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Perspective

Telephone

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As a child, you probably played the game "Telephone": you whispered a message into the ear of the person next to you, who whispered it to the next person, and so forth down the line.

When revealed at the end of the chain, the message was inevitably garbled, illustrating how fragile human communication can be. For children, these mistranslations were hilarious. But for doctors, such a breakdown in communication can be heart-rending, and we do everything we can to ensure that they never happen.

A version of Telephone played out when I was a medical student. A young, deaf Peruvian woman was in the oncology clinic, and her scans showed progression of her cancer. To communicate with her, we coordinated a high-stakes game of Telephone using an American Sign Language (ASL) interpreter to translate spoken English to ASL, and then a Peruvian Sign Language (PRL) interpreter to translate ASL into PRL. My attending physician slowly delivered the news, ensuring understanding at each step of the way. The patient was tearful, yet somehow resolute in the face of the news. She thanked us as we said goodbye. Despite our barriers of language and understanding, her emotion was something we could all recognize. I walked away knowing that sharing our voices with our patients — no matter how we do it — is a critical part of patient care. But I couldn't have imagined the communication challenges that Covid-19 would bring.

To prepare for a surge in critically ill patients, our oncology ward was converted into a fully functioning intensive care unit (ICU) in 48 hours. Our floor had originally been designed to meet the needs of patients with leukemia and those receiving bone marrow transplants, who often have extended inpatient stays. Rooms are secluded and lack the central alarm infrastructure for ventilators and medication pumps, so the unit can be eerily quiet as compared with a standard ICU. After research labs had been locked down, a student, who would otherwise have been in a lab, was drafted into a new role of "listener" to substitute for hard-wired sirens. He paced the corridors of the nascent ICU, notifying the nurses when pump and ventilator alarms sounded. This procedure proved vital. A transport ventilator, intended for only short-term use, spontaneously failed. The listener shouted for the nurse, who rallied the rest of the team while manually ventilating the patient until the machine could be rebooted.

Even something as simple as talking to a patient's loved ones, who could no longer sit at the bedside, required entirely new procedures. After rounds on my first day on the team, an intern swiftly doffed her respirator, face shield, and gown and began phoning families. She confessed that in a unit containing largely sedated patients, this human interaction was the best part of her day — despite the fact that she often had bad news to share.

Oncologists like me, tragically, must be adept at delivering bad news. This skill is so essential that in my first year of fellowship we had a seminar with simulated patients to practice the nuances of these encounters. "Take the time to find chairs so

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you can sit down face to face," we were taught. "Build rapport by touching the arm, making eye contact, or holding hands."[1] In the Covid-19 era, when families are often not in the same city, let alone the same room, how could we build a connection? While our unit worked on technological solutions to enable widespread video calling, we learned to improvise. We began sharing advice, like "FaceTime the family on your phone before entering the room and donning your mask, eye protection, and face shield, so that they can see their doctor's face. Ensure that they know their loved one is intubated, is sedated, and will not be able to respond. Alert a colleague to cover for you to prevent abrupt disconnections in the case of an emergency."

The team's first extubation was in Mr. M., a previously vigorous 87-year-old. Just 3 weeks earlier, Mr. M. had been with his extended Italian family, who had a longstanding tradition of playing bocce every Sunday. After 10 days on the ventilator, Mr. M.'s lungs had cleared, his oxygenation had improved, and he was liberated from the machine. But his prolonged ICU stay had left him weak and delirious. Over the ensuing 24 hours, his need for oxygen support escalated and his mental status declined. Our team was well aware of the emerging data showing high mortality among octogenarians with Covid-19 who needed critical care.[2] We agreed that a second intubation would not change the trajectory of Mr. M.'s illness and would only subject him to harm.

Such a dramatic change was difficult to convey over the telephone to his family, who had seen him as a vibrant man only weeks earlier. Frank discussions about the end of life are difficult enough in normal times. In the Covid-19 era, a locked unit robbed us of face-to-face conversation and the ability to let Mr. M.'s family see for themselves how severe his infirmity had become.

In oncology, a patient's inpatient care team and outpatient physicians are rarely the same, so for major discussions, the long-term outpatient oncologist usually takes the lead. We realized that Mr. M. and his family had developed a close relationship with his primary care physician (PCP) over several decades. We paged that physician, and he quickly called back — he had been following Mr. M.'s care and understood why we wanted him. He spoke to the family with a level of trust that only years of rapport can build, explaining the futility of another intubation.

Since Mr. M. was a devout Catholic, his family asked us to ensure that he received the last rites from a priest. We paged the chaplain on call to administer that sacrament. When he arrived, we learned that infection-control protocol prohibited him from entering the room. To ensure that the family could see and speak with Mr. M., we orchestrated a complex choreography: *Don personal protective equipment, place mobile phone in sterile specimen bag, dial the dozen family members, record chaplain outside the room, enter the room with the phone to allow the family to see Mr. M.*

Immediately after the call ended, Mr. M.'s eldest daughter drove to the hospital, not knowing whether she'd be allowed in, since our visitor policy was rapidly evolving. Fortunately, our charge nurse had just gotten the word that one family member would be allowed to see patients who were at the end of life. When the daughter arrived, I went to the ambulance bay and ushered her past security. Though family-member visits were technically limited to an hour, no one interrupted. Later that evening, after briefing the night team on our patients, I peeked into Mr. M.'s room and saw his daughter by his side, their hands clasped. Mr. M. died comfortably shortly thereafter.

As in Telephone, one misstep — a language barrier, a poorly organized room, or a wooden demeanor — can break down the entire chain. Without the listener, the PCP, the chaplain, or Mr. M.'s daughter, unacceptable outcomes may occur: asphyxiation, futile medical care, denial of a sacred rite, dying alone. Even as we provide the best possible medical care and work toward better treatments for Covid-19, we cannot forget to provide compassionate and humane support to patients and their families; that means planning for communication breakdowns. Face-to-face human interaction (even by FaceTime) remains essential for sustaining our humanity. On our unit, telephoning far-flung loved ones became just as vital as the ventilator.

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