Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company’s public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.
Reflective Practice

The Phone: Communication in the Age of COVID-19

Kunal K. Sindhu

Department of Radiation Oncology, the Icahn School of Medicine at Mount Sinai, 1184 Fifth Avenue, New York, NY, 10029, USA

Article history:
Received 19 May 2020
Received in revised form 3 February 2021
Accepted 5 February 2021

Keywords:
COVID-19
Patient care
Patient communication
Phone

A R T I C L E   I N F O

A B S T R A C T

In April, as the COVID-19 outbreak intensified in New York City, a radiation oncology unit was redeployed to an internal medicine service. In this submission, he discusses his experience updating families on the latest news.

© 2021 Elsevier B.V. All rights reserved.

From a convenience standpoint, phone calls are marvelous. They help maintain relationships that would otherwise decay, and keep individuals connected to the outside world. They are also an essential aspect of modern patient care. As a radiation oncology resident in New York City, I have found myself on the phone frequently, answering my patients’ questions and refilling their medications, evaluating requests for inpatient consultations, and coordinating care with my colleagues.

But phone calls are an imperfect form of communication. The lack of an opposing human presence leaves something to be desired. This is especially true in oncology. By restricting physical access to patients, they are not an ideal medium with which to evaluate medical complaints. And they are especially poor for delivering bad news. Nuance and meaning may be lost in the absence of proximity and body language, increasing the risk of a misunderstanding. Given the stakes of these emotionally charged conversations, when given the choice, I have preferred to have them in-person.

This past spring, I did not have this luxury.

In April 2020, as the COVID-19 outbreak intensified in New York City, I was redeployed to an internal medicine service [1,2]. Acting as an intern for the second time in my young career, I helped my colleagues manage an overwhelming surge of new patients. This time, however, things were different. Not only were the patients generally far sicker than those I remember caring for during my first internship, but temporary visitor restrictions enacted in response to the pandemic ensured that in-person interactions with family members were exceedingly rare. As a result, phone calls took on an entirely new meaning: they were the only means by which I could update the families of my patients.

The form that these updates took varied. During day shifts, I found myself speaking to most of my stable patients’ families for regular updates after rounds. These calls, reminiscent of those I regularly made in radiation oncology residency, were generally straightforward. During night shifts, however, I often found myself speaking to family members, many for the first time, whose loved ones had experienced a deterioration in clinical status. These calls were the worst I have ever had to make.

The scenarios were generally the same. First came the crash, the sudden downturn that has become a defining characteristic of patients with COVID-19 who experience poor outcomes. Next came the scramble, the period of frantic activity as we employed all of the tools at our disposal in an attempt to stabilize the patient. Lastly, and most painfully, came the recognition that we were on the precipice of failure.

As a radiation oncology resident, I am familiar with the concept of death, which lurks beneath every clinical encounter, its anticipation assisting both clinical and personal decision-making. With cancer, which generally progresses over weeks, months or even years, patients and their loved ones often have the opportunity to consider the possibility of death and plan accordingly. Some even come to accept it and savor the time they have left.

With COVID-19, however, death is different. It is frequently the result of a sudden, unplanned, and unpredictable deterioration. As a result, patients and their families are left with little opportunity to process its many ramifications or prepare in advance. It also often forces its victims to experience the last few moments of their lives in isolation, away from the comfort of their loved ones. In a
society that craves and values social connection, it is an unbearably cruel way to die. No one should ever have to go through it.

In this context, the phone calls to family members were heartbreaking. No amount of training can prepare anyone for the difficulty of telling someone that their loved one is prematurely and imminently dying, much less without the ability to comfort him or her in-person.

One phone call I remember particularly well came as the pandemic crested in New York City. I was working an overnight shift in the intensive care unit when a request for a consultation came from the emergency department for a patient with COVID-19 who was hemodynamically unstable. Just minutes after his arrival in the intensive care unit, his condition worsened, and it quickly became apparent to my resident and I that his condition was unlikely to improve. I had to notify his next of kin.

While I had made similar phone calls before, this one made me nervous. I had just assumed care of the patient, who had not been alert or oriented. Thus, I knew little about him aside from the medical history I had obtained from the emergency department resident and the electronic medical record. I also knew nothing about his daughter, whom I was about to call. Yet now, in the middle of the night, I, a stranger, would have to wake her with the devastating news that her father was not likely to survive the night. As difficult as the call would be for me, I knew it would be infinitely worse for her.

Despite the hour, an anxious voice quickly answered the phone. She clearly had been awaiting my call. After a greeting and quick introduction, I asked what she knew about her father's condition. Her voice, while confident, faltered as she demonstrated a clear understanding of the gravity of the situation. This was not going to be easy.

After obtaining permission to continue, I began describing her father's clinical condition in some detail. I paused frequently, hoping to provide sufficient opportunities for clarification, and I repeatedly asked her if she had any questions. Yet, despite my entreaties, no words came through my handset. Instead, shell-shocked, my patient's daughter stayed silent. At times, I had to confirm that she was, in fact, still on the line. This type of conversation had unfortunately become somewhat routine for me after weeks of treating patients with COVID-19. It is unlikely the words I spoke (or did not speak) during those few minutes will ever be forgotten by my patient's daughter.

With distance restricting my ability to utilize social cues, I felt lost. The pauses, usually an integral part of any conversation, began to feel like gaping silences. Growing increasingly uncomfortable, my face reddened and the pace of my words quickened as I tried to fill the void. Awkward word choices stuck out like a sore thumb, and small verbal stumbles felt like unwarranted missteps.

After what seemed like minutes, when sobs came from the other side of the line, I felt especially constrained. Nothing I could have said or done would have succeeded in easing the pain. But without the ability to calibrate my words and pace carefully, and take cues from her words, facial expressions, and body language, my attempts to comfort her felt especially insufficient. “I am so sorry,” four words that may have helped in person, seemed woefully inadequate over the phone.

As the call ended, an intense feeling of grief washed over me. The whole situation – from my lack of any prior relationship with my patient and his daughter to the realities of managing the COVID-19 pandemic in the United States – felt profoundly unfair. None of us had deserved to be put in this situation. Without the benefit of the typical in-person patient communication tools I had been trained to employ, I did not feel like I could deliver optimal patient care.

Several months later, having now returned to radiation oncology, I have had time to reflect on my experiences. Medical care in America has been transformed. In particular, the use of telemedicine, often with video features, has surged. Despite its limitations, telemedicine has allowed patients to continue to receive regular care as the pandemic rages. Even after the outbreak abates, it is likely to continue to play a role in the delivery of medical care.

In the longer term, however, some caution is warranted. If nothing else, the COVID-19 outbreak has shown me that nothing can ever fully replace the value of in-person visits. In our rush to adapt to an increasingly virtual and solitary society, we must not underestimate this. Phone calls, I have found, often are not enough.

Financial conflicts and disclosures

No funding or grant support was obtained to support this work. The author does not have any proprietary interests in the materials described in the article.

Acknowledgements

None.

References

[1] K.K. Sindhu, Seven O’Clock, Ann. Intern. Med. 173 (4) (2020) 313–314, doi:http://dx.doi.org/10.7326/M20-2347.
[2] K.K. Sindhu, Schrödinger’s resident: redeployment in the age of COVID-19, Acad. Med. J. Assoc. Am. Med. Coll. 95 (9) (2020) 1353, doi:http://dx.doi.org/10.1097/ ACM.0000000000003513.