Here, but Apart During COVID-19: Bringing Connection and Empathy to the Socially Distant Family Meeting

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For the millionth time that morning, I was fogged in. Squinting through the streaks on my safety goggles, I gingerly positioned my plastic chair six feet away from my patient as we awaited the arrival of the relative acting as health care proxy. Six months into a pandemic, small talk felt unfamiliar. Finally, the one visitor allowed by the hospital arrived, her eyes watering and narrowing as she beheld her dying brother over her surgical mask. Even after all this time, I still had to suppress the impulse to extend my hand.

Inpatient goals of care discussions have been indelibly altered by the COVID-19 pandemic. With family members initially barred from the bedside of seriously ill patients, clinicians and researchers turned their attention toward optimizing telemedicine for family meetings, the core intervention of empathic patient-centered care.^{1–4}

Over the last year, we have found a tentative new normal of visitor policies that allow for limited family presence.

How can a “high-touch” patient encounter adjust for the necessary “low-touch” time of the pandemic? How do we embrace patients with our words? As we seek to connect with others despite masks, distancing, and a pervasive discomfort with shared space, the in-person family meeting must be reimagined. We will offer four suggestions to support effective and empathic family meetings in this unique and challenging moment.

REASSURE FAMILY MEMBERS THAT THEY WILL BE SAFE

Families are often anxious about visiting the hospital. To allay these worries, clinicians can reach out and apprise the family members of the social distancing aspects of the family meeting before they arrive. Based upon the specific infection control policies of your institution, explain to the patient’s loved ones many visitors may attend, for how long, and whether masking is required throughout the visit. It is reassuring to explicitly state that clinicians will remain six feet apart from meeting participants. Encourage family members who live in

geographically distant locations, feel unwell, or are simply number in excess of the visiting policy to participate via telephone or video conferencing.

THINK CREATIVELY ABOUT TELEMEDICINE

Despite the drawbacks of telemeetings, there are advantages. Anyone with an internet connection can now have a seat at the table. These include local family members with travel-limiting disabilities, conflicting work or caregiving responsibilities, or simply reluctance to expose themselves to potential virus risk in public. We have also conducted meetings with loved ones from around the country and even the world, no longer limited by financial or visa-related barriers. Some have observed that telemedicine can even bring a new intimacy to the clinical encounter. Families can participate in important goals of care discussions from their homes with their chosen support people in attendance. Gazing face-to-face with a clinician can feel more connected than the sometimes-alienating experience of in-person meetings in less-than-private hospital rooms filled with ambient noise and activity. Increased implementation of telemedicine has made it possible for patients’ continuity clinicians and subspecialists to remotely attend family meetings during their workday if such sessions are scheduled as a visit. Clinicians can work from home and enjoy more time with their families, while remaining connected and integral to the patient’s plan of care.

CONNECT DIFFERENTLY

The desire to connect and empathize led many of us into the healthcare professions. When an emotionally distressed family member draws close in the unit hallway to privately disclose their worries, it can feel downright wrong to instinctively step backward. This is the interpersonal reality that we face in the COVID-19 era, masked and apart, yet we can learn to skills to adapt.

We can comfort our patients (and ourselves) with empathy. “I wish” statements help us to give words to what we have lost: “I wish that I could shake your hand” or “I wish that we could sit together on this couch.” By naming what we miss, we bring it back, albeit in a different form. Nevertheless, such statements offer us and our patients the opportunity to together

imagine an old way of connecting, and in doing so, we forge a new connection.

We can also challenge ourselves to use descriptive language. While we could once lazily rely on a smile or handshake, we must now discipline ourselves to use words: “I am so glad to meet you.” We can use words to describe the patient or families’ experience: “It is so helpful that you were able to travel to the hospital so that we can talk in person. I can see that it means a lot to your brother that you are here today.” We can also use words to better understand how patients and families are feeling. Without full facial cues, it is hard to understand the emotional impact of what we are saying. Making small guesses about patient’s emotions, and then checking to see if we got it right, is an important way to maintain an emotional connection: “I imagine this is very frustrating. Am I understanding you correctly?”

Finally, we can work with the facial muscles that we have left. Emotion researcher Ursula Hess has observed that a genuine smile can be perceived by observers even under a surgical mask as additional non-mouth muscles, the zygomaticus major and orbicularis oculi, engage.⁵ Whether from nature or nurture, humans continually search the faces of others for that disarming eye crinkle and squint. We can hold the gaze of the patient’s family member over the mask or through the screen, and crinkle those muscles extra hard, wrinkles be damned.

SHARE EXPERIENCES

While the burdens are surely distributed unequally, the COVID-19 era has wrought a shared human experience of personal vulnerability. Different from our usual stance as the healthy provider with the sick patient, we are all feeling the economic, social, emotional and physical effects of living in a pandemic. However, there is a hopeful possibility for new emotional solidarity between clinicians and patients.

As families gather in-person and on-line for a scheduled family meeting, clinicians may use the first few minutes of small talk to honestly about some of the difficulties of this shared experience. Clinicians can disclosure personal information with patients and families if they do so with caution and with awareness of their patients’ needs. If we share too much, we draw the focus of the visit away from the patient.

But our patients should feel comfortable with and connected to us. So, we have chosen to share small amounts of information about our own struggles: “This situation is so difficult. My kids are really struggling.” Increased transparency about our own struggles can build rapport with families and create deeper connection.

CONCLUSION

Even while remaining socially distanced, it is possible to communicate with patients and families effectively. By preparing patients and families, taking advantage of helpful technologies that enhance inclusion, practicing new communication skills, and being open about our own struggles, we can maintain our connection with patients and families. We might even improve healthcare.

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