

Narrative influences change: the COVID-19 experience

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COVID-19 is as much about the narrative as it is about the facts.

The way the pandemic evolves is mostly determined by human behaviour. Facts alone don't motivate humans into action, particularly in the face of limited data and uncertainty. That's why some provincial and federal public health medical officers (PHMOs) are connecting, not only with people's brains, but also with their hearts and emotions. Aimed at physician leaders who need to motivate the public at other levels of the Canadian health system, this short paper explains the importance of the narrative and how it can motivate Canadians to take action and change their behaviour.

We interpret the world in two ways: the analytic or knowledge part and the narrative or emotive part. The public's skepticism toward science and government means we can no longer just give facts and expect people to listen; the emotive part is more important than ever.

Figure 1. Use narrative to promote enabling emotions and motivate action



Our readiness and ability to act depend a lot on how we feel. During times of crisis and uncertainty, people experience emotions that inhibit the required action. However, using public narrative, leaders can engage others in purposeful action by tipping the balance from emotions that inhibit action to emotions that motivate action.

(Fig. 1). Source: Modified from Ganz Marshall 2011. Collective narrative, collective action and power. <https://dash.harvard.edu/handle/1/29314925>

Countering action inhibitors

Two major action inhibitors are inertia and apathy. We process most of the information that comes our way on "autopilot," and respond as "programmed." **Inertia** causes us to operate by habit and not pay attention because we think "it won't be that bad" or "this too shall pass." As a result, we may miss a pending threat and end up in real

trouble. In the current COVID-19 crisis, that happened in Italy and the United States. Apathy adds the feeling and belief that this doesn't pertain to us, that the problem is far away, in China or Vancouver.

We can counter inertia with urgency to capture attention and get commitment. Creating urgency is a matter of priority and timing: it is about what is happening tomorrow or next week, not what could happen next year. It is about today's shortage of personal protective equipment (PPE) or tomorrow's need for ICU beds. Removing any feeling of time latency or geographic distance helps create urgency. A sense of urgency is particularly important when new rules require commitment and intense effort.

Apathy can be countered with outrage over injustice. Outrage often grows from experiencing the contrast between the world as it is and what it ought to be – how we feel when our moral order has been violated. As Canadians, we are concerned for the weak and the physically, mentally, or socioeconomically disadvantaged. We also believe in universal health care. Failing to live up to those cultural values, as we did in long-term care facilities for example, should enrage us, because our Canadian society believes that inequity is unjust. Our values, moral traditions, and sense of personal dignity create emotions that motivate us to act. That's what we witnessed when Dr. Bonnie Henry, PHMO for British Columbia,* teared up while reporting the deaths of elderly patients in hospices.

*CSPL applauds all the provincial and federal public health medical officers and their teams. This bulletin uses examples from British Columbia, based solely on the geographic location of the author.

What can we do about **fear**? To act in the face of fear requires courage, and hope is an emotion that helps us find that courage. For many people, a source of hope is their belief in their personal values, cultural traditions, and moral understanding. Relationships offer another source of hope. Relationships, cultural traditions, and societal values are embedded in the COVID-19 slogans, “We are in this together” and “We have your back.”

The same slogans counter feelings of **isolation** by affirming solidarity. Fear creates silo thinking, a focus on “me” rather than “we,” on “us” versus “them.” It makes people hoard toilet paper. Developing relationships with people we hope to mobilize or with people who are in the same predicament as us creates a sense of solidarity. For example, people make music or noise on their balconies at night to collectively thank first-line workers, groups are set up for seniors who need help with shopping, medical students coordinate initiatives to cover a variety of community needs.

Finally, one of the biggest inhibitors of action is **self-doubt**: I cannot do it. When we feel isolated, we fail to appreciate the interests we share with others, we are unable to access our common resources, and we feel powerless. We can counter self-doubt with the belief that YCMAD: you can make a difference. Focus on what you do and what people can do, not what they cannot do. During the COVID-19 crisis, many people have been creative in making a difference. Examples include supporting health care and food supply workers, changing production lines to produce PPE and ventilators, and so much more.

How the public narrative facilitates action

The art of public narrative helps flip the balance from inhibiting to facilitating action motivators (Fig. 1). Public narrative is a leadership skill that translates values into action and is based on the fact that values are experienced emotionally. It empowers us with the courage to make choices under conditions of uncertainty, and it creates hope. A good public narrative is made up of three elements: self, us, and now.

Telling the **story of self** is a way to share the values of the narrator –in lived experience. We construct stories of self around moments when we faced a challenge, made a choice, experienced an outcome, and learned a moral. We communicate values that motivate us by selecting from among those moments and recounting what happened. Because storytelling is a social transaction, the listener can empathize and is more likely to view the narrator as authentic. We need to share the stories of our experiences and feelings as health care professionals, as family members, as humans, as defenders of the common good and health. This means stories of both pain and fear, but also hope. Not only does Dr. Bonnie Henry’s personal story include living through epidemics like SARS, but she also displays humanity and authenticity with messages like, “I’m feeling for the families and the people dealing with this right now.”

Learning to tell a **story of us** requires deciding who the “us” is: which values shape our identity and which are most relevant to the present situation. Community stories about challenges we have faced, why we stood up to them – our values and shared goals – and how we overcame them are woven throughout our traditions, identity, and culture. Once our core values have been articulated, they can be drawn on to motivate and set shared goals. By using “we” instead of “you” in briefings, Dr. Henry called on us and our values to protect the weak, our aging parents, and elderly grandparents.

The **story of now** articulates the urgent challenges and choices we face here and now. The protagonists shape the outcome and create hope by making the right choices. For example, acknowledging fear and creating a sense of urgency and hope rather than despair and panic is a skill Dr. Henry has displayed by balancing calmness with clear direction.

Public narrative is not talking about values, but rather embodies and communicates those values and the emotions they generate. It is through the shared experience of our values that we can engage others, motivate them to act by changing their behaviour and to find the courage to take risks in the face of urgent challenges. Public narrative is an unexpected skill that physician leaders need in the fight against COVID-19.

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