Barts Health
Simulation
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Difficult Telephone Conversations

As clinicians we have historically been taught not to deliver bad news over the telephone. We have had to review this policy in the current climate of dealing with the Covid pandemic when we are having to strictly limit visitors to our hospitals, and social distancing means that individuals are not able to be physically with their loved ones.

At Newham Hospital, in conjunction with our collaborative partners at Role Plays For Training, we have developed a short course for staff to address some of the challenges that this brings. This document provides a guideline that you can use and adapt for the needs of your staff in your geographical and professional areas.

This training was designed to be delivered in 1 hour time slots to allow us to engage as many staff as possible. It can be delivered in pretty much any physical space, the only equipment that is required is a telephone with a speaker facility. The group you are working with can be as small as you like, but we would suggest that there are no more than 10 participants. We would suggest that there are 2 debriefers.

We introduce the hour with a brief talk about the challenges we are facing in light of the pandemic, and that one of the issues that staff have faced is that of having difficult conversations and breaking bad news over the telephone. We then introduce a clinical scenario and tell the group that there will be 3 telephone conversations that will take place and say that we will be asking 3 different participants to make the calls. For the call the phone is put on to speaker with the trainer calling the trainer (working remotely) who will be waiting for the call. After each call the actor / trainer will give some focused feedback after which the wider group will have a short debrief before moving on to the next call.

Clinical Scenario

Call 1

You are working in an acute setting. Mike Oliver is a 52 year old male with a background of asthma who has been brought to the hospital because of difficulty in breathing. He lives with his wife and 2 children. He usually works as a carpenter. He has been unwell for around 5 days but last night was so short of breath that his wife called an ambulance. On arrival in the department he was hypoxic with oxygen saturations of 85%, a blood gas demonstrated Type 1 respiratory failure. He was initially put on to CPAP with good effect, however it is now 5 hours later and he is showing signs of tiring. You have decided to intubate and ventilate him. The first candidate needs to call his wife, Amy, to inform her of this.

Call 2

Mike has been ventilated for several hours now. Despite maximum inotropic and ventilatory support his blood pressure and oxygen saturations continue to drop. He is expected to die and the team are making him comfortable. The second candidate should call Amy to inform her of his condition.

Call 3

Mike died 10 minutes ago.
Candidate 3 needs to inform his wife.

Debrief Points

Having run this scenario with several different groups now there are several debrief points that are recurrent. And as is often the case with simulation training, we have found there are often more questions than answers.

Space and Staff
Where should these calls take place? Some favour making them from a clinical area as they feel that the next of kin will be reassured by hearing the noise around them that their loved one is being cared for in an area where clearly people are busy caring for patients. Others favour a quiet office environment, whilst some have advocated using their own phone with the number blocked so that they can make the call in a space where they are free to move around.
Some have suggested that they don't make the call alone but take a colleague with them so that they can debrief the call afterwards and offer each other support.

Silence
Allowing pauses in conversation / silence is something that many of us struggle with. Without the visual cues of being in the same room as someone, and without being able to offer any physical comfort, for example holding a hand, this becomes even more difficult.

Language
Use of ambiguous language around death and dying e.g. "passed away" has been discussed at length!

Checking Knowledge
This has made a lot of clinicians question the step of “checking knowledge of the situation to date”. It often feels borderline cruel in the second and third scenarios to check what the partner knows to date as they really just want to know how Mike is right now.

Empathy
It is clear to people in the room that the person making the call is often struggling to control their emotions / sadness. This can be misinterpreted as a “lack of empathy” from the trainer at the other end of the phone and reiterates how much we usually rely on physical cues in these difficult situations.

Reassurance
One of the most important reassurances that staff can offer the next of kin was that their loved one was not alone; that they were being cared for by a dedicated and highly skilled team. Giving the team members names also proved reassuring, for example “Emma is the nurse who is with him right now”.

It’s ok to be sorry
Saying that you are sorry that the situation is as it is is fine. Phrases like “I wish that things were different” are usually well received.

Get on with it
If you are phoning with bad news then do not give a long introduction to your news. Crack on.

Further Information

As we have needed to out this information together pretty rapidly and completely ignoring usual process and peer review, it is far from perfect. Any feedback or comment is always welcome via the following:

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