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From preparedness to adaptation: Swiss hospitals' communication strategies in a prolonged crisis

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Background: Effective communication is essential during health crises to maintain operational clarity, staff engagement, and public trust. While existing models emphasise centralised crisis response and structured messaging, few studies examine how hospital communication evolves across different phases of a prolonged emergency.

Objective: This study explored how Swiss hospitals adapted their internal and external communication strategies during the COVID-19 pandemic, identifying key challenges, approaches, and lessons for future preparedness.

Methods: We conducted a retrospective qualitative study based on semi-structured interviews with 18 communication leaders from public hospitals across Switzerland. Thematic analysis was used to identify evolving communication strategies, challenges, and adaptations over time.

Results: Four dynamic phases emerged: preparedness and early onset, peak crisis response, stabilisation, and prolonged crisis adaptation. Communication strategies shifted from rapid internal coordination and leadership visibility to targeted digital engagement and staff support. Hospitals implemented structured messaging loops, leveraged mobile platforms, engaged in proactive media outreach, and introduced psychological support and recognition campaigns. Over time, they also refined communication protocols and reduced message frequency to avoid overload. Despite these efforts, challenges remained in managing decentralised coordination, sustaining morale, and countering misinformation.

Conclusion: Hospital communication during COVID-19 required continuous adaptation. Beyond disseminating information, effective strategies fostered connection, reassurance, and trust. Our findings highlight the need for communication systems that are both structured and flexible, grounded in resilience, and integrated into broader institutional crisis planning. These insights inform future communication frameworks for healthcare institutions facing prolonged emergencies.

KEYWORDS

crisis communication, hospital management, COVID-19, qualitative study, health services research

Introduction

The COVID-19 pandemic fundamentally reshaped global healthcare systems, exerting extraordinary pressure on hospitals as they struggled to meet surging patient care demands while navigating an evolving landscape of complex communication challenges (WHO, 2020). In times of crisis, effective communication is not merely supportive but indispensable—it ensures that healthcare providers, patients, families, and the broader public receive timely, accurate, and coherent information. The pandemic underscored the critical importance of robust communication systems, particularly in a context defined by pervasive uncertainty, heightened anxiety, and the viral spread of misinformation (Paakkari and Okan, 2020; Rosenbaum, 2020).

Switzerland's healthcare system, organized under a federal structure, delegates responsibilities for healthcare delivery across the federal government, 26 cantons, and municipalities. Hospitals operate within a mixed public–private framework, but public hospitals are the main providers of acute care and are closely integrated with cantonal health authorities (Sturny, 2020; Boes et al., 2025). Hospitals are categorized according to a federal typology based primarily on activity domains and care days per division, distinguishing between general care hospitals and specialized clinics. General care hospitals are further divided into centralized care hospitals and basic care hospitals. As of 2023, the centralized care category included five university hospital centers and 39 other large establishments, typically cantonal hospitals (Kennzahlen der Schweizer Spitäler, n.d.). This decentralized and diverse structure, combined with linguistic and cultural diversity, creates both opportunities and challenges for crisis communication, particularly during prolonged emergencies.

In this context, the pandemic served as a revealing stress test for hospital communication, exposing both strengths and vulnerabilities. Swiss hospitals faced a complex set of obligations: ensuring transparency, protecting patient confidentiality, and reassuring an anxious public. At the same time, they had to coordinate with decentralized health authorities, adapt to shifting guidelines, address staff safety concerns, and communicate effectively with a multilingual and multicultural population (Schlögl et al., 2021; Rubinelli et al., 2023; Schumacher et al., 2023). These overlapping challenges underscored the need for communication strategies that were both adaptable and resilient under prolonged pressure (Ehrenzeller et al., 2022; Grazioli et al., 2022).

Traditional crisis communication models, often structured around the phases of preparation, response, and aftermath (Reynolds and Seeger, 2005), provided a starting point for hospitals. However, the prolonged uncertainty and intensity of the pandemic quickly exposed the limitations of these linear frameworks. As a result, hospitals had to develop and adapt communication strategies on the fly, learning through experience what was effective and what was not (Bloom et al., 2021; Rosenbäck and Eriksson, 2024). The pandemic thus offers a rare and invaluable lens through which to examine the effectiveness of hospital crisis communication strategies, revealing not

only critical gaps and opportunities for improvement but also the practical expertise hospitals acquired.

Despite their relevance, the specific communication experiences of Swiss hospitals during COVID-19 remain largely underexplored. This leaves a gap in the empirical and theoretical foundations needed to enhance preparedness for future crises on both national and global scales. This study aims to address this gap by systematically investigating the communication challenges encountered by Swiss hospitals during the COVID-19 pandemic and analyzing the strategies they employed to overcome these obstacles. Its objectives are threefold:

First, to identify key communication challenges faced by Swiss hospitals during health crises, including internal coordination, public information dissemination, and alignment with governmental authorities.

Second, to analyze adaptive strategies and tools used to address these challenges, such as digital communication platforms, structural innovations, and targeted messaging approaches.

Third, to provide actionable recommendations for strengthening crisis communication preparedness in healthcare institutions, offering pragmatic solutions for healthcare leaders navigating future emergencies.

Switzerland's healthcare system—marked by its decentralized governance, multilingual complexity, and commitment to high standards of care—provides a uniquely compelling case study for crisis communication in healthcare. By situating this research within the Swiss context, the study not only sheds light on local practices but also offers insights of global relevance. Its findings will contribute to the international literature on healthcare crisis communication, informing strategies that extend beyond pandemics to encompass a wide spectrum of crises, from natural disasters to public health emergencies.

Materials and methods

Study design

We chose a qualitative research design (Finset, 2008) to explore the communication challenges faced and strategies adopted by Swiss hospitals during the COVID-19 pandemic. This approach allowed us to engage directly with hospital communication leaders, capturing their perspectives and experiences in a way that goes beyond surface-level strategies to reveal the thought processes and decisions underpinning their actions. Semi-structured interviews (Cohen and Crabtree, 2006) formed the heart of our data collection, providing participants with the space to share their stories openly and in detail. This conversational format also enabled us to ask follow-up questions, clarify points, and better understand the unique contexts in which they operated. By doing so, we aimed to build a deeper, more human understanding of the complexities of crisis communication within the healthcare sector.

Participants and recruitment

The study targeted leaders of Swiss public hospitals who were directly responsible for designing and implementing crisis communication strategies during the pandemic. Depending on the hospital, these roles included the hospital director, CEO, or

Abbreviations: CEO, Chief Executive Officer; EKNZ, Ethikkommission Nordwest- und Zentralschweiz; FAQ, Frequently Asked Questions; WHO, World Health Organization.

communication specialist. Inclusion criteria specified that participants should hold managerial or leadership roles with regard to communication within their hospital to ensure that they had adequate insight into both the strategic and operational aspects of crisis communication. We systematically contacted all Swiss public hospital organizations — including both cantonal hospital networks and university hospital centers — using professional networks and publicly available contact lists. These approximately 45 organizations often comprise multiple hospital sites operating under the same administrative structure (*Kennzahlen der Schweizer Spitäler*, n.d.). Of these, 18 organizations agreed to participate, representing roughly 40% of the sector. The sample included hospitals from all three linguistic regions of Switzerland ensuring diversity in perspectives. In the Italian-speaking Canton of Ticino, the hospital sector is organized as a single public hospital network. Consequently, only one representative could be recruited from this region, reflecting the organizational structure rather than an imbalance in recruitment.

Data collection

Data were collected through semi-structured interviews, conducted via secure video conferencing platforms or in person, depending on participant preference and in observance of public health guidelines at the time. Interviews were conducted between January and July 2021, towards the end of the second wave of the pandemic in Switzerland, each lasting between 60 to 90 min. All interviews were audio-recorded with participant consent, then transcribed verbatim for analysis.

The interview guide was developed specifically for this study (*Supplementary File 1*), drawing on existing literature on crisis communication in healthcare and preliminary consultations with hospital communication experts. During the interviews, participants were invited to reflect retrospectively on several key areas: their initial reactions and preparedness at the onset of the pandemic; specific communication challenges encountered; the strategies used to address these challenges, including the deployment of digital tools and changes to internal communication structures; perceived differences between the first and second waves; and lessons learned regarding the effectiveness of their communication efforts.

The semi-structured format provided flexibility, allowing participants to raise issues specific to their institutional context while ensuring that core topics were consistently explored across all interviews.

Data analysis

We employed a codebook-style thematic analysis, drawing on Braun and Clarke's foundational principles (*Braun and Clarke, 2006*) but aligning more closely with the structured, consensus-oriented approach commonly used in applied health research (*Nowell et al., 2017*). This method, focused on transparency, consistency, and actionable findings, emphasises a collaboratively developed coding framework refined through iterative discussions, rather than the researcher subjectivity and theoretical positioning typical of reflexive thematic analysis.

Familiarization began with repeated readings of transcripts to capture initial impressions and recurring patterns. Using an inductive–deductive approach, we developed a coding framework that integrated emerging themes with insights from the literature on crisis communication. Line-by-line coding was conducted to capture both explicit content and underlying meanings, with codes iteratively refined and grouped into broader themes and subthemes to identify patterns across hospitals. Coding continued until no new themes emerged, indicating thematic adequacy in line with *Guest et al. (2006)*. Themes were reviewed for internal coherence, merging overlapping categories and retaining divergent perspectives to reflect the heterogeneity of hospital experiences.

Data organisation and analysis were supported by MAXQDA, enabling systematic coding, theme development, and efficient data retrieval. Two researchers (ND, MF) independently coded the first five transcripts, compared and refined the initial codes in joint discussions, and resolved discrepancies through consensus. The remaining transcripts were coded using the agreed framework, with regular team meetings to ensure consistency and refine thematic development. These meetings also provided reflexive spaces to critically examine the influence of the team's disciplinary backgrounds—spanning health communication, public health, and qualitative research—on analysis and interpretation, thereby enhancing rigour and grounding findings in participants' accounts.

Results

A total of $N = 18$ hospital communication leaders—including seven directors, seven communication specialists, and four CEOs—participated in the study, providing a comprehensive view of hospital communication practices across Switzerland. Most participants were male ($n = 16$) and worked in the German-speaking part of Switzerland ($n = 11$), while six were based in the French-speaking region and one in the Italian-speaking region.

Our thematic analysis revealed that hospital communication during the pandemic evolved dynamically, with strategies continuously adapting to shifting priorities, needs, and constraints. Throughout the analysis, we identified recurring patterns that captured both the phases of communication over time and the specific challenges hospitals faced within each phase. These findings highlight how hospitals navigated operational demands, supported staff well-being, maintained public trust, and coordinated with stakeholders in a rapidly changing environment.

The patterns were grouped into four phases that reflect the temporal and operational evolution of communication: (I) Preparedness and early onset, (II) Peak of the first wave, (III) Stabilization, and (IV) Second wave and prolonged crisis. Within each phase, distinct challenges emerged, alongside the strategies hospitals developed to address them. *Table 1* provides an overview of these challenges and corresponding strategies.

Phase I: preparedness and early onset

In the initial phase of the pandemic, Swiss hospitals faced significant uncertainty as they transitioned from routine operations to crisis communication. Preparing for an escalating emergency required

TABLE 1 Overview of communication challenges and strategies, by pandemic phase.

Phase	Communication challenges	Strategies
Phase I: preparedness and early onset	Activating internal communication in crisis	Establishment of communication loops
		Proactive updates
		Communication consistency
	Coordinating external communication with authorities	Federally directed messaging
		Cantonal collaboration
		Role definition and clarity
Phase II: peak of first wave	Crisis leadership and strategic messaging	Leadership visibility
		Consistent messaging
		Emotional support in messaging
	Ensuring employee information and support	Hotline implementation
		FAQs and centralized documents
		Psychological support initiatives
	Managing media relations and public messaging	Science-based messaging
		Handling media pressure
		Positive public engagement
Phase III: stabilization	Strategic pause: avoiding information overload	Reducing message frequency
		Internal debriefing and feedback loops
	Refining emergency communication protocols	Documentation of processes
		Simulation exercises
Phase IV: second wave and prolonged crisis	Sustaining employee engagement	Video messaging
		Recognition campaigns
	Maintaining transparency and public reassurance	Coordination with cantonal authorities
		Regular situation reports
	Optimizing digital communication and information flow	Use of intranet and mobile apps
		Educational content and training videos

swift action to establish internal cohesion, align with external authorities, and build public trust. Illustrative quotes for the strategies within each communication challenge are presented in [Table 2](#).

Challenge 1: activating internal communication in crisis

From the very beginning of the pandemic, hospitals had to shift rapidly from routine to crisis communication, ensuring that staff remained informed and prepared. Many described setting up structured communication loops almost immediately, with dedicated task forces, regular briefings, and internal email updates to streamline information flow. As one hospital director explained, “*We quickly established an internal email communication system called ‘Voice of Corona.’ These emails, sent regularly starting February 22nd, provided updates on the pandemic and our hospital’s response*” (H3, Female, DIR, CH-DE). These efforts not only reassured staff but also played a key role in maintaining trust and keeping operations running smoothly during an uncertain time.

Challenge 2: coordinating external communication with authorities

Hospitals worked closely with cantonal and federal authorities to ensure that communication was aligned and consistent across different

levels of governance. Many described a structured collaboration with regional authorities, where regular meetings helped synchronize policies and avoid contradictory messaging. As one communication lead explained, “*We worked to align our messaging with the canton whenever possible. Aligning did not mean repeating the same messages, but rather ensuring that we did not issue contradictory statements. On sensitive issues, we coordinated closely to maintain a unified public health message for the population*” (H16, Male, COM, CH-FR). While federal messaging provided a foundation for public communication, hospitals adapted materials to their local context and maintained clarity in roles—focusing on internal updates and operational implementation while broader public health messaging remained with cantonal and federal agencies. This balance reduced confusion, strengthened public trust, and allowed staff to concentrate on patient care rather than navigating policy debates.

Phase II: peak of the first wave

The first wave of COVID-19 presented unprecedented challenges, with hospitals managing a surge in cases while intensifying communication efforts. Maintaining clarity, morale, and public trust became critical as institutions operated under immense pressure.

TABLE 2 Phase I: preparedness and early onset—communication challenges, strategies and illustrative quotes.

Communication challenge	Strategy	Illustrative quotes
Activating internal communication in crisis	Establishment of communication loops	<i>“We quickly established an internal email communication system called ‘Voice of Corona.’ These emails, sent regularly starting February 22nd, provided updates on the pandemic and our hospital’s response.”</i> (H3, Female, DIR, CH-DE)
		<i>“From the start, internal communication was rapid and structured. We actively supported it with initiatives like a weekly town hall meeting, where the entire hospital team was updated on key developments.”</i> (H4, Male, CEO, CH-DE)
		<i>“We formed a task force that met regularly—at least once a week, sometimes more often. In the early phases, we even met up to three times a week for 15 to 30 min to ensure swift decision-making and communication.”</i> (H9, Male, CEO, CH-DE)
	Proactive updates	<i>“Immediately after the first recorded COVID case in Switzerland, we launched a patient process, including a dedicated Covid Hotline, ensuring swift access to information and guidance.”</i> (H4, Male, CEO, CH-DE)
		<i>“To address the rapid influx of questions, we quickly developed a FAQ document covering all key areas. In the early stages, our task force met daily to discuss new concerns and update protocols accordingly.”</i> (H2, Male, COM, CH-DE)
		<i>“Recognizing the urgency of the situation, we promptly set up a COVID Task Force. Comprising around ten people—including doctors and nurses—the team met frequently to assess the evolving situation and implement necessary measures.”</i> (H6, Male, CEO, CH-DE)
	Communication consistency	<i>“We realized the importance of maintaining consistency in communication. With our consent, updates from our hospital were shared with others via the cantonal hospital network. Hospitals even adjusted their own task force meetings to align with our daily updates at 1:00–1:30 PM.”</i> (H2, Male, COM, CH-DE)
		<i>“Throughout the crisis, we held regular briefings—sometimes daily—especially during critical phases such as the early pandemic response and major reorganizations. This ensured all staff received up-to-date and accurate information.”</i> (H12, Male, COM, CH-FR)
		<i>“To manage the overwhelming demand for communication, we implemented a structured plan. We strengthened our media team, expanded our internal communication channels, and reassigned editors to focus solely on drafting messages for staff and the public.”</i> (H18, Male, COM, CH-FR)
Coordinating external communication with authorities	Federally directed messaging	<i>“For posters and communication materials, we largely used the content provided by the federal government. However, we sometimes adapted it by adding specific information relevant to our hospital. For instance, we created leaflets to inform ambulatory patients about symptoms they should check before entering the hospital. This allowed us to maintain consistency with federal messaging while tailoring it to our needs.”</i> (H11, Male, COM, CH-FR)
		<i>“At the cantonal level, we were highly involved. My chief medical officer participated in the governing council’s weekly updates for a period, which I greatly appreciated. I even highlighted this in our annual report. In a small canton like ours, collaboration is essential, and we leveraged that strength. However, at the federal level, we had much less influence, and coordination was more challenging.”</i> (H9, Male, CEO, CH-DE)
		<i>“We focused our external communication on critical moments of the crisis. Otherwise, we refrained from duplicating information already being shared at the cantonal and federal levels to avoid confusion.”</i> (H11, Male, COM, CH-FR)
	Cantonal collaboration	<i>“Our exchange with the canton was crucial because, as the regulatory authority, the canton made key decisions on health measures. The collaboration was productive and became more structured over time, ensuring that important questions were addressed systematically.”</i> (H3, Female, DIR, CH-DE)
		<i>“We worked to align our messaging with the canton whenever possible. Aligning did not mean repeating the same messages, but rather ensuring that we did not issue contradictory statements. On sensitive issues, we coordinated closely to maintain a unified public health message for the population.”</i> (H16, Male, COM, CH-FR)
	Role definition and clarity	<i>“Each institution played a distinct role in the pandemic. The hospital had a communicative role, the FOPH managed national guidelines, and the canton implemented regional measures. Understanding these roles was key to effective communication and coordination.”</i> (H9, Male, CEO, CH-DE)
		<i>“Hospitals naturally collaborate on a medical level—doctor to doctor, team to team—regardless of federal regulations. The federal government attempted to formalize certain structures, even though many of these collaborative processes already functioned effectively on an informal basis.”</i> (H3, Female, DIR, CH-DE)
		<i>“We had to be clear about our role: we were not responsible for assessing or commenting on policy measures. While we were involved in the cantonal task force and provided input during planning, our primary responsibility was to implement the measures decided upon. We deliberately avoided engaging in public debates on political decisions.”</i> (H1, Male, COM, CH-DE)

COM: Responsible for communication; DIR: Hospital director; CEO: CEO of the hospital. CH-DE: German-speaking part of Switzerland; CH-FR: French-speaking part of Switzerland; CH-IT: Italian-speaking part of Switzerland.

Illustrative quotes for the strategies within each communication challenge are presented in [Table 3](#).

Challenge 3: crisis leadership and strategic messaging

Leadership played a critical role in maintaining stability and trust during the crisis, with many emphasizing that visibility and clear communication were essential for effective crisis management. Hospital leaders described making a deliberate effort to be present—walking through hospital corridors, speaking directly with staff, and ensuring that employees felt supported amidst uncertainty. As one director noted, *“When I walk through the corridors of the hospital, people are grateful and feel they have a CEO who was with them. Leadership worked alongside them, and this strengthened the connection between employees and management”* (H15, Male, DIR, CH-FR). Structured and consistent messaging was also seen as key to maintaining confidence, with many opting for scheduled updates that provided staff with a clear assessment of the situation and an outlook on what to expect. This helped to prevent information overload while ensuring clarity in rapidly changing circumstances. At the same time, leaders recognized that communication was not only about information but also emotional support—messages were framed to reinforce a sense of teamwork, solidarity, and reassurance, helping to sustain morale throughout the crisis. By balancing visible leadership, structured messaging, and emotional reassurance, hospitals were able to foster a sense of trust and collective resilience during one of the most challenging periods in healthcare.

Challenge 4: ensuring employee information and support

Ensuring that staff had access to reliable information and emotional support was a top priority for hospitals throughout the pandemic. Many institutions quickly set up hotlines to address employee concerns, repurposing mediation offices to handle inquiries and alleviate the burden on medical teams. As one communication lead recalled, *“The first thing I did was set up a hotline... repurposing mediators to manage the internal hotline, providing support for employees who were panicked or had concerns, for example, about vulnerable family members”* (H18, Male, COM, CH-FR). This direct communication approach reassured staff and allowed them to receive timely responses to urgent questions. Hospitals also created centralized FAQ documents and online platforms, where employees could regularly access updated protocols, hygiene guidelines, and supply stock reports. This transparency helped build trust and ensured that messaging remained consistent across all levels of the institution. Beyond logistical support, hospitals also recognized the emotional strain on their workforce and actively promoted psychological support initiatives, reinforcing that staff were not alone in navigating the crisis. Leaders emphasized that communication needed to go beyond operational updates—it had to provide reassurance, validation, and a sense of solidarity. By combining practical information with emotional support, hospitals were able to foster a more resilient and informed workforce during an exceptionally challenging period.

Challenge 5: managing media relations and public messaging

Hospitals played a crucial role in shaping public discourse during the pandemic, balancing science-based messaging, media scrutiny, and proactive public engagement. Many institutions emphasized the

need to uphold evidence-based communication, ensuring that all public statements were aligned with federal and cantonal guidelines, as well as international professional organizations. As one communication lead explained, *“We committed to evidence-based communication [...] We only communicated what had stable evidence and refused to engage in speculation or misinformation, such as claims that vaccines contained microchips”* (H10, Male, DIR, CH-DE). At the same time, hospitals had to navigate intense media pressure, as scientific debates—normally confined to expert circles—were suddenly amplified in the public sphere. Some interviewees highlighted how misinterpretations of data and sensationalized headlines fueled confusion, while increased visibility led to criticism, particularly from COVID skeptics. Despite these challenges, hospitals also saw opportunities for positive public engagement, using social media, storytelling, and direct collaboration with journalists to position themselves as trusted sources of health information. By combining rigorous fact-checking, strategic media management, and proactive community outreach, hospitals reinforced public trust while countering misinformation during a time of heightened uncertainty.

Phase III: stabilization

As cases declined during the summer after the first pandemic wave, hospitals shifted their focus to reflection and preparation. This phase allowed institutions to evaluate past strategies, reduce communication intensity, and strengthen their readiness for potential future waves. Illustrative quotes for the strategies within each communication challenge are presented in [Table 4](#).

Challenge 6: strategic pause: avoiding information overload

As the pandemic progressed, hospitals recognized the need to reduce communication frequency and shift toward a more strategic approach. Initially, frequent updates were essential, but over time, staff became overwhelmed by the sheer volume of information. Many institutions deliberately slowed down their messaging, focusing only on critical updates and transitioning from daily to less frequent reports to ensure clarity without creating unnecessary noise. As one director reflected, *“The frequency is decreasing a bit now. Little by little, we noticed that we had to communicate immediately when necessary, but then we had to take a step back. There was too much information, and that became a big problem”* (H14, Male, DIR, CH-FR). Beyond adjusting communication frequency, hospitals also engaged in internal debriefing and feedback loops to reflect on their crisis response. Several institutions conducted evaluations, reviewing staff perceptions of communication efforts and identifying key areas for improvement. These reflections led to practical adjustments, such as restructuring daily meetings, refining message sequencing, and addressing confusion surrounding frequently changing protocols. The shift toward intentional, well-paced communication and structured reflection allowed hospitals to move from reactive crisis management to a more sustainable long-term strategy.

Challenge 7: refining emergency communication protocols

The pandemic highlighted the need for hospitals to formalize and refine emergency protocols, ensuring that lessons learned from the crisis were integrated into long-term preparedness strategies. Many institutions

TABLE 3 Phase II: peak of first wave—communication challenges, strategies and illustrative quotes.

Communication challenge	Strategy	Illustrative quotes
Crisis leadership and strategic messaging	Leadership visibility	<i>“For me, leadership in times of crisis means communication is key. People need someone to stand up, to say what is happening, where we are headed, and what is expected. It does not need to be 100% correct, but it must be clear and precise. People need to see leadership to trust it.”</i> (H6, Male, CEO, CH-DE)
		<i>“In terms of leadership, it was extremely important for me to personally communicate updates. I would walk through the hospital, speak with employees, and make sure they felt supported. I believe this visibility helped maintain morale and trust.”</i> (H3, Female, DIR, CH-DE)
		<i>“When I walk through the corridors of the hospital, people are grateful and feel they have a CEO who was with them. Leadership worked alongside them, and this strengthened the connection between employees and management.”</i> (H15, Male, DIR, CH-FR)
	Consistent messaging	<i>“We made a point to ensure that our communication was structured and reliable. Every two weeks, I personally sent out a written update with an assessment of the situation and an outlook. People want to know what to expect, and consistency builds confidence.”</i> (H6, Male, CEO, CH-DE)
		<i>“We had to maintain a balance—communicating as little as possible but as much as necessary. People were overwhelmed with rules, so we focused on clear, simple, and repetitive messaging to ensure understanding.”</i> (H2, Male, COM, CH-DE)
		<i>“Our hospital consistently aligned messaging with the canton. That does not mean saying the same thing, but it ensures no contradictions. When dealing with sensitive topics, a uniform voice is essential to prevent confusion.”</i> (H6, Male, CEO, CH-DE)
	Emotional support in messaging	<i>“At the internal level, communication wasn’t just about providing information—it was also about giving reassurance. Messages emphasized that we are a team, that we will get through this together. This leadership aspect was essential for keeping morale up.”</i> (H15, Male, DIR, CH-FR)
		<i>“We always tried to make our processes as simple and transparent as possible. People need to feel safe, supported, and reassured that the hospital is there for them. That was a core principle of our communication.”</i> (H9, Male, CEO, CH-DE)
Ensuring employee information and support	Hotline implementation	<i>“The first thing I did was set up a hotline. We have an office attached to our communication department where mediators usually handle patient concerns. We repurposed these mediators to manage the internal hotline, providing support for employees who were panicked or had concerns, for example, about vulnerable family members. This allowed our medical teams to focus on patient care while ensuring staff received timely answers.”</i> (H18, Male, COM, CH-FR)
		<i>“On the phone hotline, how to communicate properly—these were new employees. I sat right down there, and we did it together. The direct way is the best way.”</i> (H9, Male, CEO, CH-DE)
	FAQs and centralized documents	<i>“From the very beginning, we maintained a dedicated sub-website where all the latest information was shared. The number of visits was extremely high, with thousands of staff regularly accessing it for up-to-date guidelines, hygiene protocols, and visitor regulations.”</i> (H4, Male, CEO, CH-DE)
		<i>“We set up a shared FAQ document where all standard responses were compiled. If a question arose—like about Remdesivir—we would consult with our medical experts, record their response, and update the document. This ensured that all staff and social media responses remained aligned and factually accurate.”</i> (H16, Male, COM, CH-FR)
		<i>“We provided employees with regular updates on the status of our stock, including masks, gowns, and equipment. Transparency was key in reassuring staff that supplies were being managed effectively.”</i> (H11, Male, COM, CH-FR)
	Psychological support initiatives	<i>“Given the intense pressure on healthcare workers, we actively promoted psychological support services within the hospital, reminding staff that resources were available and accessible.”</i> (H12, Male, COM, CH-FR)
		<i>“At key points, our messaging was not just about logistics—it was about emotional reassurance. We reminded employees that they were not alone in facing the crisis and that leadership was there to support them.”</i> (H15, Male, DIR, CH-FR)

(Continued)

TABLE 3 (Continued)

Communication challenge	Strategy	Illustrative quotes
Managing media relations and public messaging	Science-based messaging	<i>“Remdesivir or Hydroxychloroquine—we had to hold the line and stay on a science-based approach. That’s why the Group Guidelines doctors within the group were used extensively to give us feedback to determine what we could say and what we could not. We reinforced this process to ensure our communication was fact-based and avoided polemics.”</i> (H16, Male, COM, CH-FR)
		<i>“We committed to evidence-based communication. We followed the guidelines from the federal government and canton, as well as multinational professional societies like WHO, ECVC, or CDC. We only communicated what had stable evidence. We refused to engage in speculation or misinformation, such as claims that vaccines contained microchips.”</i> (H10, Male, DIR, CH-DE)
		<i>“In a university hospital, you cannot just say anything. Some of our doctors took a stance on treatments, which led to public criticism. We had to balance transparency with credibility, ensuring that we provided only scientifically backed information while protecting staff from attacks.”</i> (H15, Male, DIR, CH-FR)
	Handling media pressure	<i>“We have an open media strategy—nothing to hide. However, in the early days, we wished for more transparency in national-level planning. The media often focused on controversy rather than the practical aspects of hospital operations. We had to manage this by clearly communicating our resource constraints and pandemic response efforts.”</i> (H8, Male, DIR, CH-DE)
		<i>“Different interpretations of the same data, generalized interpretations—this created a lot of confusion. The scientific debate that usually takes place within expert circles was suddenly mediatized. One classic example is when the conclusions of a study became a newspaper headline, while the actual study states that more research is needed to confirm observations.”</i> (H17, Male, DIR, CH-IT)
		<i>“Our infectiologists frequently appeared in the media, reinforcing our expertise. However, increased visibility also led to criticism, particularly from COVID skeptics. We had to navigate negative reviews and misinformation campaigns on social media while maintaining our focus on professional, fact-based communication.”</i> (H5, Male, COM, CH-DE)
	Positive public engagement	<i>“We engaged with the public by leveraging social media and storytelling. During the first wave, we created a video where hospital staff clapped to thank the community for their support. This strengthened the connection between the hospital and the public.”</i> (H3, Female, DIR, CH-DE)
		<i>“Recognizing the increased public interest in scientific news, we saw an opportunity to work more closely with journalists. The demand for reliable health journalism grew, and we positioned ourselves as a trusted source by providing regular, transparent updates.”</i> (H16, Male, COM, CH-FR)
		<i>“As part of our outreach efforts, we produced clear, positive messages on public safety. We reassured people that our COVID wards were completely separate from other hospital areas and encouraged them to seek medical care without fear.”</i> (H5, Male, COM, CH-DE)

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acknowledged that in the early stages of the pandemic, decisions were often made rapidly without comprehensive documentation. As one communications lead explained, *“In the first wave, a lot of decisions were made rapidly without formal documentation. By the second wave, we ensured that all measures, from staff reallocations to new isolation procedures, were systematically documented for future reference”* (H2, Male, COM, CH-DE). Alongside this, several hospitals emphasized the value of simulation exercises, which had been conducted prior to the pandemic to test crisis communication and emergency coordination. These drills provided a structured environment to identify procedural gaps, refine response strategies, and improve the usability of internal communication tools. The experience of COVID-19 reinforced the necessity of these preemptive training efforts and real-time

documentation, ensuring that future crisis management would be more structured, evidence-based, and seamlessly executed.

Phase IV: second wave and prolonged crisis

The second wave brought sustained challenges, but hospitals applied lessons from the first wave to implement more structured and effective communication strategies. Focus shifted to supporting staff resilience, fostering transparency, and optimizing digital tools. Illustrative quotes for the strategies within each communication challenge are presented in [Table 5](#).

TABLE 4 Phase III: stabilization—communication challenges, strategies and illustrative quotes.

Communication challenge	Strategy	Illustrative quotes
Strategic pause: avoiding information overload	Reducing message frequency	<i>“The frequency is decreasing a bit now. Little by little, we noticed that we had to communicate immediately when necessary, but then we had to take a step back. There was too much information, and that became a big problem. At some point, we felt the need to slow down.”</i> (H14, Male, DIR, CH-FR)
		<i>“We realized that sometimes not communicating is actually better. Right now, there is almost more need for silence than for daily communication. We focused only on what was absolutely necessary.”</i> (H14, Male, DIR, CH-FR)
		<i>“After the summer, we reduced the frequency of internal updates to avoid overwhelming staff with too many messages. Instead of daily reports, we moved to bi-weekly updates to ensure employees received only the most relevant information.”</i> (H15, Male, DIR, CH-FR)
	Internal debriefing and feedback loops	<i>“We also did a debriefing with the communications team in June. We reviewed the results of a survey on how employees perceived the communication, and we held a full morning meeting to discuss our experiences during the first phase of the pandemic. It was almost like a post-traumatic debriefing, helping us understand what worked and what needed improvement.”</i> (H18, Male, COM, CH-FR)
		<i>“After the first wave, we conducted an evaluation to assess what had worked, what had not, and where improvements were needed. We applied these lessons to the second wave. One key adjustment was changing the sequence of daily meetings and introducing a structured newsletter to improve communication. Another major improvement was addressing staff concerns about frequently changing protection measures, which had caused confusion during the first wave.”</i> (H17, Male, DIR, CH-IT)
Refining emergency communication protocols	Documentation of processes	<i>“In the first wave, a lot of decisions were made rapidly without formal documentation. By the second wave, we ensured that all measures, from staff reallocations to new isolation procedures, were systematically documented for future reference.”</i> (H2, Male, COM, CH-DE)
		<i>“We strengthened documentation processes to ensure that the information we shared was reliable and evidence-based. Every communication, both internal and external, was carefully reviewed by medical specialists before being published.”</i> (H16, Male, COM, CH-FR)
	Simulation exercises	<i>“We had already done exercises, like crisis communication simulations. Fortunately, we have a very practical intranet tool that allowed us to quickly display and update information during these drills [...] For one exercise, we simulated a major crisis scenario and assembled a task force to test how we would communicate, react, and coordinate emergency services. It allowed us to identify gaps in our procedures before a real crisis hit.”</i> (H11, Male, COM, CH-FR)

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Challenge 8: sustaining employee engagement

As the pandemic extended into the second wave, hospitals recognized the need for long-term strategies to maintain employee engagement and morale. Leadership adapted their communication approach, for instance by making video messaging a regular practice, shifting from sporadic updates to scheduled messages that provided staff with a sense of continuity. As one hospital leader explained, *“Video messages and internal communication were once just for the boss, we very rarely made videos. Today a video message from me or other managers has become an important and extremely valued means of communication for the employees”* (H4, Male, CEO, CH-DE). While video updates became less frequent during the summer lull, they resumed in the second wave, reinforcing leadership visibility at a time when staff fatigue was growing. Beyond digital engagement, hospital leaders emphasized in-person presence, walking through COVID units daily to demonstrate support and strengthen connections with employees. At the same time, hospitals expanded recognition campaigns to sustain motivation, using social media to highlight staff efforts, sharing personal stories from COVID wards, and organizing morale-boosting initiatives, such as gratitude videos and lighthearted content. These sustained efforts helped foster a sense of belonging

and resilience, ensuring that employees remained engaged despite the prolonged crisis.

Challenge 9: maintaining transparency and public reassurance

As the pandemic entered its second wave, hospitals reinforced transparent communication strategies to maintain trust with both employees and the public. Close coordination with cantonal authorities became even more structured, with weekly meetings ensuring hospitals remained aligned with public health policies. As one director noted, *“The canton has organized a regular exchange, once a week, with all clinics and hospitals in the canton. Because we are the largest, we played a major role. The main thing was to keep the others informed and to pass on the information to them”* (H6, Male, CEO, CH-DE). Hospitals that served as dedicated COVID centers were in direct and frequent contact with government officials, working to clarify evolving policies and avoid conflicting messages. Internally, the need for regular situation reports persisted, as employees—especially those in overwhelmed COVID units—relied on structured updates to navigate shifting protocols and workload demands. Unlike the first wave, where communication

TABLE 5 Phase IV: second wave and prolonged crisis—communication challenges, strategies and illustrative quotes.

Communication challenge	Strategy	Illustrative quotes
Sustaining employee engagement	Video messaging	<i>“Video messages and internal communication were once just for the boss, we very rarely made videos, we used them very sparingly. Today a video message from me or other managers has become an important and extremely valued means of communication for the employees. In the first wave, it was almost weekly, then it became less frequent. In the summer, it was more like once a month. Then in October, with the second wave, it started again.”</i> (H4, Male, CEO, CH-DE)
		<i>“Clearly, to reach as many people as possible, because we are 14,000 employees, that was the goal. But beyond video messaging, I also made sure to be visible—walking through the COVID units for two to three hours a day, every day, including weekends, so people saw leadership in action.”</i> (H15, Male, DIR, CH-FR)
	Recognition campaigns	<i>“We created a campaign to recognize frontline staff. One of the most well-received initiatives was a video of caregivers clapping to thank the public for their support, which was widely shared on social media [...] At the end of the year, we invited a comedian to make a humorous video for staff, bringing some relief and laughter to a very difficult year. The aim was to boost morale and show appreciation for the employees’ efforts.”</i> (H15, Male, DIR, CH-FR)
		<i>“During the pandemic, we significantly increased our social media presence to highlight staff efforts. We showcased personal stories, shared photos from the COVID wards, and used platforms like Instagram to raise awareness and engage both employees and the public.”</i> (H12, Male, COM, CH-FR)
Maintaining transparency and public reassurance	Coordination with cantonal authorities	<i>“The canton has organized a regular exchange, once a week, with all clinics and hospitals in the canton. Because we are the largest, we played a major role. The main thing was to keep the others informed and to pass on the information to them.”</i> (H6, Male, CEO, CH-DE)
		<i>“With the canton and especially the DGS and then the Minister of Health, there were a lot of things that were in connection with the fact that we were the only COVID hospital. There were a lot of things that were directly linked to the DGS, so for me, that was really the main link.”</i> (H16, Male, COM, CH-FR)
		<i>“Secondly, the cantonal doctor, the services of the cantonal doctor, and the State Councillor—we met extremely regularly to avoid divergent communication. The cantonal authorities played an important role in informing the population, and they still do. There is a weekly press conference at the cantonal level.”</i> (H15, Male, DIR, CH-FR)
	Regular situation reports	<i>“We did a systematic report and then we always said that if it does not go well and the township issues its decree, and if the situation gets worse, we will close them. This helped maintain transparency and provided a structured way to keep authorities updated.”</i> (H14, Male, DIR, CH-FR)
<i>“At the internal level, employees needed to know where we were because those in the COVID departments often felt overwhelmed. So we regularly provided information on the situation, work guidelines, protocols, and other essential details.”</i> (H11, Male, COM, CH-FR)		
Optimizing digital communication and information flow	Use of intranet and mobile apps	<i>“We have an internal information application called ‘Connect,’ which functions as a corporate social network with a news feed, chat, e-learning functions, and document storage. It was deployed in 2018 but became fully integrated into our hospital in September 2020. During the first wave, not all employees had access, but now we use it as our primary communication tool, replacing email [...]The main advantage of the app is that it allows staff to access updates from their mobile phones, which was not possible with our intranet. Caregivers, who are rarely in front of a computer, found this particularly useful.”</i> (H12, Male, COM, CH-FR)
		<i>“Internally, we primarily used the intranet, where we created a dedicated COVID page with the latest regulations, guidelines, and ethical considerations. Additionally, at the end of the second wave, we launched an internal social network similar to WhatsApp but more secure, called ‘ChatHUG.’”</i> (H16, Male, COM, CH-FR)
	Educational content and training videos	<i>“At the beginning of the pandemic, there was an enormous need for training on protective materials. We produced videos on how to wear and remove protective gear properly, and these were made available internally. We also shared them with smaller hospitals that lacked the resources to create such materials [...]We developed a structured repository with Q&A and educational videos to help staff navigate the rapidly evolving guidelines. These included explanations of hospital hygiene measures, visitor regulations, and screening protocols.”</i> (H13, Female, COM, CH-DE)
		<i>“For external engagement, we created short educational videos featuring our medical experts answering public health questions, such as ‘Can I still eat fondue without risk of infection?’ These were well received, as they addressed real concerns in an accessible way.”</i> (H12, Male, COM, CH-FR)

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was often reactive, the second wave saw hospitals refining their information flow, ensuring that updates were more targeted and strategic. By maintaining open exchanges with authorities and

structured internal briefings, hospitals helped stabilize communication in a prolonged crisis phase, reinforcing both staff confidence and public reassurance.

Challenge 10: optimizing digital communication and information flow

During the second wave, hospitals further expanded digital communication tools to address the ongoing need for efficient information dissemination. Many institutions transitioned from email-based updates to mobile apps and intranet platforms, making it easier for frontline staff to access real-time information. As one communications manager explained, “*We have an internal information application called ‘Connect,’ which functions as a corporate social network with a news feed, chat, e-learning functions, and document storage [...] The main advantage of the app is that it allows staff to access updates from their mobile phones, which was not possible with our intranet. Caregivers, who are rarely in front of a computer, found this particularly useful*” (H12, Male, COM, CH-FR). Unlike the first wave, where digital systems were sometimes underutilized, by the second wave, dedicated apps and intranet pages became primary communication hubs, allowing caregivers to stay updated without relying on desktop access. The demand for educational content and training videos also persisted, prompting hospitals to refine their structured repositories with instructional materials on protective equipment, hygiene protocols, and evolving visitor policies. Beyond internal use, hospitals leveraged digital tools for external public engagement, creating expert-led videos that addressed everyday concerns and provided evidence-based health information. This shift toward integrated digital strategies during the second wave ensured that communication remained efficient, accessible, and responsive to the prolonged nature of the crisis.

Discussion

The COVID-19 pandemic placed unprecedented demands on healthcare systems, underscoring the critical role of effective crisis communication. This study explored how Swiss hospitals navigated these challenges, identifying key strategies, obstacles, and lessons that can inform future preparedness efforts. Our findings show that hospital communication evolved dynamically, with strategies adapting to the rapidly changing conditions of the pandemic. When mapped against the classic stages of crisis communication—preparation, response, and aftermath (Reynolds and Seeger, 2005)—our phase-based findings reveal a more fluid and iterative process. The early phase reflected elements of preparedness, with hospitals rapidly mobilizing taskforces, developing protocols, and aligning messaging with federal and cantonal directives to ensure internal cohesion. During the acute response of the first wave, communication intensified and external engagement became central, with leadership visibility, science-based messaging, and efforts to counter misinformation playing a pivotal role. At the same time, recognition campaigns supported staff morale and fostered community solidarity. As the situation stabilized in the summer, hospitals entered a phase of reflection and recalibration, corresponding only partially to the “aftermath” phase in traditional models. Internal debriefings, documentation, and simulation exercises enabled hospitals to assess gaps and refine protocols, while adjusting communication frequency to prevent information fatigue. During the prolonged crisis phase of the second wave, communication became more structured and digitally supported, with tools such as intranet platforms and mobile apps used to deliver real-time updates, disseminate training materials,

and maintain engagement, particularly with non-desk staff. These findings highlight that while established frameworks provided a valuable foundation, the prolonged and unpredictable nature of the pandemic required continuous adaptation, iteration, and the integration of digital solutions beyond the linear progression of classic models.

Our findings extend existing frameworks by showing that hospital communication during COVID-19 did not follow a strictly linear path. Traditional models, such as the Crisis and Emergency Risk Communication framework (Reynolds and Seeger, 2005) and the WHO pandemic phases (WHO, 2009), offer a valuable foundation but assume a clear sequence of preparation, response, and recovery. By contrast, our phase-based analysis reveals a more adaptive and iterative process, where hospitals moved fluidly between immediate crisis management, structured reflection, and the integration of digital tools as the situation evolved. This phase-emergent, experience-driven approach adds a novel layer of understanding to crisis communication, underscoring the importance of flexibility in navigating prolonged and complex emergencies. These dynamics also reflect principles of organisational resilience (Paton and Johnston, 2017), highlighting how continuous learning and adjustment supported hospitals under sustained pressure. Moreover, the emphasis on leadership visibility, role clarity, and the maintenance of trust aligns with Situational Crisis Communication Theory (Coombs, 2007), but demonstrates how these principles were contextually adapted to the realities of a rapidly evolving health crisis.

Finally, our findings reinforce the dual importance of internal and external communication across different phases of a prolonged emergency (Reynolds and Seeger, 2005). Early in the crisis, internal cohesion and alignment were critical for operational stability, whereas later phases required strong public messaging to sustain transparency and accountability. These insights suggest that effective crisis communication requires not only relevant content and timing but also the ability to adjust strategies over time—supporting both short-term responsiveness and long-term resilience.

Implications for crisis preparedness and organisational practice

The communication challenges and related strategies described by hospital leaders offer valuable insights that can inform efforts to enhance crisis preparedness and organisational resilience, while recognising that their relevance may vary across contexts. First, the early formation of taskforces and structured communication loops was key to ensuring timely decision-making and operational coherence. These findings reinforce prior research emphasising the importance of predefined emergency communication frameworks and role clarity for effective crisis response (Adini et al., 2007; WHO, 2011). Hospitals should incorporate flexible yet formalised communication protocols into their emergency preparedness plans, including predefined chains of communication and delegation of spokesperson responsibilities. Regular simulation exercises and scenario-based training—shown to improve communication coordination and confidence under pressure (Baetzner et al., 2022)—can help test these protocols in advance.

Second, staff engagement emerged as a central concern, with hospitals recognising that maintaining morale and resilience required more than information flow. Consistent leadership visibility,

emotional reassurance, and recognition campaigns were described as critical in sustaining workforce motivation. These practices align with evidence from high-stress healthcare contexts showing that transparent communication, two-way feedback mechanisms, and visible leadership reduce psychological distress and foster institutional trust (Shanafelt and Noseworthy, 2017; Ahmed et al., 2020). Embedding staff support strategies—such as psychological first aid, structured debriefings, and digital mental health tools—into routine operations can mitigate burnout and strengthen long-term team cohesion (West et al., 2016; Gilmartin et al., 2017).

Third, the use of digital platforms—including mobile apps, intranet pages, and internal video messages—enabled timely communication across diverse staff groups, particularly those without desktop access. However, hospitals also reported the risk of information overload and disengagement. This tension underscores the need for carefully balanced digital strategies. As highlighted in the literature, frequency, clarity, and channel appropriateness are key to sustaining attention and avoiding fatigue (Mehta et al., 2020; Sellnow and Seeger, 2021). Hospitals should invest not only in digital infrastructure but also in digital communication governance—defining when, how often, and through which tools key messages are delivered.

Finally, public communication played a decisive role in shaping trust, institutional credibility, and adherence to public health measures. Hospitals that proactively engaged the media and addressed misinformation reported stronger alignment with public expectations. These insights align with studies emphasising that proactive, transparent, and science-based messaging is critical to maintaining public trust during prolonged crises (Merchant and Lurie, 2020; Vraga and Bode, 2021). Integrating public communication strategies into crisis plans—such as by designating media-trained experts, pre-preparing templates, and monitoring public sentiment through social listening tools—can help healthcare institutions build trust capital before and during a crisis.

Limitations

This study has several limitations to consider. First, data were collected from a limited number of hospitals in Switzerland, predominantly in the German-speaking part, which may not fully capture the diversity of communication strategies used in other regions or healthcare systems. Additionally, while qualitative interviews provide detailed insights, they may introduce bias due to participants' recall or social desirability, potentially leading some to emphasize positive aspects over challenges. However, the structured design of the interviews helped mitigate recall bias by clearly distinguishing between different phases, allowing for more robust and reliable data collection. The focus on hospitals during the unprecedented COVID-19 pandemic may also limit transferability of our findings to other types of crises. Moreover, our findings are largely descriptive and reflect only the perspective of hospital communication leads, meaning we cannot assess how messages were received or interpreted by staff, patients, or the public. Future research integrating the perspectives of message recipients is needed to provide a fuller understanding of communication effectiveness and impact. Additionally, interviews were conducted while the pandemic was still ongoing, which means some participants may have been in an acute crisis mindset, potentially limiting their ability to critically or retrospectively reflect on their experiences. Finally, although our sample covered all three linguistic

regions of Switzerland and a range of institutional types, the qualitative nature of our study does not allow to represent the full diversity of Swiss hospitals in a generalizable way.

Future studies that integrate multiple perspectives and use mixed methods could help validate these findings and quantitatively assess the effectiveness of specific communication strategies on outcomes such as staff well-being, public trust, and operational efficiency.

Conclusion

The COVID-19 pandemic was not only a test of medical and operational capacity, but also a defining moment for the role of communication in healthcare institutions. Swiss hospitals, operating under sustained pressure, faced the dual challenge of ensuring that information remained clear, timely, and actionable, while also supporting the emotional well-being of staff and sustaining public trust. While many institutions demonstrated remarkable adaptability, communication strategies varied in effectiveness and scope, revealing gaps in preparedness, coordination, and long-term engagement.

Our findings highlight both the achievements and persistent tensions within hospital-based crisis communication. Leadership visibility, structured messaging, and digital tools played a critical role in fostering trust and ensuring continuity. Yet even these strategies were not always sufficient to overcome information fatigue, decentralised governance dynamics, or staff burnout. Hospitals were often required to pivot rapidly—recalibrating message frequency, rethinking digital delivery channels, and re-engaging both internal and external audiences in the face of prolonged uncertainty.

This study reinforces the understanding that effective crisis communication extends well beyond information dissemination. It involves building infrastructures that support emotional resilience, two-way engagement, and institutional trust—both during acute phases and in the quieter moments in between. Communication systems must be agile enough to adapt to new challenges, but also grounded in pre-established principles and feedback mechanisms. The lessons emerging from this study point to the need for healthcare organisations to embed communication planning into emergency preparedness frameworks, invest in leadership and staff capacity, and integrate digital and public-facing strategies in a coordinated, intentional manner.

In this sense, crisis communication is not a reactive task but a continuous organisational function—central to resilience, recovery, and the capacity to serve both healthcare workers and the public during future emergencies.

Data availability statement

The original contributions presented in the study are included in the article/[Supplementary material](#), further inquiries can be directed to the corresponding author.

Ethics statement

The requirement of ethical approval was waived by Ethikkommission Nordwest- und Zentralschweiz (reference number EKNZ 2020-01306).

for the studies involving humans because the study falls outside the scope of the Human Research Act and complies with the Helsinki Declaration. Participants could withdraw from the study at any moment and were assured of confidentiality and the secure handling of data. Identifying details were anonymized in transcripts and reports to protect participant privacy. Recordings and transcripts were stored on encrypted devices and will be securely deleted after the study's completion. The studies were conducted in accordance with the local legislation and institutional requirements. Written informed consent for participation was not required from the participants or the participants' legal guardians/next of kin because the interviews were conducted via Zoom in accordance of the pandemic restrictions in place at the time. All participants provided oral informed consent prior to their participation.

Author contributions

ND: Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Writing – original draft, Writing – review & editing. MF: Formal analysis, Writing – original draft, Writing – review & editing. AO: Conceptualization, Data curation, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing. SR: Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Writing – original draft, Writing – review & editing.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Generative AI statement

The author(s) declare that Gen AI was used in the creation of this manuscript. The authors used OpenAI's ChatGPT to support language editing and formatting during the preparation of this manuscript. All intellectual content, analysis, and interpretation were developed by the authors, who take full responsibility for the final version of the manuscript.

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Supplementary material

The Supplementary material for this article can be found online at: <https://www.frontiersin.org/articles/10.3389/fcomm.2025.1672472/full#supplementary-material>

References

- Adini, B., Goldberg, A., Laor, D., Cohen, R., and Bar-Dayana, Y. (2007). Factors that may influence the preparation of standards of procedures for dealing with mass-casualty incidents. *Prehosp. Disaster Med.* 22, 175–180. doi: 10.1017/S1049023X00004611
- Ahmed, F., Zhao, F., and Faraz, N. A. (2020). How and when does inclusive leadership curb psychological distress during a crisis? Evidence from the COVID-19 outbreak. *Front. Psychol.* 11:1898. doi: 10.3389/fpsyg.2020.01898
- Baetzner, A. S., Wespi, R., Hill, Y., Gyllencreutz, L., Sauter, T. C., Saveman, B.-I., et al. (2022). Preparing medical first responders for crises: a systematic literature review of disaster training programs and their effectiveness. *Scand. J. Trauma Resusc. Emerg. Med.* 30:76. doi: 10.1186/s13049-022-01056-8
- Bloom, J. R., Martin, E. J., and Jones, J. A. (2021). Communication strategies during the COVID-19 pandemic: unforeseen opportunities and drawbacks., in *Seminars in Oncology*, (Elsevier), 292–294. Available online at: https://www.sciencedirect.com/science/article/pii/S0093775421000580?casa_token=a54EHNZiYd8AAAAA:Ex02ur7wr_FkCKVQHTD5QQXrSUuFhFAX8QShSjtAXfHVeRkbsjTC8rB8MwLdPxmGyuRr0 (Accessed January 30, 2025).
- Boes, S., Weissstanner, D., and Durvy, B. (2025). Health Systems in Action: Switzerland: 2024 edition. Available online at: <https://policycommons.net/artifacts/18086897/health-systems-in-action/18986408/> (Accessed August 21, 2025).
- Braun, V., and Clarke, V. (2006). Using thematic analysis in psychology. *Qual. Res. Psychol.* 3, 77–101. doi: 10.1191/1478088706qp0630a
- Cohen, D., and Crabtree, B. (2006). *Semi-structured interviews. Robert wood johnson foundation qualitative research guidelines project*. Retrieved July 15, 2025 from https://sswm.info/sites/default/files/reference_attachments/COHEN%202006%20Semistructured%20Interview.pdf.
- Coombs, W. T. (2007). Ongoing crisis communication: planning, managing, and responding. Sage. Available online at: <https://books.google.ch/books?hl=it&lr=&id=E3fQ8EraOTIC&oi=fnd&pg=PR9&dq=ngoing+crisis+communication:+Planning,+managing,+and+responding&ots=HeasuSPNNq&sig=JpiA-XYF3egKJL0jIXpBscB0kXI> (Accessed November 29, 2024).
- Ehrenzeller, S., Durovic, A., Kuehl, R., Martinez, A. E., Bielser, M., Battegay, M., et al. (2022). A qualitative study on safety perception among healthcare workers of a tertiary academic care center during the SARS-CoV-2 pandemic. *Antimicrob. Resist. Infect. Control* 11:30. doi: 10.1186/s13756-022-01068-0
- Finset, A. (2008). Qualitative methods in communication and patient education research. *Patient Educ Couns.* 73, 1–2.
- Gilmartin, H., Goyal, A., Hamati, M. C., Mann, J., Saint, S., and Chopra, V. (2017). Brief mindfulness practices for healthcare providers—a systematic literature review. *Am. J. Med.* 130:1219–e1. doi: 10.1016/j.amjmed.2017.05.041

- Grazioli, V. S., Tzartzas, K., Blaser, J., Graells, M., Schmutz, E., Petitgenet, I., et al. (2022). Risk perception related to COVID-19 and future affective responses among healthcare Workers in Switzerland: a mixed-methods longitudinal study. *Int. J. Public Health* 67:1604517. doi: 10.3389/ijph.2022.1604517
- Guest, G., Bunce, A., and Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods* 18, 59–82. doi: 10.1177/1525822X05279903
- Kennzahlen der Schweizer Spitäler (n.d.). Available online at: <https://www.bag.admin.ch/de/kennzahlen-der-schweizer-spitaeler> (Accessed August 21, 2025).
- Mehta, J., Yates, T., Smith, P., Henderson, D., Winteringham, G., and Burns, A. (2020). Rapid implementation of Microsoft teams in response to COVID-19: one acute healthcare organisation's experience. *BMJ Health Care Inform.* 27:e100209. doi: 10.1136/bmjhci-2020-100209
- Merchant, R. M., and Lurie, N. (2020). Social media and emergency preparedness in response to novel coronavirus. *JAMA* 323, 2011–2012. doi: 10.1001/jama.2020.4469
- Nowell, L. S., Norris, J. M., White, D. E., and Moules, N. J. (2017). Thematic analysis: striving to meet the trustworthiness criteria. *Int J Qual Methods* 16, 1–13. doi: 10.1177/1609406917733847
- Paakkari, L., and Okan, O. (2020). COVID-19: health literacy is an underestimated problem. *Lancet Public Health* 5, e249–e250. doi: 10.1016/S2468-2667(20)30086-4
- Paton, D., and Johnston, D. (2017). Disaster resilience: an integrated approach. Charles C Thomas Publisher. Available online at: <https://books.google.ch/books?hl=it&lr=&id=oZknDwAAQBAJ&oi=fnd&pg=PR5&dq=Disaster+Resilience:+An+Integrated+Approach.&ots=yFln6BX4MD&sig=BoNLTrsThccwwaAvOkhdsbMpzKs> (Accessed December 3, 2024).
- Reynolds, B., and Seeger, W. M. (2005). Crisis and emergency risk communication as an integrative model. *J. Health Commun.* 10, 43–55. doi: 10.1080/10810730590904571
- Rosenbäck, R., and Eriksson, K. M. (2024). COVID-19 healthcare success or failure? Crisis management explained by dynamic capabilities. *BMC Health Serv. Res.* 24:759. doi: 10.1186/s12913-024-11201-x
- Rosenbaum, L. (2020). The untold toll — the pandemic's effects on patients without Covid-19. *N. Engl. J. Med.* 382, 2368–2371. doi: 10.1056/NEJMms2009984
- Rubinelli, S., Häfliger, C., Fiordelli, M., Ort, A., and Diviani, N. (2023). Institutional crisis communication during the COVID-19 pandemic in Switzerland. A qualitative study of the experiences of representatives of public health organizations. *Patient Educ. Couns.* 114:107813. doi: 10.1016/j.pec.2023.107813
- Schlögl, M., Singler, K., Martinez-Velilla, N., Jan, S., Bischoff-Ferrari, H. A., Roller-Wirnsberger, R. E., et al. (2021). Communication during the COVID-19 pandemic: evaluation study on self-perceived competences and views of health care professionals. *Eur Geriatr Med* 12, 1181–1190. doi: 10.1007/s41999-021-00532-1
- Schumacher, L., Dhif, Y., Bonnabry, P., and Widmer, N. (2023). Managing the COVID-19 health crisis: a survey of Swiss hospital pharmacies. *BMC Health Serv. Res.* 23:1134. doi: 10.1186/s12913-023-10105-6
- Sellnow, T. L., and Seeger, M. W. (2021). *Theorizing crisis communication*. John Wiley & Sons. Available online at: <https://books.google.ch/books?hl=it&lr=&id=YGUQEAAQBAJ&oi=fnd&pg=PP9&dq=Theorizing+Crisis+Communication&ots=sVU1rdeGF3&sig=3g1eC2SxmHzZDhgWkDWac2WQMWs> (Accessed December 3, 2024).
- Shanafelt, T. D., and Noseworthy, J. H. (2017). Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout., in *Mayo Clin. Proc.*, (Elsevier), 129–146. Available online at: https://www.sciencedirect.com/science/article/pii/S0025619616306255?casa_token=vWc8cy0mHyYAAAAA:QbNanOy2LKlnhfonsAUNpOcNw99Vd800RBFnhO-DcdZOZWdavMYzs3UU4WZc6QF8BH4LpfKh2tl (Accessed December 3, 2024).
- Sturny, I. (2020). *International health care system profiles: Switzerland*. The Commonwealth Fund. Available at: <https://www.commonwealthfund.org/international-health-policy-center/countries/Switzerland> (Accessed July 15, 2025).
- Vraga, E. K., and Bode, L. (2021). Addressing COVID-19 misinformation on social media preemptively and responsively. *Emerg. Infect. Dis.* 27, 396–403. doi: 10.3201/eid2702.203139
- West, C. P., Dyrbye, L. N., Erwin, P. J., and Shanafelt, T. D. (2016). Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet* 388, 2272–2281. doi: 10.1016/S0140-6736(16)31279-X
- WHO (2009). “The WHO pandemic phases,” in *pandemic influenza preparedness and response: A WHO guidance document*, (World Health Organization). Available online at: <https://www.ncbi.nlm.nih.gov/books/NBK143061/> (Accessed February 18, 2025).
- WHO. (2011). “Hospital emergency response checklist: an all-hazards tool for hospital administrators and emergency managers,” In *hospital emergency response checklist: An all-hazards tool for hospital administrators and emergency managers*. Available online at: <https://pesquisa.bvsalud.org/portal/resource/pt/who-349374> (Accessed November 29, 2024).
- WHO. (2020). Pulse survey on continuity of essential health services during the COVID-19 pandemic: Interim report, 27 august 2020. World Health Organization. Available online at: https://apps.who.int/iris/bitstream/handle/10665/334048/WHO-2019-nCoV-EHS_continuity-survey-2020.1-eng.pdf (Accessed November 14, 2024).