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Critical observations on and suggested ways forward for healthcare communication during COVID-19: pEACH position paper

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Objective: Communication in healthcare has influenced and been influenced by the COVID-19 pandemic. In this position paper, we share observations based on the latest available evidence and experiential knowledge that have emerged during the pandemic, with a specific focus on policy and practice.

Methods: This is a position paper that presents observations relating to policy and practice in communication in healthcare related to COVID-19.

Results: Through our critical observations as experts in the field of healthcare communication, we share our stance how healthcare communication has occurred during the pandemic and suggest possible ways of improving policy and professional practice. We make recommendations for policy makers, healthcare providers, and communication experts while also highlighting areas that merit further investigation regarding healthcare communication in times of healthcare crises.

Conclusion: We have witnessed an upheaval of healthcare practice and the development of policy on-the-run. To ensure that policy and practice are evidence-based, person-centred, more inclusive and equitable, we advocate for critical reflection on this symbiotic relationship between COVID-19 and the central role of communication in healthcare.

Practice implications: This paper provides a summary of the key areas for development in communication in healthcare during COVID-19. It offers recommendations for improvement and a call to review policies and practice to build resilience and inclusive and equitable responsiveness in communication in healthcare.

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have had to be developed at a fast pace and have necessarily relied on adjacent evidence due to the initial lack of specific research and the unprecedented urgency for guidance at many different levels on a global scale. These approaches are understandable and were the best available option at the time.

The official top-down (i.e. government instructions) approach that has been prevalent in many parts of the world has shaped communication with the public, raising a number of challenges that have implications both for those seeking care and those who provide it. Communication in healthcare impacts [1] and has been impacted by the pandemic [2]. Understanding this relationship and its relevance to policy and practice during the pandemic and beyond is essential to the improvement of communication in healthcare. A number of communication areas have been identified by the Policy and Practice subcommittee of the International Association for Communication in Healthcare (pEACH) as relevant to policy and professional practice. In this paper we provide a critical reflection on these challenges and discuss approaches that could potentially mitigate them, inform policy and practice, and improve healthcare communication as a whole during pandemics. The topics are divided into two sections: communicating with the public (e.g. uncertainty, risk communication) and communication between healthcare providers and patients, families, and carers (e.g. telehealth, bereavement). We conclude this position paper with a summary of pEACH’s position, as well as a set of recommendations for consideration by policymakers, healthcare providers, and experts in healthcare communication.

2. Communicating with the public

2.1. Communicating uncertainty

Uncertainty is a major challenge in communication about the COVID-19 pandemic due to the novel and rapidly evolving nature of the disease and situation [2]. Research and healthcare are constantly confronted with uncertainty: new hypotheses and constantly emerging new evidence undermine previous certainties and clinical and public health decision-makers often deal with unknown aspects. Patients often face uncertainty during their disease trajectory [3], and healthcare providers and researchers are faced with the challenge of communicating this uncertainty.

For healthcare providers, scientists, political leaders, and policy makers, all of whom bring specific perspectives and different responsibilities, handling uncertainty in communication with the public and media is an ongoing challenge, and one which has been highlighted at a global level during the COVID-19 pandemic [4]. The uncertainty associated with the pandemic, and the associated public response, has been heightened as a result of the extended duration of the emergency and its socio-economic impact [2].

In general, levels of health literacy in communities suggest that understanding of the concept of risk is likely to be poor, and contribute to a sense of uncertainty and confusion [5]. We know that risk is composed of a materially measurable element of the probability of an event, as well as a socially constructed element of how that probability/event is perceived by the individual and society [6,7]. The perception of risk in sociocultural context (i.e. a constructionist approach) [7] can be largely diverse in terms of language and culture [8]. Modes of communication (e.g. automated website messages, text messages to provide test results) can further exacerbate public uncertainty and anxiety and have been found to be prone to error and contradiction [9,10].

Finset et al. [2] emphasise the importance of: honesty during time of uncertainty; being transparent with the public about what is and is not known and the rapid development of new knowledge; the use of clear and consistent language; where possible, by consistent spokespersons who can demonstrate honesty; and confidence in making decisions while demonstrating empathy and concern [11]. In line with Finset et al., we argue that the process of communicating uncertainty would benefit from a multidisciplinary approach involving both laypeople and experts [2]. Both the conceptual approach to communicating uncertainty, as well as the process of communication should include strategies that allow for regular evaluation and optimisation of the communication process and its effectiveness.

Existing evidence-based strategies used in healthcare communication, including gathering patients’ information needs, involving patients in defining key messages, checking understanding, and using brief, clear and tailored messages [12], should be further invested in to respond to public health crises.

2.2. Mis- and disinformation about health-related risks during COVID-19

When public health emergencies occur, risk communication [13] from authorities to the public is essential in order for the latter to be informed and to be able to act in ways that promote their safety and health [14]. In the context of the COVID-19 pandemic, key messages about wearing masks, washing hands and maintaining social distances are essential to help combat the pandemic [15]. However, the success of institutional risk communication during COVID-19 promoted by healthcare authorities is severely challenged by the current “infodemic”. The term “infodemic”, used by the World Health Organisation, refers to an excessive amount of information about a problem that is viewed as being a detriment to its solution [16].

The information can include mis- and disinformation, that is information that is false, inaccurate or expresses the opinion of a single person and cannot be generalised [17]. Misinformation is spread without the intention to mislead, while disinformation is deliberately misleading [18]. These types of information often involve questioning, doubting, and contradicting institutional communication and can lead to a lack of trust in institutions. In response to that, governments need to produce persuasive information that is “louder” than the disinformation [19]. They need to build or re-build a trust-based relationship with the public that is based on a transparent and accountable dialogue in order to avoid mistrusting attitudes, non-adherence, reactance and conspiracy attitudes among members of the general population [20].

To support improved communication with the public, future research and policy work should include an evidence-based typology of what mis- and disinformation is, as well as strategies to enhance critical health literacy skills in the population by sustaining critical reasoning competences and psychological awareness about one’s own processes of information interpretation. Increased empowerment of health institutions and governments to monitor, evaluate and respond to disinformation that hinders the adoption of appropriate precautionary and safety measures to fight a pandemic is essential. Furthermore, developing risk communication strategies based on scientific evidence from the fields of psychological, behavioural and social sciences, by means of interdisciplinary work across these fields, may improve effectiveness and help overcome psychological barriers that can have a strong bearing on the behavioural response of the public [1].

2.3. Risk communication in linguistically and culturally diverse communities

Risk communication campaigns during COVID-19 failed to account for the needs of linguistically and culturally diverse groups of citizens in many parts of the world, especially at the beginning of the pandemic. This is because risk communication campaigns seem to have relied mostly on a realist approach [7], where risk is
seen as an objective that is independent of social context. What seems to have been overlooked in risk communication campaigns during COVID-19 is that the way we think about health is deeply cultural and that the language we use in our communication shapes our own and others' perception of health [21]. The way we apply precautionary and safety measures is largely dependent on our ability to understand information in a language we understand within a cultural framework we can relate to. Failing to do so can have negative implications for our own health and safety, as well as for those of others, by delaying the containment of the pandemic and contributing to the loss of many lives. During the COVID-19 pandemic there has been worldwide media coverage of diverse groups of people (e.g. deaf people, linguistic, cultural and ethnic minorities) not having been informed correctly or in a timely manner [22] or in a language that they could understand [23], resulting in excess deaths from the virus [24]. Governments of countries with diverse populations have been criticised for developing risk communication campaigns in specific language(s) disregarding linguistic and cultural diversity [25]. When translations of official information were provided, they were not updated in a timely fashion and were often of poor quality [26]. All of the above raise questions about representation, inclusion and inequalities in access to care and the right to health.

Risk communication campaigns require a constructionist approach [7], multidisciplinary communication practices, early consultation and continuous engagement with stakeholders from linguistically and culturally diverse communities, as well as built-in evaluation strategies.

2.4. Promoting citizens’ health engagement throughout communication

During the pandemic, promoting citizens’ motivation and adherence to non-pharmaceutical preventive behavioural recommendations – such as physical distancing, wearing a mask, and practicing frequent hand hygiene – has been one of the most challenging tasks for health communicators.

A long tradition of scientific research in psychology and behavioural sciences has demonstrated how previous and, often not completely conscious, health beliefs, attitudes, values and social pressure may hinder such change of individuals’ health conduct [27]. The ability to regulate emotions reflects variation in how well people adjust emotional responses to meet health behaviour change demands [28,29]. Equipped with this ability, individuals can aptly modify which emotions they have, when they have them, and how they experience and express them in order to reach the expected desirable health behaviour [30]. Emotional regulation, in its turn, is affected by psychosocial variables related to people beliefs about health and care, and the social influence related to health behaviours. Therefore, sustaining citizens’ engagement in health prevention requires not only information strategies, but also initiatives aimed at supporting individuals’ emotional regulation processes which enable a positive adaptation to the stress generated by the uncertainty of the emergency situation [31].

In order to become more motivated to change behaviours and to adhere to prescribed preventive measures, citizens need to feel part of a joint endeavour with scientists and health authorities. New ways of collaborating among citizens and between communities and healthcare experts, such as citizens science initiatives, are a priority to sustain healthcare systems’ ability to effectively react to a health emergency. This requires the promotion not only of a more accountable, inclusive and participatory dialogue with the community but also listening and deep understanding of citizens’ worries, concerns, unmet needs, and expectations for an actual engagement in health promotion and disease prevention [32,33].

2.5. Disease-naming

The World Health Organization (WHO) took six weeks to officially name COVID-19, with much of the media and public settling on the generic virus name ‘coronavirus’ in the interim [34]. This is in contrast to the names of previous epidemics and pandemics, which frequently received a toponym (place name), such as MERS (Middle East Respiratory Syndrome), West African Ebola Virus, and, the last pandemic of a similar magnitude, the Spanish Influenza. Toponyms for diseases are generally misleading and stigmatising [35,36]. This is because the place named is not necessarily the real place of the origin of the pandemic, and the connection of a place and its people with a disease is inappropriate.

The delay in naming by the WHO opened up the possibility that similar toponymic conventions would be applied by the media and general public, resulting in the vilification of people who appear to be from China, particularly in the earlier months of the pandemic [37]. However, despite deliberate efforts by some commentators and politicians around the world to use names like “Wuhan-virus”, toponyms for COVID-19 have not been widely used.

Choosing not to enshrine the (possible) place of origin of a global pandemic is one way of resisting a racist narrative. With increasing representation and diversity in the media and in public life in general, there is more of this resistance, which aids in countering the small (albeit loud) minority that attempts to push their racist agenda, in part, through disease-naming [38]. This highlights the necessity of diversity and representation within healthcare and research, as well as the importance of participating in deconstructing inequitable systems and ensuring a radically inclusive approach to all aspects of care. It is insufficient to be “nice”, we need to be actively resisting racist narratives through our language and our actions.

3. Communicating with patients, families, and caregivers

3.1. Telehealth

Telehealth, which encompasses the provision of healthcare remotely by using telecommunication technologies, such as video and web-based applications [39], has been touted to improve health outcomes and reduce costs [40]. Prior to and during the pandemic, three discernible telehealth trends emerged: greater availability and convenience; more focus on the management of chronic conditions; and a shift of telehealth from clinical settings to the home via the use of mobile devices [41]. Telehealth has provided an attractive and well-suited option for healthcare service delivery during the pandemic. These healthcare services included primary care, urgent consultations, chronic disease management, mental health counseling, mild to moderate COVID-19 support and follow up, as well as provider training [42,43].

While there have undoubtedly been benefits in the broader adoption of telehealth, ensuring that utilisation is optimised requires building patient and provider skills as well as and systems-level changes. Patients need instructions on using telecommunication technologies, skills to handle patient-provider interactions, and directions on following up remotely. Healthcare providers need training on setting joint agendas remotely, handling efficient patient-provider interactions, and assessing patient comprehension. They also need to recognise the limitations of the telehealth format for new patients and mental health delivery [44]. On a systems level, successful telehealth requires
convenient, fast and secure internet connections, user-friendly telehealth platforms, and affordable cost structures [45–47].

The reliance on telehealth to improve access to care during the pandemic has paradoxically exacerbated the health disparities due to race and socioeconomic status that already exist [48–50]. More research about how to address these disparities is needed. In contrast to the recommendation of ‘social distancing’ advocated by public health officials, the delivery of healthcare necessitates ‘physical distancing with social connectedness’ [51]. The pandemic provides us with an opportunity to evaluate if and how telehealth can achieve this goal during this challenging time and beyond, particularly with respect to the user experience and the outcomes of telehealth.

3.2. Bereavement conversations

The pandemic has led to extraordinary circumstances of deaths that have been challenging for both the families of the deceased and the staff within the healthcare system [52]; families could not be by the side of their dying relative, and healthcare providers comforted their dying patients. Deaths have sometimes been fast and unexpected, without the possibility of a traditional funeral and many families mourned multiple deaths at the same time. Because of these reasons, family members are at risk of complicated grief [53], and the psychological morbidities may exist [54]. Healthcare providers are trained in bad news delivery but may need support in caring for mourning families because of the current complex circumstances. They are at risk of being overburdened by the quantity and quality (e.g. loneliness) of the deaths they have attended and, because of this, may also experience increased negative feelings, such as sadness, guilt or stress [55].

One response to the needs of family members would be the provision of psychological services via telehealth to support the mourning process and prevent further psychological distress. Such services consist of phone-call conversations where psychologists offer family members the opportunity to express their grief and loss-related emotions during social distancing and quarantine restrictions, allowing for the creation of alternative death rituals, as well as providing reassurance to the family members that their loved ones were supported and comforted by the healthcare providers during their time of death. The services would also allow for referral for further psychological support as needed. This type of initiative has been successfully trialed in Italy [56] and other places have likely tried similar approaches. Psychological services for healthcare providers would also be beneficial. These interventions, however, rely on organisational support that invests in providing access to care appropriate to the needs of patients and their families. Such an approach also necessitates flexibility within the healthcare system in order to be responsive and timely to the needs of patients and families in the community.

3.3. Communicating with masks on

With the pandemic, masked clinician-patient communication in face-to-face settings is the new norm [57,58]. However, there is speculation that masks may impede effective communication by impacting both verbal (e.g. reducing or changing tone or volume of voice by masks) and non-verbal aspects, since listeners cannot see speakers’ facial reactions and lip movements. As is well established, excellent clinician-patient relationships are dependent on effective communication and it has been generally believed that speech perception and understanding is impaired if auditory input (verbal) is accompanied with visual input (non-verbal). Unfortunately, routinely used surgical masks block visual access to the verbal (mouth) and nonverbal (facial) cues.

Masks may not cause much problem for the general population but can be problematic for those with hearing impairment. In a recent study of healthcare providers, most participants reported that the use of Personal Protective Equipment (PPE) did not interfere with patient care nor did providers report any inconvenience [59]. One study has shown that the presence of a surgical mask, did not have a detrimental effect on speech understanding in either the normal-hearing or hearing-impaired groups [60]. This was confirmed in another study showing that masks did not impact the speech perception or clarity for listeners with normal hearing, even when the environment was noisy [61]. That study did show improved speech perception performance in noise for only listeners with hearing impairment when visual input is provided using a transparent surgical mask [61]. Facilitating equitable access to care, which includes effective communication, through the development and provision of transparent masks to hearing-impaired groups in a noisy environment is vital.

To build confidence in communicating with masks, policies could be devised to share evidence about effective communication, while speech and language therapists can provide specific training in variations in pitch, loudness, tempo, and rhythm to enhance clarity through the mask [62]. Continued investigation into the implications of communicating with masks during the pandemic along with an examination of adjacent evidence into communicating with face coverings and other mask-wearing will be important for developing such guidance.

3.4. Patient empowerment during a pandemic

Patient empowerment means that a patient has (a sense of) control over their healthcare and health [63]. When a person becomes ill, they also become dependent and can lose autonomy, which can lead to frustration, anger and could make them more unwell. In many countries during the outbreak, continuity of care was disrupted for people with chronic health conditions. A hospital suddenly became a place which should be avoided. The fear and risk of infection, together with government guidelines, encouraged people to lock themselves up in mini-bubbles, which again cut some patients off from care [64]: informal carers may have had to stay at home, psychological help often had to be provided over the telephone, and, in some places, physical therapy was suspended. Those who were already vulnerable due to illness or some other cause, may have felt even more fragile. Many experienced feelings of loneliness that highlighted their dependence on their loved ones and caregivers even more deeply [65]. Some family members were not allowed to be at the bedside of dying patients who were experiencing the most painful form of disempowerment (see section 3.2). Uncertainty and the feeling of risk and seriousness, as noted above, are also characteristics of COVID-19 and can increase the aforementioned feeling of dependence in patients. Learning lessons from the pandemic and preparing for the future should not be led solely by governments, politicians, and experts, but any actions taken in order to prevent and combat healthcare crises, such as the COVID-19 pandemic, should actively involve citizens, patient associations, and individual patients to better understand the implications of all of these aspects on individuals and their interactions with the healthcare system. Evidence shows that improving the level of patients’ empowerment and their engagement in healthcare is a protective factor in the COVID-19 emergency [66].

4. Concluding thoughts

4.1. pEACH’s position

The COVID-19 pandemic has both impacted upon and been impacted by healthcare communication. From behaviour change
being symbiotic through the development of policy on-the-run. To ensure that policy and practice are evidence-based, person-centred, more inclusive and equitable, we advocate for critical reflection on this relationship between COVID-19 and the central role of communication in healthcare. This can be achieved through investment in pandemic-specific research to inform the development of communication strategies, relevant and responsive training and policies, and supporting the translation of research to practice.

4.2. Recommendations

When considering communication with the public, the policy and practice priorities should be developed using social scientific evidence including listening to and working with diverse groups of citizens to improve their participation, engagement and, by extension, health literacy. For policymakers, we advise connecting with experts who are engaged in research and strive to implement the latest evidence, to help in this way build systemic approaches to improving communication during pandemics and similar healthcare crises. The credibility of messages and the way they are conveyed can make the difference between widespread community adherence to guidance and deliberate non-adherence as a form of political protest [68]. Focusing on enhancing linguistically and culturally tailored health literacy to improve public knowledge of evidence-based medicine and scientific methods, as well as ways to recognise accurate information, are also priorities.

During the pandemic, healthcare providers have needed to rely on a limited evidence to make changes to their practice and these changes will necessitate critical reflection once time allows. For healthcare providers, we advise connecting with policymakers and experts to share experiences and concerns, which will help improve both the system and practice. The use of critical reflection tools and social scientific methods to evaluate current practices will make a positive impact on interpersonal communication and facilitate interdisciplinary collaboration.

For communication experts in research and education we need to advocate for policy and research agendas. This translates to i) improving our work in sharing our research beyond our own fields, ii) including both patients and healthcare providers in the development, implementation, and evaluation of interventions so that the intervention is a product of co-creation with a wide range of stakeholders, iii) connecting with policymakers and governments beyond requesting and reporting on funding, iv) regularly updating teaching materials so that they are in line with the latest evidence, and v) promoting open-access and data-sharing whenever possible.

In this paper we have reflected on the implications of uncertainty and risk communication, the lack of pandemic-specific evidence, and the mutual influence communication and the pandemic have on each other. While pandemics are not new, we are living through an unprecedented time as communication is being transmitted through an array of channels. We now have the ability to examine healthcare communication in a pandemic through multiple social scientific lenses, thus strengthening our ability to respond to this ongoing crisis and any other that might arise in the future. We have also articulated specific areas for further research. Against our critical reflections we emphasise the need for evidence-based guidance on healthcare communication during pandemics. We propose that the evidence is generated from multidisciplinary research which is more inclusive and diverse and conducted in consultation with the public from inception to implementation. Funded research and implementation of policies should come with integral built-in evaluation strategies that aim to improve the communication and overall experience of those seeking and providing healthcare services during pandemics.

As more evidence is being generated, we call for practices and policies developed as interim solutions in response to the pandemic, as well as long-established practices and policies on communication in healthcare to be revisited as we collectively reflect on how healthcare communication has evolved during COVID-19. It is vital that we learn from the challenges faced to improve not only responsiveness to public health crises, but also to improve communication in healthcare beyond the current pandemic [69]. This requires flexibility, reflexivity (i.e. attending systematically to the context of constructing knowledge), and continual modifications at all levels. Setting policies in stone and not reflecting on how practices evolve may introduce unintended consequences and new challenges and can perpetuate inequalities in care as we move forward.

CRediT authorship contribution statement

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Serena Barello: Investigation, Writing – original draft. Eugenia Cao di San Marco: Investigation, Writing – original draft. Cinzia Coluzzi: the manuscript – original draft. Edgard Eeckman: Investigation, Writing – original draft. Paola Mosconi: Investigation, Writing – original draft. Judy Mullan: Investigation, Writing – original draft. Shakaib Ur Rehman: Investigation, Writing – original draft. Sara Rubinelli: Investigation, Writing – original draft. Elena Vegni: Investigation, Writing – original draft. Demi Krystalidou: Investigation, Writing – original draft, Conceptualization, Writing – review & editing.

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