



## A Novel Illness, a Novel Communications Approach

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The COVID-19 pandemic challenged New York City and its healthcare system in unprecedented ways. The significant increase in necessary critical care services, together with the suspension of normal visitation to prevent further spread, intensified and exacerbated the historical problem of providing quality physician–family communication in the intensive care unit (ICU) setting [11, 14].

To support New York City and New York-Presbyterian Hospital (NYPH), a tertiary care medical center with which the Hospital for Special Surgery (HSS) is affiliated; in late March 2020 HSS converted its 9th floor ambulatory operating rooms and post-anesthesia care unit into an ICU designed specifically for COVID-19 patients. HSS intensivists would be caring for an expected 400% increase in the number of ICU patients, going from a capacity of 4 beds to at least 16, with the possibility of expanding to 32 beds if needed. In effort to support HSS intensivists, a separate team was assembled to address communication with the families of hospitalized COVID-19 patients.

This initiative, which came together in the family medical communications team (FMCT), assigned experienced physician volunteers, who were not providing clinical care

during this time, to the families of patients intubated in the ICU. Once assigned, and in coordination with a designated service excellence liaison (SEL), each physician updated the family daily on the patient's medical status throughout the patient's ICU stay.

The standard for all medical decisions is to give preference to the patient's voice as the central authority in determining goals of care [3]. When patients cannot speak for themselves, those who represent them become essential. But decisions familiar to the ICU staff about continuing and withdrawing life-sustaining treatments weigh heavily on family surrogates who struggle to articulate what they think the patient would have wanted [16]. The FMCT, through consistent daily communication, sought to meet the needs of these surrogates, to help them come to an understanding of the patient's medical condition, to understand the patient's values and preferences under these unique circumstances, and then to support the surrogates in their decisions.

### The Pandemic in New York City

In the weeks prior to HSS accepting COVID-19 patients, the number of new COVID-19 cases was accelerating throughout New York City at an alarming rate. Patients were overwhelming emergency departments [7]. It was unclear what the apex would be or when it would be reached. Nor was it known how long the plateau phase would last, how effective “flattening the curve” efforts would be, how many COVID-19 patients would require ICU admission and ventilation, and for how long.

Because the virus is so highly contagious, COVID-19 patients needed to be isolated immediately. Only essential hospital staff were allowed to enter HSS. The normal bedside interaction that occurs between a clinical team and a patient's family and health care surrogates could no longer take place. Family members' bedside presence helps create assurances that the patient is comfortable, is not suffering, is being cared for [6], and will not be abandoned prior to death [6]. Before the pandemic, daily conversations between the family and the clinical team took place in this context. The

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elimination of family visitation meant the communication between the clinical team and the healthcare surrogate took on even greater importance.

It was clear that healthcare providers would be under tremendous clinical and emotional stress. We were mindful of the physical, mental, and emotional exhaustion that results from the long hours of providing clinical care for such a large number of critically ill patients. We were also concerned about the limited number of hours in the day. How could the ICU attending physician provide clinical care, communicate information about clinical care to the family, and have the emotional capacity and time necessary for difficult end-of-life care discussions? In practice, there was simply not enough time in the day to for an intensivist to add on a 20-to 30-min conversation with each patient's healthcare surrogate, which would result in 5 to 8 additional hours per day.

Additionally, with any ICU admission, there is an assumption that treatment will be aggressive and directed toward meaningful survival. However, in instances where staff begin to appreciate that a patient is not improving despite their efforts, staff themselves must come to terms with the fact, first by their growing clinical sensibility and then through their emotional acceptance. This growing sensibility can then be communicated to the family members, who are experiencing their own fear and apprehension about the prospect of death. Family members can express this anxiety through statements of self-recrimination, equivocation, a desperate search for alternative therapies, frustration, disbelief, and sadness. The transition in care from aggressive treatment aimed at cure to a focus on comfort thus entails a complex evolution of human emotions before mutual agreement between medical team and family decision-makers can be achieved [10].

It had already been well established in the literature that there are significant challenges involved in communicating with families of ICU patients [4, 5, 12, 17]. These challenges include the following:

- effectively communicating medical information and clinical care, and ensuring family understanding,
- sharing prognostic information for a disease process which has tremendous uncertainty,
- increasing trust in clinical care by assuring families that patients are not being abandoned,
- exploring patient values while reinforcing the principle of substituted judgment,
- understanding the surrogate's emotional and psychological burden and providing adequate reassurance and support, and
- preparing the family for possible bereavement.

The COVID-19 pandemic only magnified these challenges.

VitalTalk, a non-profit organization based in Seattle and focused on teaching effective communication skills to clinicians, recognized this heightened need. In April, Back et al. wrote, "In a new, cruel way, the coronavirus 2019 (COVID-19) pandemic has revealed limitations in medical capacity

that amplify the challenges that clinicians already face in communicating with patients about serious illness" [2]. The organization published a Google Doc on COVID-19 communication skills, including directives and scripts for how to talk about difficult COVID-19-related topics [1]. This "playbook" spread quickly on the internet and highlighted the need for skilled communication during the pandemic.

In the face of the crisis in New York City, NYPH had assembled teams of psychiatrists, geriatricians, and palliative care physicians to discuss goals of care with patients in the emergency department. Having such a discussion could help align treatment goals with the patient's known preferences. However, given the volume and rapidity of hospital admissions, these teams could not interview every patient. Furthermore, given the nature of COVID-19, a patient's status could change dramatically without warning. A patient might appear to be recovering and then acutely decompensate, requiring re-intubation and pressor support. Such instances required revisiting goals of care discussions, now with surrogates, and asking: "What do we (clinicians and family) think your loved one would want now?" These discussions, already inherently difficult, were also taking place remotely because of hospital access restrictions.

Once patients were transferred to HSS, these conversations needed to continue.

## The Pandemic at HSS

HSS has always valued prompt, timely communication between patients and clinical staff. HSS's service excellence department is evidence of that commitment. Before COVID-19, this department's patient liaison teams handled communication between patients' families and surgical staff. They were available on hospital surgical floors to answer questions, provide emotional support, and act as medical interpreters for the families of patients.

While good communication with patients and families is part of the patient-centered experience at HSS, the nature of the conversations around COVID-19 represented a new challenge. Family members would need ongoing medical updates and emotional support as they faced clinical decisions related to life and death decisions in the ICU [9]. Thus, the individuals engaged in these conversations needed to have medical literacy, a high level of medical expertise, strong interpersonal communication skills, and time.

To address this new challenge, the Department of Anesthesiology, Critical Care and Pain Management at HSS assembled a team of physicians to function as liaisons between the ICU team and the families of COVID-19 patients. Entitled the family medical communications team (FMCT), this coordinated effort ensured that each family was assigned one physician who gave daily medical updates, provided emotional support, and, over time, helped guide the family in medical decision-making. This approach provided structured, dependable communication from a member of the medical staff to help foster physician–family trust on the one hand, and, on the other hand, to personalize the care of the patient for the medical team in the ICU.

This team worked hand-in-hand with the service excellence department. Once it was verified that a patient had arrived at HSS, an SEL contacted the family immediately. In addition to acting in the familiar role of offering emotional support and practical help (e.g., finding the patient's belongings orchestrating a FaceTime meeting to see their loved one), the SEL made initial inquiries about who the appropriate surrogate decision-maker was [13, 15]. They explained that a member of the healthcare team would be in contact with a medical update within the next 24 h. Service excellence notified the FMCT coordinator that a new patient had arrived and the coordinator assigned a physician to the family. The assigned SEL and medical communicator then worked together, talking to the family—sometimes independently, sometimes together—every day throughout the patient's ICU stay.

The FMCT included anesthesiologists, internists, and palliative care physicians. The palliative care members were onsite, while the others worked remotely. Everyone had access to the electronic medical record and received daily emails from an intensivist, himself a member of the FMCT, who talked with the ICU team after rounds every morning. The FMCT members could contact this intensivist for further clarification regarding a patient's status at any time. If necessary, members of the ICU team could also be reached through the FMCT coordinator, though every effort was made to keep this to a minimum. This information was then passed on to the family in their daily, scheduled phone call. Information gleaned from the conversation was documented in the patient's emergency medical record in a section entitled "communications," especially designed and implemented for the team by the hospital's information technology division.

Further, the communicator and the liaison collaborated in their efforts to address the family's emotional needs. To provide assurances that their loved one was not abandoned, videoconferences were scheduled so that the family could see the patient and meet the nursing staff. To reinforce the human connection between the staff, the patient, and the patient's family, the SELs obtained family photographs that nurses put at the patient's bedside. Often enough, surrogates were themselves elderly, disabled, or suffering from depression [6, 8]. Understanding their significant emotional burden, team members made referrals to social work and pastoral care if deemed appropriate.

When it was decided to transition a patient's care from a focus on cure to comfort, palliative care physicians were instrumental. Those who were members of the FMCT were often already assigned to patients who, because of age and co-morbidities, were not expected to survive. Additionally, other FMCT members could request their advice or additional involvement when ICU staff indicated that the particularly difficult task of beginning end-of-life conversations should occur. However, when a patient did die, the FMCT member, as the primary clinician–communicator, was notified by the ICU. No matter what the time, the primary clinician–communicator called to inform the family member.

For families of patients who recovered from COVID-19 infection or whose care was transferred to other healthcare providers, special conference calls provided closure. The SEL

and the FMCT member spoke to the family together at the time of transfer from the ICU and 48 h later. For patients who were recovering, this 48-h period was considered a vulnerable time. Though they were improving, it had been recognized that they might still acutely decompensate. Therefore, maintaining the established line of communication throughout that critical transition was essential. For the families of patients who were transferred elsewhere, it was often difficult to let go of the individuals who helped them so much through this ordeal. With a transition in medical care to other providers, there needed to be a clear boundary set so that the family understood that the communicator, though a physician, was no longer in the role of intermediary. However, the family was assured that members of the service excellence division were always available for continued conversation and could contact the communicator if the need arose.

In conclusion, the family medical communications team ultimately involved more than 30 physicians, nurses, service excellence members, and administrative leaders, coming together to provide a service for the care of every HSS COVID-19 patient and family. Communicators and family members found it an extraordinarily valuable experience and expressed gratitude for a profoundly humanizing experience in the face of the challenges of dealing with COVID-19. Family members were appreciative of the dependable, consistent, daily communication from a medical expert, especially those who had sparse, inconsistent communication at a previous site of care. Some were even tearful in their expressions of gratitude. In the space of 3 days, HSS put in place a program that provided support to intensivists and families alike. It is so clearly the result of the teamwork that is a hallmark of HSS excellence and one in which it was a privilege to be a part.

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#### **Compliance with Ethical Standards**

**Conflict of Interest:** Mary Chisholm, MD; Mandip Kalsi, MD; Mary Kelly, MSN, FNP-BC; Bella Elogoodin, MBA; Bobby Stack, MSc; and Douglas Green, MD, declare that they have no conflicts of interest.

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## References

1. Back AL. COVID-Ready communication skills: a playbook of VitalTalk tips. Seattle: VitalTalk; 2020. <https://www.vitaltalk.org/guides/covid-19-communication-skills/>
2. Back A, Tulskey JA, Arnold RM. Communication skills in the age of COVID-19. *Ann Intern Med.* 2020;172(11):759-760.
3. Beauchamp, TL, Childress, JF. *Principles of biomedical ethics*, 7th. New York: Oxford University Press. 2013; 106-107.
4. Bosslet GT, Lo B, White DB. Resolving family-clinician disputes in the context of contested definitions of futility. *Perspect Biol Med.* 2018;60(3):314-318.
5. Bosslet GT, Pope TM, Rubenfeld GD, et al. An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: responding to requests for potentially inappropriate treatments in intensive care units. *Am J Respir Crit Care Med.* 2015;191(11):1318-1330.
6. Boyd EA, Lo B, Evans LR, et al. "It's not just what the doctor tells me:" factors that influence surrogate decision-makers' perceptions of prognosis. *Crit Care Med.* 2010;38(5):1270-1275.
7. Cummings MJ, Baldwin MR, Abrams D, et al. Epidemiology, clinical course, and outcomes of critically ill adults with COVID-19 in New York City: a prospective cohort study. *Lancet.* 2020;395(10239):1763-1770.
8. Curtis JR, Treece PD, Nielsen EL, et al. Randomized trial of communication facilitators to reduce family distress and intensity of end-of-life care. *Am J Respir Crit. Care Med* 2016;193(2):154-162.
9. Curtis JR, White DB. Practical guidance for evidence-based ICU family conferences. *Chest.* 2008;134(4):835-843.
10. Fins, JJ. *A palliative ethic of care: clinical wisdom at life's end*. New York: Jones & Bartlett Learning. 2006; 79-86.
11. Heyland DK, Cook DJ, Rocker GM, et al. Decision-making in the ICU: perspectives of the substitute decision-maker. *Intensive Care Med.* 2003;29(1):75-82.
12. Kryworuchko J, Strachan PH, Nouvet E, Downar J, You JJ. Factors influencing communication and decision-making about life-sustaining technology during serious illness: a qualitative study. *BMJ Open.* 2016;6(5):e010451.
13. New York State Department of Health. Deciding about healthcare: a guide for patients and families. <https://www.health.ny.gov/publications/1503.pdf>
14. Scheunemann LP, Ernecoff NC, Buddadhumaruk P, et al. Clinician-family communication about patients' values and preferences in intensive care units. *JAMA Intern Med.* 2019;179(5):676-684.
15. Swidler RN. The Family Healthcare Decisions Act: a summary of key provisions. *NYSBA Health Law J.* 2010;15(1).
16. Vig EK, Starks H, Taylor JS, Hopley EK, Fryer-Edwards K. Surviving surrogate decision-making: what helps and hampers the experience of making medical decisions for others. *J Gen Intern Med.* 2007;22(9):1274-1279.
17. You JJ, Downar J, Fowler RA, et al. Barriers to goals of care discussions with seriously ill hospitalized patients and their families: a multicenter survey of clinicians. *JAMA Intern Med.* 2015;175(4):549-556.