Original Article

Telephone communication with relatives of hospitalised COVID-19 patients by a specialised family support team: lessons learned

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Abstract

During March and April 2020, the number of hospital admissions and deaths due to the first wave of COVID-19 peaked. The objective of this study was to analyse the experiences of a team of health professionals in charge of breaking bad news over the telephone to the relatives of patients admitted to the respiratory ward of a large hospital in Barcelona.

This was a qualitative research based on semi-structured individual interviews with all the members of the team and a group interview. The interviews were analysed using Condensation of Meaning techniques.

Three central themes emerged after analysing the interviews: (1) the call itself, (2) the need for good organisational support both before and during a crisis, and (3) the care that the professionals themselves need.

To set up a large-scale operation to break bad news over the phone, some organisational aspects must be considered that go beyond the call itself. All these aspects are interrelated to a large extent, and due attention should be given to proper communication and adequate care practices for both relatives and health workers.

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Introduction

The high contagion and potential mortality rates of the SARS-CoV-2 virus (1) necessitated the isolation of affected patients as well as extensive confinement measures in many countries, including Spain (2).

In normal circumstances, information including bad news is delivered in person by the doctor in charge of the patient. However, the circumstances were anything but normal, given both the extraordinary influx of patients and the fact that relatives were not allowed into the hospital. As the respiratory ward became overwhelmed, doctors informally asked for support and the idea of forming a team dedicated to providing a channel of communication between hospital staff and the relatives of admitted patients took form.

All health professionals will have to give bad news at some point during their career, but this is a task that is hard to do correctly and might have a major impact on the well-being of many people. However, this skill is not regarded as particularly important either by those in charge of the training of future professionals or by the professionals themselves.

According to Buckman, bad news is "any news that drastically and negatively alters the patient's view of their future" (3,4). Nomen defines it as news that "drastically and negatively alters the vision somebody holds about their future, either because they are directly affected or because a loved one is" (5). This reference to relatives is quite meaningful in the context of the COVID-19 pandemic as during the initial stages, the information that needed to be transmitted consisted mostly of uncertainties and bad news.

The Spanish law states that "every professional involved in healthcare has the obligation not only to properly apply all techniques, but to fulfil all duties related to information, documentation and respect for the decisions made freely and voluntarily by the patient" (6). In order to align the health system's response with the ethics of patient-centered care and comply with the law, the Family Support Team (FST) was formed to take charge of communications with the relatives of patients admitted to the respiratory ward of a major public hospital in the province of Barcelona.

The FST consisted of five people. Four were in charge of the calls: a senior geriatrician experienced in breaking bad news, a social worker from the geriatrics department of the hospital with relevant experience, a volunteer pediatrics intern, and a student in her last year of medical school. The fifth member was an occupational therapist who took care of record keeping. The FST was stationed in the respiratory ward and would in fact meet with the doctors daily to be briefed about the status of all patients. Over the 5 weeks with the highest workload during the pandemic peak in Barcelona, the FST made almost 1200 calls related to 211 patients, with a median of 6 calls per family.

Calling people, one has never met who are not allowed to visit their hospitalized relatives or meet with the medical team in charge presented an unknown scenario, so a

search of the scientific literature was conducted to seek guidance. Unfortunately, no guidelines were found but rather a consensus on the inadequacy of the telephone for communicating this kind of news. As Buckman stated in the reference book for breaking bad news, unless it is absolutely unavoidable, an interview should be carried out in person and not over the telephone (3). Certain exceptions have been proposed, however, for instance if there is an urgent need to obtain approval for specific procedures (7), or when the closest kin is overseas (8). This exact situation applied to the relatives of all COVID-19 patients due to the lockdown. Since many patients were incapacitated, some form of communication was necessary both to alleviate the uncertainty of relatives and to involve them in the decision-making process. Therefore, the team had to modify the protocols that considered the use of the telephone as poor practice and learn what worked and what did not, using the six-step Buckman protocol (3) as a framework and making the necessary adjustments. In this article, we present the lessons learned as a result of this experience.

Methods

The present study aimed to analyse the experiences of the FST members, who were in charge of calling the relatives of all patients admitted to the respiratory ward between March 23 and April 24, 2020 during the peak of the first wave of the pandemic (9). Under the circumstances, many of the calls imparted bad news including death; so, we aimed to describe the lessons learned as part of this exceptional communication process between health professionals and relatives of COVID-19 patients.

Participants and Data Collection

This study was undertaken by a researcher external to the hospital and consisted of individual semi-structured interviews with all members of the FST, as well as a group interview with all the members. The individual interviews averaged 50 minutes, while the group meeting lasted 2 hours and 15 minutes. All five members of the team were women, between 22 and 53 years of age. The interviews were conducted on-site except for an individual one, which was conducted online. The structure of the interviews was built on blocks, as presented in Table 1.

Data Analysis

A qualitative analysis was performed, focusing on the perceptions of the interviewees and the way they related to the different roles they assumed, as calls were assigned to different team members according to their background, area of expertise and experience. For instance, a regular discharge call might be made by the social worker who would be better qualified to evaluate a patient's situation at home, while a difficult discharge call would be handled by the senior geriatrist.

Table 1- The structure of the interview guide

Block	Sample Questions
1st Block: Setup of the FST	*How did you join FST? Did you have any previous experience in breaking bad news?* *What was the situation like when you joined?* *How did the medical team react to the FST?*
2nd Block: Carrying out the work	*Describe your work during those weeks.* *What kind of relationship did you have with other members of the FST team?* *How did you deal with the situation after work? At home, with your family?* *Did you share the details of your day-to-day work routines with anybody?*
3rd Block: Assessment and subsequent situation	*What do you think worked best? And worst?* *How do you feel after the experience?* *How would you assess the FST experience?* *Is there anything else you would like to add or any important issues you wish to mention?*

The analysis was centred on meaning and, more specifically, the condensation of meaning in five distinct steps (10). At first, we conducted a reading to acquire an overall impression of the content of the interview. Second, we performed an in-depth reading of the transcriptions to determine the different units of meaning and understand the overall concept. Third, we simplified the units of meaning obtained from the words of the interviewees, expressed in a streamlined manner. After that, we tried to establish the relationships between these units of meaning and the study objective, tying up the non-redundant essential themes into a statement.

Once the condensation was completed, an inductive interpretation was undertaken. An example of condensation of meaning analysis is presented in Table 2.

Table 2- Illustration of the condensation of meaning analysis

Natural Meaning Unit	Simplified Meaning	Subtheme	Central Theme
"If one of us went down with COVID, whoever took their place had to have all the history and information available".	*Everything had to be registered*	*Need for accurate record-keeping*	*The call*
"We didn't know what to do, we felt like headless chickens, but then we reinvented ourselves and came up with something".	*Everybody at the hospital had to improvise and do their best without guidance*	*Lack of leadership*	*Organisational Support*
"What am I doing here? I started thinking about how I was lying to my family, being exposed, and I stopped by the Sagrada Familia and just cried and cried and cried".	*Fear, uncertainty and psychological stress overwhelmed them*	*Care for the team*	*Care of the team members*
"You arrive there thinking well, let's see how this works out, because in medical school we get very limited training in communication (...)".	*They did not know what to do owing to a lack of training*	*Lack of training in a specific skill*	*Organizational Support*

The situation during the first wave of the SARS-CoV-2 pandemic has clearly been very difficult, if not impossible, to replicate. Therefore, the validity and reliability of the results have been ensured through revision of the methodology by independent experts, from the choice of method to the type of analysis, including the structure of the interviews themselves.

Result

Analysis of the interviews yielded several recurring issues that can be grouped in three central themes, each including some subthemes, as seen in Table 3.

Table 3- Central themes and descriptions of the subthemes

Central Theme	Subtheme
The Call	*Before the call, collecting clinical and follow-up information* *Before the call, allocating calls to the members of the FST according to their expertise* *Before the call, making time for the psychological preparation of the professional* *During the call, establishing a trust-based relationship with the family* *During the call, adapting to the preferences, values and expectations of the patient and the family* *During the call, adapting the discourse of the professional to that of the person being called* *During the call, providing precise and clear information, making sure it is understood* *During the call, paying attention to the possible psychological issues of the relatives and refering them to the necessary health services* *After the call, recording all the information, both given and acquired*
Organizational Support	*Need for training in communication* *Need for leadership* *Need for planning* *Promotion of collaborative culture, and setting up teams* *Resource availability*
Care of the Team Members	*Care during the crisis* *Care after the crisis* *Self-care*

The Call

The call itself stands at the center of the process, so all of its stages must be carefully considered: what needs to be prepared before making the call, how the call ought to be conducted, and what needs to be done after hanging up. Patient-centered care demands that callers consider the values, beliefs and expectations of the specific person they are calling, as well as the overall cultural and material background of the society. In the words of one interviewee:

"You have to adapt to what you receive. It isn't the same when you talk to a cousin or a wife, a daughter, or a sibling… or a 16-year-old girl. That happened to me once. I had to talk to a girl who was 16". [Participant No. 3]

Three stages were identified during the interview:

Before the call: In this stage, some tasks

have to be undertaken, such as allocating the call to a specific team member according to the situation and the team members' skills, gathering all the necessary information about changes in the patient's condition or any outstanding issues pending from previous calls, and ensuring the psychological preparation of the caller.

During the call: The professional should adjust their discourse to that of the person they are calling and be empathetic but clear, not hiding the gravity of the situation.

After the call: Great effort must be devoted to accurate record keeping, as each call is both an act in itself and part of an on-going exchange between the team and the family, as some patients spend weeks hospitalised.

With regard to the need for accurate record-keeping, one team member said, *"If one of us went down with COVID, whoever took their place had to have all the history and information available".* [Participant No. 5]

Organizational Support

It became apparent during the interview that the inadequacy of organisational support was one of the outstanding issues affecting the team.

The aspects in which organisational support was found to be lacking were manifold and ranged from insufficiency of the efforts devoted to training future health professionals in communication skills, to inadequate contingency planning and a general lack of resources allocated to the task of communication in such an exceptional situation. All interviewees placed great emphasis on a lack of leadership, stating that most of the hospital staff acted ad hoc and were constantly reinventing and adapting themselves and their processes to an exceptional and fast-changing situation with little to no guidance.

As to the lack of training, we were told the following:

"You arrive there thinking well, let's see how this works out, because in medical school we receive very limited training in communication …. I was the envy of my classmates, and the great team atmosphere and support made me feel reassured in spite of my lack of experience". [Participant No. 4]

It could be argued that this pandemic inevitably led to situations where improvisation was the only answer and that nobody could have expected such a crisis. However, managerial teams have to consider critical scenarios that may never arise in order to avoid a collapse of the system. All interviewees felt that the weight of the responsibility for handling the situation fell on health workers, who relied almost entirely on their personal initiatives, lacking supervision or guidance from their superiors. As can be seen in the following statement:

"We didn't know what to do, we felt like headless chickens, but then we reinvented ourselves and came up with something". [Participant No. 1]

Care of the Team Members

Although at first the focus rested on a shortage of material resources such as Personal protective equipment (PPE), during the interviews it came to light that the

professionals felt the lack of psychological support both during and after the crisis to be the most outstanding issue. The members of the team felt a shortage of resting periods as well as psychological support and therapy, and resorted to means of self-care such as humour and peer-support to try and weather the difficult times.

Another recurrent complaint was that although health professionals received praise and recognition in the media, this did not translate into concrete and real support. In the group interview, many statements were centered on the psychological state of the team during and after the calls.

"It takes a great amount of physical and mental toll. I'm empty, to watch a film and burst out crying is no longer enough. I need rest". [Participant No. 2]

"What am I doing here? I started thinking about how I was lying to my family, being exposed, and I stopped by the Sagrada Familia and just cried and cried and cried". [Participant No. 3]

Discussion

The main finding of the study was that in a situation like this, the calls themselves are only part of what must be an institution-wide effort. Such efforts include preparation tasks (offering proper training), budgetary management (providing the necessary material and IT support), administration issues (rostering and shift scheduling) and offering psychological support to the people assigned to this task.

At the time the FST started operating, scientific literature on medical communication by telephone was almost non-existent, except to point out the undesirability of such a medium. Therefore, medical professionals had to improvise. One year later, numerous papers are being published, offering insight on how best to engage in this kind of communication. For instance, there are papers presenting guidelines on how the doctor in charge of a given patient should provide information to his/her relatives (11) or convey to them the conclusions reached by a panel of experts that reviewed relevant literature. Moreover, some papers have proposed (12) a set of good practices to follow, including different checklists for phone or video calls, and guidelines for deciding when and which clinical information should be given to the families in order to improve the outcome of the calls.

There is also plenty of literature about the psychological impact of the COVID-19 pandemic on health professionals and the need to alleviate it (13), the importance of providing adequate training (14, 15), and concern about the technological aspects and the future of remote healthcare as an aspect of standard healthcare (16).

In the case of our subjects, the doctors working in the respiratory ward had to deal with an unprecedented workload and could not provide information to patients' families. Therefore, a decision was made to dedicate to this task a multidisciplinary team consisting of senior professionals with extensive experience in breaking bad news.

The specifics of this pandemic have brought into sharp relief the difficulties of large-scale communication over the telephone, specifically when so many patients with such diverse medical prognoses were involved. In some cases, a single devastating call had to be made, but in others, many calls (up to 30) were made to the relatives of the same patient, creating a sort of personal rapport. Thus, team members had to put in a great deal of effort to make sure that no details were lost from one call to the next, and to adapt their language to that used by the person they were calling, from both cultural and technical aspects; for instance, it had to be considered whether the relatives were unfamiliar with medical terminology or were well-trained professional health workers themselves.

All of the above has resulted in a unique experience out of which valuable insights on the overarching issues that need to be addressed can be obtained, most falling under the scope of organizational support.

One of the main insights pertained to the need for better training in communication, as those crucial skills are often undervalued in medical education. In addition, health facility managers often take communication as a given that does not demand resources or attention, and this lack of preparation will not only exacerbate the distress of the relatives receiving bad news, but also increase the stress suffered by the physician (17). Thus, it is necessary to promote training in communication skills and telecommunication in particular (both telephone and video calls). Moreover, at the managerial level, emphasis must be given to communication with patients and relatives as well as internal communication, which in turn will help to build a collaborative culture and cohesive teams.

A second finding was related to the need for better planning, including thinking the unthinkable. It may be argued that the specifics of a pandemic are always unexpected and that it was not possible to prepare for this one. However, some needs should be addressed, like providing the essential supplies and ensuring that key managerial positions are staffed by people with the right leadership skills to avoid burdening the already overworked frontline health professionals with the need to improvise solutions to unexpected problems. Literature about managing crises usually centers on logistics and other material aspects (18), but communication needs are often left out. The importance of having access to material support and the existence of a culture of planning ahead cannot be underestimated, and even though unforeseen scenarios might evolve, policies can be formulated in order to better manage them (19).

The aforementioned matters must be addressed before any crisis sets in. Once the unexpected has happened, a swift response from the organisation is necessary in order to acquire or relocate technical equipment, adapt rostering and shifts to the new necessities, and provide extra support by reallocating staff where they might be most needed. If the right leadership and culture are in place, the response from the whole system will be much more adequate and burdens will be shared, so nobody will have

to bear unmanageable loads.

The third finding was about caring for caregivers so that everything keeps on working. Even in normal situations, breaking bad news is a stressful experience, but when relatives are prevented from visiting the patient and their only means of communicating with the doctors is by telephone, it will be a greater challenge still. Some of the members of the FST had extensive experience in end-of-life care and communicating bad news, which helped to ease some of the psychological stress that such heavy conversations create. However, the accumulated burden endured by a 4-member team that was dedicated exclusively to this task and performed over 1,200 calls corresponding to 211 patients in 5 weeks was enormous. In a similar experience, Chisholm et al. recounted that the team assembled to provide information to patients' families consisted of over 30 professionals, including not only health workers, but also administrative personnel and experts in service excellence, and that a specific program to provide support to physicians and families had been set up in a few days (20).

In the single other example that we found of a similar setup (21), the team had 39 members for 174 patients. These two instances showcase the difference good support makes when setting up an operation like this, and this has substantial impact on the wellbeing of the professionals involved.

In any case, the importance of previous experience in breaking bad news cannot be underemphasized. Clinicians that have had extensive experience in this area have a deep understanding of the principles involved and a wide and flexible repertoire that allows them to adapt. When massive needs for communication arise, however, less experienced clinicians must also step in and share the burden, something that might turn into a demoralizing experience (22). This agrees also with our findings, as in the FST team the more experienced professionals took the most difficult calls and supported and helped their junior colleagues.

Even though it is well known that giving bad news is only slightly less stressful than receiving it (23), this acquires more relevance during a pandemic. Many studies exist on the physical and psychological impact of the pandemic on professional health workers that have faced COVID-19. One such example is a study from the University of Turin in Italy where results showed that the professionals who worked in COVID-19 wards reported higher levels of symptoms like depression or post-traumatic stress disorder than those in other units. This reflects the unique aspects of dealing directly with the pandemic and its effect on patients and relatives (24). There was another study in Singapore and India where health professionals reported high levels of stress attributed not only to the fear of transmitting the infection to their families, but to the fact that the system was so strained that they were hesitant to apply for sick leave, a situation that often ends in burnout (25). In both studies, multiple issues affecting health workers are referenced and

special emphasis is placed on the greater incidence in women, younger or less experienced individuals, and those working in the frontline. Monitoring the people most at risk is a necessity that goes beyond the concern for the individual worker, as the number of people that can potentially be affected is large enough to threaten the sustainability of the healthcare service itself (26). As women form the majority of health workers (27), their care merits special attention from health authorities.

Carers must be cared for, or the system may fail. Those who look after the health of the rest must feel valued and well treated, knowing that their needs are covered and that they receive the acknowledgment they deserve. This includes providing them with adequate rest and psychological support, since, also for professional health workers, *primum non nocere* (First, do no harm).

Limitation

The present study was centered on professionals' experiences and did not aim to establish the degree of satisfaction of the relatives, so their opinions have not been gathered.

The setup of the FST in the respiratory ward was done on the professionals' own initiative and was not replicated in other areas of the hospital. Therefore, all the information we have available comes from the five members of this unique FST.

Finally, this work was based on the perceptions of the FST team members and might be biased since they relied on memories acquired at a time of great distress, which might have affected their accuracy and reliability.

Conclusion

The aim of this study was to learn from the experiences of the FST team taken as a whole, how it interacted with the rest of departments of the hospital. The fundamental insight derived from this study was the need to build a system that lends weight to communication as a whole, from basic training to receiving the proper managerial support. We highlighted the main aspects that need to be taken into consideration to help medical institutions set up their own protocols to better address similar situations in the future. Meanwhile, it should be stressed that all of these aspects are heavily interrelated, for instance good organizational support will bring about improvements in the quality of communication and lessen the mental load of health workers, which will in turn result in a stronger institution and better care. In Figure 1 we present a broad outline of the main concepts that we think must be considered when facing such a demanding scenario.

After all, we should not forget that communication does not just humanize care; it is what makes it possible.

Disclosures

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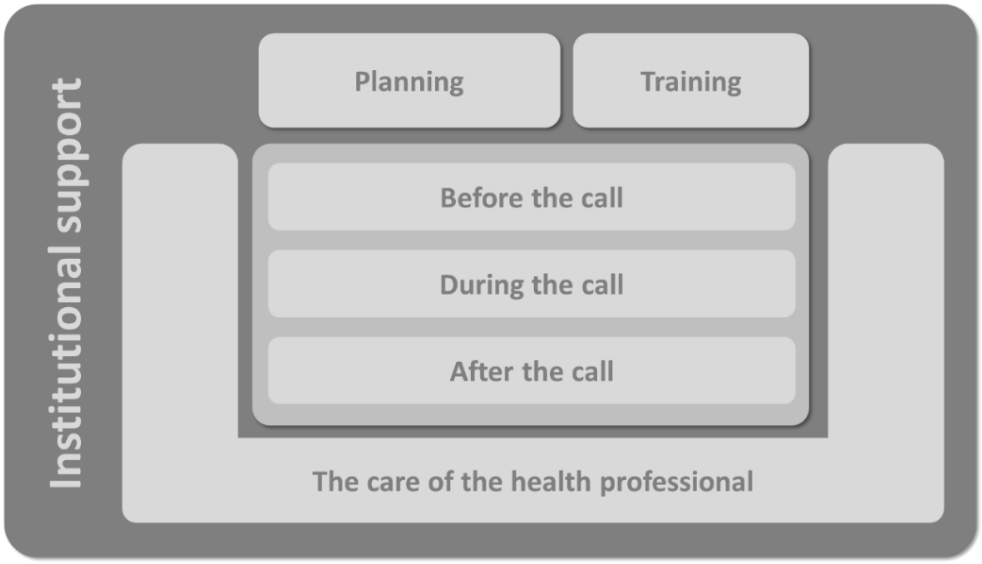

Figure 1- Main concepts to be considered

Conflict of Interests

The authors have no conflict of interests to declare.

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