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Spokespersons and Message Control: How the CDC Lost Credibility during the Anthrax Crisis

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This study evaluates the role of spokespersons and message control in complex organizations facing ambiguous crises. Specifically, the Centers for Disease Control and Prevention's (CDC) response to the anthrax crisis in 2001 is offered as a case study. A textual analysis of CDC telebriefings and corresponding print media coverage of the anthrax crisis reveals the use of multiple spokespersons and poor message control resulted in a seemingly fragmented CDC message and apparent loss of CDC credibility. The study concludes that limiting the number of spokespersons and appropriate use of strategic ambiguity may afford organizations an opportunity to make sense of the situation, avoid confusing and contradictory messages and protect organizational credibility. Recommendations include (1) limiting the number of spokespersons, which allows for greater message control while reducing contradictory and inconsistent messages, (2) maintaining an organizational willingness to revise publicly stated positions as more accurate information becomes available, and (3) actively using strategic ambiguity as a mechanism to protect organizational credibility.

Keywords: Crisis communication; Spokesperson; Message control; Organizational credibility; Strategic ambiguity

In early October 2001, the Centers for Disease Control and Prevention (CDC) announced that Bob Stevens of West Palm Beach, Florida, had died of inhalation anthrax. Further investigation of Stevens' death revealed that on September 11, 2001,

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an anthrax-laced letter had been mailed to *The Sun*, a Boca Raton, Florida publisher where Stevens worked. Later, similarly contaminated letters were received by *The New York Post*, NBC anchor, Tom Brokaw, and Senate Majority Leader, Tom Daschle. Ultimately, 22 cases of anthrax disease resulting from the tainted letters had been diagnosed and five people had died. One organizational casualty of this anthrax-related crisis was the CDC; by the time the crisis ended, the CDC had come to be viewed as slow and rigid, with serious credibility problems (Barrett et al., 2004).

This study explores CDC's public communication during the crisis, with specific emphasis on message control, the role of spokesperson during a crisis and how CDC use of these crisis communication principles impacted its organizational credibility. Finally, conclusions drawn from this review are discussed and implications for further crisis communication research are suggested.

Literature Review

Seeger, Sellnow, and Ulmer (1998) define crisis as a "specific, unexpected, and non-routine event or series of events that create high levels of uncertainty and threaten or are perceived to threaten an organization's high-priority goals" (p. 233). During a crisis, failure to communicate promptly in an orderly, precise manner damages an organization's credibility, image, and finances (Marra, 1998). Identifying and presenting centralized messages as part of an effective crisis plan, however, helps organizations retain public trust (Covello, 1992; Sellnow & Ulmer, 1995). To avoid confusion, most crisis management plans encourage the appointment of a primary spokesperson to ensure consistent messages (Benoit, 1997; Coombs, 1999; Kaufmann, Kesner, & Hazen, 1994; and Turner, 1999). An effective way for an organization to manage the messages it provides to the public is by appointing a single spokesperson (Kaufmann, Kesner, & Hazen, 1994; Benoit, 1997; Turner, 1999; Rugo, 2001). Employing more than one spokesperson can result in mixed and confusing messages (Kaufmann, Kesner, & Hazen, 1994). While a spokesperson should be an organization's top executive, depending on the situation, the CEO may not be the best person for that role (Turner, 1999; Kaufmann, Kesner, & Hazen, 1994). Two criteria for whether a senior executive should be the spokesperson depend on the severity of the crisis and whether the executive is willing to risk public scrutiny (Rugo, 2001). If the CEO is not chosen, an industry expert and organizational ally ought to be appointed (Rugo, 2001). At the very least, the spokesperson should be positive toward the press and organization and be knowledgeable and flexible in the messages he or she provides (Balian, 1999; Murphy, 1996). Best practices suggest choosing an experienced, trustworthy, credible, media trained spokesperson who is well informed, prepared, and able to control presentations to the media (Rugo, 2001; Nicolazzo & Nickson, 2001; Covello, Peters, Wojtecki, and Hyde, 2001). If more challenging information needs to be communicated with a sense of credibility, a technical expert can be trained on message delivery and supported by an experienced spokesperson (Heath, 1995). The public attributes low credibility to government and industry spokespersons and views governments as having insufficient resources to meet the

public demands and public agencies as conflict ridden and inadequate (Covello, 1992). One exception is the US President who traditionally enjoys the public trust.

The perspective of Kuypers (2002), Windt (1990) and Windt and Ingold (1983) is that US presidents use the ethos of their office to choose the political definitions of events. US presidents have the luxury of choosing which events to elevate to the level of crisis by publicly discussing them. By doing so, the president sets the context for national discussion and establishes the frame of reference used by the press and the public to make sense of these presidentially defined crises. Kuypers (2002) points out "other politicians and social leaders are not in the same position of authority" to influence media coverage or focus public attention on issues of national importance (p. 6).

While presidents can and do occasionally influence media coverage, journalists regularly set the frames of reference readers and viewers use to interpret public events (Kuypers, 2002; Neuman, Just, & Crigler, 1992; Price, Tewksbury & Powers, 1997; Scheufele, 1999; Tuchman, 1978). By presenting images and messages in a predictable and patterned way, the media construct social reality and, in the process, have a strong effect on viewers and readers (McQuail, 1994, Scheufele, 1999). Individuals develop their own versions of reality based on personal experiences and their own interpretations of mass media messages (Gamson & Modigliani, 1989; Neuman, Just & Crigler, 1992; Scheufele, 1999). Sometimes, sufficient information to make sense of a crisis is unavailable.

Although the media and other stakeholders demand immediate information during a crisis, such information may not be available or advisable for the spokesperson to share. The ambiguity inherent in a lack of information may have beneficial consequence for the organization. Spokespersons can ethically and effectively use strategic ambiguity to accomplish the organization's crisis communication goals. Sellnow and Ulmer (1995) argue, "ambiguity, when viewed in the context of a crisis situation, enables organizations to strategically communicate seemingly contradictory messages to distinct audiences" (p. 144). They suggest the use of vague or ambiguous answers may assist an organization in retaining credibility because listeners cannot use the message itself to obtain understanding. Instead, listeners use their own frame of reference to attach meaning (Sellnow & Ulmer, 1995; Ulmer & Sellnow, 2000).

Methodology

Sources for this study of CDC's crisis communication include 44 CDC press releases, transcripts of 26 CDC telebriefings and hundreds of related national and regional newspaper articles conducted and published between October 4, 2001 and February 22, 2002. The 44 CDC press releases chronicled crisis facts and for the purpose of this study provided background information. A textual analysis of the telebriefing transcripts was conducted to determine major communication themes, identify communication inconsistencies, and examine the role of CDC spokespersons during the crisis. To establish how CDC communication was publicly received, selected

newspaper articles coinciding with CDC telebriefings were chosen from a total of 503 news stories. These articles were collected from a wide variety of major US newspapers obtained from three online databases (Lexus-Nexus, InfoTrac, and Electric Library).

Results

While the study of these artifacts revealed a number of recurring topics, two major themes emerged: inconsistent message control and the use of multiple spokespersons.

CDC Communication with the Public: Use of Inconsistent Messages

In an effort to "be first, be right, and be credible" (American Medical Association, 2003) CDC announced on October 4, 2001, that Bob Stevens had contracted inhalation anthrax, that it was not contagious, and that a CDC team was "aggressively investigating the source of the infection" (CDC, 2001, October 4). CDC Director Jeffrey Koplan told the media "the likelihood that such a disease could have occurred without human intervention was 'nil to none'" (Kennedy, Goff, & Wake, 2001, p. A1), but poor message control began almost immediately when HHS Secretary Tommy Thompson, responsible for the CDC as part of his Cabinet assignment, inferred Stevens' death was his own fault by publicly speculating that Stevens, an avid outdoorsman, "apparently drank from a stream while in North Carolina, a state known for hog farming and its associated waste" (Ulferts & Ballingrud, 2001). Seven days later, CDC erroneously reported, "This appears to be a local and isolated exposure focused in one building" (CDC, 2001, October 11). Yet the very next day, a CDC press release announced that Erin O'Conner, working in New York City's Rockefeller Plaza, had developed cutaneous anthrax after opening a letter laced with anthrax spores (CDC, 2001, October 12).

During much of the crisis, CDC spokespeople insisted that to contract inhalation anthrax a person had to inhale approximately 8000–10,000 anthrax spores (CDC, 2001, November 29). CDC officials also argued sealed envelopes filled with anthrax spores could not sufficiently contaminate other mail to cause inhalation anthrax. Dr Julie Gerberding, then Acting Deputy Director, downplayed the risk: "I don't think [mail handlers] have anything to be worried about" (CDC, 2001, October 25). These and similar comments gave the nation a false assurance that the mail was sufficiently safe. The anthrax deaths of Kathy T. Nguyen and Ottilie W. Lundgren, while not scientifically linked to cross-contaminated mail, led reporters to criticize CDC insistence that inhalation anthrax could not result from cross-contaminated mail. Nevertheless, CDC continued to promulgate the same message for weeks after Ms. Nguyen died. In response to a media question, Dr. Gerberding said the CDC believed "that the few spores that might be implicated in cross-contaminated mail could cause skin disease in some people, but are extremely unlikely to cause inhalation disease" (CDC, 2001, November 15).

These and similar contradictions led to widespread concern in the media over CDC's credibility. The November 6 *Washington Post* quoted an emergency room physician: "I do not have confidence in the people who are spokesmen for the government" (p. F01). United States Senator Tom Harkin was reported to be "upset because he had thought the CDC 'was really on top of this' and it wasn't" (Borenstein, Murphy, & Pugh, 2001, p. K3813). Harkin was widely quoted as telling CDC Director Koplan, "Maybe I'm wrong, but it just seems to me that something broke down here or is broken down. It's obvious people are getting sick, people are dying, and we can't afford to keep letting this happen. ... I am very concerned about what CDC is doing and how they are operating" (McClam, 2001; McKenna, 2001, p. A12).

Finally responding to media criticism, CDC officials began to clarify the CDC's public stance in December. Koplan said, "This unsolved case of inhalation anthrax might be due to contact with cross-contaminated mail. CDC believes that also the risk of contracting inhalation anthrax from cross-contaminated mail is very, very low, it's not zero" (CDC, 2001, December 6). In effect, Koplan acknowledged that Nguyen and Lundgren died of inhalation anthrax after exposure to cross-contaminated mail. CDC further relaxed its rigid stance and admitted it did not have all of the answers. Koplan told reporters on December 6, "As with most public health emergencies or major events ... . There's [*sic*] large parts of this that are unknown" (CDC, 2001, December 6). Other CDC leaders followed suit. For example, Dr Julie Gerberding, responding to a question about the efficacy of requiring 60 days of medication for those exposed to anthrax spores, said CDC had "never done this before, and we can't be sure, so we will be monitoring people after they stop their therapy and advising them to see the doctor" (CDC, 2001, December 6).

Formal CDC recommendations to Brentwood postal workers included taking the controversial anthrax vaccine. Koplan was asked what he would have done if faced with the same circumstance. His answer, which reporters identified as a further perpetuation of the conflicting messages theme, was that he would be vaccinated. "But," he added, "if I were in your shoes and had taken 60 days of antibiotics and felt lousy from it, my answer might not be the same" (Schmid, 2002). DC Health Director Ivan Walks was quoted in *The Washington Post* as saying, "The absence of a clear communication from the CDC about who should take vaccine, coupled with the absence of any follow-up care, made it very difficult for the [Brentwood] postal workers to say 'we'll take it'" (Connolly, 2002, p. A06).

Despite some successes in communicating with the nation's health workers discussed later, CDC clearly struggled with message consistency. By its very nature, this crisis was ambiguous and complex. Before the attack, little was known about human anthrax disease, and much that was known was contradicted by circumstances as the crisis developed, making CDC's learning curve fairly steep. As new understandings emerged they were inconsistently shared, causing some groups, notably the Brentwood postal workers, to complain of unfair treatment.

Early in the crisis, CDC appeared to respond aggressively, but underestimated the full dimension of the attack, publicly announcing that the Stevens case was an

isolated anomaly. HHS Secretary Tommy Thompson's speculations did not help. His erroneous remarks reinforced CDC's basic stance to not speculate or recommend without scientific proof. CDC reluctance to venture even highly educated guesses ultimately worked against its organizational credibility. Early media reports framed CDC as more than competent to handle the crisis, but unequivocal statements based on inexact scientific "proof" eroded CDC's positive image. By late October and November, the media was struggling with CDC refusal to acknowledge that cross-contaminated mail could cause inhalation anthrax. As far as the media could determine, the only apparent source of contagion for Nguyen and Lundgren was contaminated mail. CDC officials agreed such may have been the case, but maintained a dogged refusal to conclude that cross-contamination was the culprit. CDC's unwillingness to acquiesce and make timely recommendations for dealing with cross-contaminated mail severely injured CDC credibility.

When CDC finally provided formal recommendations on dealing with potentially contaminated mail, the recommendations were too little and too late to protect the organization's credibility. As Farrell and Goodnight suggest, "When actual consensus begins to erode, the proclamations of technical authority are made to seem hollow" (Farrell & Goodnight, 1981, p. 288). The public's impatience and short attention span, accentuated by unrelenting media attention to this issue, created a distance between the media and CDC, which lasted through the remainder of the crisis.

CDC messages during the first days of the crisis were generally rigid, definitive statements containing little equivocation. When contradictory facts and educated guesses surfaced in the media, these definitive statements created problems for the organization. Had CDC couched its messages in softer, more ambiguous language, fewer discrepancies between CDC assertions and emerging media reports would have developed. CDC use of equivocation was the right idea but came too late. What Farrell and Goodnight (1981) observed about an earlier crisis can be said about this crisis: "As the crisis deepened, then, technical consensus tended to erode, uncertainties multiplied, and contingencies for action seemed disengaged from real persons. It is no wonder that the world of ordinary life seemed frightening and insecure" (p. 289).

CDC Communication with the Media and Professional Healthcare Providers

One abiding principle of crisis communication is to get the word out. That is, an organization needs to ensure its central message receives adequate media attention. In this crisis, CDC chose two central message goals. The first was to widely disseminate the best available information on how to respond to the threat of anthrax exposure and the second goal was to help calm public anxiety caused by the crisis.

Media attention was so intense during the first two weeks of the crisis that the CDC Office of Communication was overwhelmed. When it recognized that normal public relations responses using traditional press releases, MMWR reports, and informal interviews were insufficient to meet the media's demands, CDC chose to hold daily telebriefings, providing reporters across the nation with daily telephone access to

CDC officials. As a consequence, the public received the information they needed to assess the crisis' impact on them. In light of the CDC goal to diffuse this information, initiating daily telebriefings was a CDC success.

A similar effort was made by CDC officials to inform state and local health workers. In addition to weekly MMWR reports, CDC held detailed teleconferences with health practitioners across the nation, giving them the latest and best information on diagnosis and treatment of various forms of anthrax disease. Given the attack's widespread impact, the number of individuals actually contracting either inhalation or cutaneous anthrax was remarkably small, which was due in no small part to CDC's quick dissemination of accurate diagnostic and treatment recommendations and to the vigilance of the nation's health practitioners.

Use of Multiple Spokespersons

Examining newspaper accounts of the crisis, Barrett et al. (2004) identified by name and title 81 separate individuals formally and informally speaking on CDC's behalf. Of these, 62 were CDC employees, many who actively participated in the October and November telebriefings. Concern over the number of official and unofficial CDC spokespersons received front-page attention in *The San Francisco Chronicle*, which quoted Carole Gorney, a LeHigh University crisis management specialist as saying, "Part of the problem is that information is coming out from several different sources," and the article concluded "beyond the medical unknowns, many experts said inconsistent public pronouncements have added to the confusion about the danger of disease spreading" (Hall & Stannard, 2001, p. A1).

Crisis communication theory argues for one primary spokesperson, yet CDC's structure, with an institute, centers, and offices located throughout the nation, made control of media access to the 8500 employees a daunting task. When coupled with the media's unrelenting appetite for more information, it is easy to see why CDC had poor control over who spoke to the media. Even so, a large number of those who did speak were actually introduced to the media during the telebriefings. By this action, CDC inadvertently contributed to the confusing and contradictory messages that inevitably follow the use of so many spokespeople.

Recommendations

Because of the nature of modern society, complex and ambiguous crises are more likely than not to occur and with increasing frequency. Organizations compelled to respond to intense media attention should limit the number of spokespersons authorized to speak to the media. Limiting the number of spokespersons allows for greater message control, promulgates fewer contradictory and inconsistent messages, and reduces damage to organizational credibility.

Rigid and definitive public pronouncements made early in a crisis all too frequently come back to haunt organizations in crisis. Organizations should use strategic ambiguity as a means to provide time to make sense of the crisis and

identify, develop, promulgate and, when needed, revise centralized messages thereby limiting damage to organizational credibility. Crisis planning should also recognize and accommodate the intense media attention concomitant with such crises. While the CDC's quick dissemination of information through daily telebriefings to its national network of health practitioners was eminently successful in saving lives and was a good example of the proper application of risk communication theory, the national crisis it faced was unique, requiring unique responses and actions. Practitioners such as the CDC, then, should explore how these recommendations can properly function during complex and ambiguous crises.

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