


COVID-19: Lessons Learned About Communication Between Family Members and Healthcare Professionals—A Qualitative Study on How Close Family Members of Patients Hospitalized in Intensive Care Unit With COVID-19 Experienced Communication and Collaboration With Healthcare Professionals

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Abstract

Family members to patients admitted to intensive care units in general experience a psychological crisis with elevated levels of needs in support, information, assurance, and proximity. During COVID-19, this has been made more difficult as visiting restrictions prevent proximity and cause less access to communication with healthcare professionals. This study aims to explore and understand how communication with healthcare professionals was experienced by family members to patients admitted to intensive care units with COVID-19. To gain knowledge about this, 12 qualitative interviews with family members of patients hospitalized with COVID-19 were conducted. Adopting Reflexive Methodology, the interpretation is carried out following 4 levels, where the empirically grounded themes are analyzed and discussed using Habermas's theoretical concept of communication. The analysis brought forward 2 interconnected themes about how family members experienced the communication with the healthcare professionals during their loved one's hospitalization with COVID-19: The Structure and Form of the Communication and The Contents of the Communication. The study concludes that the family members experienced large variation in the ways that healthcare professionals communicated with them. This variation in communication goes for the when, how, what, and who—all adding to the level of uncertainty. The analyses show that the family members need more fixed patterns for the communication, more continuity in terms of who they speak to, and that they wish that the communication be conducted in a way that is true, right, and truthful.

Keywords

COVID-19, healthcare professionals, communication, reflexive methodology, family members

Highlights

• What do We Already Know About This Topic?

In general, family members to patients admitted to intensive care units experience a psychological crisis

with elevated levels of needs in support, information, assurance, and proximity. During COVID-19, this has

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been made more difficult as visiting restrictions prevent proximity and cause less access to communication with healthcare professionals.

• How Does This Study Contribute to the Field?

The study gives an in-depth understanding on how communication with healthcare professionals was experienced by family members close to patients admitted to intensive care units with COVID-19.

• What Are Your Research's Implications Toward Theory, Practice, or Policy?

The research points out that family members experienced large variation in the ways that healthcare professionals communicated with them. This variation in communication goes for the when, how, what, and who—all adding to the level of uncertainty. The findings have implication for practice in terms of how to plan and conduct communication with relatives to patients hospitalized with COVID-19.

Introduction

Illness is rarely an individual matter, as it affects the whole family.¹ This also goes for COVID-19 where there is a wide range of aggravating circumstances due to profound uncertainty regarding the prognoses and trajectory of the disease. Furthermore, visiting restrictions to prevent transmission of the virus sets a new frame for interaction and collaboration during hospitalization.² This article concerns family members to patients admitted to intensive care units (ICU) with COVID-19 and how they experienced the communication and collaboration with the healthcare professionals (HCPs).

Background

Studies show that family members of patients admitted to an intensive care unit (ICU) often encounter a psychological crisis and experience stress and depression and therefore have elevated levels of needs in support, information, assurance from the HCPs, as well as proximity.³ This has to do with the seriousness of the situation and the fact that patients in ICU often receive invasive mechanical ventilation and cannot themselves talk to their families. Normally, HCPs in ICU adopt many measures to meet family members' needs, where the communication is frequent and often less informal.⁴ There

is, however, still a need to reduce the psychological burden on family members of patients admitted to ICUs by the implementation of more structured information and support interventions.⁵

The pandemic-related visiting restrictions have caused fundamental changes in the way it is possible to establish communication between family members and HCPs. A study on how HCPs perceive communication with family members during COVID-19 shows that they were very concerned about the family members' mental wellbeing, as it is well known that ventilated COVID-19 patients are at serious risk of dying.⁶ On top of this, the HCPs are aware that social isolation causes the absence of the usual proximity and visual insights that are so important for family members in coping with this stressful situation.⁶ According to Morley and colleagues, this situation gives rise to the risk of dehumanization. They stress the importance of HCPs' role in tempering potentially dehumanizing scenarios, in which they should not forget to communicate with family members even though they focus on their battle with COVID-19, including safety and efficiency.⁷

Studies on communication between family members and HCPs about end of life due to COVID-19 point to the importance of adequate communication. During times of limited in-person visits, only 13% of the relatives were present at the time of death at hospitals, and 24% of the cases in nursing homes.⁸ This accentuates the importance of communication between family members to patients dying from COVID-19 and the HCPs, where families report that low-quality communication caused profound distress and affected the quality of bereavement. Family members valued staff availability and being kept informed of the patient's condition and plan of care.⁹

The issue at hand is thus a complex situation, where family members of patients admitted to ICUs in general experience psychological crises with elevated levels of needs for support, information, assurance, and proximity. During COVID-19, this has been made difficult, as visiting restrictions prevent proximity and cause less access to communication with HCPs.

With this backdrop, it was found to be relevant to explore and understand how communication and collaboration with HCPs was experienced and perceived by family members to patients admitted to ICUs with COVID-19.

Methodology

To obtain knowledge about how family members of patients hospitalized with COVID-19 experienced communication and collaboration with HCPs a qualitative interview study was conducted.¹⁰

The fundamental approach in the present study to gathering and interpreting data is philosophical hermeneutics as formulated by Gadamer (1900–2002) in his main work "*Truth and Method*."¹¹ Philosophical hermeneutics is a continuation and break with Dilthey's (1833–1911) traditional,

methodical and historical hermeneutics. It is about understanding, interpreting, and applying in a hermeneutic circle, moving dialectically between wholeness and parts. In philosophical hermeneutics, understanding is linked to being in the world ontologically, where the argument is that if we are to understand something, we must already be in a world and then have some understanding of it in advance. Philosophical hermeneutics offers a stance that emphasizes pre-understanding, language, historicity, tradition, and meaning in relation to understanding and interpreting.¹¹

To obtain a transparent and critical way of producing, interpreting, and presenting the empirical material, a reflexive methodology was adopted, where 4 levels of interpretation is recommended, this is called quadri-hermeneutics.¹² In this approach, the 4 levels allow a reflexive way to handle the process of interpretation of the interpreting subjects and interpretation of the interpretation.

Recruitment and Participants

12 family members of patients hospitalized with COVID-19 from 3 regions in Denmark participated in the period from the 31st of March to the 7th of May 2020. A convenience sampling strategy was used¹⁰ by giving out flyers to healthcare professionals at relevant ICUs in different regions of Denmark describing the study and encouraging family members of patients hospitalized with COVID-19 to email the research team if they were interested. To reduce the spread of infection the interviews were conducted by telephone, audio-recorded, and subsequently transcribed. Table 1 illustrates the relation the family members have to the patients and some details on the patients' situation.

Data Collection

Using Reflexive Methodology,¹² data collection is conceived as the *first level* of interpretations, namely, producing

the empirical material; here interviewing family members of patients hospitalized with COVID-19; and transcribing it into text. The transcription were done verbatim and in [blinded for review]. The translation from [blinded for review] to English was done by the first author and sent to the research group to adjust and qualify. A semi-structured interview guide¹⁰ supported the 3 interviewers had following overall areas: the family members' perspectives on the trajectory of their loved ones' disease, their own worries, visiting restrictions, support from network, and communication with HCP. When asked about their experiences about the communication with HCPs, focus was on what they found important to talk about and not specific details on differences between professions.

Throughout the interview, the participants were encouraged to talk about what they found important and probing question encouraging elaboration were asked. At the first level, interpretation is already going on, as both parties are engaging in a dialogue and the interviewer asks certain follow-up questions on the background of (pre)understandings about what is at stake. The interviewers were, however, determined to explore what was said as openly as possible.

Data Analysis

The *second level* of Reflexive Methodology¹² is about the interpretation of the transcribed interviews. There are no unambiguous procedures when interpreting and the quality of the interpretation depends on the researchers' ability to identify themes that are empirically founded but also meaningful in the context of communication between family members to patients admitted at ICUs and the HCPs on a larger scale.¹² This is in line with the epistemological viewpoint that truth, in a hermeneutical way, is a question of it being meaningful in the context it is presented.¹¹

In striving to identify empirically embedded themes, the research team read all interviews individually. This was

Table 1. Participants.

Participant	Relation to Patient	Age	COVID-19 Themselves	Information on Patient
P1	Husband	64	Yes	Wife admitted at intensive care unit
P2	Daughter	57	No	Father discharge from a medical ward
P3	Daughter	41	No	Father admitted at intensive care unit
P4	Daughter	46	No	Mother discharge from a medical ward
P5	Wife	53	Yes	Husband discharged from a medical ward
P6	Daughter	49	No	Father admitted at intensive care unit
P7	Daughter	48	No	Mother admitted at a medical ward
P8	Brother-in-law	63	No	Brother's wife admitted at intensive care
P9	Son	55	No	Father admitted at intensive care unit
P10	Wife	51	Yes	Husband discharged from intensive care unit
P11	Wife			Husband admitted at medical ward, dementia
P12	Husband		Yes	Husband admitted at intensive care unit

All patients admitted to intensive care units had long admissions and received invasive mechanical ventilation.

followed by a collective interpretation of each interview and a process where units of meaning that appeared strongly across the interview were identified. Units of meaning in one interview were in this way decontextualized and combined with units of meaning from other interviews with a similar meaning. Thus, moving from wholeness to smaller parts followed by a recontextualisation creating a new wholeness.¹² These new “wholes” are presented as empirical themes. At this level, new and more nuanced understandings of how family members of a patient hospitalized with COVID-19 experienced communication with HCPs emerged and are presented in *Findings*.

The *third level* is a critical interpretation of the themes, which was done by contextualization in relation to relevant research within the field of family members of critically ill persons, COVID-19 and cooperation with HCPs, as well as theoretical conceptualizing. Both other research and theory were chosen *after* the second level of interpretation. In this way, the theory does not get to control or gain supremacy over the empirical derived analytical points but gives a conceptualized perspective on the empirical analysis

We sought to achieve new understandings and analytical generalizability through an abductive process, where cross empirical analyses at the second level of interpretation were combined with contextualization in relation to other research as well as theoretical conceptualization of the empirical themes. In the philosophical hermeneutic tradition, this kind of interpretation can provide a fusion of horizons.¹¹ This level of interpretation is presented in the section *Discussion*.

The *fourth level* of interpretation is the researchers’ self-reflection on their own text and claims to authority—including choices of theoretical conceptualization and selectivity of the voices represented in the text.¹² This will be reflected upon in the section *Methodological considerations*.

In the following sections, the theoretical concepts adopted are presented.

Theoretical Concepts

To gain a deeper understanding of the themes concerning communication we adopted sociologist and philosopher Habermas’s concept of communicative action, as formulated in “The Theory of Communicative Action.”^{13,14} According to Scambler,¹⁵ this theory offers a relevant framework for a critical analysis within the field of health. Habermas introduces, in the theory of the communicative action, the idea of system and lifeworld. His main task is to set up a “lifeworld” and the associated communicative action as a counterpart to the system, and the associated steering media; power/bureaucracy and law.^{13,14} Both system and lifeworld are necessary for modern societies, but according to Habermas, we must be aware of the tendency of the system to colonize the lifeworld, which results in reification.^{13,14} The choice of this theory was found to be relevant, as communication between HCPs and family members can be seen as a meeting between a representative of the (health) system, which is

subject, in particular during the COVID-19 pandemic, to a wide range of standardized working guidelines (bureaucracy), for example, visiting restrictions, and a family member, who is part of the ill person’s lifeworld, where they are normally intertwined in each other’s everyday lives.

As this study focuses on communication, Habermas’s specific concept of “speech act” is applied. Here, Habermas describes the normative idea of ideal communication free from asymmetric power relations, and although it can be criticized for being naïve, simplified and unrealistic,¹⁶ the point is, that it is worth striving for. When used in this study, it is thus to clarify what family members of persons hospitalized with COVID-19 are looking for in relation to their communication with HCPs and to critically reflect on the conditions for this. In applying this theory about communication, we aim to provide a critical analysis and an extended understanding of how family members of patients hospitalized with COVID-19 experience communication and collaboration with HCPs.

Ethical Considerations

The participants received written information about the study including assurance that interview data would be treated confidentially and that they could withdraw at any time. Participants gave informed oral and written consent before being interviewed. The interview and the analysis focused on the participants’ narratives about *their own* situation and not their loved ones’ situation. It is therefore not considered an ethical problem that parts of their stories evolve around their loved ones, whom we could not ask for permission.

The participants chose when the interviews would take place and the researcher phoned them at the time agreed. As the interview touched on emotional topics, the interviewer held the interview in an empathic manner and the participants expressed relief about being able to talk about their experiences and feelings. Participants were offered the possibility to phone back if they felt they needed to talk again, but nobody did.

All data material was treated in confidence and participants were assured that no personal data about them would be accessible for others. The study was approved by the Danish Data Protection Agency (P-2020-276) and followed the recommendations of the Declaration of Helsinki II.¹⁷

Findings

A fundamental characteristic of the communication and collaboration between the family members and HCPs during COVID-19 is that the family members are restricted in visiting. This means that their access to knowledge on how things were going is obtained over the phone. If their loved ones were able to talk over the phone they did so. But as the disease for many produces the need for invasive mechanical ventilation, direct communication between the patient and the

family member was often prevented. Thus, the only source of knowledge about their loved ones was *through* the HCPs—over the telephone and not face-to-face. Direct access to knowledge about their loved ones—seeing, touching, and perhaps talking to them—was cut off, making the family members to patients hospitalized with COVID-19 utterly dependent on the HCPs' efforts to collaborate and communicate.

Although the participants' stories both covered communication with nurses and doctors, they did not specifically differentiate between the two professions when they talked about their experiences. For this reason, nurses and doctors are described as HCPs in the following presentation of the analytical findings.

In general, the participants expressed gratitude toward the HCPs both for taking care of their loved ones and for talking to them, the latter being their lifeline. They also expressed great understanding for the HCPs situation in terms of being busy and dealing with great uncertainty and many were concerned that they might burden the HCPs in their work by taking up their time when phoning. That said, the participants also expressed different perspectives on how the communication and collaboration could have been optimized. This both goes for the structure and form of communication as well as its contents.

The Structure and Form of the Communication

The participants spoke in different ways about when and how often they spoke to the HCPs and they found the communication frequency to be somewhat arbitrary:

“Occasionally you could call the hospital and be notified but sometimes you couldn't. Is it allowed to call? When do we have to call? How much can we call? Sometimes they [HCPs] have been annoyed” (P7).

The participating family members tried to create a fixed rhythm or pattern themselves, where they, for example, phoned the ward every morning and every evening, and where they had to balance their own need to get certainty with not wanting to burden the HCPs. A family member said:

“It was very, very difficult to get a firm pattern for when to call me. I understand that they have been under pressure, but I really missed they had a fixed procedure [for the communication]. Because sometimes I had to call and wait an hour and then the doctor still did not have time or had even left for the day. And I've been sad about that, actually. They are of course not used to relatives not being there, so it was strange for them to suddenly have to be calling relatives. But I could have wished they were a little quicker to establish a fixed pattern, [for example] phone us every day after patient rounds and conference” (P2).

As the quote illustrates, family members struggled with two things regarding communication and collaboration: the

lack of a fixed pattern in *when* to communicate and also that it was often initiated by the family member and not the HCPs. Thus, many expressed the view that they lacked explicit agreements about when to communicate, which many thought could prevent them from calling in vain due to constantly busy lines, waiting a very long time on the phone or getting hold of someone who did not have time to talk.

The ones who experienced communication proactively established in fixed patterns by the HCPs were very satisfied:

“We had fantastic dialogue with the intensive care unit. They have proactively called us to update. It has been super” (P10).

This may also prevent some anxiety in the waiting for updates. A family member explains how it felt waiting for not-scheduled phone calls from the hospital:

“*Every time the phone rang, we were scared to death. Our nerves and adrenaline were running at high pressure for three weeks in a row, and we just sat waiting for them to call, and then when they did actually call, we were very scared*” (P4).

Some family members also stated that HCPs helped them with active use of FaceTime or photos in the communication, so the family member could see their loved ones and their surroundings.

The Content of the Communication

Besides questions on when, how often, and initiated by whom, the family members had some different experiences and reflections in terms of the actual “what” or content of the communication and how it was given.

In general, they all had a big need for extensive information on how things were going, as they could not get access to this knowledge themselves. None of the family members experienced that they have received too much information or received information they could not understand or handle, quite the contrary. The family members who experienced thorough and detailed information about how their loved ones were doing appreciated it greatly:

“They have been really good and thorough in explaining how she was and so on” (P2).

Many family members found it important to follow things like blood test results, level of oxygen supply, personal care, nutrition, and mobilization on an everyday basis:

“[I could wish for] something more relevant about how things look, that is, when he, for example, when he had the respirator taken out of his throat [I liked hearing things like...] “now he gets his teeth brushed” and such things. It is nice to hear those everyday things” (P11).

Besides wish for detailed information about the state of their loved ones, the family members appreciated openness

toward their need for information and honesty, also when it came to the health professionals' own lack of knowledge and experience. One says:

"They [both nurses and doctors] were actually very sweet. I told them that I needed to call them three times a day to follow up on how things were going. And they were very open to this. It was busy [at the ward] and they were open about that too and it [COVID-19] was still new for them, and they were figuring it out themselves. I found it helpful to understand a little about their work environment and felt that they were doing what they could (P5).

As the quote indicates, honesty and openness about the HCPs' working conditions in having little experience of treating and caring for patients with COVID-19 led to more understanding and trust from the family member.

Another family member explained that she had a fixed appointment for a daily call:

"...and when it was really bad, I also called in the evening. And they were always really nice. I didn't feel that I was in the way or annoying to them. I felt they showed great understanding for my difficult situation" (P8).

Many family members express, like in the above quote, that it meant a lot for their experience of support from the HCPs, that they do not feel that they were a burden and that it was okay for them to call, and that the HCPs understood that it is a difficult situation they as family members found themselves in.

However, many family members did experience that the communication fluctuated due to person-dependent differences in approach and communication skills, both regarding how accommodating they were toward speaking to the family member and how they talked about the patient. A family member said:

"They have been really professional and accommodating and nice. There have been a few nurses who have been dismissive and said that we should only call once a day. But we have chosen to think that they have had a bad day because all the others have taken their time to talk with us"(P4).

This difference in the way of being accommodated as a family member was strongly expressed in the narratives and dealing with dismissive HCPs left the family members in a powerless position. Some found it very frustrating when having to deal with a dismissive health professional which left the family members alone and insecure.

Another dimension of the different ways of communicating what the family members weighed as important was the way that the HCPs describe the condition of their loved ones. One said:

"But it's different every time you talk to the doctors and nurses. Some choose to shine a positive light on progress while others give a more negative impression [...]. So, it varies how we can interpret how it is going. And it's a strange thing from a distance" (P2).

As shown here, the relatives were very dependent on how the HCPs communicated about their loved one's condition. The fact that many experienced it as because the HCPs communicated in different ways and not because the situation had actually changed, was difficult to navigate and left the family members a desire for a person continually responsible for communication with relatives:

"[...] it could be a good thing with a regular person to communicate with, but I know that would be a little difficult [to accommodate]"(P9).

Discussion

The empirical findings show that family members of persons seriously ill with COVID-19 and admitted to ICUs experience a profound dependency on the HCPs during hospitalization. The structure and the form of communication between home and hospital could be difficult and the family members sought fixed patterns in the communication with the HCPs. They also needed detailed information about their loved ones' condition as well as a wish for being met with a HCP who encouraged hope and showed understanding.

A study shows that family members to patients admitted to ICUs with COVID-19 are in a vulnerable situation with a high degree of unpredictability and seriousness as well as powerlessness due to visiting restrictions.¹⁸ It is thus understandable that our analysis shows that family members hang on to every word the HCPs say—making the when, how, and what of communication between family members and HCPs crucially important. When the ill person is hospitalized, we found that family members' priority was that their loved one received good health care. However, communication between family members and HCP were central for family members' ability to cope with the difficult situation.

Regarding the structure of communication, the analysis shows that the family members spent a lot of energy trying to create a pattern, for example, phoning every afternoon and evening at specific hours. It also shows that family members appreciated it when the HCP took the initiative to call and/or suggest specific hours for the phone calls. Other studies concerning families of patients in ICUs confirm that structured information improves satisfaction and reduces the psychological burden.⁵

The participants in this study did not make use of technologies other than the phone when talking to HCPs. Other studies concerning communication between family members and HCPs during COVID-19 pandemic have dealt with pros

and cons in terms of, for example, phone and video communication.^{19,20} It is pointed out that both family members and HCP think phone calls are useful for information-sharing and brief updates, while video calls are preferable for aligning family members' and HCPs' perspectives.²⁰ The present analysis shows that family members found great differences in the ways that the HCPs communicated about the same issue and that this could give rise to even further uncertainty. Knowing from research that video calls have more potential to align the two parties' perspectives than phone calls is, therefore, important knowledge to recognize.

To further conceptualize the analytical findings concerning the content of the communication, we will adopt Habermas's¹⁴ normative concept of *speech act*. Habermas's interpretation and representation of speech act theory and communication reflect his concepts of the 3 worlds: the objective, the social, and the subjective world. In the objective world, the validity claim is *truth* gained through an objectifying attitude and constative speech acts representing the state of affairs; the social world, where the validity claim is *rightness* gained through a norm-conformative attitude and regulative speech acts established in interpersonal relations (inter-subjectivity)—simply that what is said is the right thing to say in the situation for the involved persons, and finally the subjective world, where the validity claim is *truthfulness* gained through an expressive attitude and self-representation.

In this theoretical perspective, it can be said that the family members need the communication to be valid in term of being true in the objective world, right in the social world and truthful in the subjective world. The family members appreciate it when HCPs with an objective attitude represent the state of affairs by telling them, in detail, about their loved ones' medical condition and everyday activity—the *truth*. They also appreciate it when this is told in a way where the HCPs take on a regulative speech act in the social world, for example, put the emphasis on the positive things of the situation—encouraging hope in the inter-subjective communication with the family member—including giving the communication time and showing understanding for the family members' difficult situation—*rightness*. And finally, the family members emphasized the importance of honesty, where the HCPs through their expressive attitude communicate about what they know about the disease and what they do not—*truthfulness*.

It might be asked what it takes to be able to communicate in this manner. According to research about the psychological experience of nurses caring for COVID-19 patients, they feel discomfort, fatigue, helplessness, fear, and anxiety—especially at the beginning of their work with patients suffering from COVID-19.²¹ Even though they gradually got more positive with self-coping styles like psychological and life adjustment, altruistic approach and team support, this does not change the fact that they work under enormous pressure. Often they have a large workload and work under

uncertain conditions both regarding the treatment and care of the patients, colleagues, wards, and time horizons.²¹ On top of this, they must protect the patients and themselves from infection by wearing extra protective equipment, making the performance of the different caring tasks less flexible.

Knowing this, it is understandable if the individual HCP finds it challenging to take the initiative to regularly phone family members and find the right balance in giving the right amount of information (the truth in detail) in the right way (encouraging hope and showing empathy toward the family member's difficult situation) while being truthful about their own limitations, for example, within experience on the treatment and care of patients suffering from COVID-19.

This makes a systematic approach to corporation and communication with family members even more relevant. Our study shows that family members go through a tough period, where after a hard time getting their loved ones admitted to hospital, they experience fluctuating and diverse communication with the HCPs during hospitalization, followed by concerns about their loved ones' homecoming and too early discharge with no follow-up. These findings are in line with Hart et al (2020), who stress that family support is even more important during COVID-19, especially as maintaining public safety necessitates visiting restrictions. It is recommended that healthcare systems quickly adapt procedures for communication with family members to circumvent restrictions on physical presence. These procedures must acknowledge the conditions under which the HCPs work.²²

Methodological Considerations

This study makes use of qualitative interviews with 12 family members of a person hospitalized with COVID-19. This was to gain knowledge on how they experienced communication with the HCPs. Though the interpretational levels a sort of "collective subject" was constructed, as themes strong across the interviews were brought forward and less represented themes and perhaps contradictions in their viewpoints were left out. Even though there are details in the individual interview which the analytical process has left out, the reflexive methodologies' emphasis on the researchers' ability to bring forward the important messages from the empirical material supports this way of producing new knowledge. There is however some drawbacks that should be taken into consideration.

First, the socio-demographic differences between the participants were not analytically considered. For example, the participants' different relations to their loved ones, where some were spouses, others grown up children, and one brother-in-law, as well as the participants' differences in terms of age, gender and life situation in general. It is known that these factors have an impact on how the situation is experienced and thus give rise to differences when it comes to the need for support from HCP.²³

Second, some of the interviews were conducted while their loved ones were still at the hospital and others were discharged. This may give different perspectives and rationales on what is the most important when it comes to communication. For example, that those whose loved ones were still in hospital may be more anxious about the future, than those whose loved ones are home again. They were however all involved in the situation as we spoke to them, thus not being a past-tense phenomena.

These differences among the participants can also be considered a strength as the objective of the study is communication and collaboration with the HCPs, where various type of relations and time in the patient trajectory gives richness to the nuances in the analyses.

Conclusion

The analysis of 12 qualitative interviews with family members to patients hospitalized at ICUs with COVID-19 about their experiences of communication with HCP provides important insights into their needs regarding collaboration with HCPs during hospitalization.

When hospitalized, and thus restricted from visiting, the family members experienced large variation in the ways that the HCPs communicated with them. This variation in communication went for the when, how, what and who—all adding to the uncertainty. The analyses show that the family members need the communication to be valid in term of being true, right, and truthful: *True* in terms of telling, in detail, about their loved ones' condition, treatment and care—as they cannot see or talk to them themselves, *Right* in the way this is told, where hope is encouraged and understanding for the family member shown, and *Truthful* about the lack of knowledge and experience when dealing with a new and unknown disease.

Taking the working conditions for HCP during the COVID-19 pandemic into consideration, a systematic way of establishing communication and collaboration between family members and HCP is crucial for both parties.

Implication for Practice

- HCPs should proactively plan and offer fixed timeframes for communication
- Information on the patient's condition should be factual and include everyday activities within care
- HCPs should be honest in terms of prognoses and lack of knowledge and experience
- Continuity with regard to the HCP(s) talking to family members is preferable
- Communication with family members should be kind and accommodating

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Author Contributions

The research team developed the study protocol together and conducted all in-depth interviews.

All authors did the analyses together.

CB drafted the manuscript and all authors critically reviewed and approved the final manuscript.

All authors had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

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References

1. Wright LM, Bell J. M. *Beliefs and illness: A model for healing*. 6th ed. 4th Floor Press; 2009:IX-IX.
2. Luttik ML. The COVID-19 pandemic: A family affair. *J Fam Nurs*. 2020 May 19;26(2):87-89. Available from: <http://journals.sagepub.com/doi/10.1177/1074840720920883>.
3. Alsharari A. The needs of family members of patients admitted to the intensive care unit. *Patient Prefer Adherence*. 2019;13:465-473.
4. Au SS, Roze des Ordon AL, Amir Ali A, Soo A, Stelfox HT. Communication with patients' families in the intensive care unit: A point prevalence study. *J Crit Care*. 2019;54:235-238.
5. Scott P, Thomson P, Shepherd A. Families of patients in ICU: A scoping review of their needs and satisfaction with care. *Nursing open*. 2019;6(3):698-712.
6. Ellis CJ. Communication in the time of COVID. *Future Healthcare J*. 2020;7(3):e362020-0115e38.
7. Morley G, Grady C, McCarthy J, Ulrich CM. Covid-19: Ethical challenges for nurses. *Hastings Cent Rep*. 2020; 50(3):35-39.
8. Strang P, Bergström J, Martinsson L, Lundström S. Dying From COVID-19: Loneliness, end-of-life discussions, and support for patients and their families in nursing homes and hospitals.

- A national register study. *J Pain Symptom Manag.* 2020;60(4): e2-e13.
9. Feder S, Smith D, Griffin H, et al. "Why couldn't i go in to see him?" Bereaved families' perceptions of end-of-life communication during covid-19. *J Am Geriatr Soc.* 2021;69(3):587-592.
 10. Polit DF, Beck CT. *Nursing Research: Generating and Assessing Evidence for Nursing Practice.* 11th ed. Wolters Kluwer; 2020:163-334.
 11. Gadamer HG. *Truth and Method.* London: Sheed & Ward; 1989.
 12. Alvesson M, Skoldberg K. *Reflexive Methodology: New Vistas for Qualitative Research.* 2nd ed. SAGE Publications; 2009: 263-318.
 13. Habermas J. *The Theory of Communicative Action: The Critique of Functionalist Reason.* 5th ed. Beacon Press; 2004:VOL 1, 113-405.
 14. Habermas J. *Theory of communicative action: Reason and the rationalization of society.* Polity Press; 2015:Vol II, 1-366.
 15. Scambler G. *Habermas, critical theory and health.* New York: Routledge; 2001.
 16. Honneth A. *The Critique of Power : Reflective Stages in a Critical Social Theory.* MIT Press; 1991. (Studies in contemporary German social thought.).
 17. World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. *J Am Med Assoc.* 2013 Nov 27;310(20):2191, 4. Available from: <http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.2013.281053>
 18. Bernild C, Missel M, Dagyarani I, Christiansen SW, Berg SK. The eye of the hurricane: A qualitative study on what is at stake for close family members to patients hospitalized with COVID-19. *Am J Nurs Sci.* 2021;10(No. 4):191-200. doi:10.11648/j.ajns.20211004.11.
 19. Sacco G, Ll eonart S, Simon R, Noublanche F, Annweiler C. Communication technology preferences of hospitalized and institutionalized frail older adults during covid-19 confinement: Cross-sectional survey study. *JMIR MHealth UHealth.* 2020; 8(9):e21845e21845.
 20. Bashshur R, Doarn CR, Frenk JM, et al. Telemedicine and the COVID-19 Pandemic, Lessons for the Future. *Guest Editorial, Telemedicine and E-Health.* NO 5. Mary Ann Liebert Inc.; 2020:26, 571-773.
 21. Sun N, Wei L, Shi S, et al. A qualitative study on the psychological experience of caregivers of covid-19 patients. *Am J Infect Control.* 2020;48(6):592-598.
 22. Hart JL, Turnbull AE, Oppenheim IM, Courtright KR. Family-centered care during the COVID-19 era. *J Pain Symptom Manag.* 2020;60(2):e93-e97.
 23. Rolland JS. *Helping Couples and Families Navigate Illness and Disability: An Integrated Approach.* 1st ed.: The Guildford Press; 2018.