practical models to help them with risk identification, assessment and management. More so “practitioners can learn from reading about novel ideas and solutions – even if the risk models are from different cultures, disciplines or industries” (Goodwin & Strang, 2012, p. 9).

Two major global health care pandemics occurred in 2003 and 2009 which were considered more life threatening than the 2008 global economic crises or the 2010 earth quake tsunamis in Japan: they were the avian/swine flu influenza (H1N1 virus) and the Severe Acute Respiratory Syndrome (SARS). Both of these crises were independent events yet both were similar and thought to originate in China. H5N1 and SARS both met the four criteria to be considered as a public health emergency of international concern as defined by the United Nations World Health Organization (WHO).

In fact WHO physician Dr. Carlo Urbani identified SARS as a new disease in 2003, based on a diagnosis from a sick 48-year-old businessman who had traveled from the Guangdong province of China, through Hong Kong, to Hanoi, Vietnam, and then he quickly died (WHO, 2006e). The hallmark symptoms of SARS were: difficulty breathing, fever greater than 100.4 degrees F (38.0 degrees C), chills, shaking, cough that produces phlegm (sputum), diarrhea, dizziness, nausea, vomiting, runny nose and sore throat (WHO, 2006e) - more so when most of these symptoms are present at the same time.

In the meantime, during February-March 2003, SARS was spreading quickly around the world, including Asia, Australia, Europe, Africa, as well as both North and South America. WHO identified SARS as a global health threat, and issued a travel advisory. The 2003 SARS outbreak had an estimated 8,000 cases with 750 deaths, but more importantly, SARS is a distinct new virus which appears to be here to stay. Therefore we can learn relevant information about uncertainty and risks associated with the best-practices of WHO practitioners in mediating the global SARS crisis.

The H1N1 outbreak in April 2009 was similar to SARS but occurred in Mexico and the USA whereupon it was subsequently declared a pandemic by the WHO, moving the alert level to phase 6, marking the first global pandemic since the 1968 Hong Kong flu (WHO, 2010). According to the WHO: “213 countries and overseas territories/communities reported laboratory confirmed cases of pandemic influenza H1N1 2009, including at least 16,931 deaths” (WHO, 2010, para. 5).

To that end this study examines the experiences of WHO practitioners stationed in Hong Kong during the SARS pandemic, so as to document their perceptions of risk categories, in order to produce a model.

LITERATURE REVIEW

Risk analysis is generally described as the identification of the hazards and possible problems, the evaluation of their importance and the drawing up of plans to monitor and deal with those problems (Goodwin & Strang, 2012). Thus good risk management should be able to assist the reduction of uncertainty for health care projects, especially pandemics like SARS, should this reoccur.

Risk Management in Health Care

Risks have become more uncertain, complex and global, while risk governance processes in health

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