The New Normal: Key Considerations for Effective Serious Illness Communication Over Video or Telephone During the Coronavirus Disease 2019 (COVID-19) Pandemic

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On 4 March 2019, a year before the coronavirus disease 2019 (COVID-19) pandemic descended on the United States, a doctor delivered difficult news to a 78-year-old man who was in the intensive care unit with advanced chronic obstructive pulmonary disease (1). His granddaughter, sitting beside him, recorded the interaction on her cellphone. First, we see the nurse roll in a piece of equipment with a screen. She attends to other tasks in the patient’s room while a man on the screen—the doctor—begins to speak. We hear only parts of what he says: damage to the man’s lungs cannot be fixed; morphine may help him feel better. The granddaughter asks her grandfather if he understands; we cannot hear his response. The clip ends. The man died the next day. His family, deeply dissatisfied with the interaction, released the video to the press, and articles with titles like “Doctor delivers end-of-life news via robot” were broadly disseminated.

Fast forward to now. Across the country, clinicians are using telecommunication (by video or telephone) for serious illness communication with hospitalized patients with COVID-19 and their loved ones, together or separately. The term serious illness communication refers to communication between clinicians and patients about prognosis, goals, values, priorities, and recommendations for goal-concordant treatment plans (2). The pandemic brings new barriers to effective serious illness communication: widespread fear and uncertainty, surging work demands for clinicians, and the clinically appropriate but unfamiliar use of telecommunication to reduce exposure to the virus and preserve personal protective equipment. Here, we discuss how frontline clinicians can have meaningful conversations with patients who are seriously ill and their loved ones using telecommunication during this extraordinary time.

Preparing

Serious illness communication, whether in person or by telecommunication, requires careful preparation. Clinicians should assess the patient’s ability to participate, their need for a translator, and their preferences to include loved ones. An advantage of telecommunication is that loved ones can be included from a distance. A review of prior advance care planning documentation can identify legal decision makers and guide decision making when patients cannot participate. If using video, clinicians should ensure patients can use the equipment; some hospitals have engaged volunteers to help with this. If possible, a clinician should conduct visits from a private space where they can remove their mask and preserve the patient’s privacy. Clinicians should identify hearing and vision impairment and adjust their environment and communication accordingly (Table). Finally, clinicians should start the actual conversation by checking in with themselves first—especially now with the distractions of the pandemic. A deep breath brings one into the present to focus on the needs of the patient and family.

Having the Conversation

Before the conversation, clinicians should consider their agenda: Is the communication task information sharing, providing emotional support, identifying goals and values, or decision making? Many open-source, step-by-step frameworks, some specific to COVID-19, have been disseminated, including guides to breaking bad news, identifying goals of care, and advance care planning (3–6). An advantage of telecommunication is that clinicians can have a framework up on their screen as a cheat sheet during ongoing conversations, which may be especially helpful for clinicians new to serious
illness communication. However, we caution clinicians to avoid strict adherence to algorithms and to remain flexible. Asking permission at regular points in the conversation provides natural transitions, builds psychological safety, and allows patients and families some control. For example, a clinician can ask, “May I tell you what I understand about how your father is doing today?” Likewise, clinicians should regularly check for understanding, use summarizing statements, and orient back to patients when loved ones are also in the conversation.

**Responding to Emotion**

During the pandemic, clinicians, patients, and loved ones may have new or heightened emotions, including sadness, fear, worry, and even moral distress and trauma (10). In the absence of nonverbal cues, clinicians must be highly intentional about identifying and responding to emotion. Clinicians should pay close attention to signs of distress, which may be overt (for example, crying) or subtle (for example, long pauses or repeated questions). Frequently pausing and asking, “Does that make sense?” or “OK if I go on?” may help persons feel included. When using silence to respond to emotion, clinicians should physically indicate that they are present and listening by nodding. The acronym NURSE (Name, Understand, Respect, Support, and Explore) provides examples of empathic responses to emotions (Table) (7).

The story about the “robot doctor” from last year demonstrates the risk that families will feel abandoned...
without in-person serious illness communication. Yet, we now must encourage clinicians to embrace opportunities to have high-quality conversations with their patients, no matter the method of communication. Effective serious illness communication through telephone or video can empower patients and align treatment options with their values while preserving warmth, meaning, and human connection. Patients and their loved ones are likely to be understanding, even appreciative, as clinicians provide guidance during these extraordinary times.

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