Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Humanities and Medicine

Communication in the Time of COVID-19

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□ **Abstract— The ideal way to make a connection with patients and their families is well studied. Despite these prescriptive measures, communication in emergency medicine is never easy. This past year and a half with restrictions imposed by coronavirus, all levels of communication have been made more difficult. This humanities in medicine essay uses patient examples to illustrate the challenges and pitfalls encountered when family and friends are no longer able to participate in history taking. © 2021 Elsevier Inc. All rights reserved.**

□ **Key Words—Communication; COVID-19; Patient care; Humanism**

In mid-April 2020, when the world was in the grip of Coronavirus disease (COVID), I received a call. My friend's father, who lived several states away, had fallen ill. He had malaise, fever, and a low oxygen saturation. He and his wife were both physicians. What followed can only be described as absurd. His wife had driven him to the hospital when he was still talking, despite his increasing breathlessness. She had to leave him at the emergency entrance alone. After he was admitted, she still was not permitted to visit. Over the course of the next 24 hours his oxygen dipped dangerously low. He refused to comply with wearing the oxygen supply that would stabilize him. He needed to be intubated, but when the doctors told him, he refused. The doctors did not tell his wife, though. He seemed lucid, and able to make his own decisions. What they didn't know was that he had lost the will to live several months before, when his only son died of a malignancy. When his wife checked with his nurse, she found out that he was worsening. Over a video connection she begged him to let the doctors intubate him. He refused.

The one loophole in the visitation policy for that hospital was that an exception could be made for life or death. A brief visit might be allowed. She told her husband that she was on the way. He agreed to be intubated as long as she did not come. She started driving back toward the hospital, anyway, hoping that the loophole would apply to her.

At 11 that night he was intubated by the doctors in intensive care. This was not communicated to his wife. She found out when somebody called to get consent for a central line now that he couldn't speak for himself. The doctors agreed that she could come in to see him briefly given his change in condition. By 11:30 PM he had self-extubated himself. Again, nobody called his wife. Why should they? The patient, who was notably hypoxic, was refusing intubation again. The team honored his wishes. His wife was at the intensive care unit desk by then, asking to speak with the doctors. Nobody came. She called me, at a loss as to what to do. Although a physician herself, she wasn't adept at navigating this new system. The unit clerk who I heard on the other end of the phone said, "You can't talk to the doctors. They are too busy." His wife called patient relations.

This was a man who was severely depressed, and also hypoxic. The doctors only had part of the story. The other missing half of the story was with his wife. The doctors will never know that though. He coded at 1:15 AM when his oxygen level dipped down to 28%. She was finally at

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his bedside to see him. It turned out to be the most important thing to her. When I spoke with her again in the morning, the tumult of the night before behind her, that is what she took away. Despite the errors, omissions, and questions about his care, in the end, she was there with him. For that she was grateful.

The ideal way to make a connection with a patient and their family is not a mystery. To the contrary, it has been well studied; sit down at the bedside, let the patient speak without interruption, make eye contact, reflect back what they've said to see if your history taking is accurate, then circle back with updates and plans to keep them and their families informed (1,2). Despite these prescriptive measures, communication in emergency medicine is never easy (3,4). We see people at a time of pressing need with only minutes to make a personal connection. We interrupt to a fault in an attempt to speed along our history taking. We face both limited information and limited time to explain the treatment and forge a therapeutic relationship so that our recommendations are heeded. There are many places we could fail. Any member of our extended team, from the valet to the radiology tech, can be abrupt, not look up from a phone, snap at a family member, and all our hard teamwork is lost.

On top of our normal challenges, this past year and a half we have faced, and continue to face, restrictions imposed by coronavirus. All levels of communication have been made more difficult. We didn't sit at bedside for fear of getting sick ourselves. Patients were given masks and separated from their families and friends who provide physical and emotional solace.

As vaccination rates increase in the United States, precautions and restrictions have begun to ease. Still, globally, $< 1\%$ of the developing world has received one dose of the vaccine (5). Even in the United States the threat of dangerous variants lurks. As a result, many doctors and nurses have not been able to let down their guard. For patients with respiratory complaints, we continue to go in "gowned up," in n95 masks and face shields, goggles, and gowns. Only our eyes are visible behind the foggy lenses. Even talking and hearing is difficult. Our voices are muffled. We're in a hurry to get out of the room, not only because of our discomfort under our personal protective equipment, but also because of fear; fear of risking a longer exposure than necessary, fear of coming into contact with viral droplets that the rest of the world is hiding from. Interviews and instructions are rushed, leading to countless mistakes or lack of understanding of the treatment plan.

The first time I gowned up during the COVID-19 crisis, I went in to see a young man with a fever who had just returned from South America. He stared at me wide-eyed. I must have looked terrifying to him. Despite my deliberate speech and eye contact, I'm not sure if he ever got a sense of who I was or why we were doing what we were doing. The connection between patient and doctor in these circumstances is easily lost. We become anonymous.

During most of the pandemic, family and friends who are key sources of information were banned from visitation, no longer available to be with the patient in the emergency department (ED) or to inform our decisions. Visitor restrictions, which were desperately needed during this crisis, were draconian. Restrictions were nearly universal across hospitals: no visitors for adult patients unless it was a true matter of life or death. The night that visitor restrictions were imposed in our hospital, a young woman was transferred to my ED. Her family, who came from over an hour away, was told to stay in the car. They circled the hospital, waiting. We were making a decision to intubate her without the most important element—participation and support of her family.

During the pandemic we quickly adopted innovations in the ED, encouraging video calls with family to get consent so they could see who was speaking. We collected mobile numbers, interviewing patients, updating them, and explaining discharge instructions by phone, through the glass door, to minimize exposure and use of masks and gowns—a sort of in-person telemedicine. It seemed to help make a connection and moved communication closer to normal.

Once the patient was admitted to the floor, the challenges persisted. There was no daily visitation. For a patient who was not critically ill there may be FaceTime and phone conversations between the family and patient, but for those who were sick enough to really need input from their families, we were constrained. Around the world, these same challenges continue to play out even now. Communication is shown to be a key driver in patient perception of care. Anything we can do to enhance communication, such as follow-up nurses, engaging allied staff in supporting patient care, and teleconferencing, helps to address the constraints imposed by COVID (3). As we move back toward "normal" and enjoy welcoming our colleagues—care coordinators, social workers, chaplains, and translators to our side, I hope we will not forget all that we learned as we fought our way through this past year and a half. We are left strengthened, more creative, more flexible, more adaptable, and more capable than we ever knew we could be.

Despite all our innovations we can still fall short of our ideals. I learned an important lesson that night in April. No matter how busy you are, no matter what you think you know, you only have half the story when the family is left out. Critical information important to patient care can easily be missed. The ones left behind are the ones

who will remember how we carried ourselves. I hope that we somehow showed them the human side beneath the mask.

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