Telephone communication with patients' relatives: A meta-synthesis

Comunicació telefònica amb familiars de pacients: una metasíntesi

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ABSTRACT:

The relationship between doctor and patient has evolved over time and the paternalistic attitudes that were held for centuries have been progressively superseded by patient-centred medicine, in which communication plays a key role. The COVID-19 pandemic has introduced serious challenges in this field.

This investigation aims to review the scientific literature dealing with this issue, from 2015 to the end of 2021. The methodology employed has been a meta-synthesis, allowing the review and analysis of different qualitative studies. Some differences have been found between the pre- and post-pandemic periods, together with a lack of theoretical corpus.

Telehealth will grow in the years to come and so will distance communication, so it is necessary to consider all possible drawbacks and risks and mitigate them before they may turn into serious problems, such as issues related to patient safety, security, and confidentiality; hidden costs; lack of training; or the digital breach.

KEYWORDS:

patient-centred communication, telehealth, healthcare professional-family relations, telephone communication, patient-centred care, hidden costs.

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RESUM:

La relació metge-pacient ha canviat al llarg de la història i, en l'actualitat, s'ha abandonat progressivament el tipus paternalista que s'ha mantingut durant centenars d'anys fins a arribar a la medicina centrada en el pacient. En aquesta, la comunicació té un paper principal. La pandèmia de la covid-19 ha suposat importants reptes en aquesta matèria.

Aquesta recerca pretén revisar la literatura científica sobre el tema, des de 2015 fins a finals del 2021. La metodologia emprada ha estat una metasíntesi, que ha permès revisar i analitzar diferents estudis qualitatius. S'han trobat diferències entre els períodes pre- i postcovid-19, a més d'una manca de cos teòric.

La telemedicina creixerà en els pròxims anys i també la comunicació a distància, per la qual cosa és necessari considerar tots els possibles inconvenients i riscs que puguin presentar-se i mitigar-los abans que es converteixin en problemes greus, com podrien ser qüestions relacionades amb la seguretat dels pacients, la confidencialitat, la seguretat física, els costos ocults, la falta de formació del personal o la bretxa digital.

PARAULES CLAU:

comunicació centrada en el pacient, telemedicina, relacions professional-família, comunicació telefònica, medicina centrada en el pacient, costos ocults.

1. Introduction

Communication skills are fundamental in allowing health professionals to carry out their work in the best possible way: this is an incontrovertible fact and it has always been the case. Although it is not advisable to lose sight of the need to maintain good relationships between health professionals themselves, or of the importance of health communication with society as a whole, the most important aspect of communication in the health field is undoubtedly the so-called *doctor-patient communication*, which, despite its name, encompasses all health professionals, on the one hand, and patients and their relatives or representatives, on the other.

This is the type of communication that this study deals with and to understand its importance and characteristics it is necessary to review how its purpose has changed over hundreds, if not thousands, of years.

Laín Entralgo (1969) explores the relationship between doctors and patients from Classical Greece to the middle of the 20th century and speaks of four main moments of the medical act, namely: the cognitive moment (diagnosis), the operative moment (treatment), the affective moment (friendship) and the ethical-religious moment (habits and beliefs in force at the time and place of the medical act). Moreover, he explicitly points out the need for the relationship between doctor and patient to be based on what he calls "medical friendship", the specific mode of which is trust.

This relationship is particularly important because, as Rodríguez Marín (2010) says, "the form and content of communication between doctor and patient depend on the nature of the relationship established between them". It must be said that this author considers the usefulness of information simply as a means to achieve a good diagnosis and as a tool to ensure that the patient follows the treatments correctly, something which, as we will see further on, is not enough for what is considered today to be a good doctor.

This is the result, however, of a historical evolution in this type of relationship that has directly influenced how health professionals communicate with the people who need their services, i.e., with each and every member of society at some point in their lives. According to Siegler (2011) – although, as he points out, his vision is deeply influenced by his American culture – this evolution involves the passage through four different ages: the age of paternalism, which lasted from the dawn of medicine until the 1960s, in which the relationship was practically unidirectional and the doctor held complete control based on his *autoritas,* even though his technical capacity was actually very limited; the age of autonomy, in which it was the patient who had all the power and the doctor was simply devoted to satisfying his needs, something which occurred with the improvement of treatments and which in some cases continues today; the age of bureaucracy, which began when public organisations started to pay for medical services and ended up imposing economic issues and the common good over the wishes or needs of the doctor and his

patient; and lastly, the fourth, usually referred to as patient-centred medicine, which arose from the 1960s onwards and prioritised the relationship between doctor and patient, leading to shared decision-making.

However, from a European point of view, these phases or ages are not apparent and some characteristics clearly overlap. One may speak of the existence of a paternalistic age, involving a kind of relationship that was maintained for thousands of years, but due to the creation of public health systems in Western Europe at the end of the 19th and beginning of the 20th century, the age of autonomy is not observed there except in the field of aesthetic medicine, where many of the procedures are performed in compliance with patients' wishes and are not fully based on health needs, although we can nevertheless recognise some of the characteristics that Siegler attributes to the age of paternalism (Paoli & Procacci, 2019).

On the other hand, the so-called *bureaucratic age* is not such in reality either, being rather an economic and functional scheme that is superimposed on the doctor-patient relationship in its paternalistic version or its patient-centred version.

At present, restricting our scope to the situation in Spain, despite having a healthcare system with differences in terms of its services and management in the various autonomous regions, we can see that doctors carry out many administrative procedures typical of the so-called *bureaucratic age* while the relationship with the patient tends to move beyond paternalism – a paternalism which undoubtedly persists in some professionals (Herreros *et al*., 2020) and not only among doctors (Taleghani *et al*., 2022) – to a patient-centred or shared decision-making model.

Now we may ask, what is meant by shared decisions? In the second half of the past century, it became apparent that the growing standardisation of medical procedures was increasingly influencing the doctor-patient relationship, making it more distant and colder, with the emergence of informed consents, apparently replacing the previous relationship based on paternalism, which was nevertheless a much closer relationship. Informed consents gave greater autonomy to the patient while limiting potential legal problems (Slim & Bazin, 2019). The compulsory use of these consents ended up, in many cases, reducing them to simple administrative formalities that were only applied when a surgical or therapeutic procedure involving a certain risk was to be performed.

From the 1980s onwards, the need for patients to receive information that is truly appropriate to their knowledge and capacities began to be raised, so that they could be involved in making decisions about their health and thus respect the principles of bioethics: autonomy, beneficence, non-maleficence and justice (Beauchamp, 2003). This concern was embodied in what is now known as the shared decision-making model or SDM (Childress & Childress, 2020). In this model we have, on one hand, the doctor – an expert in technical medical issues – who presents the different options as well as the advantages and consequences of each of them, and on the other hand, the patient – an expert on his or her vision of life and personal circumstances – who explains his or her preferences, wishes and values,

with a collaborative relationship being established between the two to find a satis-factory response to the patient's needs. There is no single way to achieve this type of collaborative relationship and multiple options have been proposed with differ-ent steps to achieve it (Coulter & Collins, 2011; Elwyn *et al*., 2012; Eder *et al*., 2021), including tools for decision-making support (Scalia *et al*., 2018).

In 1988, a further step was taken: "the Picker/Commonwealth Program for Patient-Centered Care (now the Picker Institute) coined the term 'patient- centred care' to call attention to the need for clinicians, staff, and health care systems to shift their focus away from diseases and back to the patient and family" (Barry & Edgman-Levitan, 2012; Gerteis, 1999). This implied a new paradigm as it not only took the patient and his or her needs, wishes and values into account when deci-sions had to be made, but also placed the patient at the centre of all medical prac-tice. Even the principles of so-called *evidence-based medicine* or EBM include the idea that medical evidence is not sufficient to make a clinical decision and that the needs, preferences and values of patients have to balance the evidence to make the best decision in each case (Guyatt *et al*., 2015). There is sufficient evi-dence that, when adopted by health systems, this is a good approach both in terms of improving patients' quality of life and from the standpoint of economics (Oshima Lee & Emanuel, 2013).

In order to practice patient-centred medicine, it is necessary to pay attention to multiple issues such as carrying out personalised medicine or having good coordi-nation between the different professionals involved in the care, but what is per-haps most important is that all this cannot be achieved without adequate communication between all actors in the process and this includes the patients themselves or, as appropriate, their relatives, bearing in mind that the term "rela-tive" must be defined in a very broad way, as proposed by the experts of the American Geriatrics Society: "Family is broadly defined to include all the individuals whom the patient wants involved in his/her care, regardless of whether they are related biologically, legally, or otherwise; if the patient is noncommunicative, health professionals will make their best effort to identify and include the individu-als whom the patient would want involved in his/her care" (American Geriatrics Society Expert Panel on Person-Centered Care *et al*., 2016). In this way, a concept of central importance emerges, namely patient-centred communication (PCC). This type of communication strengthens the doctor-patient relationship in aspects such as mutual trust, respect, and commitment. It is defined by a process that involves:

"— Eliciting, understanding, and validating the patient's perspective (e.g., con-cerns, feelings, expectations).

— Understanding the patient within his or her own psychological and social context.

— Reaching a shared understanding of the patient's problem and its treatment.

— Helping a patient share power by offering him or her meaningful involve-ment in choices relating to his or her health." (Epstein & Street Jr. 2007)

There is ample evidence of the benefits of PCC, including patient satisfaction, improved adherence to treatments and patient understanding of treatments, improved health outcomes, as well as reduced claims (King & Hoppe, 2013).

Often, due to the inability to communicate effectively with the patient (such as in the case of minors, people with dementia or unconscious people) or when a fatal outcome is to be communicated, health professionals must contact the patient's relatives, and this involves a number of very specific issues to be considered, such as those relating to confidentiality (Geiderman *et al.*, 2006) or difficulties in contacting the right person (Furlong & Leggatt, 1996).

In early 2020, the world was shaken by the emergence of a virus that eventually proved to be pandemic, SARS-CoV-2 (Gorbalenya *et al.*, 2020). It was not the first time that humanity as a whole had been struck by a pandemic, and it is unlikely to be the last (Huremović, 2019), as there are active viruses with the potential to become epidemic or even pandemic at any time, as can be seen in the surveillance protocols that the UN has been implementing for years (WHO, 2022). Nevertheless, it was the first time that many countries decreed strict confinements for the whole population (Koh, 2020) and that the families of patients were not allowed access to the hospitals where the patients were being treated and where many of them died without their families being able to say goodbye to them (Hugelius *et al.*, 2021).

This situation forced health professionals to contact relatives by telephone, video call or email, whereas using these means would previously have been considered bad practice and would have been avoided as far as possible. Thus, the man who is considered by many as the ultimate reference in the communication of bad news says: "Unless it is absolutely unavoidable, an interview about bad news should be carried out in person and not over the telephone" (Buckman, 1992: 68).

In this review, we have analysed publications dealing with telephone communication with relatives of patients in order to look for differences in the research conducted before and after the pandemic and to extract the main ideas of the articles.

2. Methodology

A qualitative analysis has been carried out in the form of a meta-synthesis, which allows the study and interpretation of different likewise qualitative studies in order to generate new lines of research, detect knowledge deficits and clarify concepts (Carrillo-González *et al.*, 2007) in the field of distance communication with patients' relatives. For this analysis, we followed the steps proposed by Finfgeld (2003): first the focus of the study was determined, then the data were collected and lastly they were analysed.

Thus, the focus of this study has been defined as understanding the state of research on medical communication conducted remotely by telephone with the relatives of patients, regardless of whether the latter were hospitalised or not.

To select relevant articles, SCOPUS, WoS and MEDLINE were searched according to the following concepts and keywords: *relatives or family*, *communication*, *by telephone* and *doctor* or *physician* or *nurse* or *health professional*. In addition, the search was restricted to between 1 January 2015 and 30 September 2021 to analyse the 5 years prior to the COVID-19 pandemic and a certain period following it.

The next step was to select relevant articles for the study, which had to meet the following inclusion criteria:

1. The articles were to deal with communication between health professionals and patients' families.
2. They had to deal with communication carried out by telephone.
3. They were articles as such.
4. They were written in English or Spanish.

A first selection was made by reading the abstracts, after which the selected articles were analysed, starting with a review of the references to see if more articles could be found that fit the inclusion criteria and that had not been located in the initial search due to the limitation of the search words used.

In order to analyse the data obtained in the previous steps, a careful study was carried out by decontextualising the findings and referencing them, looking for patterns, contradictions, and unanswered questions.

3. Results

3.1. Article search and selection

A total of 28 articles were found that met the chosen criteria (see figure 1), of which 12 (42.9%) correspond to the 5 years prior to the COVID-19 pandemic. The other 16 (57.1%) were published between 1 January 2020 and 30 September 2021, showing a large increase in the number of articles devoted to this subject after the pandemic. The number of articles per year before the pandemic shows an average of 2.4, while after the outbreak of COVID-19 an average of 9.1 articles were published on the subject of this study, implying an increase of 380% (see figure 2).
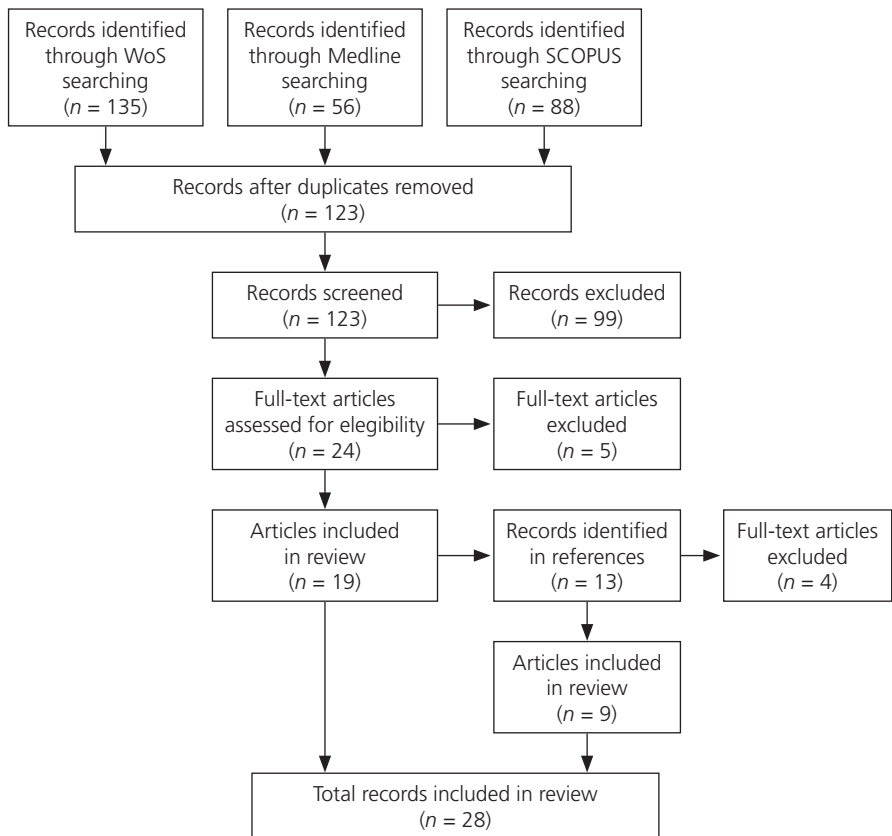
Figure 1.   Articles selection flowchart

Source: Own elaboration.

All articles, without exception, were published in scientific journals devoted to medicine.

In addition, 24 of the 28 articles (85.7%) have a female first author and the only 4 articles with a male first author are among those published post-COVID-19.
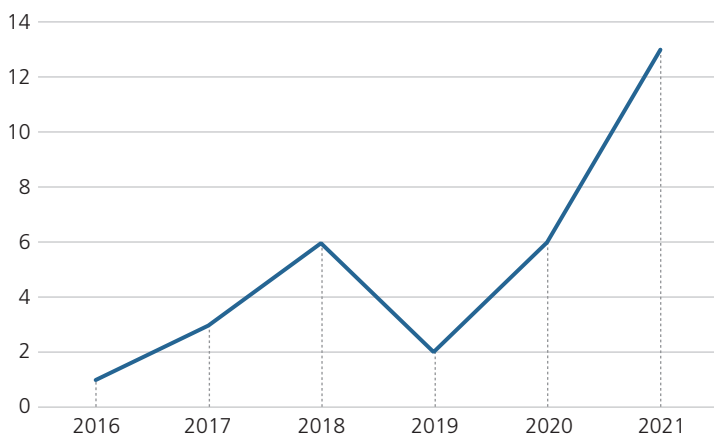
Figure 2.   Number of articles published per year (normalised)

Source: *Own elaboration.*

3.2. Analysis results

A number of key themes emerged from the analysis of all the articles included in this study and these themes are shared by the articles published pre- and post-COVID-19.

— *Patient safety.* Patient safety is a healthcare discipline that emerged with the evolving complexity in health care systems and the resulting rise of patient harm in healthcare facilities. It aims to prevent and reduce risks, errors and harm that occur to patients during the provision of healthcare (WHO, 2019). This theme is addressed in several of the reviewed articles, like [B7], "If we can further support and educate carers by providing support delivered by a nurse, this may reduce carer distress, increase preparedness for caring and in turn assist patients throughout their disease trajectory through reducing unplanned healthcare visits and hospital admissions" (Halkett *et al*., 2018), or in [A6], "To manage the lack of visual cues, telenurses have developed alternative interactional skills, such as voice modulating, transposing care over the phone and listening for physical signs and background sounds. Good communication skills are essential for telenursing and help to improve patient safety" (Yliluoma & Palonen, 2020).

— *Confidentiality and data security issues including legal derivatives.* Data safety relies on three basic principles: confidentiality, integrity and accessibility (Kim, 2022), and this is dealt with in depth in article [B2], but only with reference to US law. There are other references both in pre- and post-pandemic articles like [A3], "Paying attention to professional confidentiality builds" (Mistraletti *et al*., 2020).

— *The generation of a relationship of trust between professionals and families.* Most articles analysed refer to this trust relationship owing to the great importance it has in the proper care of patients. The relevance for SDM is specifically stressed

in [B4]: "The recommended model for decision-making in the ICU requires that families have trust in the clinical team to engage in collaborative decision-making and to genuinely consider the team's recommendations" (Seaman *et al.*, 2017).

— *Economic issues*, in terms of savings both for health providers, such as reduced needs for infrastructure, and for families, by avoiding travel costs.

— *Problems arising from potential digital divides*. Some of the potential digital divides are dealt with in most articles by pointing out issues arising from a lack of technical skills or means, and there is also mention of socioeconomic and cultural factors in families [B12].

— *Family members' satisfaction with this type of communication.* This may be the theme that is addressed the most, with only 7 of the 28 articles not mentioning the satisfaction of families.

3.3. Pre-COVID-19 articles

In the articles studied whose publication was prior to 2020 (see table 1), communication with patients' relatives by telephone is not usually the main topic but it is included as part of long-distance patient follow-up studies in which the valid interlocutor was a family member or other close relative. The patients in these cases usually belong to one of three groups: severe cases in ICU or ED unable to communicate [B2, B4], patients with chronic diseases and/or dementia and/or people under palliative care [B3, B6, B7, B10, B11, B12] and, lastly, paediatric patients [B5, B9].

In the case of the first group, the communication normally consists of a single event motivated either by immediate urgency, such as a serious life-threatening accident, or by the inability of the relatives to travel to the hospital, and in both cases these are articles that propose protocols for action.

In the second and third groups, remote communication often involves families residing in highly isolated rural environments [B12] and the focus is on convenience for families since calls are often limited to routine follow-ups or triage of paediatric patients [B9]. In some of the articles reviewed, cost-saving issues are cited as the main motivation for such remote consultations.

Most of the articles studied are nursing-oriented, including 4 of the 5 articles that have telephone communication as a focus, or health professionals in general, while only 2 have physicians as their protagonists. All articles are research articles except for 3 which are guides on how to communicate with relatives, but none of them have the telephone as the main medium.

3.4. Post-COVID-19 articles

From the time of the COVID-19 pandemic onwards, an increase in the number of published articles related to telephone communication with patients' relatives was detected. This was foreseeable, since, with the decreeing of generalised confinement which resulted in severe or complete restrictions on hospital visits by relatives, the need for telephone communication increased dramatically and, in addition, the nature of such communications was modified since, in another situation, a visit in person would have been expected by default.

Most of the post-COVID-19 articles fall into three categories (see table 2):

Firstly, there are guides and protocols for making calls to relatives, either of patients with COVID-19 or of patients with any other pathologies whose relatives, due to mobility restrictions, could not attend hospitals or consultations in person [A1, A3, A7, A15]. Most of the protocols found are adaptations of existing protocols for face-to-face communication [A15], usually involving the SPIKES protocol (Buckman, 2005), as it is the most common, and only a few included specific aspects related to the communication medium used. A single article presents a set of good practices proposed by a panel of experts for both telephone and video calls [A3].

Secondly, there were articles emphasising the need for specific training for health professionals [A11, A13]. Communication as a whole is a skill that usually receives little attention in the training of health professionals, and the little attention it receives is often addressed to physicians, yet the professionals who are most often involved in long-distance communication are usually nurses, who do the bulk of the follow-up in chronic patients or in those whose care must be discussed with the family, such as elderly people with dementia or young children. This is also apparent in the training articles studied, which are focused on medical students.

Thirdly, some articles presented the setups established in medical centres to provide information about inpatients to families [A5, A10, A12]. It is noteworthy that, although most of the training material emphasised video calls or certain computer platforms, the documented cases in which these devices were used show that the main means of communication was the telephone.

The increase in articles devoted to communication with family members after the pandemic is very significant and it seems clear that this is due precisely to the pandemic since, of the 16 articles studied from this period, a total of 10 (62.5%) refer to COVID-19 and its consequences.

ID	Authors	Title	Health professionals
B1	(Hodgson *et al*., 2016)	Outcomes of a randomised controlled trial of a complex genetic counselling intervention to improve family communication	All
B2	(Francis *et al*., 2017)	A clinician's guide to privacy and communication in the ICU	Medical doctors (MDs)
B3	(Nashef & Leach, 2017)	SUDEP, the aftermath: Supporting the bereaved	All
B4	(Seaman *et al.*, 2017)	An Integrated framework for effective and efficient communication with families in the adult Intensive care unit	MDs
B5	(Geissler *et al.*, 2018)	Individualised short-term therapy for adolescents impaired by attention-deficit/hyperactivity disorder	All
B6	(Gusdal *et al*., 2018)	Family health conversations conducted by telephone in heart failure nursing care	Nurses
B7	(Halkett *et al*., 2018)	Feasibility testing and refinement of a supportive educational intervention for carers of patients with high-grade glioma	Nurses
B8	(Overby, 2018)	Stakeholders' qualitative perspectives of effective telepractice pedagogy in speech-language pathology	Others
B9	(Payne *et al*., 2018)	Interventions to improve response time to nurse triage phone calls in a tertiary care pediatric otolaryngology practice	Nurses
B10	(Wittenberg *et al*., 2018)	Pilot study of a communication coaching telephone intervention for lung cancer caregivers	Nurses
B11	(Hermosilla-Ávila & Sanhueza-Alvarado, 2019)	Intervention of humanized nursing accompaniment and quality of life in people with advanced cancer	Nurses
B12	(Paul *et al*., 2019)	Web-based videoconferencing for rural palliative care consultation with elderly patients at home	All

Table 1. **Articles before COVID-19 pandemic**

Source: Own elaboration.

Patients	Type of article	Focus on the telephone	Economic issues	Patient safety	Confidential issues	Digital divide	Trust relationships	Satisfaction of families
Others	Research	X			X			
ICU	Guide				X			
Palliatives / dementia / chronic conditions	Guide						X	X
ICU	Guide			X			X	X
Paediatric	Research							
Palliatives / dementia / chronic conditions	Research	X					X	X
Palliatives / dementia / chronic conditions	Research	X	X	X			X	X
Others	Research			X	X	X		
Paediatric	Research	X	X	X				X
Palliatives / dementia / chronic conditions	Research	X						X
Palliatives / dementia / chronic conditions	Research			X			X	X
Palliatives / dementia / chronic conditions	Research		X		X	X	X	X

ID	Authors	Title	Health professionals
A1	(Belli, 2020)	Recommendations for communicating bad news by phone during the SARS-CoV-2 pandemic	Medical doctors (MDs)
A2	(Hagi-Pedersen *et al.*, 2020)	Comparison of video and in-hospital consultations during early in-home care for premature infants and their families: A randomised trial	Nurses
A3	(Mistraletti *et al.*, 2020)	How to communicate with families living in complete isolation	All
A4	(Rowett & Christensen, 2020)	Oncology nurse navigation: Expansion of the navigator role through telehealth	Nurses
A5	(Wammes *et al.*, 2020)	Evaluating perspectives of relatives of nursing home residents on the nursing home visiting restrictions during the COVID-19 crisis: A dutch cross-sectional survey study	Nurses
A6	(Yliluoma & Palonen, 2020)	Telenurses' experiences of interaction with patients and family members: Nurse-caller interaction via telephone	Nurses
A7	(Galway *et al.*, 2021)	Fifteen-minute consultation: A practical approach to remote consultations for paediatric patients during the COVID-19 pandemic	MDs
A8	(Hastings *et al.*, 2021)	Video-enhanced care management for medically complex older adults with cognitive impairment	Nurses
A9	(Kim *et al.*, 2021)	Do post-operative phone calls enhance family satisfaction and outcomes after outpatient paediatric urological surgeries? A prospective study	Others
A10	(Lopez-Soto *et al.*, 2021)	The role of a liaison team in ICU family communication during the COVID-19 pandemic	All
A11	(Ludwig *et al.*, 2021)	Telephone-based communication training in the era of COVID-19	Medical students
A12	(Piscitello *et al.*, 2021)	Family meetings in the intensive care unit during the coronavirus disease 2019 pandemic	All
A13	(Rivet *et al.*, 2021)	Video-mediated breaking bad news simulation	Medical students
A14	(Santos *et al.*, 2021)	Case report: Parental loss and childhood grief during COVID-19 pandemic	MDs
A15	(Vitto *et al.*, 2021)	Teaching toolbox: Breaking bad news with virtual technology in the time of COVID	All
A16	(Wenderlich & Herendeen, 2021)	Telehealth in paediatric primary care	MDs

Table 2.   Articles after COVID-19 pandemic

Source: *Own elaboration.*

Patients	Type of article	Focus on the telephone	Economic issues	Patient safety	Confidential issues	Digital divide	Trust relationships	Satisfaction of families
COVID-19	Guide	X						X
Paediatric	Research			X				X
COVID-19	Guide	X		X	X	X	X	X
Palliatives / dementia / chronic conditions	Guide	X	X	X			X	X
Palliatives / dementia / chronic conditions	Research	X		X		X	X	X
Others	Research	X		X		X	X	X
Paediatric	Case study / guide	X		X	X	X		
Palliatives / dementia / chronic conditions	Research					X	X	X
Paediatric	Research	X		X				X
ICU-COVID	Case study	X					X	X
Others	Education	X						
COVID-19	Research	X		X		X		X
COVID-19	Education				X	X		X
Paediatric	Case study		X	X	X		X	
COVID-19	Guide	X						X
Paediatric	Short communication	X	X	X	X			X

4. Discussion

From the study of the results obtained in the two phases, pre- and post-COVID-19, a series of topics may be observed that are common to both periods. Moreover, although in the articles published from 2020 onwards the pandemic was the main issue mainly due to the lack of general training among healthcare personnel who had to provide information on admitted patients to families, and to the lack of protocols to carry out this task, sometimes without the appropriate infrastructure or resources, the truth is that there is a series of general aspects that should be considered regarding this type of telemedicine, such as patient safety, economic issues, confidentiality and data security or the different ways in which a digital divide can arise.

It is also noteworthy that, although many articles focus on means of communication such as video calls or web-based applications, it is observed that, whether or not it may be due to technical difficulties (Hagi-Pedersen *et al*., 2020), most communication is by telephone: "Family meetings continued to occur during the COVID-19 pandemic with the majority occurring by telephone rather than in-person or by video." (Piscitello *et al*., 2021). There is no consensus on which is better as a means of communication and contradictory results are presented with respect to satisfaction, comparing phone calls with video calls. For example, in favour of the telephone we find the study by Gusdal *et al.* (2018), while in which nurses feel less vulnerable than if they were to use visual media, in contrast with that we have the study by Hastings *et al*. (2021), which states that the advantages of using video calls "included relationship building and enhanced communication, and patient engagement".

The kind of telemedicine discussed in this study, focusing on remote communication with patients' relatives, is not something that arose with the pandemic, but it has certainly increased markedly in its wake. It should not be assumed, however, that once the pandemic is over there will be a return to the situation in which this type of communication was anecdotal, as health providers have found that it allows them to reduce costs and some users appreciate the advantages of accessing health services remotely: "Conducting rural palliative care consultations by WBVC, instead of in-person, saved the time and cost of travel for consultants. These savings could enable consultants to see more patients in a day, improving patient access and health system efficiency, an observation mirrored by others." (Paul *et al*., 2019). All in all, it is reasonable to assume that such practices will continue to be commonplace in the future. Nevertheless, as previously mentioned, there are some obvious benefits, such as ease of access for people living in remote locations or for those with travel difficulties: "Likewise, phone updates are especially valuable to family members who cannot travel to the hospital because of health issues, distance, or transportation difficulties. Daily communication via updates, both bedside and by telephone, can help to build trust with clinicians." (Seaman *et al*., 2017).

In addition, there are potential cost reductions in both time (calls are often shorter than face-to-face visits) and infrastructure (as facilities in remote areas are reduced and can be smaller by eliminating or reducing the need for waiting rooms or other equipment), but there are some disadvantages that need to be mitigated before they become serious problems, some of which are outlined by Hjelm (2005): "The main ones that can be envisaged are: a breakdown in the relationship between health professional and patient, a breakdown in the relationship between health professionals themselves, issues concerning the quality of health information, and organisational and bureaucratic difficulties."

Patient safety must remain the focus of any medical intervention whether in person or by telephone. The availability of telephone triage services provides families reassurance and advice for simple questions, ranging from such matters as managing postoperative pain to more complex issues, such as airway concerns (Payne *et al.*, 2018), although it is also clear that some interventions cannot be carried out over the phone or even by video call, such as, for example, conducting a proper examination of the patient. Likewise, there are aspects of the face-to-face visit that are complicated or unfeasible over the phone, including such matters as simply taking a pulse or observing symptoms that the patient's relatives or carers do not mention such as a tremor in the hands or difficulty walking. However, Asch (2015) maintains that "the innovation that telemedicine promises is not just doing the same thing remotely that used to be done face-to-face but awakening us to the many things that we thought required face-to-face contact but actually do not".

Developing and maintaining a *trusting relationship with the patient (and/or families)* can be more difficult, and trust is a fundamental part of successful treatment, as Lee (2008) explains: "Within the health-care system, patient trust is not just a lubricant to decrease disputes with the physician, prevent possible lawsuits, and increase a patient's satisfaction, but may also play a critical role in the one thing physicians are concerned with most, patient health outcomes." On the other hand, the telephone can facilitate more constant and fluid contact, enhancing this relationship of trust: "Telephone contact – destined to strengthen interpersonal communication, secure the person with cancer-caregiver-nursing professional transpersonal relationship and remote accompaniment" (Hermosilla-Ávila & Sanhueza-Alvarado, 2019).

The *digital divide* is an issue that remains unresolved, although in the past the only population group that was mentioned in this respect were the elderly, in what was called *the generational digital divide* (Levy *et al.*, 2015). As Narasimha (2017) rightly says: "Telemedicine system designers need to consider the age-related issues in cognition, perception, and behaviour of geriatric patients while designing telemedicine applications". However, it has become clear that there are also gender-based (Macaya *et al.*, 2021) or educational and socio-economic gaps (Kontos *et al.*, 2014). Therefore, a widespread implementation of this type of telemedicine could

aggravate the discrimination suffered by the most vulnerable groups and have a negative impact on their health: "Rather than reducing existing rural-urban inequities, conducting all consults by WBVC could deepen the divide by depriving rural patients of access to real doctors, in-person care, and the human touch available to their urban counterparts." (Paul *et al.*, 2019). Neither should it be forgotten that this type of discrimination would also be suffered by certain groups of patients with disabilities such as hearing impairments, since the implemented IT platforms often lack accessible options.

On the other hand, medical consultations must remain in the private sphere, so attention must be paid to *confidentiality and physical security of data* as sensitive information about a person's health is exchanged and stored. As Kahn (2020) says, "patient confidentiality is not only an ethical imperative, it is a legally protected right". The irruption of technology implies a new challenge in the protection of patients' data, which, in many cases, are subject to rules imposed by large technological companies that are barely comprehensible: "Information use and disclosure is largely determined by technology companies, with few (if any) legal limits or meaningful opportunities for individuals to control information flow." (Hall & McGraw, 2014). Information must remain secure from cyber-attacks (Seh *et al.*, 2020), something made difficult when one end of the communication is in the hands of users who may not necessarily have the knowledge to keep their devices safe from such attacks. Another aspect to be taken into account is the lack of privacy that a patient may have at home for different reasons: "Maintaining privacy and confidentiality can be worrisome, especially for large families living in small houses, where it can be difficult to find an isolated place to talk openly and freely with the psychiatrist." (Santos *et al.*, 2021). This would disproportionately affect patients who are vulnerable for socioeconomic reasons.

The legal issues involved are addressed differently depending on the legal systems of the country concerned, and each health system should strive to ensure that its professionals are aware of and apply appropriate safeguards.

Perhaps what has been most evident with the COVID-19 pandemic is the widespread lack of skills and insufficient *training in communication*, and this lack has been exacerbated by the fact that distance communication has specific key characteristics and aspects, and that an effort is needed to provide health professionals with the knowledge and tools necessary to carry out their work in the best possible way, thereby increasing both patient and self-satisfaction. As Steiner-Hofbauer (2018) says, "it should not be left to chance if and how this core element of the doctor-patient relationship works out".

In addition, communication skills tend to decrease as medical training progresses: "The attitudes of students in the later years of medical school are more doctor-centred or paternalistic than those of students in earlier years. Doctor-centred attitudes have been shown to be associated with lower patient satisfaction and may contribute to decreased trust in the doctor-patient relationship." (Haidet *et al.*, 2002).

On the other hand, professionals may have an inadequate perception of their own skills and "many doctors tend to overestimate their ability in communication" (Ha & Longnecker, 2010).

Even in those cases in which there is time devoted to training in communication, the specific aspects of remote communication, whether by videoconference or telephone, are rarely dealt with or practiced as they should be: "Telephone calls are proposed to improve communication, but effective telephone communication is also a skill that requires practice." (Rivet *et al*., 2021). In the case of communication via telephone, one must be aware of the loss of non-verbal communication that has to be replaced by verbal or paraverbal communication, not only in terms of the information obtained by the professional but also and not least in terms of the information received by the patient or, where appropriate, the relative. As we may see in (Marcinowicz *et al*., 2010), this has to do with eye contact, facial expressions, gestures and postures, interpersonal distance, physical contact, the professional's clothing and even the characteristics of the physical space of the doctor's practice.

It should be added that patients and professionals often have hugely different perceptions of the importance of interpersonal communication: "Communicative competences are therefore clearly in focus of patient satisfaction questionnaires while doctors' opinions rated 'medical competence' and 'ethics' most important. 'General interpersonal qualities' and 'communication and patient involvement' are much less valued. In none of the included studies was communication rated as the most important attribute of a good doctor" (Steiner-Hofbauer *et al*., 2018).

5. Conclusion

It is clear that technology facilitates many aspects of life today and that the use of the telephone as a means of communication between healthcare professionals and patients' families, whether in an emergency situation or due to different circumstances such as the patients' incapacitation or age, has proved its usefulness before and after the COVID-19 pandemic. However, telemedicine, in any of its versions, presents challenges that must be taken into account to avoid dysfunctionalities that could end up causing harm to patients, their families and, therefore, to society as a whole. Indeed, despite the economic advantages on which managers focus their attention, there are also some hidden costs that may not be apparent at first glance but which can have a major impact, such as costs in infrastructure and IT platforms, those arising from the need to provide specific training to professionals and, above all, those that can have an impact on the health of patients if errors occur due to the failure to detect issues that would be immediately apparent in a face-to-face examination. In effect, due to the fact that a remote examination may

not detect issues that would be immediately apparent in a face-to-face examination, there is a risk of errors, above all including those that may have an impact on the health of patients, or those which arise because some people are not comfortable with remote interaction and postpone their consultation or do not adhere correctly to the prescribed treatment. As Kahn (2015) says, "in solving some problems, telemedicine will surely create others. Our job is to minimise the potential harms by insisting that implementation of telemedicine is based on solid data. That way, it can lead to health care that is not just different and more modern but also better". Beyond all this, however, if we focus on what strictly refers to communication, there is a lack of theoretical corpus in the field of doctor-patient-family communication at a distance, something which does not seem to attract much attention from communication researchers. This is shown by the fact that all the articles found for the review were led by health professionals and published in medical journals and no literature was found in scientific journals belonging to the field of communication and social sciences. For this reason, the availability of this kind of theoretical material could perhaps improve the training offered to health science students and thus make communication as important as it should be in the context of health care. C

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