The New Normal: Key Considerations for Effective Serious Illness Communication Over Video or Telephone During the Coronavirus Disease 2019 (COVID-19) Pandemic

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On 4 March 2019, a year before the coronavirus disease 2019 (COVID-19) pandemic descended on the United States, a doctor delivered difficult news to a 78-year-old man who was in the intensive care unit with advanced chronic obstructive pulmonary disease (1). His granddaughter, sitting beside him, recorded the interaction on her cellphone. First, we see the nurse roll in a piece of equipment with a screen. She attends to other tasks in the patient's room while a man on the screen—the doctor—begins to speak. We hear only parts of what he says: damage to the man's lungs cannot be fixed; morphine may help him feel better. The granddaughter asks her grandfather if he understands; we cannot hear his response. The clip ends. The man died the next day. His family, deeply dissatisfied with the interaction, released the video to the press, and articles with titles like "Doctor delivers end-of-life news via robot" were broadly disseminated.

Fast forward to now. Across the country, clinicians are using telecommunication (by video or telephone) for serious illness communication with hospitalized patients with COVID-19 and their loved ones, together or separately. The term *serious illness communication* refers to communication between clinicians and patients about prognosis, goals, values, priorities, and recommendations for goal-concordant treatment plans (2). The pandemic brings new barriers to effective serious illness communication: widespread fear and uncertainty, surging work demands for clinicians, and the clinically appropriate but unfamiliar use of telecommunication to reduce exposure to the virus and preserve personal protective equipment. Here, we discuss how frontline clinicians can have meaningful conversations with patients who are seriously ill and their loved ones using telecommunication during this extraordinary time (Table).

Preparing

Serious illness communication, whether in person or by telecommunication, requires careful preparation. Clinicians should assess the patient's ability to participate, their need for a translator, and their preferences to include loved ones. An advantage of telecommunication is that loved ones can be included from a distance. A review of prior advance care planning documentation can identify legal decision makers and guide decision making when patients cannot participate. If using video, clinicians should ensure patients can use the equipment; some hospitals have engaged volunteers to help with this. If possible, a clinician should conduct visits from a private space where they can remove their mask and preserve the patient's privacy. Clinicians should identify hearing and vision impairment and adjust their environment and communication accordingly (Table). Finally, clinicians should start the actual conversation by checking in with themselves first—especially now with the distractions of the pandemic. A deep breath brings one into the present to focus on the needs of the patient and family.

Building Rapport and Trust

Serious illness communication requires rapid establishment of rapport and trust, which can be challenging over video or telephone (8), especially in the context of shift work and rotating clinicians. Clinicians can foster continuity by including a nurse or staff member who regularly works with the patient or an established primary care provider. Some clinicians have been redeployed as family liaisons to provide regular medical updates during the hospital stay; these liaisons can be included (9). Whenever possible, we suggest having several brief conversations rather than 1 prolonged meeting. An initial conversation without urgent decision making allows participants to adjust to telecommunication, troubleshoot technologic glitches, and begin to build rapport. Even for urgent conversations, a few minutes spent chatting about a patient's interests or background can quickly build rapport. To further build trust, clinicians should acknowledge that telecommunication is not optimal. If patients or family members express disappointment, clinicians can use "I wish" statements (for example, "I wish I could be there in person to support you."). Clinicians should be mindful to demonstrate that they are listening by making eye contact with the camera, not the device screen, and giving brief verbal responses ("yes . . . " or "go on . . . ").

Having the Conversation

Before the conversation, clinicians should consider their agenda: Is the communication task information sharing, providing emotional support, identifying goals and values, or decision making? Many open-source, step-by-step frameworks, some specific to COVID-19, have been disseminated, including guides to breaking bad news, identifying goals of care, and advance care planning (3–6). An advantage of telecommunication is that clinicians can have a framework up on their screen as a cheat sheet during ongoing conversations, which may be especially helpful for clinicians new to serious

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Table. Strategies to Address Common Barriers to Successful Conversations Over Telephone or Video

Key Elements of Serious Illness Communication	Barriers During Telephone or Video Visits	Strategies to Address Barriers During Telephone and Video Visits
Preparing	Unclear communication preferences or language discordance	Assess the patient's ability to participate, preferred language, prior documentation on legal proxies and wishes, and which loved ones to include
	Poor internet connection or inexperience with technology	Engage volunteers to help set up technology in the hospital; invite family members to join a few minutes before the meeting; if there are several family members, designate 1 or 2 as primary spokespeople; participants should mute if not talking, or leader should mute others
	Hearing impairment	Speak slowly, start sentences with the person's name, silence hospital devices, use hearing aids, use pocket talkers if available, and avoid yelling or exaggerating one's voice
	Vision impairment	Ensure the patient's use of glasses and good lighting
	Mask obscuring clinician's face	Clinicians and participants can call from private locations with masks removed
	Clinical distractions	Take a deep breath before starting conversations, and silence cellphones or pagers
Building rapport and trust	Difficulty in building rapport or trust when interactions are remote	Communicate early and often, and encourage storytelling by patients and families to build connection (e.g., "Tell me about life before coronavirus." "I'm glad you have pictures in your room, can you tell me about them?")
	Lack of continuity due to transitions in clinical providers or shift work	Include staff who regularly work with or have a previously established relationship with the patients (e.g., nurses, primary care physician, or clinical liaisons)
	Disappointment with telecommunication	Use "I wish" statements (e.g., "I wish I could be there in person to support you.")
	Clinicians may appear distracted	Look at the camera (rather than the screen) and give brief verbal responses ("Yes." "Go on.")
Having the conversation	Conversations can be disorganized or difficult to initiate over the telephone or video	Consider the agenda and limit meetings to 1 or 2 top priorities
		Consider a communication framework (e.g., CALMER [Check in, Ask about COVID, Lay out issues, Motivate to talk about what matters, Expect emotion, Record conversation])*; keep the framework on a separate screen as a reference during conversations
		Ask permission to discuss difficult topics or to transition to a new topic
		Check for understanding by referring to persons by name, using summarizing statements, or orienting back to patients
Responding to emotion	Limited nonverbal emotional support, such as touch or silence	Listen and watch for verbal and physical signs of distress (e.g., crying, long pauses, repeated questions); pause frequently to check for understanding or permission to go on; when using silence, indicate you are present and listening by nodding
	Impression of being cold or robotic	Acknowledge that these are extraordinary times and use NURSE (Name, Understand, Respect, Support, Explore) statements†

* From references 3 through 7.
† From reference 7.

illness communication. However, we caution clinicians to avoid strict adherence to algorithms and to remain flexible. Asking permission at regular points in the conversation provides natural transitions, builds psychological safety, and allows patients and families some control. For example, a clinician can ask, "May I tell you what I understand about how your father is doing today?" Likewise, clinicians should regularly check for understanding, use summarizing statements, and orient back to patients when loved ones are also in the conversation.

RESPONDING TO EMOTION

During the pandemic, clinicians, patients, and loved ones may have new or heightened emotions, including sadness, fear, worry, and even moral distress and trauma (10). In the absence of nonverbal cues, clinicians must be highly intentional about identifying and responding to emotion. Clinicians should pay close attention to signs of distress, which may be overt (for example, crying) or subtle (for example, long pauses or repeated questions). Frequently pausing and asking, "Does that make sense?" or "OK if I go on?" may help persons feel included. When using silence to respond to emotion, clinicians should physically indicate that they are present and listening by nodding. The acronym NURSE (Name, Understand, Respect, Support, and Explore) provides examples of empathic responses to emotions (Table) (7).

The story about the "robot doctor" from last year demonstrates the risk that families will feel abandoned

without in-person serious illness communication. Yet, we now must encourage clinicians to embrace opportunities to have high-quality conversations with their patients, no matter the method of communication. Effective serious illness communication through telephone or video can empower patients and align treatment options with their values while preserving warmth, meaning, and human connection. Patients and their loved ones are likely to be understanding, even appreciative, as clinicians provide guidance during these extraordinary times.

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