Let's Talk About It: What COVID-19 Has Taught a South African Intensive Care Unit About Communication

Many countries are reeling from the devastating effects of COVID-19.[1,2] To date, the international mortalities exceed 800 000.[3] The economic impact has been staggering; a modest estimation by the World Bank predicts an 8% global financial decline. The recovery of all economies is expected to be difficult because many countries will be plummeted into a recession.[4]

Countless lives have and will be directly and indirectly affected by the SARS-CoV-2 pandemic. The restrictions placed on the public ensured limited foot traffic through hospitals but then also prevented families from seeing their sick loved ones. Although ample efforts have been launched to combat the virus, these measures have unmasked one of the significant indirect complications of the viral pandemic. Communication poverty has emerged with its associated repercussions. Distance and isolation have unmasked a phenomenon of "infodemics," which speaks to misinformation or lack of information culminating in a spectrum of fear and anxiety.[5] Communication between family, patients, and health care workers has in the past proven difficult, with a tendency toward misunderstandings. The net effect of all these COVID-19 measures places even greater strain on this doctor-patient relationship.

A greater concern, however, is for the family and loved ones and their inability to follow up and interact with their sick family members especially once admitted to an intensive care unit (ICU). The psychological impact of these fears and elevated levels of anxiety were previously allayed during visitations and meetings with treating physicians.[6] COVID-19, quarantine, and social distancing have removed this appeasing measure. The ICUs globally were challenged by this distancing, encouraging a reliance on technology. Cellular devices and telecommunication platforms have aided in bridging this social divide, but even this remedy proved to be challenge for lower income countries.[7] Intensive care unit physicians and mental health specialists have previously emphasized the importance of family engagement. It has proven benefits for not only patient health but also the well-being of the concerned family member. The ICU is an environment where issues of consent, confidentiality, and disclosure of information occur daily. The authors raise concern regarding the poverty of communication tools and the impact it has on the greater population, especially at times of crisis.

HUMAN COMMUNICATION

Communication is multilayered and complex. It can be both verbal and nonverbal,[8] and added to these nuances, there are language barriers, cultural interpretation, and nonverbal cues, as well as levels of understanding, which factor into creating an effective environment for communication. In the medical arena, the introduction of and rightful focus on informed consent has heightened the need for optimal physician communication, especially in the critical care setting where most patients are not able to speak for themselves and family members are involved in a 3-way conversation with the treating physician and patient.[9]

As recently as 2015, a significant "communication" asymmetry was proven in a survey of more than 300 people. This indicated that what medical professionals feel is important information to relay to family members and what family members actually want to know are often not aligned.[10] A further survey also indicated that comprehension of the information given, as well as what is communicated, significantly affects patient and family satisfaction.[11]

ABCDEF BUNDLE AND COMMUNICATION ERRORS

With more than 4 million patients admitted into critical care units in the United States alone every year, the focus

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on patient care has moved from survival to a more holistic view on survival as well as the quality of survivorship.[12] In 2013, the Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit was introduced to provide recommendations to better manage critically ill patients. This has recently been updated, and many elements of this guideline can be implemented using the multicomponent, evidence-based guide for the coordination of multidisciplinary ICU care —the so-called ABCDEF bundle.[12] This bundle incorporates family engagement and empowerment, a further indication of the recognition of and essential value that good communication has with regard to patient outcomes in the critical care setting. It has even been suggested by some small studies that enhanced family involvement can lead to reduced ICU stay for patients.[12]

James Reason's Swiss cheese model of error reduction has had a suggested revision by Li and Thimbleby[13] to a hot cheese model, but the basic tenets of the model remain the same: errors in patient management are usually attributable to small errors adding up to a catastrophic failure, with the theory being that, by ameliorating the smaller errors, we can avoid the ultimate negative outcome for a patient. One of the frequently cited "small errors" among staff or between staff and family members is communication or lack thereof. This is further supported by a 2020 review that suggests that omission of information is one of the biggest culprits with regard to medical communication and its associated failures.[14] This is important to take note of in the context of the COVID-19 pandemic with increased strain on communication due to limitations on family involvement with patients and especially in the African context. To name a few, limited data availability for mobile calls, various language and cultural barriers that need to be overcome, and overworked staff who often have pressing clinical needs that overwhelm the ability to take time communicating with their families make the ability to maintain clear lines of communication tremendously difficult.

TRADITIONAL COMMUNICATION METHODS IN ICU

Communication in the ICU is messy and complicated. It differs from the conventional doctor-patient relationship, in that patients find themselves in disabled capacities with varying degrees of organ failure and/or often requiring intubation and ventilation. No longer can patients verbally communicate their questions, needs, or wants. For patients who are awake in ICUs, communication may be limited to simple head nodding, with only being able to assent to ongoing procedures. In the cognizant patient, communication may be aided with pictograms (of basic needs), or if able, a patient may communicate in the written form. At times, because of sedation or muscle weakness, communication via pictograms or writing is stunted, rendering these patients incommunicado. Often, these patients find themselves completely vulnerable and disempowered, leaving their next of kin as their only voice.[15]

Communication with family may be as simple as a pamphlet containing information on the ICU that their loved one is admitted to. Information as basic as visiting hours, direct contact information, and the process for gaining updates from a doctor in the intensive care opens the door to better health care worker and familial interactions.[16] Traditionally, communication media were either personal or telephonic.

Telephonic interaction was used for obtaining more medical history about the patient and informing the family of a patient's medical condition, enabled obtaining informed consent from next of kin, and also used to request an in-person family conference. Personal communication is known to establish better relationships, because it allows for clearer verbal and nonverbal cues. In the context of the multiracial and multilingual country that South Africa is, the presence of nonverbal cues makes it easier to identify whether there are gaps in understanding as well as allow for smoother communication via an interpreter.[17] Being a diverse nation, these conferences also enable the health care practitioner to recognize cultural beliefs and enables accommodation of this in the patient's health care journey. The complexities and nature of pathology in critically ill patients necessitate a clear understanding between health care practitioner and family. It is vital that such family discussions occur as a matter of priority with every patient admitted to the ICU and not only when an end-of-life scenario occurs.[18] This will allow early formation of relationships, for the condition and expected prognosis of a patient, and enquire about express wishes that a patient may have or if a medical directive exists. Communication thereafter will serve to reinforce what was said in the first conversation and provide families with the ability to process the emotions that they have during this time.[19]

COMMUNICATION DURING THE COVID-19 PANDEMIC

The COVID-19 pandemic brought about many challenges in our clinical practice. One stark reality is that we went from having most COVID patients ventilated and deeply sedated to having awake patients on high-flow nasal oxygen therapy. This allowed for the cognizant patient to have an active role in understanding his/her condition and the changes that occurred daily. It also allowed patients to verbally communicate with their families and loved ones. Although this sounds ideal, a new barrier dehumanized the interaction, with actual physical barriers being masks, shields, and gloves.[20] Something as simple as a reassuring smile or the warmth of a hand can no longer be offered. Face shields and masks inhibit voice projection, resulting

in individuals having to turn up the volume. With this comes the loss of gentle and soothing tones of kind and reassuring words.

Furthermore, COVID-19 and lockdown regulations brought an end to family visitation. In hospitals and ICUs that were overwhelmed with the sheer volume and severity of illness of patients, there was little time for protracted family conversations. Worse still, these conversations could no longer take place in person but had to be done telephonically.[21] Families' fear of their loved ones "dying alone" was realized, with no opportunity for saying their last goodbyes and thus achieving a necessary further step to closure.

Patients in low-risk/non-COVID ICUs experienced the same fate, being critically ill with their loved ones unable to visit. This created much confusion and turmoil for patients' families who had to come to terms what this pandemic is taking away from them even if they did not have the disease. It marred the health care worker and family relationship because first there was resentment before understanding could begin.[21] Most South African households are reliant on mobile cellular connections for communication and data-based activities.[22] Although cellular data is most reliable, they are still more expensive than a fixed connection, and the speed and quality of the connection may be hindered by the traffic on a particular tower. End-of-life discussions became more arduous with health care practitioners left further unsure whether the message had been delivered between heightened emotions, poor cellular network connectivity, and language barriers.

In a bid to accommodate the myriad of emotions and allow a personalized connection, video calls were offered at specific times, thus enabling loved ones to "see" the patient and take in the visual cues, which assist with understanding the severity of being critically ill.[23] It enabled families to hold "bedside" prayer and integrated them into the patients' clinical care.[24]

OBSTACLES TO CLEAR COMMUNICATION

Technological solutions to this increased distancing proved challenging for all ICUs, particularly those of lower income countries. The technological solution unmasked an inherent socioeconomic problem experienced by South Africans and, indeed, many other low-income nations. Research shows that more than 89% of South Africans have access to a mobile device, a falsely reassuring fact.[25] The general population has access to cellular devices; however, data packages and airtime may prove too costly for poverty-stricken individuals.[26]

The presumed benefit of cellular access is communication in forms of telephone calls and applications that allow for face-to-face communication. The applications that allow for "face time" were of particular interest to intensivists. It not only connects family but also allows for a visual explanation of patients' state. Clear communication is of paramount importance to the ICU team because they often must gain consent from next of kin for various procedures. The value that this technology affords cannot be understated when one considers the importance of informed consent. However, it is this very concept of informed consent that is called into question as illustrated in a survey exploring health care workers' perceived duty to inform next of kin when done telephonically as opposed to family conferencing.[27] Most doctors felt that, when sharing information to next of kin during family conference, relatives should be kept fully informed, whereas those being informed telephonically felt the information should be tailored to the knowledge of the person being spoken with. This study speaks to the obligation observed by the physician to the "person" (next of kin) versus the "machine" (handheld).

It also presents challenges in terms of patient privacy and issues around confidential discussions. Although it is possible to communicate with great depth with the next of kin, it remains incumbent on the treating physician to safeguard against the undue dissemination of information and images of the critically ill patient. This is considerably difficult when one considers that conversations and calls may be recorded without knowledge and consent. In addition, where previously sensitive conversations could be contained in an appropriate family conference room, the current situation steps out of the accepted social norms and standards.[18] Even the most basic concept of dignity cannot be ensured in teleconference because these interfaces may happen at times of inconvenience and situational inattention.

FAMILY CONFERENCES OF OLD

Technology makes it possible to bridge enormous gaps; however, physician intuition still lends itself to the previous way of doing things.[28] Hospital visits allowed an amount of empathy and professionalism that a handheld device struggles to afford. The digital world has certainly made access to knowledge much easier, but the processing of sensitive information and the humane aspect of the doctor-patient relationship cannot be surrogated by telemedicine platforms. Confidentiality is fundamentally important in all areas of health care, and the ICU is no different. However, the nature of ICUs and the expected and unexpected life-threatening situations dealt with daily make the safeguarding of privacy and confidentiality a tall order.[27] Patients often share a room, presenting the structure of these units as another obstacle in view of privacy preservation when videoconferencing and teleplatforms are used. Family conference rooms are ideally suited to the gravity of the type of discussions, which are commonplace in the intensive care world. Conversations around futility, end of life, and worsening or improved clinical conditions

are better suited to respectful, empathic in-person discussions. The important nature of these discussions cannot be protected in busy environments with unexpected interruptions. Intensivists are thus duty bound to carefully balance patients' rights against the desires and needs of patients' families.

WHAT COVID-19 HAS TAUGHT US

The COVID-19 pandemic has highlighted the multiple limitations in the medical field that contribute to the difficulties of communicating with families and their families.[29] A 5-point approach to comprehensive family involvement has been suggested with less focus on family visitation and improved planning with regard to written information sheets, regular phone calls to update families, and technological assistance in the form of video calling. Added to this is the ongoing reminder that communication also has an emotional component to it and that, when dealing with critically ill patients, this is especially heightened for everyone involved.

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