



# COMMUNICoVID

POSITION PAPER

## HOW TO COMMUNICATE WITH FAMILIES LIVING IN COMPLETE ISOLATION



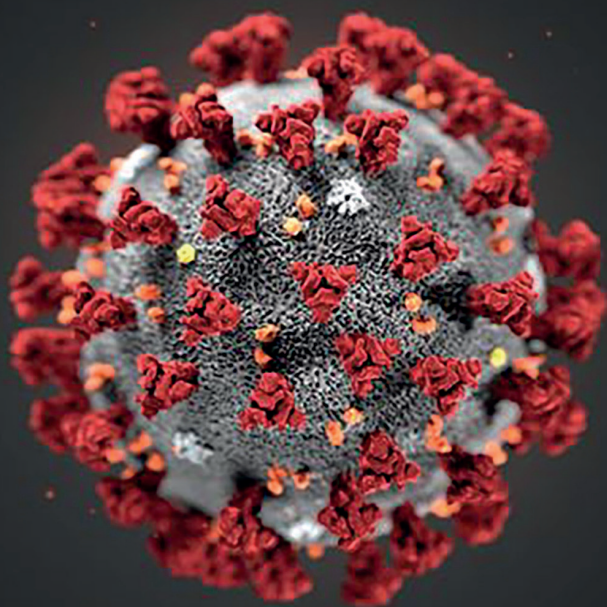
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### HOW TO COMMUNICATE WITH FAMILIES LIVING IN COMPLETE ISOLATION

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## Summary

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### List of abbreviations

**SARS-CoV-2** - Severe Acute Respiratory Syndrome - Corona Virus-2

**CoViD19** - Corona Virus Disease 2019

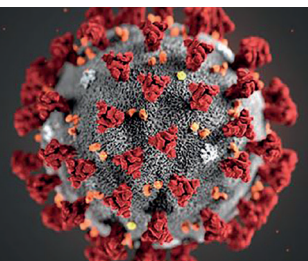
**PPE** - Personal Protective Equipment

**SIAARTI** - Società Italiana di Anestesia, Analgesia, Rianimazione e Terapia Intensiva

**Aniarti** - Associazione Nazionale Infermieri di Area Critica

**SICP** - Società Italiana di Cure Palliative

**SIMEU** - Società Italiana di Medicina d'Emergenza-Urgenza



## 1

## Graphical abstract



Aims of communication with family members	Topics discussed in this position paper	Statements on communication with families
<b>A</b> To <b>provide understandable information</b> about the disease and treatment options	<b>A1</b> Relational aptitude <b>A2</b> Preparation <b>A3</b> Justice	<b>S1</b> Relatives must be given clinical information at least once a day, and more often in case of any substantial and unexpected worsening in the patient's condition. <b>S2</b> A doctor who knows the patient directly must be the person to give the relatives clinical information.
<b>B</b> To <b>obtain information</b> on expectations and choices	<b>B1</b> Confidentiality	<b>S3</b> Any healthworker who feels it is too much of a burden at that specific time is not obliged to give the relatives information. <b>S4</b> The staff's mental and emotional wellbeing must be taken into consideration and protected.
<b>C</b> To show <b>collaboration</b>	<b>C1</b> Health workers' wellbeing <b>C2</b> Internal communication	<b>S5</b> Different modes of communication can be used - such as phone, video call or email. <b>S6</b> Communicating by email or, in general, in writing can be useful as a complement to verbal communication.
<b>D</b> To <b>allow</b> relatives to express <b>their emotions</b>	<b>D1</b> Grief	<b>S7</b> Information must be given in an appropriate, unequivocal, truthful way. <b>S8</b> Attempts to reconstruct the patient's preferences should be carried out together with the family.
<b>E</b> To <b>prevent misunderstandings</b> and conflicts with the care team	<b>E1</b> Management of different tasks <b>E2</b> Truth, coherence, gradualness <b>E3</b> Legal aspects	<b>S9</b> Relatives should be given full information about pain control. <b>S10</b> Room should be made for relatives' emotions.

## The peculiarities of complete isolation

The global emergency caused by the SARS-CoV-2 pandemic <sup>(1)</sup> **has suddenly changed how we communicate with families in all the CoViD19 care settings**, on account of the need to maintain complete social isolation. <sup>(2)</sup> Far-reaching **mental suffering** manifests itself in widespread anxiety. Health workers are isolated from their families, and must manage the consequences of this isolation just like the patients under their care.

Patients and their families perceive not only the clinical results but also the **personal attitudes, closeness and psychological support** from the care teams. <sup>(3)</sup> This perception of genuine participation by the health worker in the course of the treatment is especially important when a patient dies, and may influence the whole process of grief. <sup>(4)</sup>

## Clinical communication with family members

The pillars of effective communication are truthfulness, consistency and gradualness.

Clinical communication has several precise aims:

- A. to give understandable information about the disease and treatment options;**
- B. to obtain information** on the relatives' expectations about the disease and the patient's values and choices;
- C. to show empathy and participation** (through non-technical language and with an attitude that is neither too detached nor excessively emotional, and is adapted on a case-by-case basis to create the best possible caring relationship with family members); <sup>(5)</sup>
- D. to allow relatives to express** their emotions;
- E. to prevent misunderstandings and conflicts** with the care team.

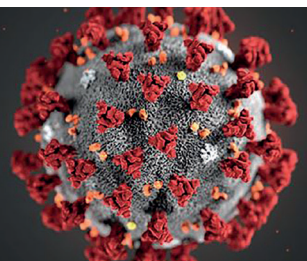
## Aims of the present document

This document is intended for all healthcare institutions that handle **people with CoViD19**, particularly those in an unstable clinical condition.

This document aims to help the care team **in communicating with families living in complete isolation from the patient**.

The document consists of three parts:

- ▶ presentation of the statements for communicating with family members in isolation;
- ▶ instructions for telephone communication, with checklist and worksheet;
- ▶ discussion of key points of the current situation, as a theoretical framework for the statements.



# 3

## Methods

The spread of the SARS-CoV-2 virus has generated an unprecedented pandemic in modern medicine. As yet there are no randomized controlled trials or any meta-analysis in the scientific literature about clinical communication in settings of complete isolation, and inadequate healthcare resources in relation to needs.

The authors took into consideration in this analysis the scientific evidence<sup>(6)</sup> and guidelines<sup>(7,8,9)</sup> currently existing,<sup>(10,11)</sup> **mainly referring to other settings**, and have collected information from specialists with direct experience in the treatment of CoViD19 patients. This document was written by **authors from different disciplines** (doctors, nurses, psychologists, jurists) and was then reviewed by a group of experts comprising professionals, people who have experienced ICU hospitalization, and their families. It was approved by the National Boards of the scientific associations SIAARTI, Aniarti, SICP, and SIMEU.

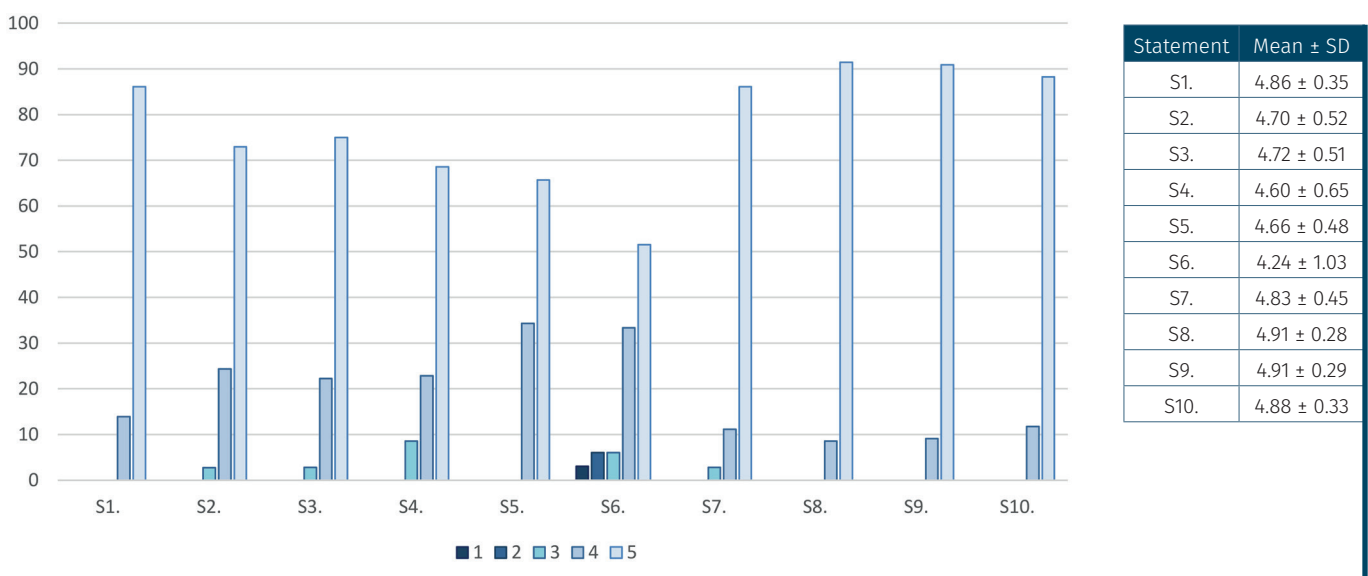
The statements will be updated as the social/health situation shifts.

# 4

## Consensus on statements

The statements set out here were written by the lead authors, reviewed by experts, and then shared in a web conference during which all the authors reached agreement. In a second web conference, all the authors rated their approval of each single statement (1 = complete disagreement, 5 = maximum agreement). Ratings are illustrated below.

### PREVALENCE OF CONSENSUS ON INDIVIDUAL STATEMENTS (37 voters)





## Statements for communication with families

**S1 Family members must be given clinical information at least once a day, and more often in case of any substantial and unexpected deterioration in the patient's condition.**

These daily communications must cover the diagnosis and prognosis.<sup>(12)</sup> Information can be provided by any means (e.g. telephone, video call or e-mail), agreed between the healthworker and relatives, based on their preferences.

**S2 A doctor who knows the patient directly must give the clinical information to the family members, and this must be specified in the medical record.**

If possible, **nursing staff** who have direct contact with the patient **should be included in the conversation**,<sup>(13)</sup> and communication should be organized so that **the same doctor is always involved**, to ensure continuity, avoid repetition and build trust. If this is not possible, in addition to the documentation in the folder it is useful to give the newly involved doctor specific information (during staff briefings).

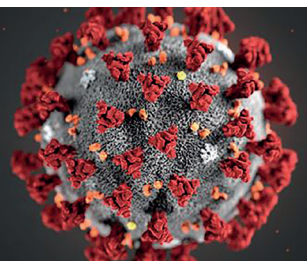
In case of a video call, **the speaker's face should be visible** (without a mask), and if possible **another health worker should be connected** remotely or be present, by speakerphone.

**S3 If resources and organizational needs permit, any healthcare professional who feels it is too much of a burden at that specific time should be exempted from the above task.**

Communication to family members must be guaranteed. If a health worker considers him/herself temporarily unable to make a telephone call, s/he should be permitted to honestly express discomfort - without feeling obligated to participate - if resources allow or if it is possible to ask for help from colleagues. In case of persistent difficulties, the health worker should receive psycho-emotional attention in order to overcome these critical issues.

**S4 Health workers' mental and emotional balance must be taken into consideration and protected.**

Emotional fatigue due to protracted emergencies may compromise the health worker's ability to act effectively and efficiently.<sup>(14)</sup> They must therefore be encouraged to admit this and to tackle it with the support of team colleagues, and with the facility's clinical psychologists. If this is not possible, it is advisable to seek the support of external associations, specialized in psychological management of emergencies, if appropriate with professionals consulted by videoconference.



**S5 Health workers should decide with the hospital management how to organize communications with relatives.**

**The different communication possibilities** include phone or video calls with family members, video message/video call with the patient (if requested by patients and their families), or email/text messages (if requested by family members).

If a video call between the relative and the patient is planned, **both should be prepared for it**, especially if the patient has signs that are obvious consequences of the disease or the intensive treatment (swelling of the face, tubes, etc.) or if s/he is not aware of other traumatic events in the family during the hospital stay (e.g. bereavement). In these cases, it is advisable for the health worker to first make a preparatory call to a family member, and then a second call including the health worker, patient and family member.

**S6 Communicating by email/text message can be useful to enable relatives to read again and learn about the patient's information whenever it suits them.**

If the patient is in an Intensive Care Unit, a standard introductory email from the ward (provided by the Project Intensiva 2.0)<sup>(15)</sup> can be sent to start with, followed up with personalized emails regarding the specific case.

**S7 Health communication must be unequivocal, truthful, reasoned, and appropriate to the recipient's ability to understand, their emotional state and life situation, with particular attention to frailty (e.g. elderly family members, language barriers or mental disorders).<sup>(16)</sup>**

Speak honestly and sensitively, **avoiding technical language and euphemisms**. Clarify misunderstandings. Suggest hope by not creating or encouraging unrealistic expectations. Evaluate the need for a cultural mediator.<sup>(17)</sup>

**S8 Reconstruct the patient's preferences and values - also through communications with family members - so as to respect their autonomy.<sup>(18)</sup>**

Respect for autonomy is essential and must always be maintained. Therefore, as far as possible, informed consent should be requested, Shared Care Planning implemented and any Advance Healthcare Directive respected. The preferences and values of patients should be reconstructed with family members, too.<sup>(19)</sup>

**S9 Give full information about pain control.**

It is essential to reassure the family that palliative treatment of distressing symptoms is a goal that is constantly pursued and achieved even in the most difficult stages of care.<sup>(9)</sup>

**S10 Leave room for and welcome the relatives' emotions.**

If there is any noticeable, very intense emotional reaction, or difficulty in adapting to the situation (denial, aggression), it is advisable to suggest support from a psychologist, and be ready to ask for it.





## T1. Preparation

- T1.1** Health workers should **know the name and surname of the patient** and family member, and be aware of the patient's current **clinical conditions, past medical history**, resources and conditions of particular fragility.
- T1.2** It is preferable to **organize a suitable quiet place**, even if not optimal, for the call. Check the technical equipment (e.g. cordless/mobile phone battery, video call platform, and connection, audio and video function...).
- T1.3** If the health worker who is calling needs to be changed during the week, **include in the handover data on communication** with family members (contact person, family resources, content, critical issues).
- T1.4** Evaluate the possibility of **making the call together with another health worker** (connected remotely or hands-free), both for greater effectiveness and for feedback.
- T1.5** Call the telephone **number indicated at admission and at a pre-established time** (in order to avoid anxiety-provoking expectations).

## T2. Opening

- T2.1** **Introduce yourself in a clear and calm tone of voice (name, surname, qualification).**
- T2.2** Ask to speak with the person identified as the contact person, referring to them by name and surname, and **checking their actual relationship with the hospitalized person.**
- T2.3** In case of vulnerable family members (elderly, foreigners, people with psychiatric disorders): **propose to disclose clinical information to a third person at home**, who can act as an intermediary for the vulnerable family members.
- T2.4** Before starting the interview, check if the person is **in a place and at a time suitable** for communicating.
- T2.5** **Find out what the interlocutor already knows** and what s/he wants to know.<sup>(20)</sup> In case of negative news, start with a **"warning shot"** (e.g. *"I have to warn you that unfortunately I have no good news ..."*).

## T3. Conduction

- T3.1** **Communicate "one piece at a time"**, gradually presenting the clinical severity in order to adapt the information to the needs and level of understanding of the family members.
- T3.2** **Frequently assess the understanding of what has been said**, also through the interlocutor's emotional reactions; when in doubt, invite them to tell you what they have understood.
- T3.3** **Use everyday language**, avoiding technical and scientific jargon and ambiguous words or euphemisms.<sup>(21)</sup> Speak directly, **using simple, short sentences**, avoid being vague or too harsh.
- T3.4** Pay the utmost attention **to listening to whoever is answering** - better a second of silence than two people talking at once. **Do not interrupt the family member** and accept interruptions without getting impatient: the health workers are the professionals!<sup>(22)</sup>
- T3.5** Questions about technical information on intensive care units can be redirected to **certified websites** (e.g. [www.intensiva.it](http://www.intensiva.it) or [www.icusteps.org](http://www.icusteps.org)).<sup>(23)</sup>

## T4. Listening

- T4.1** Take interest in the **emotional state of the family member**. **Detecting and recognizing emotions** as legitimate enables you to create trust and therapeutic alliance.<sup>(24)</sup>
- T4.2** **Give the prognostic estimate honestly** in response to an explicit request from the family member. (e.g. *"How long will s/he stay?"*; *"When will it happen?"*). It should be specified that the prognosis forecast by the team is merely an estimate, and may well change.
- T4.3** **Welcome the interlocutor's emotional response** (fear, sadness, anxiety, anger), both through silence and by allowing the interlocutor to cry or make verbal outbursts.<sup>(25)</sup>
- T4.4** **Psychological alarm bells**: if you notice very intense emotional reactions or fatigue in adapting to the clinical situation (negation, aggression), it is advisable to offer psychological support and make yourself available to activate it.
- T4.5** Be interested in **the health situation of family members** (e.g. *"how are you?"*), both psychological and physical (e.g. *"Can you sleep at night? Do you have respiratory symptoms? Are you alone or with someone?"*).

## T5. Managing grief

- T5.1** **When a patient dies, use the word "death"**. **Allow for an appropriate listening time**, before providing clinical/organizational indications. In the event of **extreme clinical severity**, replace the word *"serious"* with **unequivocal phrases** such as *"desperate condition"*; *"high risk of death"*; *"need to prepare for the worst"*.
- T5.2** Welcome the emotions of the interlocutor, **making good use of silence**.<sup>(26)</sup>
- T5.3** In case of death, make it clear that even though the treatments were ineffective, **patient care was never interrupted**, both in terms of **physical proximity** (e.g. *"your husband was isolated, but never left alone"*), and in terms of treatment **aimed at relieving pain or other symptoms of suffering** (e.g. *"we can guarantee you that your father did not suffer"*).<sup>(9)</sup>
- T5.4** **Accept requests for religious assistance** and facilitate their implementation, if possible.<sup>(27)</sup>
- T5.5** In case of death, **consider whether to make two calls**. In the first one, the doctor reports the death. In the second, another healthworker (nurse or psychologist)<sup>(28)</sup> gathers the grief, helps the person(s) process of the loss in conditions of distance and isolation, verifies the family's spontaneous psycho-emotional resources and supports them.

## T6. Closure

- T6.1** **Urge the person answering the phone to express their doubts through open questions** (e.g. *"is there anything else you want to know?"* Or *"do you want to tell me more?"*). Answer questions **sincerely**, honestly stating what we know and what we don't from a scientific point of view.<sup>(29)</sup>
- T6.2** **Offer suggestions for operative solutions** for video calls, if requested.
- T6.3** **Provide information on your availability** (repeat your name and surname, department from which you are calling, number at which you can be called). Specify that the **next day s/he will be called again, at an agreed time, unless unexpected** hospital emergencies arise.
- T6.4** **Avoid promises on communications or appointments** that cannot reasonably be kept: **unfulfilled expectations** break the bond of trust.
- T6.5** End the interviews with reassurance that in the event of any **major clinical changes**, the family members will be **promptly contacted** by the health workers.

After a call it is a good idea to take a few minutes to restore your own calm, perhaps sharing the emotion of what happened with your colleagues, if this compatible with your work schedule.

There are on-line courses for 'remote learning' on the complicated issue of informing relatives of the death of a loved one. For example:

<https://www.simeu.it/w/articoli/leggiArticolo/4020/leggi>

Other on-line courses in English are available, free, for instance at "Center to Advance Palliative Care"

<https://www.capc.org/toolkits/covid-19-response-resources/>

## 7

# Operating tools for telephone and video calls

The following pages give:

- ▶ a single-sheet checklist, to be hung on the bulletin board or where you call;
- ▶ an "operational card" for the schedules of calls for the next 7 days;
- ▶ a checklist for video calls.

### **Video calls with conscious, oriented and collaborating patients:**

Suggest they see their family in a video call.

If they agree, ask whether they want their family to see them.

### **Video calls with unconscious patients:**

Request from family members to see their relative.

If deemed feasible in the light of local conditions, first recommend a visit to a certified website (if the patient is in intensive care) to familiarize themselves with the ICU environment:

[www.intensiva.it](http://www.intensiva.it) or [www.icusteps.org](http://www.icusteps.org).

**Video calling is not recommended for patients who are conscious but uncooperative.**

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**It is better to use the communication platform with which you are most confident.**

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**It is preferable to make video calls rather than sending photos or videos (in view of the risk of their not promptly reaching the person concerned, and they could be forwarded to third parties).**

# CHECKLIST FOR PHONE CALLS



## T1 Preparation

T1.1	Do you know their full names (patient and family member), medical history, current clinical situation?
T1.2	Are you in the best possible place? Can you find somewhere quieter?
T1.3	Have you had briefings on previous calls?
T1.4	Is there another colleague you can involve in the call?
T1.5	Call the family member at the prearranged time.

## T2 Opening

T2.1	Introduce yourself with name, surname, qualification.
T2.2	Check who you are talking to and their relationship with the patient.
T2.3	If family members are "vulnerable": is it possible to involve someone else?
T2.4	Check whether it is the right time for the family member.
T2.5	What do you already know? What do you want to know? Think if a "warning shot" is necessary.

## T3 Making the call

T3.1	Communicate "one piece at a time" and check what has been understood.
T3.2	Use everyday words and simple, short sentences.
T3.3	Avoid technicalities and euphemisms. Avoid being vague or too brutally direct.
T3.4	Allow people to speak in turn - do not interrupt the family member.
T3.5	For more detailed information, refer to certified sites ( <a href="http://www.intensiva.it">www.intensiva.it</a> , <a href="http://www.icusteps.org">www.icusteps.org</a> ).

## T4 Listening

T4.1	Acknowledge the emotional state of the person receiving the call.
T4.2	If requested, honestly communicate the estimated prognosis.
T4.3	Accept his/her emotions!
T4.4	Are there alarm bells? Does s/he need a psychologist for further calls?
T4.5	Show interest in the health of family members: "How are you"?

## T5 Grief

T5.1	When the patient dies, use the word "death" or "died". Then wait a moment.
T5.2	Leave room for the listener's emotions, making good use of silence.
T5.3	Explain that patient care was never interrupted, particularly in avoiding pain and suffering.
T5.4	Accept requests for religious assistance.
T5.5	When a patient dies, consider whether two calls are appropriate.

## T6 Closure

T6.1	Solicit the expression of doubts through open questions.
T6.2	Offer, if required, suggestions for video calls.
T6.3	Let them know where you can be reached, and tell them someone will call the next day.
T6.4	Avoid promises you cannot keep, so as to main the relatives' trust.
T6.5	If the clinical situation changes, assure the relatives that they will be contacted immediately.

**After the call, take some time to get your own breath back!**

# FAMILY PHONE CALL FORM



Patient name and surname: \_\_\_\_\_

Family member's name: \_\_\_\_\_

Family member's phone: \_\_\_\_\_

Husband /  Son /  Daughter  Wife  Other \_\_\_\_\_

**PAST MEDICAL HISTORY:**

**CURRENT CLINICAL SITUATION:**

**CALL NOTES:**

Date: \_\_\_\_\_

Caller: \_\_\_\_\_

Date: \_\_\_\_\_

Caller: \_\_\_\_\_

Date: \_\_\_\_\_

Caller: \_\_\_\_\_

Date: \_\_\_\_\_

Caller: \_\_\_\_\_

Date: \_\_\_\_\_

Caller: \_\_\_\_\_

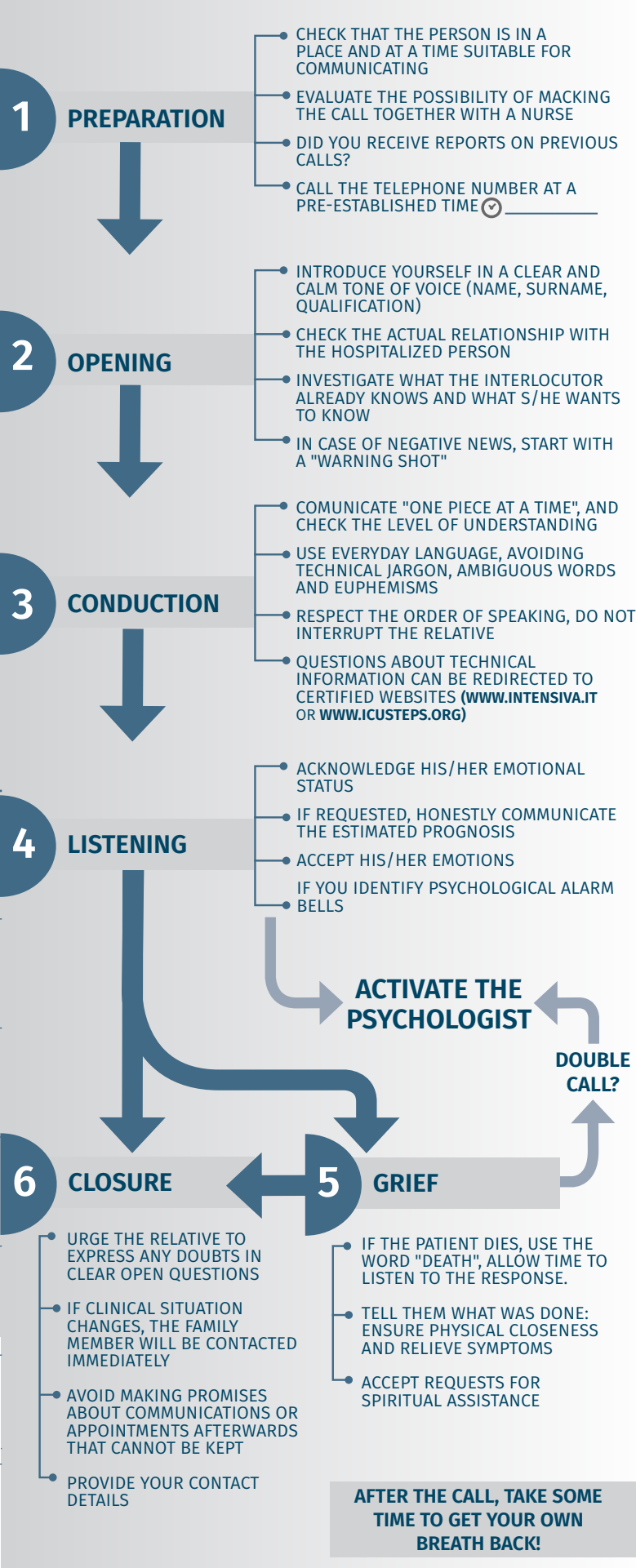
Date: \_\_\_\_\_

Caller: \_\_\_\_\_

Date: \_\_\_\_\_

Caller: \_\_\_\_\_

**IMPORTANT COMMUNICATIONS:**



**IMPORTANT COMMUNICATIONS:**

# CHECKLIST FOR VIDEO CALLS BETWEEN PATIENTS AND FAMILY MEMBERS



Patient's name and surname \_\_\_\_\_

Name, surname of the family member \_\_\_\_\_

Contact details of the family member \_\_\_\_\_

## V1 Arranging the call with the family member

V1.1	Agree to a specific time for the call
V1.2	Suggest sitting in a quiet place.
V1.3	Agree whether children should be present.
V1.4	Inform the person receiving the call that the video call must be brief.
V1.5	Patients not able to express themselves (e.g. intubated): warn the person answering the call not to ask questions requiring a complex replay.
V1.6	Suggest that family members think beforehand about what they want to say.

## V2 Preparing the patient

V2.1	Inform the patient (if conscious) that the video call will be brief.
V2.2	Reassure the patient (if conscious) that s/he will not be left alone during the call.
V2.3	Optimize position and lights; cover the patient's body adequately.
V2.4	Consider lowering the volume of alarms.
V2.5	Enable patients to see themselves, and ask again if s/he wants to do the video call

## V3 Preparing staff

V3.1	Inform the team that a video call is about to take place.
V3.2	If appropriate, involve other professionals.
V3.3	Check your appearance.
V3.4	If possible, remain with your face uncovered, wearing your identification tag.
V3.5	Call the family member at the prearranged time.

## V4 Opening

V4.1	Start the video call out of the patient's sight.
V4.2	Introduce yourself with name, surname, qualification.
V4.3	Check the identity of the person you are talking to.
V4.4	If the patient does not want to be seen, turn the camera off.

## V5 Conduction (if conscious)

V5.1	If the patient wants to be seen, select a close-up (face/torso).
V5.2	Stay close and check the patient's reactions.
V5.3	If necessary, help in understanding the contents.
V5.4	If the patient shows fatigue, lack of interest or any other unfavourable condition, bring the communication to a close.

## V6 Conduction (if not conscious)

V6.1	Frame the hospital bed as a whole and present it to the family members saying: " <i>Here is where we treat [patient's name]</i> ".
V6.2	Reassure that <i>[patient's name]</i> is sedated and does not suffer unpleasant sensations or pain.
V6.3	Postpone any clinical questions to a later time.
V6.4	Ask family members " <i>Do you want to say a few words to [patient's name]?</i> "

## V7 Closing

V7.1	Thank the patient (if s/he is conscious) telling him/her you will be back soon.
V7.2	Make yourself available to family members to clarify any doubts or answer questions.
V7.3	Ask family members " <i>How are you feeling?</i> " and let them express their emotions.
V7.4	Use expressions of sympathy: " <i>I imagine it must be very difficult</i> ".
V7.5	End by agreeing, if appropriate, on a later video call.

## V8 After closing

V8.1	Return to the patient (if conscious) to clarify any doubts or questions.
V8.2	Debrief colleagues on what strengths and critical issues have arisen, and discuss ideas for improvement.
V8.3	Take a few minutes for yourself.

### A1 Relational aptitude

In this pandemic, where isolation is necessary, **the relational and human dimension**, always fundamental in any treatment situation, becomes even more important. Establishing and maintaining effective verbal communication between healthcare staff and patients is harder than usual, partly because of the unstable clinical picture but also because of the need to use personal protective equipment (PPE) that makes it difficult to recognize people. At the same time good communication is essential, because the patient in a CoViD19 care setting can interact in person only with the staff.

Besides verbal communication, non-verbal interaction also takes on special meaning. Despite the limitations of PPE that make the health workers unrecognizable, with no detectable facial expressions, **they are required to play the relational role normally held by relatives and friends** and are the only people who can stay close to the patient even at the moment of death.

Talking to a family member on the phone is also complicated,<sup>(30)</sup> because one must provide clinical information about unexpected or even dramatic situations **in the absence of a face-to-face therapeutic relationship**. Family members themselves experience a sensation of isolation, as they are not backed by their local social network and many are not able to use computerized means of communication independently. Now as ever, it is clear that **treatment is always a 'relational' matter - even in emergency settings.**<sup>(31)</sup>

### A2 Preparing the communication

Good communication **reduces stress for the healthcare professional, the patient and family members**. In an emergency, priority must be given **to the accessibility of information** and the clarity of the messages that guarantee the patient's care is a priority. Checking that this has all been understood provides reassurance for relatives and staff.

The ordinary procedures of clinical communication are inevitably distorted by the workload and limited time available to all involved. **It is important that communications with family members follow unambiguous schedules and methods shared by the whole team**. Family members must be guaranteed an appropriate time for communication in a situation where, in view of the characteristics of the emergency setting, its non-verbal components and its therapeutic value are unfortunately severely limited.

Nonetheless, there is still room for us **to improve how we communicate** disease, suffering and death, regardless of the circumstances.<sup>(32)</sup> To achieve this, all available professionals must be engaged synergistically. **They can each encourage, correct and support** their colleagues, offering honest and motivating feedback, sometimes via telephone or video calls. This helps preserve the mental health of the health workers, enabling them at the same time to pursue their care work: communication, compassion, quality of life and, where possible, healing.

### A3 Justice during a pandemic

The four general ethical principles that guide every clinical decision (**autonomy, beneficence, non-maleficence, justice**)<sup>(33)</sup> remain valid even in the face of a massive influx of seriously ill people into the hospital. In extreme cases where the care pathways (particularly intensive and palliative treatments) are affected by the enormous disproportion between need and limited resources,<sup>(34)</sup> clinical choices can be modified according to the conditions in which you have to make decisions.<sup>(35)</sup> When communicating with family members, pay close attention to **describing all the efforts made**, clinical and organizational, to try to overcome the difficulties imposed by the tragedy of the situation and to deliver **adequate treatments in every case**. Unfortunately, all too often scarce human resources are likely to limit the possibility of good communication.

## B1 Confidentiality

Confidentiality signifies attention to professional secrecy and the relationship of **mutual trust that unites the healthcare professional and the patient** in the course of caring.<sup>(36)</sup> The team is required to know and respect the values and choices of the hospitalized person, acting in this situation as their **custodian**.

Doctors and nurses are witnesses - with a frequency never experienced before - both of the **fragility of human beings**, in their illness and unfortunately in their deaths, and the emotional suffering of their families. **This important role can be extremely demanding from an emotional point of view, for the whole care team.**

In the setting of isolation, the **visual communication** made possible by video systems is of enormous benefit to combat the inevitable feeling that loved ones have vanished, or are cared for by faceless strangers: for this reason it is preferable, when technically possible, to make video calls between doctors and family members, rather than a simple phone call. In addition, if those who are in hospital want it, and compatibly with their family situations, it is good to encourage video calls between patients and their families too.

## C1 Protecting the healthcare workers' psychological well-being

In an emergency, **self-awareness of one's resources but also of one's limits and one's emotional state is fundamental**, in order to promptly take measures to protect one's own psychological balance. The heavy workloads and emotional stress mean that it is common to suffer insomnia, flashbacks, intrusive thoughts. In addition, the objective risk of viral contamination exposes one to the risk of **post-traumatic stress** symptoms related to concern for one's own physical safety.

With today's limited resources, it may happen that the best possible behavior is not aligned with one's ethical and professional values, and this can lead to **moral distress** (inevitably having to do something that one considers morally questionable or inappropriate).

In these situations, as never before, **it is useful to get in touch with your colleagues**, reference people or psychologists.<sup>(37)</sup> When possible, *debriefing* meetings are useful at the end of the shift, or *defusing* occasions involving all staff. In this way it is possible to build a common understanding of how best to communicate with patients and their families, and thus manage particularly stressful situations more effectively.

Good communication enables you to maintain a **sense of effectiveness**, to build trusting relationships with family members, and avoid further suffering.

## C2 Internal communication

The present extraordinary emergency leads professionals to operate in conditions of **stressful overwork**. Clinical uncertainty, impediment of movement by PPE, collaboration with new colleagues, media bombardment of often inflated and unfounded news, the sense of helplessness, fear of contagion, the distance from and fear for one's family aggravate the already scarce spaces for emotional decompression.

**The clarity of orders in a solid and organized chain of command** are proven elements of support for professionals. The forms of internal communication that quantify therapeutic successes, transfers to less intensive care units, and **information related to good news** are strong motivators for all staff and help establish a positive climate.

## D1 Grief

Experiencing grief when the patient is in isolation is traumatic.<sup>(38)</sup> The proximity of the family and the funeral rituals normally help one cope with the loss and facilitate the process of grief. In a time of isolation this is all lacking, and poses a risk for the development of elaborate grief.<sup>(39)</sup>



The chance to see a loved one who died is essential for natural grief; it is an objective to be pursued<sup>(27)</sup> in line with official directives, structural limits and legal obligations. Even if in today's situation family members cannot visit their relative just before death, we can at least do something so that the story of the loss of that person can begin to be told.

In order to prepare for communication with the family of a patient who died alone, health workers can focus on their own emotional regulation, on the preparation of particular communication strategies that feel suitable for themselves, and on emotional recovery.

After the doctor has informed the family about the death, **a second call** can be made (by nurses or psychologists) to acknowledge the grief, help processing the loss in conditions of distance and isolation, and verify and support the family's spontaneous mental and emotional resources.

If religious assistance is available, one can ask family members if they want the blessing of the body, partly to give them the opportunity for decision-making in a situation of powerlessness and isolation. This small but significant gesture can meet **a family's need to feel they can part from their loved one with dignity**, and to know that health workers took care of him/her in the best possible way.

Returning the body and its belongings is an important stage of bereavement but, in a pandemic it cannot always be organized, for sanitary reasons. **Information on what happens after** the patient's death and the procedure applied in each hospital can partially replace the support offered in a normal situation. Prompt information about returning personal belongings, or procedures for managing the body, and the probable timing for its return to the family, can prevent behaviors arising from psychological distress, sometimes accompanied by reprisal moves.

## E1 Compatibility of the different tasks

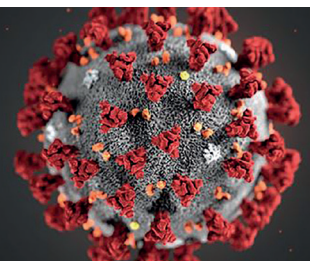
Since communication time is part of treatment time, this task must be explicitly assigned a suitable slot. If it is not possible to entrust this task to any single person, it is advisable to integrate the activities carried out in three areas: allocation of resources, management of therapy, and communication to relatives, through **work organization that allows them to be carried out as far as possible at different times**.

Inevitably cases will arise in which these tasks can only be carried out by the same person, but this must provide the possibility of lightening the emotional weight of the allocation of resources from that of clinical and organizational management, and from that of communication to family. To be sustainable over time, these tasks tend to be separated, to maintain the high quality of their performance and to defend the psychological and moral balance of the healthcare operators.

The aggressiveness of family members, while understandable and foreseeable, can create discomfort and disorientate health care, already strained by clinical fatigue and difficulties. One must keep in mind that family anger is often a response to the situation, not towards the person bearing the news. Recognizing the efforts of family members can be useful, especially by naming other underlying emotions (e.g. "I feel s/he is amazed, disappointed, incredulous, ..."). In any case, one must be ready to identify it early and ignore threatening and useless comments, preventing any escalation of aggression. After having accepted the fatigue of others and using firm courtesy, without responding to sterile criticism or verbal aggression, attention has to return to the salient aspects of the conversation, and to the news that must be transmitted.

## E2 The content of the communication

The content of communication has to be managed in relation to the care relationship, with responsibility, benevolence and reassurance. After establishing a relationship with the reference family member, **the content of the clinical information is decided in full respect of the autonomy, confidentiality and secrecy of the care relationship** (emotional, psychological, practical aspects) and the dignity of the patient.<sup>(40)</sup> The treating communicator selects the most important clinical information and presents it within the time allowed by the circumstances, taking responsibility for deciding how much of the situation to describe and in what timeframe to share health information, depending on the family member's situation. **Omissions in communication should ideally be avoided**, but it is also appropriate to assess the family's desire and need for information from time to time.



In communicating bad news to patients, one must also focus on the "how" and "when". **Honestly offering a presentation of the truth** does not mean it is necessary to go into great detail and unless this is explicitly requested it may not be deemed necessary, or there may be good reasons to postpone full communication.

Even in a situation like this pandemic, **decisions to limit or discontinue disproportionate treatments must be inspired by the approach and clinical and ethical principles** recommended in various official documents, and must be communicated honestly, clearly and unequivocally.<sup>(41, 42, 43)</sup> It is always advisable to investigate and respect the patient's wishes, and communication with family members also has the important purpose of acquiring information on the patient's expected wishes and preferences regarding treatments.<sup>(44)</sup>

**The final decision on the clinical appropriateness of the therapies is, however, always made by the care team.**<sup>(45)</sup> The need to make clinically appropriate and ethically legitimate choices should be explained to family members. It is important to make it clear **that relatives have no decision-making responsibilities and therefore should not feel guilty about the choices.**<sup>(46)</sup>

The content of communications with patients and their family members must be briefly reported in the medical record and presented to colleagues during the handover, so as to share the communication strategy between colleagues, and to ensure consistent messages.<sup>(47)</sup>

### **E3** Communication to family members: the legal point of view

Even in an emergency situation, when the patient is capable **consent for processing personal data is always required**, together with the indication of a family member authorized to receive medical information and the methods for communicating that information. If the patient can no longer communicate with the medical staff, his/her wishes must be respected. Examining the clinical histories of patients with CoViD-19, in most cases they enjoy a long time during which they are able to communicate, understand and decide. Therefore, it is important that **the medical staff promptly collect the wishes regarding present and future treatments from all patients**, together with their contacts' phone numbers, and the names of persons of trust, and that they organize themselves according to their means of communication. These may change depending on how the situation develops.

If the patient is already incompetent, in the absence of their trustee (in Italy according to legislation no.219/2017)<sup>(48)</sup> or a legal representative (e.g. parents for minors, legal guardian, support administrator previously nominated for a person who is partially or totally non-autonomous) **communications with family members are necessary even when it is not possible to obtain consent from the patient.** It is important to try and identify the appropriate contact person. When patients find themselves physically incapable or legally unable to give their own consent, processing personal data regarding their health is considered legitimate **if it is necessary to protect the patient's or another person's life** - even more so for public health reasons (see reg. EU, no. 679/2016, art. 9). The most appropriate form of communication must be decided on a case-by-case basis, keeping in mind the principles of **necessity, proportionality and adequacy** and - depending on the emergency situation - trying to limit any possible risks linked to the data processing. One must be careful to act according to the principles set out in art 5, reg. EU 679/2016 and to agree about the modalities with the coordinator of the facility and the data protection officer.

It is useful to recommend that **it is in the patient's interest to involve family members**; it allows their medical history, life history and values to be traced. The patient is not alone and future home care can be arranged in the best possible way, with caregivers aware of the clinical course. **The inclusion of a relative is also in their own interest**: communication with the medical staff establishes a relationship with their loved ones and permits the best possible health care. From a physical point of view, correct, accurate and reassuring communication reduces the family's stress response and allows the use of the best therapeutic and preventive measures to limit the spread of the virus and its clinical consequences for people who have been contaminated. From the psychological and social points of view, there is no doubt that communication about the clinical course of a loved one plays an important role **in reducing the psychological anguish of the family.**

As far as the law is concerned, when it comes to communication with the patient's family members of trust, it is important in Italy to recall **legislation no. 219/2017** (with regard to informed consent and prior instructions regarding treatment). This legislation is based on a **judicial, ethical and cultural understanding** that considers the treatment on a personal level and lays stress on **doctor-patient communication** during the treatment itself.

According to this legislation, communicative and relational skills are complemented by technical expertise, and involve the organizational aspects of the healthcare facilities called upon to ensure its implementation. Implementing the tools to guarantee **correct communication** also enhances the **consistency and quality of the therapeutic and caregiving process**, restores the therapeutic alliance, generates faith in the national healthcare system, and prevents errors.

In legislation it is also important to bear in mind that the **therapeutic relationship takes on a multi-subjective dimension**, engaging all the healthcare workers who are part of the team and, if the **patient wishes, family members** (the spouse or life partner, or the person of trust), who are authorized to receive information about the patient's health and to **express consent regarding the treatment on his/her behalf**.

Especially in an emergency, both the disease and the treatment concern not only the patient but also their loved ones. Fundamentally it is the patient who specifies the people they do or do not want to involve in their own treatment. However, communication may still be necessary to protect their family members' wellbeing as well as public health. In cases where there is no indication from the patient, **the law does not specify criteria to identify the family members of trust**.

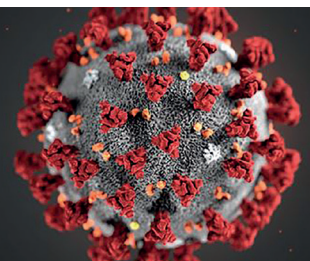
It may be useful here to recall some criteria from a particular regulatory source (article 3, page 2, paragraph 91/1999 in the matter of organ and tissue removals and transplants; article 408, page 1,...). These criteria are intended to be approximate, non-hierarchical and flexible. The primary point of consideration for selecting the person to whom the information is given **is always the patient's best interests**. In addition, moral solidarity, rights and duties which drive family relationships and have their own constitutional recognition (arts 2,29,30 of the Italian Constitution), stand out.

In the exceptional context of a health emergency and total isolation of the patients (often from their close family too) - also involving extreme psychological stress - **any omissions or impairment on a communicative or relationship level can have important negative implications on the mental and physical health of the patients and their families, as well as public health**, which is a basic constitutional right (art 32, Constitution).

Also, in an emergency the patient's right to self-determination must be respected, and **wishes and directives regarding treatments must be applied as far as possible**. If the patient is incapable or has a legal representative (e.g. parents, legal guardian or similar) they must always be involved in the therapeutic relation in a manner appropriate to their abilities (see art. 3, page 1; legislation no. 219/17).

According to the legislation, in an emergency the doctor and the medical staff need to ensure **necessary treatment is provided**, respecting the patient's wishes in all the clinical circumstances in which they are able to express them. Relatives should be informed and reassured about the patient's right of access to palliative care and pain therapy (legislation no. 38/10; legislation no. 219/17).

When a patient is not able to express an opinion, or faces incapacity, if the prognosis is poor it seems **useful to plan "shared treatment" involving family members**, or registered partners, or a cohabitee, or a trustee. Good communication with family members is necessary in order to respect the patient's wishes and find solutions best adapted to their personal interests.



The right to the protection of personal data **is not an absolute priority**, but must be **considered in relation to its function in society** and be balanced against other fundamental rights, like health, in both the individual and collective dimensions, in accordance with the principle of proportionality.

If the patient is physically or legally unable to express opinions, processing personal data **will be lawful when necessary to protect the best interest of that patient or other people**, as well as for reasons of public health (arts. 4, 46, 54, Reg. EU 2016/679).

According to European regulation on specific categories of personal information, such as the state of health, personal data processing **is lawful** when it protects the involved person's life or that of someone else **if the involved person is physically or legally unable** to give free and informed consent, as well as for reasons of public interest in the field of public health (cf. art. 9 paragraph 2 lett. c), i), Reg. EU 2016/679).

The urgent decree for strengthening the Italian national health service in relation to the CoViD19 emergency (art. 14, DL 14/20) provides **rules derogating from the privacy legislation** and simplifications aimed at balancing the management needs of the emergency with confidentiality of the parties concerned, without prejudice to compliance with the principles relating to the processing of data pursuant to art. 5 of EU Reg. 2016/679 on the lawfulness, correctness, transparency, accuracy and minimization of data communication and the adoption of adequate technical and organizational measures aimed at guaranteeing their safety.

When a patient is in total isolation for the protection of individual and public health, **the means of communication must minimize** – as far as possible – the risks concerning personal data processing connected also to technology, considering, however, the present period of extraordinary emergency.

Any **evaluation in terms of responsibility** for a violation now **cannot be separated from this extraordinary health emergency** we are witnessing.



## We believe in the healing power of words ...

### Project "We write history"

<https://vissuto.intensiva.it>

### "SIMEU stories" project

<https://www.simeu.it/w/articoli/leggiArticolo/335/dir>

The communication typical of the globalized world, in this period of an overwhelming pandemic, can give way to **silent solitude**: loneliness for the patient, the anguished isolation of family members, and of health workers within their own hospitals.

There is the loneliness of illness and often the loneliness of a death unaccompanied by affection. Moreover, in the future there will be the stress of a trauma that has marked us all and that we will have to learn to manage.

In the combined efforts to save the lives of the thousands of infected people, **the absolute therapeutic commitment** of doctors and nurses, however, **has touched a peak of humanity in this inhuman condition**. The relational space aims at establishing a form of contact with the patient, with family members, and healthcare professionals, driven by a **feeling of dedication** not only towards others but that becomes a need for ourselves, to give meaning to this terrible isolation from affections.

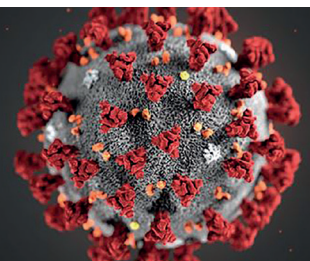
A phone call, a video call, an email, a written story ... all try to replace the physical contact that the virus prohibits: **communicating with the family** allows people to create a listening space where worries, anguish of death, and fears are collected for themselves and their loved ones far away, and in which they try **to instil trust and hope**. A path of solidarity is perhaps the only gift of this tragedy.

It is extremely important to establish contact with family members. A phone call, without ever replacing the doctor's daily communication on the development of the disease, becomes a tool to help those who cannot personally assist their loved one, suffering the anxiety of not having direct information and often the burden of a sense of guilt linked to 'the feeling of abandoning one's family'. **We inform, reassure, collect tears, and together we identify a path of hope** for containing and eventually overcoming a trauma that will leave its marks in future years. Otherwise we end up accompanying the pain of a death, without closeness and with no direct participation - only unsustainable distance - but **at least not loneliness**.

Rapid clinical choices engage the ethical and moral spheres of health care, leaving a load that never abandons those involved; day and night the terrible match with death is replayed, isolated, far from loved ones, from the embrace of their children. Psychologists do all they can to help, building up support and listening, to contain the anguish and stress of those who, although trained to work with death, could never have imagined managing this huge amount of pain, without the right weapons that research is still preparing.

Psychological support in groups formed by doctors and nurses is an immediate measure that helps regenerate forces in the daily battle, but **accompaniment and support will also be important in the near future** when in the emotional sphere compromised by such vast pain, emotions and images will resurface in the memory, causing great distress.

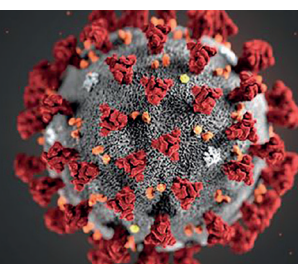
Someone must look after those who look after, first of all **breaking up the loneliness with gatherings and narration**. We are all players in this hard struggle, it is true, but we will never give up.



1. Nacoti M, Ciocca A, Giupponi A, Brambillasca P, Lussana F, Pisano M et al (2020) At the Epicenter of the Covid-19 Pandemic and Humanitarian Crises in Italy: Changing Perspectives on Preparation and Mitigation. *NEJM Catalyst* DOI: 10.1056/CAT.20.0080
2. Cluver L, Lachman JM, Sherr L, Wessels I, Krug E, Rakotomalala S et al (2020) Parenting in a time of COVID-19. *Lancet* doi: 10.1016/S0140-6736(20)30736-4
3. Giannouli V, Mistraletti G, Umbrello M (2017) ICU experience for patients' relatives: is information all that matters? *Intensive Care Med* 43:722-3
4. Benatti SV (2020) Love in the Time of Corona. *Annals of Internal Medicine* doi: 10.7326/M20-1137
5. Levin TT, Moreno B, Silvester W, Kissane DW (2010) End-of-life communication in the intensive care unit. 32:433-42
6. Scheunemann LP, McDevitt M, Carson SS, Hanson LC (2011) Randomized, controlled trials of interventions to improve communication in intensive care: a systematic review. *Chest* 139(3):543-554. doi: 10.1378/chest.10-0595.
7. Davidson JE, Aslakson RA, Long AC, Puntillo KA, Kross EK, Hart J, et al. (2017) Guidelines for Family-Centered Care in the Neonatal, Pediatric, and Adult ICU. *Crit Care Med.* 45(1):103-128.
8. Curtis JR, White DB. (2008) Practical guidance for evidence-based ICU family conferences. *Chest.* 134(4):835-43.
9. Orsi L, De Biasi F, Sempredoni A, Busatta L, Mazzon D (2017) La comunicazione della cattiva notizia in ambito sanitario: da sconosciuta a perno della relazione di cura. *BioLaw Journal – Rivista di BioDiritto*, n. 1/2017
10. Warrillow S, Farley KJ, Jones D (2016) How to improve communication quality with patients and relatives in the ICU. *Minerva Anestesiol* 82:797-803
11. Bajwah S, Wilcock A, Towers R, Costantini M, Bausewein C, Simon ST, et al. (2020) Managing the supportive care needs of those affected by COVID-19. *Eur Respir J.* doi: 10.1183/13993003.00815-2020. [Epub ahead of print]
12. Black MD, Vigorito MC, Curtis JR, Phillips GS, Martin EW, McNicoll L, et al. (2013) A multifaceted intervention to improve compliance with process measures for ICU clinician communication with ICU patients and families. *Crit Care Med.* 41(10):2275-83
13. Lautrette A, Darmon M, Megarbane B, Joly LM, Chevret S, Adrie C, et al. (2007) A communication strategy and brochure for relatives of patients dying in the ICU. *N Engl J Med.* 356(5):469-78.
14. Sanchez-Reilly S1, Morrison LJ, Carey E, Bernacki R, O'Neill L, Kapo J, et al. Caring for oneself to care for others: physicians and their self-care. *J Support Oncol.* 2013 Jun;11(2):75-81.
15. Mistraletti G, Mezzetti A, Anania S, Ionescu Maddalena A, Del Negro S, Giusti GD et al. (2019) *Contemp Clin Trials* 86:105847
16. Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP (2000) SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer. *The Oncologist* 5:302-11
17. Van Keer RL, Deschepper R, Francke AL, Huyghens L, Bilsen J. (2015) Conflicts between healthcare professionals and families of a multi-ethnic patient population during critical care: an ethnographic study. *Crit Care.* 19:441.
18. Lind R, Lorem GF, Nortvedt P, Hevrøy O. (2011) Family members' experiences of "wait and see" as a communication strategy in end-of-life decisions. *Intensive Care Med.* 37(7):1143-50.
19. Kleinpell Ruth, Zimmerman J, Vermoch KL, Harmon LA, Vondracek H, Hamilton R et al. (2019) Promoting Family Engagement in the ICU: Experience From a National Collaborative of 63 ICUs. *Crit Care Med* 47:1692-8
20. Lilly CM, Daly BJ. (2007) The healing power of listening in the ICU. *N Engl J Med.* 356(5):513-5.
21. Mistraletti G, Umbrello M, Mantovani ES, Moroni B, Formenti P, Spanu P, et al (2017) A family information brochure and dedicated website to improve the ICU experience for patients' relatives: an Italian multicenter before-and-after study. *Intensive Care Med* 43:69-79
22. McDonagh JR, Elliott TB, Engelberg RA, Treece PD, Shannon SE, Rubenfeld GD, et al. (2004) Family satisfaction with family conferences about end-of-life care in the intensive care unit: increased proportion of family speech is associated with increased satisfaction. *Crit Care Med.* 32(7):1484-8.
23. Nguyen Y-L (2019) Dealing with internet-based information obtained by families of critically ill patients. *Intensive Care Med* 45:1119-22
24. Di Bernardo V, Grignoli N, Marazia C, Andreotti J, Perren A, Malacrida R (2015) Sharing intimacy in "open" intensive care units. *J Crit Care* 30:866-70



25. Seaman JB, Arnold RM, Scheunemann LP, White DB. (2017) An Integrated Framework for Effective and Efficient Communication with Families in the Adult Intensive Care Unit. *Ann Am Thorac Soc.* 14(6):1015-1020.
26. Maynard DW (2017) Delivering bad news in emergency care medicine. *Acute Med Surg* 16;4:3-11
27. Cook D, Rocker G (2014) Dying with Dignity in the Intensive Care Unit. *N Engl J Med* 370:2506-14
28. Curtis JR, Treece PD, Nielsen EL, Gold J, Ciechanowski PS, Shannon SE, et al. (2016) Randomized Trial of Communication Facilitators to Reduce Family Distress and Intensity of End-of-Life Care. *Am J Respir Crit Care Med.* 2016 Jan 15;193(2):154-62.
29. Cox CE, Jensen HI. (2017) The unmet need of information access for family members of ICU patients. *Intensive Care Med.* 43(2):240-242.
30. Langeron O, Monsel A (2016) Communication with patients and relatives in ICU: a skill to master. *Minerva Anesthesiol* 82:733-4
31. Quintel M. (2017) "I feel how you feel": reflections about empathy in the relationship between ICU physicians and relatives. *Intensive Care Med.* 43(11):1723-1724.
32. Turnbull AE, Chessare CM, Coffin RK, Needham DM. (2017) A brief intervention for preparing ICU families to be proxies: A phase I study. *PLoS One.* 12(10):e0185483.
33. Vergano M, Magavern E, Zamperetti N (2018) Clinical ethics: what the anaesthesiologist and the intensivist need to know. *Minerva Anesthesiol* 84:515-22
34. Vergano M, Bertolini G, Giannini A, Gristina GR, Livigni S, Mistraletti G et al (2020) SIAARTI Recommendations for the allocation of intensive care treatments in exceptional resource limited circumstances. *Minerva Anesthesiol* DOI: 10.23736/S0375-9393.20.14619-4
35. Berlinger N, Wynia M, Powell T, Hester DM, Milliken A, Fabi R et al. (2020) Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19). Guidelines for Institutional Ethics Services Responding to COVID-19. The Hastings Center
36. Thompson IE (1979) The nature of confidentiality. *J Med Ethics* 5:57-64
37. Cicekci F, Duran N, Ayhan B, Arican S, Ilban O, Kara I et al. (2017) The communication between patient relatives and physicians in intensive care units. *BMC Anesthesiol.* 17(1):97.
38. Azoulay E, Chaize M, Kentish-Barnes N. (2014) Involvement of ICU families in decisions: fine-tuning the partnership. *Ann Intensive Care.* 30;4:37.
39. Courtright KR, Benoit DD, Halpern SD. (2017) Life after death in the ICU: detecting family-centered outcomes remains difficult. *Intensive Care Med.* 43(10):1529-1531.
40. Gristina GR. (2018) From the other side of the door. *Minerva Anesthesiol* 84:996-997.
41. Gristina GR, Orsi L, Carlucci A, Causarano IR, Formica M, Romanò M. (2014) Part I. End-stage chronic organ failures: a position paper on shared care planning. *The Integrated Care Pathway. Recenti Prog Med.* 105(1):9-24.
42. Gristina GR, Orsi L, Carlucci A, Causarano IR, Formica M, Romanò M. (2014) Part II. Scientific evidence in end-stage chronic organ failure. A position paper on shared care planning. *Recenti Prog Med.* 105(1):25-39.
43. Barbisan C, Casonato C, Palermo Fabris E, Piccinni M, Zatti P. (2014) Part III. Ethical and juridical aspects in end-stage chronic organ failures. A position paper on a shared care planning. *Recenti Prog Med.* 105(1):40-44.
44. Scheunemann LP, Ernecoff NC, Buddadhumaruk P, Carson SS, Hough CL, Curtis JR (2019) Clinician-Family Communication About Patients' Values and Preferences in Intensive Care Units. *JAMA Intern Med* 179:676-84.
45. Roeland E, Cain J, Onderdonk C, Kerr K, Mitchell W, Thornberry K (2014) When Open-Ended Questions Don't Work: The Role of Palliative Paternalism in Difficult Medical Decisions. *J Palliat Med* 17:415-20
46. Parker AM, Bienvenu OJ. (2015) Posttraumatic stress disorder symptoms among family decision makers and the potential relevance of study attrition. *Crit Care Med.* 43(6):1334-5.
47. Schwarzkopf D, Behrend S, Skupin H, Westermann I, Riedemann NC, Pfeifer R, et al. (2013) Family satisfaction in the intensive care unit: a quantitative and qualitative analysis. *Intensive Care Med.* 39(6):1071-9.
48. Gristina GR, Busatta L, Piccinni M (2019) The italian law on informed consent and advance directives: its impact on intensive care units and the european legal framework. *Minerva Anesthesiol* 85:401-11





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