Empathetic Communication and Caring for the Caregiver During COVID-19 – FAQs

There are certain states, such as Florida, that have no protections for apology and/or disclosure. How do you find the balance in having these empathic conversations with patients and caregivers without creating clinician liability?

Expressing empathy is always appropriate, and there is a legal difference in saying, “I am sorry this is happening” or “I regret you are having to go through this,” versus saying “I am so sorry I made this mistake and it hurt.” The last statement is an admission of liability, therefore, we do not recommend using it unless there has been due consideration of the facts and circumstances by appropriate persons.

With that said, see these references with embedded links to the manuscripts. Research now shows that even apologizing for errors does NOT automatically increase liability.

As healthcare leaders, most of us feel like we have to have the exact answers for our patients and families. To actually respond with "I'm not sure, but I'm here with you in your pain," are unfamiliar words for some of us. What can I say when I am not sure?

I very much agree with this comment and recommend we must become familiar with a phrase shared with me from Mike O’Conner, the CMO for Risk at Banner Health. Mike is in the habit of saying “This is what I know, this is what I do not know, and this is what I am going to do to find out more, but in the meantime, I am with you... and I realize this uncertainty may be painful or frustrating to hear.”

A lot of communication between humans is nonverbal, and unfortunately during these unprecedented times these conversations are occurring over the phone since visitors are not allowed in the hospital. Can you provide some guidance regarding phone conversations?

The fundamental empathic/compassion approach is the same although during phone conversations greater focus on the use of silence, voice tone, and cadence are critical. It is also a good practice to try and use FaceTime or Zoom or some other way to make facial contact. I also think it is important to remember these conversations are a process and not a single “event” so scheduled follow up is critical.

Does anyone have any suggestions for how to end these conversations? I find that when practicing empathy in patient conversations, it’s hard to get out of the “hopelessness” that patients are feeling. Without painting a silver lining, how do you navigate the conversation to end on a more hopeful note?

The research suggests that it is critical to conclude conversation with the communication of solidarity and non-abandonment and even acknowledging, “This feels hopeless for you right now, do I have that right?” And then offer to stay in touch and make plan for follow up and let them know you will not abandon them. As Brene Brown says—making the human connection is critical and, of course, avoid “at least.”
Should we be concerned that the patient may have been confused when making the statement regarding the vent; the patient’s oxygen saturation was low and he may have been confused. Is this part of the conversation we need to reconsider?

Patient competency is critical when having these conversations. In the fact pattern we provided, we stated, “The patient “calmly and clearly” made his wishes known.” The presumption should be the patient is competent, but the question points out the need to ensure such statements are made with confidence in their competency.

Why aren’t they wearing masks?

They should have been wearing PPE but we wanted people to see facial expressions as part of the empathic/compassionate response.

The female kept her hands clenched and for most of the time had her legs crossed. She did not lean in. As a listener, receiving the message being delivered, her words would sound empty when coupled with the body language.

This was done intentionally with the hope that participants would see and discuss. There are other “opportunities to improve” that we hope others identified.

How does HIPAA play into this? How are hospitals handling this staff information for Peer Support?

Peer supporter conversations should be built in to the Quality Assurance/Process Improvement [QA/PI] processes of organizations as the data now shows these conversations improve patient safety. In addition, we train peer supporters to focus on emotions and not the facts of the case, or even identifiable information related to the specific patient.

Can you comment on the effectiveness of providing caregiver support via laptop rather than in person? It seems much more of a challenge to ask someone to open up to an image rather than establishing a true human connection.

It is a challenge, and requires practice as part of the training for peer supporters. Also, see the answer regarding the use of phone conversations. The fundamental empathic/compassion approach is the same, although on the phone, greater focus on the use of silence, voice tone, and cadence are critical. It is also a good practice to try and use FaceTime or Zoom or some
other way to make facial contact. I also think it is important to remember these conversations are a process and not a single “event” so scheduled follow up is critical.

Finally, there is more work showing members of the care team feel “thought of” and supported if they are sent a thoughtful text message from someone they know and care about.

The comment, “We’re going to get through this” sounds so trite. Is there anything better to say?

You might consider saying, “We have no idea how long this is going to last, but I want you to know, I will be here with you and for you throughout.”

How are Social Workers and EAP members being utilized in this process?

Social workers and other EAP members can also function as Tier 1, 2 or 3 supporters but they need to maintain appropriate boundaries in each of those Tiers. Some social workers are excellent candidates to be part of the communication teams for patients and families as well.

Should you ask the person to specifically give a description of what happened, or just allow them to speak freely?

Generally speaking, the approach to motivational interviewing—peer support conversations—rests on the asking open ended questions versus specific closed ended questions. In addition, for peer supporter conversations the goal is NOT to do a root cause analysis as that will happen through another process. The goal is “feelings first” coupled with curiosity and solidarity.

If a provider refuses peer support initially, how and when should the supporter attempt another contact?

In my opinion, it depends upon the severity of the “trauma” or perceived “trauma” to the potential recipient of the peer support. In more severe events we would not recommend waiting more than a day or two to reach out. In other cases, we would reach out within a week.

How did you train peer supporters?

Training peer supporters is a comprehensive process that involves several steps that include:
1. Selection of candidates for training using the Communication Skills Assessment at AHRQ.GOV/CANDOR and having staff identify people who they naturally go to for support from the various units/clinics of the organization
2. Series of didactic presentations as provided in this webinar
3. Use of role playing with appropriate debriefing techniques, including scenarios in which a higher level of care should be recognized and referrals made.
4. Monthly or quarterly meetings to do group debriefing and lessons learned.

All of this can now be done “virtually.”

References with more details can be found at AHRQ.gov/CANDOR or more specifically: https://www.ahrq.gov/patient-safety/capacity/candor/modules/notes6.html

As a non-clinical healthcare worker (project manager in patient safety), I have a difficult time knowing what to say to clinical friends. How can I emotionally support friends going through this without being a ‘peer’ in the way described so far?

Never underestimate the power, as a PM in Patient Safety, of your ability to make a connection with clinical team members. You are a peer in Patient Safety. The principles discussed are the same—approach the conversation with humility and curiosity and state upfront that you do not presuppose to know what they are going through clinically, but that you care about them as humans. Be curious, be vulnerable, and provide them with solidarity and a promise of being there for them. Being curious means asking open ended questions such as how they are doing, how are they sleeping, and is there anything right now that they need. And then listen. Silence is golden.

Typically we are supporting Incident and Risk System managers. Some of these staff have gone to the front line, others are still trying to do their jobs. Do you have any thoughts on the best way to support our customers who are supporting the clinical staff?

I would follow the same advice provided in the answer above. The principles are the same.

In the UK, especially in the National Health Service, I’m really concerned about how many staff are going to have PTSD. Do you have any thoughts on treatment?

PTSD should be anticipated, and we train peer supporters on motivational interviewing with an eye toward identification and then referral to a Tier 3 support system. Tier 2 Peer Supporters
should be trained to recognize possible signs of PTSD, but should recognize their limitations and refer such persons to those more professionally trained to manage it.

Is it possible to develop standard guidelines to support care providers as being second victims?

Guidelines can be found at these references and details can be found at AHRQ.gov/CANDOR or more specifically: https://www.ahrq.gov/patient-safety/capacity/candor/modules/notes6.html

How can we better interact with angry relatives who do not accept the bad health status of their loved ones?

Experience shows that listening and naming their emotions is an empathic/compassionate way of responding. For example: “You appear to be angry to me, do I have that right? Tell me what makes you most angry,” and then pause and listen. Many experts recommend you not try to fix it, or tell them “calm down, do not be angry.” Meet them where they are and say “yes” to their experience. And ask, “What can I do for you or what do you need right now? And, using reflective listening, repeat back what they say. “I hear you saying etc.”