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Commentary: Communicating in crisis: Reflections, opportunities, and challenges for healthcare communication in the COVID-19 pandemic

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ABSTRACT

Background: The coronavirus disease 2019 (COVID-19) pandemic has changed how healthcare professionals, patients, and relatives communicate with each other. **Aim**: We take stock of the current state of affairs in healthcare communication research amid the continuing pandemic. We draw upon our expertise as communication researchers and clinical experience as a medical professional working in the pandemic to reflect upon the challenges and opportunities that the pandemic has created for healthcare communication research and practice. **Findings**: We explore five topics of importance for research on healthcare communication during COVID-19 and its aftermath. First, we discuss how the 'epistemics' of COVID-19 are navigated in patients' communication with doctors. Second, we elaborate on the problems in communicating the prognostic uncertainty of COVID-19. Third, we consider online COVID-19 support groups as an important site for investigating the pandemic's multi-dimensional impacts. Fourth, we consider the challenges of the shift from face-to-face to video-mediated healthcare service provision. Fifth, we explore how fast-tracking graduate medical students into the workforce left them feeling unprepared for the communicative demands of such work. **Conclusion**: We call for direct collaboration between medical professionals and healthcare communication researchers to utilize evidence-based findings to solve the communicative demands posed by the pandemic. Collaboration and research need to be adaptive to the dynamic nature of the pandemic.

KEYWORDS

Communication problems, communication training, COVID-19, doctor-patient interaction

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Introduction

Over two years ago (at the time of writing), the first case of an at-the-time unnamed viral disease was reported in Wuhan, China. Since then, it has become near parody to use phrases such as "unprecedented" and "once in a lifetime" to describe just how drastically the world has changed. All that being said, the coronavirus disease 2019 (COVID-19) pandemic has led to radical socio-cultural, economic, and even political upheaval (Bonotti & Zech, 2021). However, nowhere else has this disruption been more prevalent than in the healthcare sector. At the beginning of the pandemic, our screens were filled with the emotive images of overflowing critical care wards, the creased and scarred faces of healthcare workers, and desperate family members who were missing out on their loved ones' dying moments. After somewhat of a lull, some of these harrowing scenes returned in 2021 with the emergence of the delta variant (Mahase, 2021). Furthermore, in recent weeks (at the time of writing), the highly transmissible omicron variant has led to record-high infection rates and fears of possible vaccine resistance (Torjesen, 2021; Wang et al., 2021). In addition, healthcare systems have been put under further pressure with the mammoth tasks of large scale vaccination programmes, in an effort to return to some semblance of normalcy (Mills & Salisbury, 2021). Even as some countries begin to open up and ease travel restrictions, there remains the threat for healthcare systems to be subject to strains in the future. In contrast, some jurisdictions such as China, Hong Kong, and Taiwan continue to pursue a 'zero-COVID' strategy in order to prevent the potential overwhelming of the healthcare system. Finally, with the ever-present threat of other possible mutations on the horizon and the unknown effects of the omicron variant, it is clear that the impact of COVID-19 is with us for at least the near future.

Given the relatively advanced state of the COVID-19 pandemic and its impacts on healthcare sectors, it is worth taking a step back and asking where academic research has focused its attention. From the beginning of the pandemic, extensive investment and research efforts were directed towards developing accurate tests, vaccine development and distribution, contact-tracing technologies, and effective antiviral treatments. This has undoubtedly been the fact in our respective areas of the world. In Hong Kong (David Edmonds [DE] and Olga Zayts-Spence [OZS]), there have been multiple rounds of funds allocated for COVID-19 research from the territory's main funding body. For example, a total of $350 million HKD has been allocated for research directly related to the disease by the University Grants Committee (2021). In Great Britain (Katharine Alder [KA]), the government pumped millions of pounds into developing the Oxford-AstraZeneca vaccine (UK Research and Innovation, 2021). Such an outpouring of resources has undoubtedly been necessary—yet as healthcare communication researchers (DE and OZS) and a medical practitioner (junior doctor, KA), we have been concerned by the relative side-lining of health communication research during the pandemic in funding terms from various bodies and government entities.

We are now over two years into the pandemic, and it is clear that the impact of COVID-19 stretches far beyond just the illness and symptoms themselves. Indeed, the pandemic has prompted empirical interest from the healthcare communication research community. Existing commentaries and emerging empirical studies in healthcare communication research have acknowledged the substantial changes that COVID-19 has caused to communication

between patients, families, and healthcare professionals (e.g., Hanna et al., 2021; Wherton et al., 2020; White et al., 2021). Nevertheless, given the continually evolving nature of the pandemic and that its aftermath is likely to be felt for years to come, we see the necessity for another opportunity to 'take stock' of the current state of affairs. Our aims in this commentary are twofold. First, we reflect on the challenges and opportunities that the COVID-19 pandemic has created for healthcare communication—both in terms of communication *about* COVID-19 and how communication has been (externally) impacted *by* the pandemic. Our unique contribution is to do so by drawing upon our experiences as healthcare communication researchers in Hong Kong and as a clinical practitioner who has worked in COVID wards and high-dependency units in the United Kingdom throughout the pandemic. Specifically, we address the following topics; (1) the epistemic dimensions of communication about COVID-19, (2) doctors' difficulties in communicating the uncertainty in prognosis for infected patients, (3) the provision of psychosocial support in online groups that have emerged during the pandemic, (4) the challenges posed by the shift from face-to-face to video-mediated communication in healthcare service provision, and (5) the difficulties faced by junior doctors 'fast-tracked' into clinical work during the pandemic without adequate communication skills training. Second, we suggest directions for how healthcare communication research can aid in expanding our understanding of these issues during and after the pandemic. Ultimately, as the pandemic continues to unfold, healthcare communication research will provide an invaluable tool in addressing the communicative challenges that continue to be faced by the medical sector.

COVID-19 and healthcare communication

Our first order of business is to reflect upon how COVID-19 has taken centre stage, so to speak, in healthcare communication 'at the frontline' It is hard to overstate the tightly intertwined relationship between healthcare communication and COVID-19. At a broad level, COVID-19 has exerted *external pressures on* communication on the 'shop floor.' For instance, with successive waves of infections, a junior doctor's (KA) job can become difficult just for the simple reasons of time and workload pressures. During normal times, there might not be enough time for doctors to interact with patients in a way that allows them to fully talk about the condition and answer any questions that the latter might have. During the pandemic, junior doctors have had to, in effect, 'ration' their communication with patients in order to meet the other constraints of their jobs. In other words, doctors have to spend less time talking with patients, and must also be more concise in what they do say. Social distancing and infection prevention requirements that are necessary to stop the spread of the virus also present an external force that has shaped, and contributed to, communicative practices. In specialized COVID isolation wards, communication can be hampered due to the full personal protective equipment (PPE) worn by doctors, and in some instances, such interactions must even be conducted via video-mediated means (Chau et al., 2021).

At another level, a lot of the clinical work involved with COVID-19 patients is *communicative in nature*. This is especially true for doctors who have worked in emergency and intensive care contexts with COVID-19 patients. Such communicative work is diverse in kind and involves constantly updating patients and relatives about the status of the illness, and unfortunately, in some cases breaking bad news. KA found that it was often the case that the first time she spoke to family members was to inform them that their relative was dying of COVID-19.

Another crucial communicative task for healthcare professionals with infected patients was to provide forms of informal emotional counsel and support to help them get them through their illness and corresponding isolation (see also Chau et al., 2021). Finally, healthcare professionals such as junior doctors must also explain risk to patients and their family members. At the beginning of the pandemic, in the United Kingdom, patients that were dying of COVID-19 were only allowed to have a single family member physically present in full PPE. KA often had to explain to relatives the possible risk of infection that they faced just by being present, which was a challenge to adequately explain to highly emotional people. The communicative demands of working with COVID-19 patients also, understandably, takes its toll on healthcare professionals. KA reported that she regularly questioned herself about how she could have interacted better with patients and families throughout the pandemic. The communicative work required of healthcare professionals during the pandemic is clearly emotionally and psychologically demanding—something that has only just begun to be acknowledged in empirical research (Chau et al., 2021; Liu et al., 2020).

As with normal times, it is clear that during the pandemic, healthcare professionals have a repertoire of roles that they must adopt in their communication—they are diagnosticians, counsellors, and risk communicators. It is clear that more research is needed to understand both how these roles might be different in the pandemic to 'normal times,' and how healthcare professionals might navigate these roles in their communicative work. Just as we are only beginning to understand the psychosocial impacts of the COVID-19 pandemic on people (Crawford & Orion Crawford, 2021; Danielis et al., 2021), it is also worth investigating the effects that engaging in such difficult conversations has had, and continues to have, on healthcare professionals during the pandemic. Having now established just how much medical work in the pandemic hinges upon communication, we will explore five specific topics in more depth. These topics are drawn from clinical experience in the pandemic and what we believe offer fruitful opportunities for communication researchers.

The epistemics of COVID-19

Clinical practice in medicine is usually characterized by a large gulf between what doctors and patients *know* about a disease, prognosis, and treatment options. Indeed, such an asymmetry lies at the very heart of doctors' jobs—they tell patients what she/he are suffering from and the risks and benefits of treatments. Many interactional studies have documented the epistemic gap between doctors and patients. Conversation analysts in particular have explored the interactional mechanics of how parties orient to and manage this knowledge gap in actual medical interactions (Landmark et al., 2015; Lindström & Weatherall, 2015; Perakyla, 1998; Pilnick & Zayts, 2016; Stivers, 2005). Yet, in many health communication settings, such a knowledge discrepancy is not always so sharp—as is the case during the current pandemic. Indeed, KA's clinical experience attests that when she and other doctors encountered patients and their families, the latter already possessed a great deal of knowledge about COVID-19. Such an observation is perhaps not surprising given that throughout the pandemic innumerable news articles and television segments have bombarded us all with information about the disease, including details such as, mode of transmission, survival rates, and forms of treatment.

The reduced knowledge gap between doctors and patients has very practical consequences in healthcare communication. For example, KA has found that herself and other doctors have to do much more work to justify their treatment decisions to patients and their families, who understand much of the clinical jargon and are aware of alternative options. Thus, communication researchers using discourse and conversation analytic methods are well-placed to investigate the discursive practices that family members deploy to challenge doctors' treatment decisions and push for alternatives, and relatedly, how doctors might 'fend off' these challenges.

In a related vein, patients and family members have acquired information and knowledge about COVID-19 somehow. Health literacy researchers are presented with a valuable opportunity to examine how people seek out information about COVID-19, and thus, how they might acquire 'literacy' about the disease. Existing commentaries and discussions on the pandemic and health communication have acknowledged the pernicious influence of misinformation on the general public (Ahmed et al., 2020; Finset, 2021; White et al., 2021). Yet, the focus on the challenges posed by misinformation has largely been through a 'macro' lens—that is, on how healthcare communication researchers can understand and shed light on this through examining public health messaging and mass media (Bridgman et al., 2020; Lwin et al., 2021). Yet, people will also talk about and exchange such (mis)information together. Thus, we suggest an additional perspective; for future research to take a 'micro' lens and examine how patients and relatives present misinformation about COVID-19 in their interactions with healthcare professionals, and how the latter might correct these misunderstandings. Such findings will provide a more holistic understanding of the communication of misinformation in the pandemic.

Communicating uncertainty in prognosis

At the beginning of the pandemic, there was understandably a lack of knowledge about COVID-19 (Koffman et al., 2020). However, as the pandemic has unfolded, we know a great deal more about the progression of the disease and effective treatment options (Baraniuk, 2021; Tsang et al., 2021). Nevertheless, there still remains uncertainty with regards to some patient's prognoses once they are admitted to hospital. Based on clinical reflections, it can sometimes be difficult to tell if a patient will survive or recover from the disease once they are in hospital. While statistics bear out a higher death rate amongst certain populations, such as the obese and the elderly (Jordan et al., 2020; Popkin et al., 2020), many apparently healthy and young patients also become very sick, and can die (Swann et al., 2020). In other words, there is still sometimes uncertainty in terms of just who might fare worse from the disease, as well as how the disease itself might progress (Cheng, 2021; Driessen et al., 2021).

Clinical reflections reveal that, throughout the pandemic, junior doctors (KA) have found it hard to communicate certainty in prognosis for those patients infected with COVID-19 and their families. Healthcare communication research, in particular that of a microanalytic orientation, for many years has focused on the communication of certainty in illness prognosis in medical interactions. Clinicians working with cancer patients use vague language when discussing prognoses and precise survival rates are often not discussed (Chou et al., 2017). Furthermore, some studies of palliative care consultations have shown how patients and clinicians talk about certainty in life expectancy (Ekberg et al., 2020; Parry et al., 2014). For

example, patients anticipate clinicians' inability to provide concrete estimates when they ask the latter how much "time" they have left (Pino & Parry, 2019). Yet, these studies examined interactions involving patients with illnesses who will not necessarily die within a matter of hours or days. Once COVID-19 patients are admitted to intensive care units, some of them may only have days left to live and thus certainty about the precise 'time' they have left can become difficult to ascertain and communicate (Koffman et al., 2020; Larsson et al., 2021; Lim et al., 2021). As such, there is an opportunity for further research on how certainty is expressed in interaction by healthcare professionals, to and for, patients with COVID-19. Another relevant question relates to our changing understanding of the disease itself. As the pandemic continues to unfold, we will learn more about COVID-19 and effective treatment options, thus, it is worth investigating how the communication of certainty in prognosis might change as the medical understanding of the disease improves.

Online support when socially distant

To halt the spread of the virus, many jurisdictions have had to put in place a diverse range of social distancing requirements—such as lockdowns, quarantines, and medical isolation (Atalan, 2020; Mahtani, 2021; Wells et al., 2021). As a result, many people have spent a great deal of time apart from one another. Such sustained periods of isolation create many problems, ranging from adverse mental health to sleep and weight disturbances (Robinson et al., 2021; Rossi et al., 2020). While remaining in isolation, it has been imperative for people to retain their social connections, which has largely taken the form of video calls (e.g., Zoom and Skype) and text-based messaging.

Beyond simply maintaining connections, it is also important for people to have emotional and psychosocial support to quell the adverse mental health effects of such isolation (Crawford & Orion Crawford, 2021). To address this need, online support groups have flourished during the pandemic, as a means for the socially distanced to remain 'connected' and supported. Indeed, there is a support group for any seeming need, such as for those suffering from 'long COVID', for those needing parenting advice, and for refugees needing socio-cultural integration (Chivers et al., 2020; Surayya, 2021; Teh, 2021). These groups provide a novel source of data for healthcare communication researchers in the context of the pandemic.

One notable kind of online support group arose in the context of Hong Kong in response to the territory's implementation of lengthy quarantine periods for all inbound travellers. To maintain a stringent 'zero COVID' policy, the city's government implemented quarantine periods of up to 21 days (Tam et al., 2021). Perhaps unsurprisingly, a Facebook support group for those undergoing quarantine was created, which at the time of writing numbered around 60,000 members. This Facebook group even received attention in the overseas news media (Berlinger, 2021; Jett, 2021). Many different activities occur in this group, including requesting information about quarantine requirements, as well as the order and delivery of goods. Yet, perhaps the most crucial function of the group is to obtain forms of psychosocial and emotional support from those in the community who have, or are currently going through a similar experience.

We suggest that online groups such as this one, in the context of the pandemic, provide potentially fruitful directions for healthcare communication research. Medical advice is of course sometimes provided in these kinds of support groups. Yet, as with other kinds of

support groups, the support provided in the Hong Kong quarantine group is emotional rather than medical in nature and is provided by lay people rather than medical experts (Fage-Butler & Jensen, 2017; van Uden-Kraan et al., 2008). What makes quarantine-focused groups interesting is the provision of psychosocial and emotional support in the context of prolonged social isolation. Healthcare communication researchers could investigate how emotional support is solicited and received in such groups, as well as how 'lay' identities might be negotiated in the provision of psychosocial support during sustained social isolation. When one author was undertaking their mandatory quarantine period, they noted that in the group, members sometimes acted with humour towards the official government health advice. Such an observation could prompt further investigation of how members of such groups might accept or contest official public health messaging in the context of their isolation and the pandemic. As a data source, these groups give us insights into the multidimensional impacts of the pandemic on health communication. That is, COVID-19 has not just caused a shift in the medium of communication (from face-to-face to video-mediated), but it has also necessitated a whole new means of soliciting and providing emotional and psychosocial support between isolated individuals (see also Moorhead, 2017; Watson & Gallois, 2007). Ultimately, such data sources could likely provide rich insights into how people obtain online proximity—through emotional and psychosocial support—despite remaining socially distanced.

Suffering over a screen: Video-mediated communication and COVID-19

Social distancing and infection prevention requirements that were implemented in the wake of the pandemic led to a shift in how many healthcare professionals did their jobs. One of the most prominent changes to medical work was the shift from face-to-face to video-mediated consultations for everything from general practice to specialist medicine (Cottrell et al., 2021). Doctors have been seeing patients over FaceTime, Zoom, Skype, and the like. In addition video-based chat platforms have also been an important way that COVID-19 infected patients in medical isolation have been able to communicate with their families (Chau et al., 2021). Unfortunately, for many infected patients dying in hospital, for much of the pandemic the only way that their families could be connected with them was through video-mediated technology. Empirical evidence suggests that healthcare professionals and patients have been satisfied with, and valued, the shift to video-mediated consultations during the pandemic (Cottrell et al., 2021; Imlach et al., 2020). However, in KA's clinical experience, video-mediated interactions between dying patients and their families were stressful and emotionally demanding for all participants. KA posited numerous reasons for this, including that, families were separated in their time of need, without the possibility for physical touch. Another reason is that family members were often at home while their loved ones were in hospital. Video-mediated interactions with dying relatives brought the confronting scenes of the hospital—such as intubated patients and clinicians in PPE—into the comfort and relative safety of the home. In some jurisdictions face-to-face consultations have resumed, yet in many cases, those dying of COVID-19 are still denied the physical presence of their loved ones and must be 'connected' to their families via video-mediated means (Smith, 2021).

Some existing commentaries and studies from health communication researchers have addressed the technological and organizational changes that are needed for the successful shift to telemedicine, as well as, the interactional problems that need to be navigated in these video-mediated interactions (Imlach et al., 2020; Shaw et al., 2020; Wherton et al., 2020). We

suggest that video-mediated interactions between COVID-19 patients and their relatives also present a valuable source of data for healthcare communication researchers. On the one hand, researchers could examine recordings of these interactions, and investigate how parties try to comfort and support one another during these difficult encounters. Micro-analytic studies have provided us with an extensive understanding of the interactional accomplishment of empathic support in face-to-face medical encounters (Ford et al., 2019; Ruusuvuori, 2005; Wu, 2021). Indeed, supportive touching is one means of comforting patients in medical interactions (Doehring, 2018; Ellingson, 2002). Yet, what happens when family members try to reassure their relatives dying of COVID-19 in the absence of touch and co-presence? On the other hand, researchers could take a broader focus and interview family members to obtain an understanding of their lived experiences of the last moments with their loved ones over the screen. Research should explore why family members might find these encounters stressful, and also, what aspects of these encounters family members value. Insights from both kinds of studies could feed into developing recommendations for how to make such encounters 'easier'. Recommendations grounded in the findings of such research could include advice for healthcare professionals on how they can prepare family members for these confronting interactions and suggested interactional practices for comforting others over screens.

The expansion and implementation of video-mediated encounters in medical practice also has wider implications, in particular for the training of medical students and junior doctors. Prior to the pandemic, most (if not all) medical communication training for KA and other junior doctors was premised on face-to-face interaction. However, it is arguably now necessary for medical communication training to be expanded to include education in effective skills for video-mediated consultations. Healthcare communication researchers have an unprecedented opportunity to examine how communication skills training is adapted in the face of crises like pandemics. Research is needed on how students are taught about video-mediated communication, in particular addressing questions such as, what aspects of video-mediated communication are emphasized in training, and how are communicative and technological problems overcome in training contexts? It is likely that the insights gained from such research will be valuable in the long term as well, given that video-mediated encounters are now commonplace, and thus, telemedicine is here to stay.

'In the deep end': Communicating without adequate training

In the initial stages of the pandemic, immense strains were placed on healthcare systems across the world—including shortages of PPE, intensive care beds, and staff (Cohen & Rodgers, 2020; Sen-Crowe et al., 2021). In the United Kingdom, one way that the National Health Service dealt with staffing shortages was by fast-tracking graduation requirements in order to allow medical students to join the workforce earlier (Harvey, 2020; University College London, 2020). Thus, with such changes, students 'joined the frontline' to help fight the pandemic. While desperate times called for desperate measures, junior doctors were 'thrown into the deep end'—placed into a crisis that required advanced skills, including those related to communication, which they may not have fully acquired. Indeed, empirical evidence has emerged from the pandemic that even experienced healthcare professionals found interacting with patients and families challenging (Chau et al., 2021; Hanna et al., 2021). Thus, it is perhaps unsurprising that a junior doctor like KA felt that she lacked the communication

skills necessary for the difficult conversations that she had to have in the pandemic, such as breaking bad news and dealing with distraught families.

KA's experience during the pandemic testifies to the need for effective communication skills training. Before the pandemic, KA's colleagues had to break bad news possibly once a week, depending on the specialty in which they worked. However, during the pandemic, KA found that she was usually having these conversations a few times each day. Breaking bad news has always been an essential part of medical communication training (Soosaipillai et al., 2020). Yet, owing to a lack of full training before being fast-tracked into the workforce, KA felt unprepared for such difficult conversations. This problem was compounded by the added challenge of sometimes having these conversations over the phone or screens. In fact, during her downtime, KA had many discussions with other healthcare staff on how they could have approached these conversations differently. Existing medical communication training for breaking bad news often takes the form of simulated role-plays, or it utilizes a 'recipe-book' of prescriptive instructions (Bumb et al., 2017; Paramasivan & Khoo, 2020). In KA's experience, the uncertainty inherent in COVID-19 meant that the small amount of training which she had seemed rather ineffective in preparing her for the reality of clinical encounters in the pandemic. Despite the good intentions of her training, KA felt that the methods were disconnected from how communication on the shopfloor occurred (see also Pilnick et al., 2018; Pun et al., 2020). Instead, she relied more on 'on-the-job' training—learning how to best interact with patients and relatives as she went. KA did so by observing how more experienced clinicians interacted with patients and relatives and then adapting what these clinicians did 'successfully'—whether it was a supportive tone of voice or certain phrases that worked—into her own practice.

Healthcare communication researchers are well placed to examine how junior healthcare professionals can be better prepared for both the present pandemic and future crises, to ensure that they are equipped for the communicative demands of medical work. One recommendation could be implemented at the curricular level—with a greater emphasis on communication training *throughout* medical education programs, rather than as an add-on at the end (as was the case for KA). Importantly, there is a need to ensure that any communication training that is provided to students is *effective*. The current overreliance on roleplays in some communication training programs is problematic, as they have clear limitations (Kelly, 2009; Pilnick et al., 2018). These limitations include the stakes in roleplays being completely different to real-life interactions, the scenarios are often artificial, and how people speak in these 'controlled' contexts is often not how they interact in authentic clinical encounters (Stokoe, 2013). Relatedly, recipe-book approaches with prescriptive instructions for how clinicians *should* interact are often not flexible enough to cover the idiosyncrasies of shopfloor interactions. Ultimately, this all requires collaborative involvement from healthcare communication researchers, medical schools, and students, but it is crucial for the quality of care and communication provided to patients. Such research and collaboration will likely mean that medical students are adequately prepared for the communicative demands of clinical work, should another crisis necessitate their deployment to the frontline.

Concluding comments

Healthcare communication is a topic of vital importance during the pandemic. Doctors can communicate *about* COVID-19 every day—for instance, justifying their treatment decisions and being honest about the uncertainty in the prognosis of the disease to patients and their families. The pandemic has also shaped *how* communication is done; video-mediated consultations have become commonplace, there is the need for online proximity and support during periods of isolation, and there are difficulties in clinical work without adequate communication training. Healthcare communication researchers have been, and will continue to be, at the forefront of understanding and addressing the challenges faced by healthcare professionals, patients and families during the pandemic. Yet, as we hope to have shown in this commentary, some of the communicative matters relevant to the pandemic are not immediately obvious until we consider healthcare professionals' perspectives and experiences. As such, we believe that direct collaboration between medical professionals and healthcare communication researchers, with a goal towards utilizing evidence-based findings to address the communicative demands of the pandemic is the best way forward. Such research will need to be adaptive to the dynamic nature of the pandemic—although some areas are returning to 'normal,' there remains the potential for unforeseen changes and further 'shocks' to the healthcare sector. As a final remark, once this all 'settles down,' healthcare communication researchers will be perfectly placed to assess and shed light on how the pandemic may have changed health communication in more permanent ways.

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Conflict of interest

Olga Zayts-Spence is on the advisory board of *Qualitative Health Communication*.

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