



Time-critical telephone conversations in the emergency department: lessons learnt from a pilot educational project to improve communication skills over the telephone in response to the COVID-19 global pandemic

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ABSTRACT

In many countries, the COVID-19 pandemic resulted in restricted hospital visiting by relatives. Staff have been forced to deliver unwelcome and bad news over the telephone. There are few training resources around how to do this. We created a bespoke training package consisting of a 15 min eLearning session and a 1-hour facilitated role-play session. Two simulated telephone calls to a professional actor posing as the relative were undertaken on a speakerphone. Following each simulated call, the actor gave feedback to the caller, focusing on the likely experience of a relative during these conversations. Elements specific to telephone conversations included ensuring the safety of the recipient to take the call (eg, not driving a car), ensuring they had adequate local support, and allowing a deliberate silence after delivering the bad news. Silence has a powerful impact, despite being uncomfortable. The opportunity to have written notes before calling and to offer a return call was seen as an opportunity for improving communication. We collated these experiences into a series of phrases found most useful and empathic by the actor and participants. A practical aide-memoir was created from this learning that could be used to help deliver bad news quickly in the emergency department.

INTRODUCTION AND BACKGROUND

The global COVID-19 pandemic has brought about many challenges to the emergency medicine (EM) community around the world. To reduce the spread of COVID-19, many hospitals restricted visiting.¹⁻³ Having difficult conversations over the telephone in time-critical situations has been an unexpected consequence and a challenge of the pandemic.⁴ Staff in emergency departments (EDs) may have to gather information from relatives, if the patient is unable to give the full information, while breaking difficult news of their current (critically ill) condition. Breaking bad news (BBN) is traditionally encouraged as an in-person conversation to optimise communication (such as body language, eye contact and touch).¹⁻³ However, during COVID-19, this has had to be modified. BBN in person, let alone via telephone, is a challenging task. Within the ED, there is the added pressure of doing this with patients and their relatives when the physician has only known the patient for a short period of

time or not at all. The Royal College of Emergency Medicine in the UK acknowledges and states that BBN is an important skill for healthcare professionals who work in the ED.⁵

There is limited research in delivering bad news from the ED over the telephone. Models such as SPIKES,⁶ BREAKS⁷ and Kayes⁸ (figure 1) are rooted in the oncology or palliative care setting.⁶ Here there is often time to build rapport (through regular clinic visits) and deliver bad news in a quiet, unhurried setting. SPIKES is a six-step approach first described in 2000, having been created to assist oncologists with a structure for BBN.⁶ In 2010, the BREAKS protocol for generic BBN was developed⁷ with the Kayes 10-step model being developed in palliative care in 1996.⁸ These models offer a reminder of important concepts that need to be considered for BBN, but these are focused on the face-to-face setting. Undoubtedly, these core concepts apply to everyday EM practice in relation to BBN. However, these models were not set up for the acute setting. Evidence does suggest that BBN is challenging in the ED, with physicians and those they speak to not always understanding or agreeing on what was said.⁹

Existing training resources usually recommend delivering unwelcome news face-to-face in a planned environment. Reisman and Brown² offered scenarios around how a telephone barrier can make communication difficult and miscommunication more likely. Their case-based paper does highlight that telephone conversations are challenging and require a different set of skills. Collini *et al* recognise that training for difficult conversations and BBN is an important skill needed in the ED¹ and describe their telephone simulation project. This concept paper will share how our telephone simulation training project has helped us understand best practices for delivering these challenging conversations in the ED and allowed us to form an aide memoir for practical use.

INTERVENTION DEVELOPMENT

We developed a bespoke training package aiming to provide practice for staff on having difficult conversations over the telephone. This pilot project was set in Leicester Royal Infirmary, ED in the UK, a tertiary university teaching hospital serving a population of 1.1 million people, with approximately



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SPIKES	BREAKS	Kayes Model – 10 Steps
Setting	Background	Preparation
Perception	Rapport	What Does the Patient Know?
Invitation	Exploring	Is More Information Wanted?
Knowledge	Announce	Give a Warning Shot
Empathy	Kindling	Allow Denial
Summary	Summarise	Explain If Requested
		Listen to Concerns
		Encourage Ventilation of Feelings
		Summarise
		Offer Further

Figure 1 Comparison of some common breaking bad news models.

240 000 annual patient attendances. The project was advertised to doctors and nurses working in the ED through departmental email and social media. For this pilot, we aimed for approximately 10% of staff to attend in the first instance.

The training package comprised two elements: a pre-session eLearning package followed by a 1-hour facilitated role-play session using trained actors for two simulated calls. The eLearning package (on Google Forms LLC) was created using information from existing ‘delivering bad news’ resources, experiences of senior ED staff and with advice for obtaining information in stressful circumstances from a Leicestershire Police call-handling trainer. The eLearning was reviewed and revised by three experienced EM consultants with input from specialist palliative care nurses.

The role-play session (online supplemental material 1) involved creating a typical COVID-19 scenario (box 1) based on the types of cases we were seeing in early to mid-2020. Using a small group of senior ED clinicians, we iteratively tested the scenario over one afternoon session with a small group of senior ED clinicians and actors who provided feedback about the scenario to ensure it was realistic from the perspectives of both the clinician and the relative. Following this feedback, the scenario was modified; evaluation and reflection forms were changed; and the session running times were adjusted. We sought to minimise patient-facing time away from the ED to maximise attendance. This resulted in a 1-hour training session with staff allocated to attend in advance of their shift.

Following this, the pilot programme was rolled out over a 6-week period. Learners were initially invited to attend sessions through advertising via email and local social media groups. If there were spaces left on the day, learners were then allocated to sessions. Each group included one actor via telephone, with typically eight learners, two of whom would act as call-makers, with the remainder as active observers. Active observers were

Box 1 General scenario

A 42-year-old patient, Jamie Smith, is critically unwell and has been ‘red called’ into the emergency room. Paramedics handover that he has asthma. There are no relatives with the patient. There is no information on the hospital system as they don’t live locally and are visiting family. The man looks severely breathless. Prehospital oxygen saturations were 80% on air. It is suspected he has COVID-19. Non-invasive ventilation (CPAP (Continuous Positive Airway Pressure) is commenced. There is no improvement.

One hour later, Jamie has a cardiac arrest and dies.

encouraged during the calls to reflect on phraseology, tone of voice, pacing and structure that they might use in their future practice, and to share this learning in a group discussion after the call. The script required critical information to be exchanged: scenario 1 conveying grave and uncertain prognosis and scenario 2 delivering news of the patient’s death (online supplemental material 1). The actor gave feedback to the call-maker, reflecting on their experience as a ‘relative’ during these conversations. The actor’s feedback was unscripted and did not follow a set pattern; it primarily covered positive aspects, with suggestions for improvement and any points of clarification. The facilitator used the actor’s feedback to encourage discussion and learning among the group. Feedback was written down and available for participants to take away and reflect on. All forms including actor’s feedback, participant’s reflections and evaluation forms were collected (examples in online supplemental material 1). The data were reviewed looking for useful phrases and structures that could be used in clinical practice.

A total of 61 members of staff (10% of the total ED staff) were trained between May and June 2020, with slightly more doctors (35) than nurses (25) and a medical secretary. We analysed the data from these initial pilot sessions to help understand what learning there was and what could potentially be used in clinical practice. Two of the authors (SE and LK) reviewed observers’ written reflections and suggestions for improvement, actor’s feedback and the evaluation forms.

WHAT DID WE LEARN?

Preparations for these conversations is crucial. Like face-to-face conversations, the physician should be sure to have the correct patient notes and find a quiet, private space in which to make the phone call. Mental rehearsal for the call ahead is a useful practice. An advantage of the telephone calls over a face-to-face conversation, participants noted, is the ability for the physician write down a plan for the key points to cover within the call.

One essential aspect of telephone calls the actors emphasised is the need to check if it is a safe time to talk. With most people using mobiles, there are many anecdotal stories of patients having bad news being broken while driving, shopping and at the gym. All BBN teaching emphasises the need for language and tone to be sympathetic and empathic.^{1 6 7 10 11} In face-to-face conversations, the physician can use body language or offer tissues or a cup of tea, but with telephone calls, tone and language are the only thing one has.

Understanding what relatives know of the patient’s situation can help to sign post how you approach the next aspect of the call. The actors found it useful for helping to build rapport with someone they had not met as it felt as if the clinician was really trying to understand what was going on. These questions can also provide insight in to the relative’s emotional state.^{10 11}

BBN recommendations all suggest that the physician deliver a ‘warning shot’, which allows the receiver of the news to be prepared.^{4 6 7 10-13} The ‘relatives’ found this even more important over the telephone. They recommended keeping it simple and not going into too much detail at first. For example, after introductions and checking that the person is in a safe place to talk, the person delivering the news should say something like ‘I’m really sorry but the news I have for you is bad. Sadly, a short time ago Jamie died’. Surprisingly, repeated feedback from the relatives was the need to get to the point of death quickly, after an appropriate warning shot. Going into details of what happened, and then finally saying the person died made the relatives feel as if they were being given false hope.

Box 2 An example of a structure to approach delivering news that a relative has died/is critically unwell over the telephone in the emergency department

Set-up

- ⇒ Gather notes, review previous conversations.
- ⇒ Rehearse explanations and language.
- ⇒ For telephone conversations, you can keep notes in front of you.
- ⇒ Your language and tone are all that is available on the telephone—plan ahead to get them right.
- ⇒ Tell the team what you are doing.
- ⇒ Consider taking someone with you.

Safety

- ⇒ Are you in a quiet place where there is minimal chance of being disturbed?
- ⇒ Is the person on the end of the phone safe to talk? (not driving, at the gym, etc)
- ⇒ Are you speaking to the person you think you are, and is that the right person to talk to about this patient?
- ⇒ Are you the right person to have this conversation?

Situation

- ⇒ Check knowledge of events.
- ⇒ Try not to draw out delivery of unwelcome news.
- ⇒ Use unambiguous language that is less likely to be misinterpreted.

Space and silence

- ⇒ Allow some silence, with time and space for questions and emotions.
- ⇒ Remember it is much more difficult to take in information over the telephone, and you only have your voice and words to get your message across, so *take your time!*
- ⇒ Consider offering a call back if the person is unable to take things in.

Suggest

- ⇒ Explain what will happen next.
- ⇒ Avoid too much detail if you have passed on news of death or other unwelcome news—no one is able to take in lots of information when they have received bad news.
- ⇒ Provide important numbers/information.
- ⇒ Plan a second conversation (potentially with a different person) if required.

Sum up

- ⇒ Reiterate important information and the plan.
- ⇒ Provide contact details for further discussions.

Stop!

These conversations can sometimes be stressful and emotional for you and the other person. Do not be afraid to ask for a few moments to find the right words or even to arrange for someone else to call back if it is not proceeding as you planned.

Are *YOU* ok?

Do *YOU* need some time out or an opportunity to debrief?

Giving space and silence after delivering the initial information to the relative gives them time to take it in and digest it. Silence is known to be crucial when news such as this is given.^{1 6–8 10 11} While on the telephone, everyone making the call found the

Box 3 Empathetic phrases from both observers and actors

- ⇒ 'Are you safe to talk or would you like me to call back in a few minutes?'
- ⇒ 'I need to give you some difficult news, would you like to call someone to be with you?'
- ⇒ 'He is extremely unwell, I'm worried that this could be life-threatening'.
- ⇒ 'He is unwell enough that he could die'.
- ⇒ 'I'm so sorry but unfortunately...died a few minutes ago'.
- ⇒ 'I'll give you some time to take this all in, I'll be right here on the end of the phone with you'.
- ⇒ 'I'm sorry we had to do this over the telephone'.
- ⇒ 'You don't need to do anything right away'.
- ⇒ 'We'll take you through what happens next'.
- ⇒ 'Is there anyone else you'd like me to call?'
- ⇒ 'I'll call again in 30 minutes to give you a bit of time to let all this sink in'.

silence uncomfortable. However, from the 'relative's perspective', it was felt to be a great comfort.

Not all information needs to be given on the first call. As in the face-to-face setting, information such as bereavement services can be discussed later. Offering to call back and check in or call another family member was found to be a useful tool to ensure the well-being of the relative receiving news of a death over the phone. One key point is to ensure that if you say you are going to ring back, this needs to happen.

BBN, especially saying someone has died, be it on the phone or in person, is undeniably an emotionally challenging situation.^{1 4 13 14} Allowing the person who has made the call to have time to reflect after may reduce the risk of them overwhelmed by the task. Telling someone that their relative has died is probably one of the most difficult tasks healthcare professionals undertake.^{6 7 10 11}

Additional points from the actor feedback included avoiding medical jargon, speaking slowly and using unambiguous terminology, avoiding overoptimism.

MOVING FORWARD AND CONCLUSION

Some of the themes that emerged from these trainings are similar to those raised in face-to-face conversations. Elements specific to telephone conversations included ensuring the safety of the recipient to take the call, that is, not driving a car, and ensuring they had adequate local support. Then after delivering the news, allowing a deliberate silence. This has a powerful impact, despite being uncomfortable. Not everything has to happen in one conversation. While it may seem more imperative to do everything in a single phone call, it may be preferable to handle the situation in the same way as when a relative is present in the ED. The recipient of bad news can be allowed time to digest a small amount of information, and then spoken to again after a short period, when they may have some questions and be ready to take on board the next steps (eg, hospital processes post death).

Our aide memoir (box 2 and online supplemental material 1) could help any caller think about what they need to do for a BBN. This training is now incorporated as a standard part of our induction period for new doctors to our ED.¹⁵ To help staff even further, we have combined this learning into a flash card to carry around (online supplemental material 1). Some of the key empathetic phrases from both observers and actors that could be used are in Box 3. Further work is being undertaken to look at the longer-term impact of this

training. Anecdotally and from feedback received, overall confidence has improved.

Delivering unwelcome news over the telephone has been a consequence and challenge of the COVID-19 global pandemic. Moving into the future, it is likely this form of BBN will need to continue. The skill of communicating over the telephone is useful to staff working in EM and can be enhanced by focused training.

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