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Communication strategies to mitigate fear and suffering among COVID-19 patients isolated in the ICU and their families

The COVID-19 pandemic has challenged modern health care practices globally. With insufficient preparation, healthcare providers are facing high volume of severely ill patients requiring advanced life-sustaining treatments (LSTs) in intensive care units (ICUs). Many of these patients are unable to communicate consistently, if at all, with their ICU medical teams due to work of breathing from respiratory failure, mechanical ventilation to support respiratory failure, or delirium associated with their severity of illness. Isolation precautions-necessary to mediate infection rates- have led to devastating realities and communication challenges for patients and their families kept physically separated from each other, giving rise to great fear and suffering. We offer several practical and actionable communication strategies to offset these burdens among isolated COVID-19 patients and their families.

Perform a communication intake

Rapidly employed interventions to support acute respiratory failure, shock, and multiorgan system failure are the primary focus during the initial hours and days of an ICU admission. Admission to the ICU is a frightening experience, but timely and effective communication among patients, families, and health care workers (HCWs) can lessen fears, even if only by acknowledging they exist.[1] Under pandemic conditions, communication may be overlooked by HCWs due to the prioritization of life-sustaining needs. The absence of a loved one at the bedside, typically serving as the patient's advocate and as a potent reminder of the patient as a whole person rather than solely as a critically ill patient, may also contribute to HCWs overlooking the communications needs of patients and their loved ones. Earliest possible and then routine assessment of patient and family information needs and preferences can relieve psychological suffering and enable more familiar exchanges as important medical decision-making proceeds.

Initial assessment of communication preferences includes asking interactive and competent patients who, if anyone, they wish HCWs to update on their condition. Frequency and modality of communication can then be addressed, i.e., telephone or video conferencing using computer or smart phone apps. ICU teams should establish which team member(s) will be responsible for which types of communication. For example, a daily check-in might be scheduled in lieu of the standard practice of informal check-ins during family visits. The ICU team should plan which team member(s) will be the primary outreach representative each day and assure flexibility to respond to family-initiated communication requests as a team when bedside providers cannot respond immediately.

Family meetings should occur as early as possible, ideally within 5–7 days of ICU admission, and at regular intervals thereafter. The family should be informed that palliative care specialists may provide additional support. Current guidelines for ICU family meetings may be tailored for use during the COVID-19 pandemic.[2,3] A communication intake can facilitate patients' control of their health information and keep them connected to loved ones as much as possible while also promoting confidence in and accountability for the ICU team as they exchange information and address clinical challenges.

Establish ongoing, bi-directional communication

Establishing bi-directional communication can help ease fear of abandonment and feelings of uncertainty that many patients and families experience during COVID-19 hospitalizations. Communication includes a reminder of HCWs' obligation to treat symptoms as well as the disease, and that HCWs remain committed to addressing, and hopefully relieving, patients' suffering. While the course of COVID-19 is becoming better understood, there remains substantial incertitude. Ongoing discussions with patients and families about emerging clinical scenarios can foster shared decision-making. Early communication also fosters trust regarding recommendations about the limitations of LSTs for patients succumbing to the disease.

Share changes in care standards as appropriate

Under standard clinical care in the ICU, patient autonomy drives patient care decision-making.[4] Contingency and crisis standards of care are required when healthcare systems and hospitals face limited resources, such as during the current COVID-19 pandemic.[5] Contingency standards adapt existing healthcare resources to expand clinical services to more patients and are generally equivalent to standard clinical care. Crisis standards of care are necessary when the demand for LSTs and healthcare resources far exceed supplies (e.g., ventilators, dialysis machines, nursing staff) despite adaptations and expansions under contingency standards. Crisis standards prioritize population health ethics, assuring justice, transparency, and equity with the allocation of LST resources to patients most likely to survive to hospital discharge (vs. providing LSTs to any patient who wishes to receive them under standard and even contingency standards). Decisions to shift to these different standards of care are not made lightly and are not made at the individual provider or even individual hospital level, but instead are made jointly across states or regions. It is important for healthcare systems to consider how to best share changes in care standards with ICU patients and families, maintaining

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a balance between keeping them informed and minimizing the stress and alarm that such decisions may cause.

Use palliative care specialists as partners in communication

Specialist palliative care providers play important roles in patient and family support and communication through in-person or virtual visits in conjunction with ICU teams. Palliative care can enhance the quality of communication by using specialized communication techniques. Additionally, palliative specialists can provide communication coaching to treatment teams, helping them find empathic pearls when discussing goals of care for COVID-19 patients. Palliative care support is indispensable in supporting bereavement and ensuring continuity of care for families. Palliative care is especially important when operating under crisis standards of care to support patients and families and to provide the highest quality of end-of-life care when needed.[6] Communication about the impact of rationing LSTs on individual patients while continuing to acknowledge the value of the patient dying from COVID-19 and providing assurance of the commitment to avoid patient suffering requires engagement and leadership from palliative care providers to support patients and families through crisis standards.

Fear and suffering are real and present among ICU patients and families under normal circumstances; the COVID-19 pandemic has magnified these burdens. Communication among patients, families, and HCWs at all phases of an ICU admission can help to relieve patients' and families' fear of abandonment, reduce feelings of isolation, and relieve psychological suffering. Examination of long-term psychological effects such as anxiety, depression, and post-traumatic stress symptoms among COVID-19 patients and families is warranted to determine how best practice communication strategies can help alleviate the inevitable psychological toll.

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