COVID-19

Communication in the time of COVID

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ABSTRACT

The risk of infection precluded normal visiting by relatives of COVID-19 patients in an intensive therapy unit (ITU). Instead, a team of medical students and retired consultants telephoned next of kin with a daily update. A categorised selection of the students' reflections on their experiences is presented and discussed.

KEYWORDS: Communication, COVID-19, ITU, medical students, family liaison

DOI: 10.7861/fhj.2020-0115

Introduction

The COVID-19 outbreak necessitated the expansion of ventilator capacity from 12 to 36 patients in the intensive therapy unit (ITU) of an inner-city teaching hospital. Additional staff were drafted in, but all were fully occupied in patient care, in full personal protective equipment, leaving no one available or able to communicate with relatives. Undergraduate medical students volunteered for this role and after two months' experience they recorded their reflections, excerpts from which are presented below.

When patients were being prepared for artificial ventilation, they were informed that their family members would not be permitted to visit but would receive a daily phone call to update them on their condition.

The students' day began with attendance at ITU handover at which each patient's case was presented, the previous day's progress summarised and the next day's care plan agreed. The handover was also attended by a retired consultant physician in person on alternate days, and by other retired consultants with ITU experience remotely on the other days. The families of all new patients and of the most critically ill were then called by the consultant and the remaining calls divided between the students. All calls were recorded in writing and were discussed at the end of the session and any difficulties identified. Three of the 99 families contacted asked to speak only to a consultant.

Reflections of the students

One typical student reflection on the whole experience is given in Box 1. Excerpts from the reflections of other students are given below.

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Reflections on preparation

Getting the words right is vital; they could be given more weight than I intended as the family scoured for positives in every call.

I found it helpful to ask what the family already understood before going on with the update. Based on what they knew, I could decide how best to update them.

I needed to understand the information and be clear about the main message.

Reflections on the call

It was only when I called a patient's relative for the first time that I began to comprehend the gravity of the situation. The family huddled around the phone waiting for that one daily update.

I found the absence of non-verbal cues difficult at first, but it gave me the opportunity to listen attentively in a way I never had before.

Box 1. A typical student reflection

I entered my family liaison role having never been on an ITU and only ever having had fleeting interactions with relatives. Suddenly I am the point of contact between critically ill patients' families and ITU.

The first few phone calls were difficult. It was hard to know the right words to say, how much information to give and the tone in which to give it. As I learnt more about intensive-care medicine and witnessed conversations between consultants and relatives my uncertainty began to ease and my confidence grew but, as time passed and the words came more easily, the conversations only became more difficult. Through days of speaking to relatives I had formed relationships; I knew the person at the other end of the phone and I liked them. Hearing the news that a patient's condition had deteriorated was not only sad, it now came with a burden; I had to break the news to someone I cared about. I knew that empathy was necessary for a clinician but I've now had to learn to deal with its weight; to feel the sadness of a family before moving on to feel the sadness of another.

But alongside sadness I have seen kindness and resilience. In a time when it may have been weeks since they last saw their loved one, when they can't visit them and can only wait for the next phone call, relatives have been nothing but thankful and full of words of praise. I am amazed by the resilience of these families and will always remember their strength and kindness.

I found it difficult to ascertain how the information I was giving was being received… especially when I was met with moments of silence as the relative was affected by something I had said.

I found that just spending time listening, explaining misunderstandings and not getting bogged down in the details really helped.

The conversations were emotionally demanding and I had to think about everything I said, carefully choosing the right words. I never fully appreciated the power of words until I did this job. The words I used would be scribbled down and circulated around the wider family.

I learnt quickly to adapt my language, to slow down my speech and stagger information into digestible amounts, repeating key messages.

We had no time limits so we could take our time not only explaining medical concepts to family members, we could also ask how they were coping and were they all well.

I allowed the relative to decompress and become less anxious as they offloaded on me.

We took personal messages to be passed on to the patient. One was just: 'please come home Daddy'.

Reflections on the relatives' responses

The relatives' responses were a source of inspiration for the students. The response of one family was: 'We want to thank you from the bottom of our hearts for the support, guidance, empathy and compassion you have shown us in our darkest moments.'

There was the resilience and kindness shown by the family members who asked if we were doing ok.

The overwhelming grace and gratitude of the relatives have been truly inspiring.

Every call ended with appreciation and gratitude.

Reflections on the impact on the students

It took me several days to get over some conversations which replayed in my head at night.

I cried most days. It was not easy to listen to their pain, their grief and their tears. I tried to stay professional and clinically distant but I struggled to put my emotions to one side.

Speaking to patients' loved ones and hearing the pain in their voices as they describe how they die a thousand deaths each night as they wait for one phone call, will stay with me forever.

The worst conversations were when day after day there was no change.

I spoke to certain relatives almost every day and inevitably became invested in their journey, hoping every day to give them good news but often not being able to.

I have developed a deeper appreciation of the concomitant suffering which relatives endure through a patient's illness and will never underestimate the importance of family communication.

The skills I have gained from this will stay with me for life.

I am extremely grateful to the relatives for they have taught me more than any amount of formal education ever could.

The conversations have helped me define the type of doctor I want to be.

Discussion

The widely cited figure of 50% survival of ventilated COVID-19 patients and the unique stress of social isolation made concern for the relatives' mental wellbeing a prime concern for the caller. This, coupled with the absence of the usual visual insights into the impact of information, made a real dialogue essential. Perhaps the students' very inexperience was actually an advantage here. The concern in normal times that the relative must be left in no doubt as to the real possibility that their loved one might not survive was tempered, though not obscured, by the importance of preserving hope. Only when all hope of survival was gone would this be communicated to the family and on these occasions, a senior member of the ITU team made the call.

Could we have done better? Were there to be a further similar outbreak, we would certainly attempt to provide the students with a brief introduction to intensive care medicine together with a glossary of current acronyms. But no matter how thorough the preparation, the students would experience an unprecedented baptism of fire and their supervisors would need to be alert to its possible impact, recognising the students' inexperience in identifying professional boundaries and encouraging them to share their reflections and utilise whatever sources of mental health support work for them.

Conclusion

The COVID-19 pandemic has presented these medical students with a unique crash course, not only in the diagnosis and management of respiratory failure and acute kidney injury but in the importance of good communication. Their communication with patients' relatives has engendered huge respect for people from the widest possible range of backgrounds but this acquisition, though invaluable, has been gained at considerable emotional cost. It is to be hoped that sensitive debriefing with mutual support and the experience of reflecting in writing will have helped the communicators cope. They have already met with the ITU psychologists and know how to access support in the future.

Further resources

A number of organisations, including the British Psychological Society[1] and the Academy of Medical Royal Colleges,[2] have published resources focused on mental wellbeing for healthcare workers during the COVID-19 pandemic which can be consulted for sources of support and which signpost to further resources. ■

The Heartlands Hospital ITU Family Liaison Team

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Consultants: Christopher Ellis, Samia Fayek, Jo James and Dominic Siggins.

Acknowledgements

We acknowledge the calm competence and never-failing support of the ITU team at Birmingham Heartlands Hospital and the courage and resilience of the families of its COVID-19 patients.

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