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COMMUNICATION OF BAD NEWS IN THE HEALTH FIELD IN TIMES OF COVID-19. TELEPHONE COMMUNICATION

Comunicación de malas noticias en el ámbito sanitario en tiempos de COVID-19. La comunicación telefónica

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Abstract

This article has examined the telephone communication of bad news in the health field during the public health emergency of international concern decreed by the WHO on March 11, 2020. Communicating bad news is not an easy or pleasant task, especially when it comes to a death. Its effects, both for the sender and the receiver, will depend on the way it is carried out. In relation to the recipient, adequate communication can facilitate the process of acceptance and adaptation to the new reality, the one in which your loved one is no longer. Regarding the issuer, a correct transmission of information can lead to a reduction in stress levels, increasing the efficiency of communication, present and future, as well as reducing the probability of problems such as burnout. A good notification of unfavorable news requires communication skills and the handling of basic technical guidelines for action, for which training is necessary. The pandemic situation caused by the SARS-CoV-2 virus has made the communication of bad news, until now considered a minor competence, a central element of the care process. The exceptional circumstances of this health emergency have also meant having to carry out communications over the phone on many occasions, an action not recommended in normal situations due to the associated inconveniences and which has been a real challenge for professionals. The scarcity of specific material on remote communication in exceptional situations such as the current one, makes it necessary to study and research in depth on the area. This article has attempted to address these issues.

Keywords: Communication; Bad news communication; Remote communication; Telephone communication; Communication skills; Death; Grief; Trauma; Health emergency; Pandemic; Coronavirus.

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Resumen

Este artículo ha examinado la comunicación telefónica de malas noticias en el ámbito sanitario durante la emergencia de salud pública de importancia internacional decretada por la OMS el 11 de marzo de 2020. Comunicar malas noticias no es una tarea fácil ni grata, especialmente cuando se trata de un fallecimiento. Sus efectos, tanto para el emisor como para el receptor, dependerán del modo en que esta se realice. En relación al receptor, una adecuada comunicación puede facilitar el proceso de aceptación y adaptación a la nueva realidad, aquella en la que su ser querido ya no está. Por lo que respecta al emisor, una correcta transmisión de la información puede suponer una disminución de los niveles de estrés aumentando la eficacia de la comunicación, presente y futura, así como reduciendo la probabilidad de aparición de problemáticas como el *burnout*. Una buena notificación de noticias desfavorables precisa de habilidades de comunicación y del manejo de pautas técnicas básicas de actuación, para lo cual es preciso formación. La situación de pandemia ocasionada por el virus SARS-CoV-2 ha convertido la comunicación de malas noticias, hasta ahora considerada una competencia menor, en un elemento central del proceso asistencial. Las circunstancias excepcionales de esta emergencia sanitaria han supuesto además, tener que realizar en muchas ocasiones las comunicaciones a través del teléfono, acción no recomendada en situaciones normales por los inconvenientes asociados y que ha supuesto un auténtico reto para los profesionales. La escasez de material específico sobre comunicación remota en situaciones excepcionales como la actual, hace necesario estudios e investigaciones que profundicen sobre el área. El presente artículo, ha tratado de abordar estas cuestiones.

Palabras clave: Comunicación de malas noticias; Comunicación remota; Comunicación telefónica; Habilidades de comunicación; Muerte; Duelo; Trauma; Emergencia sanitaria; Pandemia; Coronavirus.

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1. INTRODUCTION

The pandemic situation generated by the SARS-CoV-2 virus has placed healthcare professionals in a truly complex scenario in which they have had to adapt and reinvent themselves, both at work and personally (Vila, 2020; Ezquerro et al., 2020; Hernández-Sanz, 2020).

Several factors seem to be contributing to the complicated situation:

1. The global impact it is having at all levels and in all spheres: health, economic, social, etc. (WHO, 2020a; WHO, 2020b; WHO, 2020c; Carrasco, 2020; Moya et

al. (WHO, 2020a; WHO, 2020b; WHO, 2020c; Carrasco, 2020; Moya et al., 2020; Xiong et al., 2020; Nicola et al., 2020; Pakpour and Griffiths, 2020). In this aspect, the healthcare professionals themselves, whose job has been to ensure the physical and psychological well-being of the citizen, have also been influenced, constituting a population at risk as they are exposed to real physical danger as well as to critical situations and decision making with a high emotional impact (Chacón-Fuertes, Fernández-Hermida and García-Vera, 2020; Legido-Quigley, Mateos-García, Campos, Gea-Sánchez, Muntaner, & McKee, 2020; Chacón, 2020a; Chacón, 2020b; Villacañas, Felix-Alcántara, & Buiza, 2020; De Pablo et al., 2020; Arango, 2020; Xiang et al., 2020; Lai et al., 2020).

2. It is a situation unknown to the present generations, who have never before faced an event of these characteristics and dimensions (Brody, 2020; García-Vera, 2020a; Moya et al., 2020; Arango, 2020).
3. The existence of a complex scenario where a series of variables converge and contribute to amplify the perception of risk² (Slovic, 1992; Chakraborty, 2020; Cori, Bianchi, Cadum and Anthonj, 2020). Thus, like any virus, SARS-CoV-2 is invisible to the human eye; the assumption of the risk it poses is not only involuntary but uncontrollable, even for governments and health authorities themselves; it is an unusual risk with no remedy or specific treatment at present, of unknown origin (which fuels conspiracy theories, putting the focus on a possible human origin), disproportionately impacting vulnerable populations, potentially endemic and with no observable benefits for the population immersed in a global crisis; and there is poor confidence in those managing the situation, fueled by factors such as the lack of consensus in the scientific community, erratic policies to control the virus and the way information is handled. Research shows a positive correlation between risk perception and pandemic fear and anxiety (Ari, Yilmaz, & Arikan, 2020) that could lead to adoption and compliance with preventive measures (van der Weerd, Timmermans, Beaujean, Oudhoff, & van Steenberghe, 2011; Burger, Christian, Maughan-Brown, Rensburg, & Rossouw, 2020; Cori et al., 2020; Khosravi, 2020), but also motivate people to use unproven methods (Ho, Chee, & Ho, 2020). Inadequate risk information

² Perceived risk refers to individuals' psychological evaluations of the probability and consequences of an adverse outcome (Sjöberg, 2000). Different individual, social, cultural and contextual factors influence the perception of risk. It is therefore a subjective psychological construct that is influenced by cognitive, emotional, social, cultural and individual variation both between people and between different countries (van der Linden, 2015; Dryhurst et al., 2020). Risk perceptions can act as triggers for preventive behaviors. Risk perception related to SARS-CoV-2 varies significantly between different places and people, indicating that it is a strong modifier of pandemic evolution, as it can influence the number of new positive cases (Cori et al., 2020).

A study of COVID-19 risk perceptions worldwide (Dryhurst et al., 2020) showed that, despite substantial variability across cultures, individualistic worldviews, personal experience, prosocial values, and social amplification through friends and family were determinant in more than half of the countries examined. Risk perception correlated significantly with informed adoption of preventive health behaviors in the ten countries studied (United Kingdom, United States, Australia, Germany, Spain, Italy, Sweden, Mexico, Japan, and South Korea). Currently, researchers from the National Epidemiology Center (CNE) of the ISCIII are coordinating a World Health Organization (WHO) study on population risk perception of the COVID-19 pandemic in 31 countries (COSMO-Spain) (ISCIII, 2020).

management can lead to psychological mechanisms of neutralization, denial or minimization of risk, rumor spreading, unease, alarm or, at the other extreme, discouragement and indifference (Robles and Medina, 2008). As Morillo (2020) points out, the invisibility of the threat posed by the virus can hinder the adoption of individual and collective prevention measures while adherence to them can be affected by the lack of a visible and tangible impact of the actions implemented (Chapman and Loewenstein, 2020)³.

4. This event was somewhat unexpected for a large part of the population, despite the fact that scientists had already warned of this possibility (Cheng, Lau, Woo and Yuen, 2007). At first, what was happening in other countries was seen as something very distant, and its severity, capacity and speed of propagation were underestimated (Raffio, 2020; ATLAS, 2020).
5. There is a media coverage of the event that has never been observed before in history. The WHO itself (2020d), prior to declaring the situation a pandemic, had already warned of the existence of a massive "infodemic" due to an excess of information⁴ (in some cases, imprecise, uncertain or not very timely), which has made it difficult for people to find reliable sources and adequate guidance. Media overexposure, particularly at the height of the pandemic, may have posed a threat to the well-being of particularly vulnerable people, increasing the sense of health risk and amplifying responses and issues associated with stress, anxiety and depression (Xiong et al., 2020; Ashokkumar and Pennebaker, 2020; Garfin, Silver, and Holman, 2020; Carrasco, 2020; Moghanibashi-Mansourieh, 2020; Olagoke, Olagoke, and Hughes, 2020; Gao et al., 2020).
6. It is a situation that is being maintained over time, and with it high levels of stress, which are affecting the physical and psychological health of the population in general and of at-risk and especially vulnerable groups in particular (Villacañas et al., 2020; García-Vera, 2020a).
7. Finally, it is a reality that is leading to a decline in one of the main coping and protection strategies that human beings have, which is social support. We are a contact society. In this situation of collective affectation, not only has it been possible to experience one's own drama, but many people have been exposed to the drama of family and friends. In normal situations these natural networks can serve as support, but here they may be ineffective as they are also affected (Moya et al., 2020; García-Vera, 2020a).

³ Different aspects such as optimistic bias (tendency to overestimate the probability of positive events and underestimate that of negative events), the illusion of control, the feeling of invulnerability, confirmation bias, the adaptation effect (particularly strong when little hope of improvement in the situation is perceived) and the belief in one's own experience versus other data provided (lack of direct experience with the virus and its consequences during the "first wave"), may also be present in part of the population as tools for managing the discomfort that the situation provokes (Dryhurst et al., 2020; Garcia-Vera, 2020b; Burger et al., 2020).

⁴ A study carried out by Comscore on online behavior shows that in Spain information consumption grew by 59% the week of March 23rd (in the middle of the pandemic), compared to January of the same year. Similar data were obtained in the rest of the countries analyzed, all of them with an increase of over 50%, with Italy standing out with a 68% growth (Gevers, 2020).

It can be said that, if anything is characterizing this pandemic, it is the changing scenarios and the uncertainty they entail, as well as the need to adapt to them in short spaces of time (Moya et al., 2020; Moreno et al., 2020; Colegio Oficial de la Psicología de Madrid, 2020). This circumstance, for many people, is generating high levels of stress that manifest themselves at the cognitive, physiological, motor and emotional levels (Colegio Oficial de la Psicología de Madrid, 2020), although it is not the subject of this article due to its length.

But if anything has really shocked the world, it has been the high number of deaths⁵, especially during the peak of the contagion curve, many of whom have died alone without the possibility of communicating with their loved ones. This has been a major challenge for healthcare professionals who have not only assumed the functions of their job, but also, on many occasions, have taken charge of the emotional needs of patients in their last moments (Hernández-Sanz, 2020; Chacón, 2020b). This situation has involved an added psychological strain to which, on many occasions, the communication of bad news to family and relatives has had to be added, since it has been carried out remotely and not in person. Thus, professionals have had to face a highly stressful and difficult reality, with the tools available at the time, which in many cases have turned out to be scarce, diminished, deficient or inappropriate (Chacón-Fuertes et al., 2020; Villacañas et al., 2020; Hernández-Sanz, 2020), as has been the case with the notification of bad news by telephone (Moriconi and Valero, 2020); an aspect on which the present article has tried to focus.

2. COMMUNICATION OF BAD NEWS

Many are the definitions that have been given of "bad news", from the classic Buckman (1992) which states that it consists of "any news that drastically and negatively alters the vision that a person has of himself and his future"; to that given by Nomen (2008) for whom bad news is "that information (...) capable of drastically altering the vision that a person may have regarding his future, either because it affects him directly and personally, or because it refers to a loved one"; to that given by Bor et al. (1993) who define it as a "situation where there is a feeling of hopelessness, a threat to the mental or physical well-being of the person, risk of altering an established lifestyle or where the message delivered conveys few life options"; to the one presented by Bascuñán (2013) who defines as bad news "any information that negatively affects the patient's expectations of himself and his future". In short, it can be seen that bad news is information that entails negative consequences and/or loss of gratifying stimulation for the recipient (Muñoz et al., 2001), alters future expectations and therefore represents a vital turning point for the recipient (Pacheco, Garrosa, López & Robles, 2012).

Bad news, therefore, does not necessarily imply a patient's death or critical deterioration, although this article will focus on these issues.

⁵ As of September 25, 2020, 983. 492 deaths have been recorded worldwide (CSSE JHU COVID-19 Data, 2020).

Communicating information that is known to have a negative impact on another person is neither an easy nor a pleasant task for the person who has to do it. Moreover, authors such as Bernardo and Brunet (2010) point out that many professionals consider it to be the most difficult task to perform despite their training and experience in the area, which might lead one to think that they are used to it and that it does not pose any difficulty for them.

Thus, despite the empirically proven benefits (Ribes, 1990; Gómez-Batiste et al, 2003; Curtis, 2004; Kübker-Ross and Kessler, 2005) that a correct communication of bad news can have for the receiver (reduction of uncertainty and thus of anxiety, increase of behaviors that increase the perception of competence and controllability of the situation, growth of autonomy in decision making improving self-concept and self-esteem, promotion of behaviors that increase the immunocompetence of the person, improvement in the psychological adaptation to the situation, reduction of emotional isolation, satisfaction with the attention received...) and for the sender (increase of confidence and the feeling of competence, reduction of emotional isolation, satisfaction with the attention received...) and for the sender (increased confidence and feeling of competence, reduced anxiety and frustration, reduced risk of *burnout*, improved therapeutic relationship...); this type of communication is still a pending issue due to the difficulties involved from the point of view of the sender, the receiver and, of course, the system (Bascuñán, 2013).

As authors such as Alves (2003) or Gómez (2008) point out, as far as the sender of the message is concerned, it is not uncommon to encounter fears associated with the unknown, with causing pain, with being blamed (by action or omission), with not knowing what is happening or how to act, with saying "I don't know", to over-empathize or sympathize with the person receiving the news, to over-identify with the person (sometimes over-involving oneself), to be negatively evaluated as professionals, but also as human beings (often because of the feeling of responsibility for the information given), even death itself.... Fears that can regularly lead to the adoption of dysfunctional attitudes such as flight, haste in notification, concealment of information or delay in communicating it, overprotection of the recipient, distancing from the latter, dehumanization and even early referral to other professionals or an inappropriate multi-care approach.

In relation to the receiver, the most frequent difficulties are found in the handling of the information, denial of the situation, its consequences and the resulting emotional reactions, or mistrust (in the information, the professional, the system...).

From the point of view of the system, the lack of information and adequate training of professionals and the lack of resources (time, adequate space for proper communication, trained professionals...), constitute the main stumbling block.

Communicating bad news may be an inherent part of medical care functions and a central aspect of clinical practice (CEEM, 2010; Bascuñán, 2013), but until now it has not been given the value it really has for the well-being of the interlocutors. This is

embodied in aspects such as the fact that the complaints presented by patients often do not focus on the absence of clinical competence per se, but on the perception of a lack of communication and an inability on the part of the professional to adequately convey a sense of care (DoH, 2000), with these communication problems often being an important factor in litigation (Levinson et al., 1997).

As can be intuited, bad news is not only difficult to hear but also to transmit. This has often led to the desire to hide the information, omit it or distort it, despite the benefits that knowing the truth, today it is known, has for both the sender and the receiver (Bascuñán, 2013).

In the health field, the law is clear (Law 41/2002), stating that the patient has the right to determine what he/she wants to know and the professional has the duty to communicate it to him/her in a way that he/she is able to hear and process it. Hiding the truth from those who wish to know it can be as reprehensible and maleficent as forcing a person to hear it if they do not want to (Bascuñán, 2013).

People not only need to be adequately informed, but they also need this information to be transmitted by a competent professional with skills and knowledge in the field. Thus, a study carried out in 1995 by the European Federation of Traffic Accident Victims on the main needs expressed by those affected by an accident in case of communication of bad news, indicated as main priorities: 1st) to be informed of the death of their loved ones by a person qualified for this task, 2nd) to have access to the body and 3rd) to receive professional support, both psychological and practical and legal (Bernardo and Brunet, 2010).

On the other hand, different studies have found that although health professionals are the ones who think about death the least, they are the ones who fear it the most (Antonelli, 1990), sometimes adopting distorted attitudes such as not wanting to name it or putting into words pathologies that "attract" it, not looking patients or relatives in the eye, incongruence between what they say nonverbally and what they express verbally, or an increase in technological attention as opposed to empathic-affective attention⁶(Gala et al., 2002). This leads us to propose, as a first step for the correct communication of bad news, the need to be aware of one's own limitations, since personal history, culture, defense mechanisms, coping styles and strategies of each human being... and in short, the attitude towards death, losses and changes in general, greatly influence the way of communicating (Alves, 2003).

⁶ Most of the complaints reported by patients in the relationship with the professional in care settings have to do with the lack of gentleness and understanding in the treatment, the excessive speed of care and the perception of being assisted in a more mechanical than human, close and empathetic manner (Martín and Muñoz, 2009). An analysis carried out by Wisten and Zingmark (2007) showed that, in part, the lack of satisfaction on receiving the news of the death of a loved one is due to the relatives' perception that they have not been given sufficient information, that their doubts have not been answered and that no real interest has been shown in their loved one.

The professional cannot change the situation, cannot alter the circumstances that have led the person to die or to be in this process, but the way he/she communicates it will determine whether it facilitates or hinders the person's acceptance and adaptation to this new reality. And for this, not only the experience or preparation of the health professional is important, but also his or her personal and emotional background (Pacheco et al., 2012).

3. COMMUNICATION OF BAD NEWS, BEREAVEMENT AND COVID-19

Mourning can be defined as the "set of psychological and psychosocial processes that follow the loss of a person with whom the bereaved, the debtor, was psychosocially linked" (Tizón, 2004). Bowlby (1993), details grief as "all those psychological processes, conscious and unconscious, that the loss of a loved one sets in motion, whatever the outcome". More broadly, it could be said that grief is a normal and natural response to a loss or separation (real or symbolic), with the loss of a loved one being the most painful experience especially when its cause has been death (Montés, Jiménez and Jiménez, 2019).

Grief⁷, which comes from the Latin *dolus* (pain), is personal and unique, and as Montoya-Carrasquilla (2004) points out, it affects the whole person, in all areas and at all levels (psychological, emotional, family, social, physical and spiritual). Mourning is, therefore, a biopsychosocial process in the face of a significant emotional loss, whether material or symbolic (Robles and Medina, 2008). Overcoming it involves a process of readaptation. It implies, therefore, a series of psychological processes that involve the adaptation and acceptance of a new internal (emotions, cognitions, fantasies) and external reality (a space where the person, in this case, is no longer) (Tizón, 2004).

Grief can be caused by emotional losses (separations, deaths...), social losses (unemployment, retirement, change of status...), physical losses (amputations, illnesses...) or losses inherent to the evolutionary process (loss of childhood or youth...), but it cannot be ignored that the main losses are often linked to others of an initially secondary nature (Brickell and Munir, 2008; Montesinos, Román and Elías, 2013). When a loved one dies, as has happened so many times during this pandemic, it is not only their presence that is lost, not being able to hug or kiss them again. You may lose a life project, the belief in a safe, fair and meaningful, benevolent world, where most things are thought to be controllable... With the death of that person, part of oneself vanishes, the one built relationally with the other (Moriconi, 2020).

If there is one thing that is certain, despite the little that is known about it and the uncertainty it arouses, it is the existence of death. And despite this, in our current society, we are not adequately prepared for it (Gala et al., 2002; Cabodevilla, 2007; González, 2013). The research carried out by Herrán, Rodríguez and De Miguel (2019), on the inclusion of death awareness in the Spanish educational curriculum determines

⁷ Grief should not be confused with mourning. While mourning consists of internal and subjective manifestations, bereavement consists of social and external expressions (Tizón, 1998; Flórez, 2002).

this, pointing out that despite being present in all spheres of life, "death is a secondary content that is tangentially included in other priority areas".

The impact of the bereaved after the loss and the subsequent mourning process depend on multiple factors (Montés et al., 2019): the object lost, the value given to it, the idiosyncrasies of each person at the biological, psychological and social level, the relational bond, the circumstances of the death.... Thus, if there are some variables that influence the difficulty or ease of mourning (in addition to the personal characteristics, resources, life and circumstantial history of the mourner, and the kinship and attachment relationships with the deceased), these are the type of death, which in this pandemic situation, in many cases has been unexpected and highly traumatic (something that involves a double effort for the mourner: the elaboration of the loss and the elaboration of the trauma⁸), and the lack of real and/or perceived social support before, during and after the death of the loved one (a situation that has also occurred as a result of the collective impact of the pandemic).

In cases of death by COVID, there are many factors that the scientific literature (Tizón, 2004; Pangrazzi, 2008; Robles and Medina, 2008; Worden, 2013), place as predictors of complex, complicated and even pathological grief⁹, that we can find. As various experts report (Moriconi, 2020; González, 2020; Araujo, García and García-Navarro, 2020; Ho et al, 2020; Moriconi and Valero, 2020; Fouce, 2020; Lacalle and Barbero, 2020; García-Vera and Cordero, 2020), in addition to the unexpected and, in many cases, sudden nature of death due to a rapid worsening of the clinical condition, during the worst moments of the health crisis caused by COVID-19 there have been traumatic separations of the deceased who, after being hospitalized, lost all contact with family and relatives. The impossibility of seeing and communicating with their loved one, of having constant updates on their state of health from a reference professional, or not being able to accompany the deceased in the last moments of their life (sometimes for fear of contagion, generating guilt), has left "unfinished business"¹⁰ and unanswered

⁸ Trauma is understood as the psychological reaction (state) derived from a traumatic event, defined as an "intense negative event that arises abruptly, is unexpected and uncontrollable and, by endangering the physical or psychological integrity of a person who is unable to cope with it, has dramatic consequences for the victim, especially terror and helplessness" (Echeburúa, 2005).

⁹ Horowitz (1980) defines complicated grief as "that whose intensification reaches the level where the person is overwhelmed, resorts to maladaptive behaviors, or remains endlessly in this state without advancing in the grieving process towards its resolution". Although there is no diagnostic criterion, since there is no consensus among experts, complicated grief would include those alterations in the process which, due to their duration or intensity (either excessive or absent), could be susceptible to needing extra support or professional help. Reality indicates that there are people who require more time to adapt to the loss and it is not possible to apply a strict chronological limit. Pathological grief is that which, because of its severity, intensely disturbs the mental activity of the person, to the point of causing mental disorders. This type of grief would necessarily require the intervention of a specialized professional (Jiménez, Montés and Jiménez, 2014). The International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) refer, respectively, to Prolonged Grief Disorder (in the latest version, ICD-11) and Persistent Complex Grief Disorder (within conditions requiring further study in the DSM), in reference to the complications that may occur in the process.

¹⁰ Unfinished business is the product of past situations or unresolved intra-psychic conflicts, all those unsaid and unexpressed things that remain inside and are not resolved. In the case of COVID-19 deaths,

questions for the bereaved, making it difficult to deal with the loss. To this has been added, on many occasions, the impossibility of seeing the body to mourn and watch over it, preventing personal and social rituals such as funerals, which could facilitate the acceptance of the new reality, the assumption of new roles, the validation of emotional reactions and the reinforcement of social cohesion, making the death less painful. The bereaved has had to face all this in a context of multiple losses, starting with the loss of a way of life that articulated their identity, their relationships, their beliefs and their way of facing a now unknown world. On many occasions, the news of the death of their loved one has reached them while confined and alone, having to face the loss at the same time as their own isolation and perhaps that of other close relatives of the deceased who, due to different circumstances (age, previous pathologies) have had to remain in quarantine due to contact with the affected person, in a state of special vulnerability. The social isolation of the survivors in quarantine has prevented the reception of physical signs of affection and affection, so important in bereavement due to biopsychosocial issues (Moriconi, 2020).

As already pointed out at the beginning of this text, the support networks that previously facilitated the coping of complex situations for the person, when also affected by this situation, have not been useful on many occasions, generating frustration, anger, guilt, shame... both in the habitual sender of this support and in the mourner.

Factors that can complicate the elaboration of grief also present on numerous occasions in this type of death by COVID, have been the age of the mourners (a large number in late life)¹¹, high degree of dependence, having been caregiver of the deceased (many of them, in this pandemic, had previous pathologies that have made them more vulnerable to the coronavirus and to require care prior to it)¹¹, the existence of previous pathologies in the debtor such as anxiety or depression (which may have been accentuated either by the pandemic situation itself or by its consequences such as confinement, the scarcity or inadequacy of health and mental health care resources or

not having been able to take care of the deceased, not having been able to accompany him/her or tell him/her how much he/she was loved, ambivalent or conflictive unfinished relationships, are pending issues that generate deep psychological discomfort (Moriconi and Barbero, 2020). According to Moriconi (2020), the few empirical investigations on this construct have shown that unfinished business represents a relatively common source of distress and anxiety for bereaved individuals. Likewise, different studies have shown correlations between the presence of unfinished business and prolonged bereavement and other psychological and psychiatric disorders.

¹¹ In Spain, the analysis of COVID-19 cases with a diagnosis date prior to May 11, 2020 (at which time there is a change in the form of notification), revealed that 87% of the patients who died during the most acute moments of the pandemic were over 70 years of age, 95% of them had some type of previous underlying disease and 60% suffered from cardiovascular disease (RENAVE, 2020a). The latest technical report prepared by the Ministry of Health corroborates that the percentage of hospitalizations and deaths with COVID-19 increases with age (RENAVE, 2020b). On the other hand, the largest described series of hospitalized patients in Spain with confirmed COVID-19 disease, and one of the largest in the world to date, shows a high percentage of patients with comorbidities (61.4% had a moderate or severe Charlson index). Additionally, 16.5% of patients had a moderate or severe degree of dependence for activities of daily living (Barthel index below 60) (Casas-Rojo et al., 2020).

In the same vein, WHO stresses that there are numerous reports reflecting that age, gender and underlying comorbidity influence the severity of COVID-19 (WHO, 2020e).

the fear of going to a specialist due to the risk of infection) (Wang et al., 2020; Chacón-Fuertes et al., 2020; Zhou, 2020; Xiao, 2020; Mazza et al., 2020; Özdin and Özdin, 2020; Ho et al., 2020; Brooks et al., 2020) or the fact of living alone, having little socio-familial support (real and/or perceived) and having few personal resources such as work or hobbies (Lei et al., 2020; Xiong et al., 2020). All of these variables are present in a high percentage in a sector of the population particularly affected by the pandemic, the elderly (Chacón-Fuertes et al., 2020). It should also be noted that the highest number of deaths in Spain has occurred during a state of alarm in which people had to remain confined to their homes ("limitation of freedom of movement") as an exceptional measure to mitigate the consequences of the coronavirus and reduce its transmission¹². This meant limiting leisure activities, but also work activities. Therefore, to the health crisis should be added the existence of other concurrent crises: social, labor, economic (Perez, 2020).

On the other hand, deaths in Intensive Care Units (ICU), which have occurred so frequently in recent months, are associated with an increased risk of psychological sequelae in the relatives of the deceased (Kentish-Barnes et al., 2015; Probst, 2016). As noted by Moriconi (2020), bereavement following the death of a family member in an ICU is associated with worse acceptance of the loss and with symptoms compatible with complicated grief (5% - 52%), post-traumatic stress disorder (PTSD) (14% - 50%) and depression (18% - 27%).

Finally, two risk factors should be taken into account in the acceptance and elaboration of death. One is the distance from the traditional socio-religious and family support system that the person may have had, as in the case of immigrants in different parts of the world (Petalanda, García-García, de Vizcaya and Complicado, 2001; Ho et al., 2020). And two, the so-called disavowed duels, which, as defined by Alba Payás (2017), are those that "are neither socially recognized nor (grief) publicly expressed". This can occur when the relationship is not recognized as socially significant (e.g., the death of a lover, an ex-partner, a friend, a non-admitted homosexual partner or a patient), when what is not recognized as socially significant is the loss (e.g., loss of the child in the perinatal period, death of a person with severe incapacitating illness or the death of a pet), when the mourner is not validated (e.g., people with intellectual disabilities, children or elderly people with severe neurological diseases) or when the type of death is not socially accepted (e.g., death by suicide or death by overdose or having deliberately exposed oneself to risk). As Payás (2017) points out, this type of unrecognized grief is more likely to lead to pathological grief, as it involves a cumulative trauma (the pain of loss is compounded by the damage caused by the failure to obtain support and social recognition).

Taking this last point into account, it is essential to consider not only the complexity of loss in these circumstances for the bereaved, but also for the professionals (Chacón,

¹² During the state of alarm decreed in Spain from March 14 to June 21, 2020, official data show that 27,916 deaths occurred. The highest number of deaths was between March 26 and April 2, 2020, with 6,762 deaths (Centro de Coordinación de Alertas y Emergencias Sanitarias, 2020).

2020b), who have had to add to their own personal losses others, perhaps not socially validated. The loss of patients with whom they may have established an emotional bond, the loss of the ability to decide how to make the person's last moments of life easier and perhaps accede to their wishes for family reunion or not being able to communicate the news in the most suitable way possible (in person, dedicating the necessary time...), has, in many cases, shaken their beliefs and negatively affected their mood.

We could therefore say, on the basis of the above data, that the type of death that health professionals have had to deal with in this pandemic has been traumatic for many bereaved. The grief that follows these deaths is usually more devastating than other bereavements, since the suddenness of the death shatters the survivor's confidence about the world and confirms that it is an insecure, unpredictable and anxiety-provoking place, so that the bereaved have a strong sense of unreality and disbelief, finding the environment they knew strange and often feeling guilt (towards themselves and/or others) and the need for answers (Moriconi, 2020). Similarly, scientific studies (Echeburúa, 2005; García-Viniegras and Pérez, 2013) indicate that survivors of a traumatic death may experience more intense and lasting depressive manifestations than when the death is expected. Likewise, in this type of death, previous pathologies may be aggravated and even new ones may appear, including post-traumatic ¹³stress symptoms (Moriconi, 2020) such as: re-experiencing the event in the form of nightmares, thoughts or images that generate discomfort; avoidance of places, people or conversations that may remind the person of what happened; inability to remember aspects of the event; persistent negative emotional state (anger, guilt or shame); feeling of detachment from others or inability to experience positive emotions; irritable or reckless behavior; concentration problems and sleep disturbances.

Helping people who have suffered a loss to accept it, process it and integrate it, firstly involves listening to it and processing it (not only at a cognitive level, but also at an emotional level) and here a correct communication of bad news can be an essential facilitator.

4. TELEPHONE COMMUNICATION

The current pandemic has meant that many relatives of people affected by SARS-CoV-2 have had to receive news about the deterioration of the health or death of their loved one in a non-face-to-face manner (generally by telephone), either because of the need to maintain physical distance to avoid new infections, or because of the mobility restrictions imposed on the population (Hernández-Sanz, 2020; Belli, 2020). This type of remote communication, although the scientific literature discourages it in this type of situation (notification of adverse information) (Belli, 2020), has existed and has been a major challenge for health professionals who have had to adapt, document, train and finally put it into practice (Ferrer, 2020).

¹³ Post-traumatic stress disorder (PTSD) is characterized by persistent and involuntary repetition of the traumatic event, avoidance behaviors, negative cognitive and mood alterations, and a change in alertness and reactivity associated with the event, all for a period of more than one month (APA, 2014).

While telephone communication can have important advantages in certain contexts and situations by being fast, cheap, saving time and effort, facilitating the resolution of urgent issues and even neutralizing difficult relationships or cooling hot issues (Acinas et al., 2019); it also presents important disadvantages in circumstances where physical presence becomes necessary (Kendrick, 1997).

As far as differentiating aspects are concerned, in telephone communication, paralinguistic elements (tone, volume, speed, intonation...) acquire special relevance. These elements have a very important weight during the conversation, since due to the lack of any kind of visual information during communication, they are the ones that convey the emotional dimension (of the sender and receiver) (Rizo, 2015). Another characteristic, therefore, of this type of communication, is that the interlocutors cannot see each other, there being no body language to accompany this exchange of information. As Acinas et al. (2019) point out, the telephone thus becomes an intermediary, an interpersonal mediator in the communication process.

In remote communication by telephone, one of the major handicaps that discourages its use in certain circumstances, such as the communication of bad news, is the loss of nonverbal elements that facilitate knowing the state in which the person may be, as well as whether he/she has really understood the information transmitted and whether the consequent reaction is adaptive. Thus, different experts (Pettinari and Jessop, 2001; Taylor, 2007), point out that remote communication should be avoided at all costs in these contexts, mainly because effective communication depends, to a large extent, on body language, so that the exchange of information through a telephone call tends to be less effective.

Other drawbacks of this type of communication are (Rocamora, 2013; Acinas et al., 2019): a greater speed in the resolution of the call than if it were a face-to-face conversation; poor suitability in the circumstances in which the call may occur (lack of privacy and that others hear the conversation or see the person in a state that in another situation they would not like, being performing or going to perform a risky activity such as driving, social support not present, health circumstances that discourage situations of a high emotional impact of an abrupt nature....); health problems of the receiver that hinder communication (such as hearing or speech impairments); difficulty in capturing the attention of the interlocutor and fragility in communication, which can be interrupted at any time and, in the most complex cases, prevent knowledge of the physical and psychological state of the receiver who could carry out disruptive or inadvisable behaviors in response to the information received.

In summary, it can be pointed out that the absence of eye contact and the fragility of the relationship make communication by telephone unsuitable for the transmission of information that is known to have a strong impact on the receiver, and its response will also have an impact on the sender.

5. COMMUNICATING BAD NEWS IN TIMES OF COVID-19: TELEPHONE COMMUNICATION

Knowing how to adequately communicate bad news is perhaps one of the most important tasks in the healthcare setting and yet it is often considered a minor skill, especially when compared to other technical aspects of healthcare activity (Belli, 2020). Professionals point out this practice as one of the most stressful to develop (Bernardo and Brunet, 2010; Bascuñán, 2013; Bousquet et al., 2015; Arnold and Koczwara, 2016; Torregrosa, Gempeler and Silva, 2020) and yet not enough resources are devoted to the preparation and training of healthcare workers in this area (Almanza, 2003; Suquilanda and Manuel, 2016; Monden, Gentry and Cox, 2016; Belli, 2020). Thus, when communicating bad news, in addition to the fears already existing in the professional, there is deficient training that does not provide sufficient coping resources or adequate training in communication skills to enable him/her to perform this task optimally. This fact increases the levels of stress and anxiety in the healthcare professional, reducing the effectiveness of the task, which in turn affects his self-confidence and security for future communications and can influence the appearance of problems such as *burnout*¹⁴.

People need to know the information, and they need to know it as soon as possible in order, as far as possible, to reduce the chances of a death becoming traumatic because of its unexpected or surprising nature and what this entails. Something that has not always been possible during the worst moments of the contagion curve. Adequate communication in terms of mode, time and space can facilitate the process of acceptance and adaptation after the loss or, on the contrary, hinder it.

The psychological impact of a traumatic death, such as many of those that occurred during the pandemic, is greater than that generated by other types of deaths. If we understand that a traumatic death usually involves a series of characteristics, we will also understand how adequate communication can reduce the appearance of many of these variables and thereby reduce the likelihood of greater psychological damage. As Alba Payás (2017) points out, a traumatic death is usually defined by: surprise (if the death cannot be anticipated, the person cannot prepare), helplessness (being surprising, there is no capacity to respond), incomprehension (the lack of information makes it difficult to understand the reasons for what happened), speed (there has been no time to assimilate the death), loneliness at the moment of death or communication of the death (the fact that the event is surprising, the person may receive the information without the support of anyone at the time) and subsequent loneliness (the bereaved has had no one with whom to share what has happened). Therefore, if there is a possibility

¹⁴ The term *burnout* emerged in the mid-1970s as a problem characteristic of the "helping professions". Studies indicated a higher incidence in health and public safety professionals (Cherniss, 1980), although it can occur in many other professions involving direct contact with people, as later scientific literature pointed out. *Burnout* is originally defined as "emotional exhaustion leading to a loss of motivation and usually progressing to feelings of inadequacy or failure" (Maslach and Jackson, 1981). Emotional exhaustion, depersonalization (which would imply negative or insensitive attitudes towards the recipients of the services provided), and a negative appraisal of oneself and one's achievements, would constitute its most prominent symptoms.

of anticipating and preparing the person for the death of their loved one, although this does not reduce the grief of the mourner, it will favor a better readaptation to the event, having given rise to a gradual emotional preparation for the changes that will occur and having allowed to progressively come to terms with the loss (Montés et al., 2019).

Far from what might be thought, when communicating bad news, good intentions or common sense are not enough, even in times of crisis such as the current pandemic; it is necessary to have knowledge, skills, preparation and supervision (Buela, 2008; Mirón, 2010). Taking care of the "what" and "how" is transmitted is especially relevant if the communication is done at a distance through the telephone. As expressed by Montés et al. (2019), "words are not neutral, on the contrary, they can carry an enormous emotional charge, and can act as a lacerating whip on our thoughts and, consequently, on our emotions". Therefore, knowing how to communicate information properly will not only reduce the psychological impact on the receiver, but also on the sender, who will face fewer scenes with high emotional content (Montés et al., 2019).

This pandemic situation has posed significant challenges for health professionals, who had never before faced a health emergency situation of these dimensions and which has required adapting to it with the resources existing at the time, which have sometimes proved ineffective or insufficient (Chacón-Fuertes et al. , 2020; Legido-Quigley et al. , 2020; Lorenzo, 2020; Linconao, 2020; McMahon, Peters, Ivers and Freeman, 2020; Ezquerria et al., 2020; Emanuel et al., 2020). At the care level, the communication of bad news has acquired special importance due to the magnitude and characteristics of the situation. This fact has led to an increase in the stress levels of professionals, since, in addition to having to communicate bad news, the unconventional way of doing so, usually by telephone, has been added to the unconventional way of doing so, at a distance. As Belli (2020) points out in relation to this aspect, professionals have had to face a series of particular obstacles: a) the little or no training in this type of communication skills that most of them have, b) the absence of body language in this type of exchange, which is one of the bases of effective communication of bad news, and c) the scarce literature available to guide those who must perform this task, as this type of remote communication is not recommended, except in exceptional situations such as the present one. In addition, it should be added that on many occasions the communication has been carried out by professionals who had never performed this task before, as it is not within their usual competencies. The characteristics of the situation (care congestion, difficulty in the organization of shifts and functions of the professionals, rapid worsening of the clinical condition of many patients, contagion of the health care professionals themselves...) (Rodríguez-Leor et al., 2020; Ferrer, 2020; Ezquerria et al, 2020; Chacón, 2020a; Villacañas et al. , 2020) have also meant that, frequently, during the most critical moments of the pandemic there was no relational link with the interlocutor, who lacked a professional reference who could keep him/her informed of the evolution or situation of his/her family member.

The communication of bad news in the field of emergencies is a process that pursues clear objectives: to minimize the psychological impact of the loss (especially if it is sudden or unexpected), to help people to use their coping skills to adapt to the situation

(for example, seeking social support), to favor emotional relief, to support and facilitate the start of the grieving process by identifying risk factors and indicators of possible complicated or pathological grief, and to reduce the probability of the appearance of physical and/or psychological pathologies in the short, medium and long term. As Pacheco et al. (2012) point out, "for adequate communication there must be a basic ability to know how to communicate in professionals, as well as a knowledge of the basic technical guidelines". And this becomes especially relevant when it is necessary to mitigate the inconveniences that a telephone communication of bad news entails.

As regards basic communication skills for conveying negative information (empathy, active listening, appropriate use of verbal and nonverbal communication strategies, etc.), the positive aspect is that they can be learned and improved through adequate education and training (Razavi et al., 2000; Fallowfield et al., 2001; Wilkinson et al., 2002; Fellowes et al., 2004). All individuals may have certain skills more or less innately, but they can always be polished and nuanced, making them a more effective tool. This is essential because, as Fellowes et al. (2004) note, many of the complaints from patients, family members or relatives who receive bad news focus on deficiencies in communication, with the professional's "willingness to listen and explain" being the most valued attributes (Moore et al., 2004).

With regard to basic guidelines to facilitate communication, and as we have already pointed out, despite the existing models in hospital and even prehospital care practice, there is practically no literature that provides guidance on how to properly carry out remote communication (Belli, 2020). In this sense, we have proceeded to adapt classic strategies to the requirements that this type of remote communication implies.

5.1. The importance of communication skills

For a correct communication of bad news, the first thing to consider is that communication is a complex exchange process that takes place in several steps (Sarabia, Ortego and Torres, 2013): elaboration of the idea, codification of what is intended to be said, transmission of the message, reception of the information by the interlocutor, decoding of the message, integration of the message and *feedback* (information collected by the sender on the effects that his message has had on the receiver, verifying the degree of understanding of the message). It should be considered that throughout the process a degradation of the message takes place and information is lost, in such a way that one thing is what the person thinks he/she wants to say, another is what he/she transmits, another is what the receiver perceives and another is what he/she ends up interpreting. Therefore, the professional must be especially careful in conveying the information, avoiding improvisation and planning in advance what and how to convey the news so as not to add to the pain that the information about the loved one will cause. In general terms, communication is considered effective when the message is adapted to the interlocutor, so that it is perceived, understood, accepted and integrated. The act of communicating is, therefore, active and bidirectional, since it implies a reaction of the receiver to the message sent by the sender, hence it is more correct to speak of "communicating bad news" and not of "giving bad news" (CEEM,

2010), since during the conversational act there is a constant exchange of messages and, consequently, of roles (sender-receiver).

In communication over the telephone, as in other types of information exchange, there may be certain barriers that need to be neutralized so that the message can be received (and responded to) correctly. Some of the problems that healthcare workers usually encounter are related to (Álvarez, 2015):

- a) Not saying everything that the professional wanted to say. This is often the result of improvisation due to the pressure of care that makes it difficult to dedicate time to the communication process, the lack of training and knowledge about the importance of planning as a step prior to any action, and the lack of experience and difficulty in emotional self-management that can lead the health professional to behave impulsively. The key here is to prepare what and how the news is to be communicated, as well as the response to possible doubts and objections (Buckman, 1992; Baile et al., 2000; Taylor, 2007).
- b) The person is not able to hear everything the professional has said or is saying. In the case of communication by telephone, this is a point that must be taken into special consideration, choosing an appropriate time and place to make the call (Belli, 2020). It is best to choose a place free of noise and distractions, with time to be able to make the communication and resume it in case of interruption (Buckman, 1992; Baile et al., 2000; Taylor, 2007; Belli, 2020). If possible, choose a time when the family member is in optimal physical and psychological conditions that allow him/her to concentrate in order to receive the information.
- c) The person is not able to listen to what the professional has transmitted or is transmitting. Here, in addition to taking into account the considerations of the previous point, it is necessary to assess the possibility that the person has implemented a defensive mechanism of denial to reduce the impact of the painful stimulus (Bernardo and Brunet, 2010; Bascuñán, 2013). We should consider that both denial and guilt (the false illusion of control can make people feel responsible for not having foreseen what could happen and avoiding it), are two reactions that appear frequently in close relatives who receive the news of an unexpected death (Montés et al., 2019). In these cases, in addition to respecting the times, it is necessary to ask control questions so that the listener has to explain, summarize or give some answer about what has been heard. Likewise, it may be convenient to repeat, by the professional, the same information in different ways to facilitate its processing (Cerezo, 2012).
- d) The person has not understood what the professional has said. The use of technical terms, the lack of clarity and the existence of ambiguity in the message or a code that is not shared (different language, age, culture...), may mean that the person does not understand what was intended to be transmitted (Wright, 1996; Cooke, 2000; Harrahill, 2005; Belli, 2020). It is essential to be able to adapt to who we have to communicate (Taylor, 2007; Bascuñán, 2013). Let us not forget that SARS-CoV-2 has affected people from all walks of life, posing an

added challenge for professionals who, in some cases, have even had to resort to "opportunity" interpreters¹⁵.

- e) The person has understood, but does not accept the information communicated. As we said, it is normal that in the first moments defense mechanisms such as denial are activated, which reduce the person's contact with a painful reality that he/she does not want to face (Taylor, 2007). On the other hand, there may also be mistrust towards the situation itself in general and towards the professional in particular. Let us remember that during the worst moments of the pandemic, family contact with people affected by the virus was not possible and information was scarce and even contradictory, favoring anxiogenic activation processes due to helplessness, frustration and uncertainty. Respecting time, being empathetic, accessible and available for further contact is helpful (Cooke, 2000; Pettinari and Jessop, 2001; Taylor, 2007; Belli, 2020).
- f) The person has understood and accepted the message transmitted, but is not able to retain it. Given the emotional impact suffered, it is possible that blockages may occur that hinder the processing and integration of the information. Some studies speak of up to 40% of the information transmitted being forgotten as a result of these blockages (Pacheco et al., 2012; Bascuñán, 2013). It is important to summarize, repeat and if possible pass on, even in writing, the most relevant information, especially that related to forms of contact and guidance on the next steps to be taken (Buckman, 2000). If social support is important throughout the process (Bernardo and Brunet, 2010), at this point it is key for the person on the other end of the phone to have physical and emotional support that facilitates coping with the situation; something that during the state of alarm, sometimes, has not been possible due to the limitation of people's freedom of movement and collective affectation.

5.2. The importance of basic guidelines for action

Taking into account the aforementioned obstacles, most of the protocols designed for remote communication have been based on an adaptation of the classic guidelines provided by various authors (Edlich and Kubler-Ross, 1992; Buckman, 1992; Kaye, 1996; Rabow and McPhee, 1999 and Baile et al., 2000), which are similar in terms of the key principles and steps on which they are based: preparation, communication of the news, management of emotions and planning of the next step. Knowing and knowing how to apply these guidelines is essential for the professional who can reduce his or her anxiety levels, increasing the likelihood of effective communication. As Wright (1996) indicates, most of the concerns of professionals when they have to communicate bad news over the telephone are: not talking to the right person, the receiver of the bad news getting blocked and collapsing, and being asked directly if the patient has died and, in that case, not knowing how to respond. These are concerns that, with proper training, can be reduced considerably.

¹⁵ When the language or culture of the person with whom the healthcare professional must communicate is unknown or not adequately known, it is advisable to use interpreters who are properly trained for this task (Bernardo and Brunet, 2010).

However, we cannot lose sight of the fact that although the guidelines or protocols for the communication of bad news are very useful, as they allow the health professional to have a basic framework for action, organize the communicative task and show the patient as the axis of the process; these guidelines, which are necessary, are not sufficient, as they are general guidelines that should be interpreted by the professional according to the circumstances of each case and the socio-cultural reality in which he/she finds him/herself (Bascuñán, 2013).

One of the most frequently adapted protocols for telephone communication of bad news in general, and on the occasion of COVID-19 in particular (Sacyl, 2020; SaludMadrid, 2020), has been the Baile and Buckman protocol (Baile et al., 2000) for communication of bad news in the healthcare setting (SPIKES). The protocol consists of 6 successive staggered steps: 1st) prepare the most appropriate physical (and emotional) context, 2nd) find out how much the patient knows, 3rd) find out what the patient wants to know, 4th) share the information, 5th) respond to the patient's feelings, and 6th) plan and follow the process. Each of these steps (which should always be adapted to the pace of the interlocutor), would be associated with a specific set of skills, although not all communications of unfavorable information would require the full set of tasks.

In the field of emergencies, a simplified four-phase protocol is frequently used (Taylor, 2007; Belli, 2020) in accordance with the four key points on which most classical models agree (Edlich and Kubler-Ross, 1992; Buckman, 1992; Kaye, 1996; Rabow and McPhee, 1999 and Baile et al., 2000), which very briefly would be:

1st) Preparation: in this phase the professional should gather as much information as possible from the person to be notified, organize it and prepare the message to be transmitted, clarifying exactly what he/she is going to say and how he/she is going to say it. It is important here to know exactly what has happened, as well as what measures have been taken, are being taken and will be taken. Preparing the answer to possible questions that may arise is also essential. Information about the person who is to receive the information, his or her needs and special circumstances should also be gathered, if feasible, in order to be able to adapt the communication to the interlocutor. Since the literature shows that people prefer to hear bad news from professionals who have cared for them, know their relatives or have treated their loved one (Fallowfield and Jenkins, 2004), this criterion will be used to decide who is to convey the unfavorable information. An appropriate time and place for communication, free of interruptions and without time constraints, should be sought.

2º) Communication of the news: after introducing the professional and ensuring the identity of the interlocutor, communication should be carried out progressively in clear and simple terms, avoiding technicalities and set phrases and through a descriptive-narrative message of what happened, verbalizing the reality of the death. It is advisable to start the communication with a preparatory phrase; point out that everything possible has been done; if something positive can be said, say it and end by showing

condolences. If it is feasible, it is important to know if the relative is accompanied by other people (and their characteristics), as well as if there are any special circumstances. In a telephone communication this is essential since it can be interrupted for various reasons (Taylor, 2007, Belli, 2020). It is also essential to make sure that it is the right time for the receiver to pick up the phone. As Buckman (1992) points out, it can be helpful both to begin by acknowledging the difficulty of maintaining the conversation over the phone, as this will reduce its negative impact and serve as a warning shot about the seriousness of the situation; and to acknowledge the last contact made with the family member before formally indicating that bad news is about to be communicated.

3º) Managing emotions: after communication, time must be allowed for the receiver's emotional response, questions, doubts and even moments of silence (Pacheco et al., 2012). Shock is usually one of the most frequent responses expressing itself in a variety of forms, including denial, anger, bargaining, tears or acceptance (O'Donovan, 1999). According to Buckman (2000), "the central tenet of effective therapeutic dialogue is that the patient must perceive that his or her emotions have been heard and acknowledged by the professional ", which is why it is so important here to adopt a genuine attitude of active listening, acceptance, and emotional validation. The warm and empathic attitude must be present in the professional throughout the communicative process¹⁶(Belli, 2020). Conveying that one is at the mourner's side and that one does not shy away from the situation makes it possible to contain and gradually allow the mourner, at his or her own pace, to assimilate the information, while showing that the situation is not unapproachable, modeling an active coping with it (Bascuñán, 2013). Communication strategies such as summarizing, paraphrasing, reflecting... can be useful. It is important in this phase to normalize and resignify physical symptoms and emotional reactions to the news, as well as to assess the existence of post-impact blockage. On the other hand, professionals should be prepared, if necessary, to activate an emergency assistance resource for certain reactions or symptomatology that may be more difficult to assess and/or control over the telephone (Taylor, 2007).

4º) Planning the next step: once the bad news has been communicated, it is important to anticipate the steps to be taken, provide guidance on the procedures to be followed, assess and ensure that the person's needs are covered and, if they are not, help him/her in the task (search for social support, access to resources, medical-psychological care or follow-up by a professional if necessary). The professional should always end by showing his or her accessibility and availability and, if circumstances permit, set a date and time for a next contact. At this point, in a normal situation, the family member could be given the opportunity to say goodbye physically to his or her

¹⁶ A study conducted by Fallowfield and Jenkins (2004) showed that what recipients of bad news expect from health care professionals is essentially that they: are able to understand what is important to the patient, show some concern and distress about the news rather than coldness, allow enough time to talk and ask questions, and have the knowledge to convey the message clearly and with respect for privacy.

loved one (Taylor, 2007). In the situation that has been experienced, this has been unfeasible in many cases, complicating the communication of the news.

As can be seen, unfortunately, at the height of the pandemic situation, many of these guidelines could not be followed due to the medical demands of the moment and the pressure and burden of care to which professionals have been subjected. In this sense, the need for professionals to become aware of their limitations, reflect on their strengths and support elements and adopt active self-care behaviors is particularly relevant¹⁷(Bascuñán, 2013). Thus, just as it is important, once the news has been communicated, to evaluate the strategies used and whether they have been effective, it is also important for the health professional to evaluate himself and analyze what repercussions the situation has had on his psychophysiological state, what tools he has used to deal with them and whether they have been useful.

We must not lose sight of the fact that the objective of the intervention is not to eliminate the pain of the loss, but to facilitate its adequate coping.

6. CONCLUSIONS

Communicating bad news, especially if it involves a death or the drastic and irreversible worsening of a patient's clinical condition, is not an easy task. The SARS-CoV-2 pandemic has posed great challenges for health professionals who have been forced to confront the situation with the resources available at the time, which in many cases have proved to be insufficient, ineffective or inadequate.

Providing adverse information remotely, in this case by telephone, except in exceptional circumstances and situations such as the one experienced, should never be the procedure of choice, since the non-verbal component, key in communication, is lost, the relationship established is more fragile and we miss information that in many cases may be vital to know. All this reduces the likelihood of a truly effective communication where the interlocutor has the feeling of having been properly served.

Adequate communication of bad news has benefits for both the transmitter and the receiver. For the receiver it can be a facilitator for acceptance and adaptation to the new situation. The literature tells us that the way in which bad news is given and the subsequent actions taken can influence the grieving process (Wright, 1996). For the sender, it means gaining security for future communications, improving his/her self-concept, self-esteem and thus reducing the probability of the appearance of problems

¹⁷ According to the work of Borrell-Carrio and Epstein (2004), improving the emotional and cognitive skills of physicians could prevent many failures. The authors point out that there is evidence that many of the mistakes made by physicians and the breakdown of the therapeutic relationship that sometimes occurs are often not the result of a lack of knowledge but are due to the interference of their emotions. Hence the need to incorporate elements of self-knowledge and self-reflection of the professional in their training process. Self-care is presented as essential to be able to care for the other.

such as *burnout*. In short, for the professional it means increasing the probability of effective future communications.

But for a correct transmission of information that is known to be unfavorable, common sense, good intention or simply experience is not enough (Fellowes et al., 2004), it is necessary for the professional to be properly trained and educated. Knowing and properly using communication skills, as well as the basic technical guidelines for action, is essential.

A well-conducted communication can be therapeutic in itself. It is not only a matter of transmitting painful information, but also of cushioning its impact, providing resources for containment and coping and preventing future complications. Therefore, it will be essential to take care of the language used during communication, listen actively, adopt an appropriate attitude (show empathy and genuine interest), manage emotions properly, control reactions, maintain concentration, take care of the voice (intonation, articulation and rhythm are the most relevant characteristics of the voice in telephone communication) and feel confident in what is being done, in one's own skills and in the usefulness and importance of the work being performed. All this without losing sight of a key element, the axis of communication, the interlocutor; to whose idiosyncrasies, times, needs and circumstances the professional must adapt.

For years, knowing how to communicate unfavorable news appropriately has been considered a minor skill compared to other technical aspects of healthcare practice. The current pandemic has demonstrated its importance for professionals, patients and their families and relatives.

In view of the above, specific protocols (and the training of professionals in them) are necessary in situations such as the one experienced, beyond the adaptation of the classic models, mostly designed for face-to-face communication.

In short, we must not forget that the purpose of a correct transmission of bad news is not to eliminate the pain but to help the person to cope with it, reducing as much as possible the impact of the news, accompanying the mourner and guiding him/her in whatever he/she needs at that moment.

7. REFERENCES

Acinas, M., Alonso, C., Alonso, J., Peláez, J., & Suárez, B. (2019). Comunicación en condiciones difíciles. Acinas, M. (Ed.), *Habilidades de comunicación y estrategias asistenciales en el ámbito sanitario (II). Actions in emergency situations and emergencies* (pp. 53-101). Jaén, Spain: Formación Alcalá.

- Almanza, M. J. J. (2003). La comunicación de las malas noticias en la práctica médica.. *Rev Neurol Neurocir Psychiat*, 36(4), 165-176. Retrieved from <https://www.medigraphic.com/pdfs/revneuneupsi/nnp-2003/nnp034b.pdf>
- Alvarez, A. I. (2015). *Comunicación en situaciones críticas* [Classroom material]. Health of Castilla y León (Sacyl). Castilla y León, Spain.
- Alves, A. E. (2003) ¿Cómo comunicar malas noticias a nuestros pacientes y no morir en el intento? *Revista Argentina de Cardiología*, 71(3), 217- 220.
- Antonelli, F. (1990). *Per moriré vivendo*. 3rd ed. Rome: Città Nuova Editrice.
- American Psychiatric Association (APA). (2014). *Manual diagnóstico y estadístico de los trastornos mentales (DSM-5). 5th Ed.* Madrid, Spain: Editorial Médica Panamericana.
- Arango, C. (2020). *La respuesta emocional de los sanitarios durante la pandemia* [Conference 18/09/2020]. I National Congress COVID-19. Spain.
- Araujo, M., García, S. & García-Navarro, B. (2020). Abordaje del duelo y de la muerte en familiares de pacientes con COVID-19: revisión narrativa. *Enfermería Clínica*. DOI: <https://doi.org/10.1016/j.enfcli.2020.05.011>
- Ari, E., Yilmaz, V., & Arikan, İ. (2020). The Effect of Perceived Risk of COVID-19 on Anxiety: Developing a Scale. *Integrative Journal of Medical Sciences*, 7. DOI: <https://doi.org/10.15342/ijms.7.190>
- Arnold, S.J and Koczwara, B. (2006). Breaking bad news: learning through experience. *Journal of Clinical Oncology*, 24(31), 5098-5100. doi: [10.1200/JCO.2006.08.6355](https://doi.org/10.1200/JCO.2006.08.6355).
- Ashokkumar, A. and Pennebaker, J. (2020). Locked indoors: What we do daily is related to mental health. *The Pandemic Project and the University of Texas at Austin*.
- ATLAS (2020, 01, 31)"España no va a tener, como mucho, más allá de algún caso diagnosticado" Retrieved from https://www.abc.es/espana/abci-fernando-simon-espana-no-tener-como-mucho-mas-alla-algun-caso-diagnosticado-202001311357_video.html
- Baile, W.F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., Kudelka, A. P. (2000). SPIKES-A six-step protocol for delivering bad news: Applications to the patients with cancer. *The Oncologist*, 5, 302-11.
- Bascuñán, M. (2013). Comunicación de "malas noticias" en salud. *Revista Médica Clínica Las Condes*, 24(4), 685-693. doi: [10.1016/S0716-8640\(13\)70208-6](https://doi.org/10.1016/S0716-8640(13)70208-6).

- Belli, L. F. (2020). Recomendaciones para la comunicación de malas noticias por teléfono durante la pandemia por SARS-CoV-2. *Pan American Journal of Public Health*. 44:e69. doi: [10.26633/RPSP.2020.69](https://doi.org/10.26633/RPSP.2020.69).
- Bernardo, Y. & Brunet, N. (2010). Comunicación de malas noticias. *Cuadernos de crisis*, 2(9), 48 - 58.
- Bor, R., Miller, R., Goldman, E., & Scher, I. (1993). The Meaning of Bad News in HIV Disease: counseling about dreaded issues revisited. *Counsel Psychol*, 6(1), 69 - 80.
- Borrel-Carrio, F. & Epstein, R. (2004). Preventing errors in clinical practice: a call for self-awareness. *The Annals of Family Medicine*, 2(4), 310-316. doi: [10.1370/afm.80](https://doi.org/10.1370/afm.80).
- Bousquet, G., Orri, M., Winterman, S., Brugière, C., Verneuil, L., & Revah-Levy, A. (2015). Breaking Bad News in Oncology: A Metasynthesis. *Journal of clinical oncology: official journal of the American Society of Clinical Oncology*, 33(22), 2437-2443. doi: [10.1200/JCO.2014.59.6759](https://doi.org/10.1200/JCO.2014.59.6759).
- Bowlby, J. (1993). *La pérdida afectiva*. Barcelona, Spain: Paidós.
- Brickell, C. & Munir, K. (2008). El duelo y sus complicaciones en las personas con discapacidad intelectual. *Revista Síndrome de Down*, 25(2), 68-76. Retrieved from <http://www.downcantabria.com/revistapdf/97/68-76.pdf>
- Brody, J. E. (2020/04/14). *Managing coronavirus fears*. Retrieved from <https://www.nytimes.com/2020/04/13/well/mind/coronavirus-fear-anxiety-health.html>
- Brooks, S. K., Webster, R. K., Smith, L. E., Woodland, L., Wessely, S., Greenberg, N., & Rubin, G. J. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *The Lancet*, 395(10227), 912-920. doi: [10.1016/S0140-6736\(20\)30460-8](https://doi.org/10.1016/S0140-6736(20)30460-8).
- Buckman, R. (2000) Communication in palliative care: a practical guide. In: Dickenson, D., Johnson, M. and Katz, J.S, (eds). *Death, Dying and Bereavement*. 2nd ed. Sage, London: 146-73.
- Buckman, R. (1992): *How to break bad news. A guide for health-care professionals*. London: The Johns Hopkins University Press.
- Buela, G. (2008). La comunicación de malas noticias. *Evidencia, actualización en la práctica ambulatoria*, 11(5). Retrieved from <http://www.evidencia.org/index.php/Evidencia/article/view/5866/3429>
- Burger, R., Christian, C. , Maughan-Brown, B., Rensburg, R. & Rossouw, L. (2020). COVID-19 risk perception, knowledge and behaviour. *National Income Dynamics Study (NIDS) - Coronavirus Rapid Mobile Survey (CRAM)*.

- Cabodevilla, I. (2007). Las pérdidas y sus duelos. *Anales del Sistema Sanitario de Navarra*, 30(Suppl. 3), 163-176. Retrieved from http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1137-66272007000600012&lng=es&tlng=es
- Carrasco, M. (2020). *La salud mental de la población general* [Conference, 18/09/2020]. I National Congress COVID-19. Spain.
- Casas-Rojo, J. M., Antón-Santos, J. M., Millán-Núñez-Cortés, J., Lumbreras-Bermejo, C., Ramos-Rincón, J. M., Roy-Vallejo, E.,..., & Freire-Castro, S. J. (2020). Características clínicas de los pacientes hospitalizados con COVID-19 en España: resultados del Registro SEMI-COVID-19. *Spanish Clinical Journal*. doi: [10.1016/j.rce.2020.07.003](https://doi.org/10.1016/j.rce.2020.07.003).
- Center for Systems Science and Engineering (CSSE). (2020, 09, 19). *COVID-19 Data Repository*. Johns Hopkins University. Retrieved from <https://github.com/CSSEGISandData/COVID-19>
- Health Alerts and Emergencies Coordination Center (CCAES). (2020). *Update No. 208. Enfermedad por el coronavirus (COVID-19): 16.09.2020*. Spain: Ministry of Health. Retrieved from https://www.mscbs.gob.es/profesionales/saludPublica/ccayes/alertasActual/nCov/documentos/Actualizacion_208_COVID-19.pdf
- Cerezo, R. (2012). *Las barreras comunicacionales de la familia y su incidencia en la formación de los adolescentes del cantón Babahoyo, provincia de "los ríos"*. (Doctoral thesis). Technical University of Babahoyo. Ecuador.
- Chacón, F. (18/09/2020a). *Atención psicológica a profesionales sanitarios: intervención y prevención* [Communication]. I National Congress COVID-19. Spain.
- Chacón, F. (2020b/05/06). Interview with Fernando Chacón, Dean of the Official College of Psychology of Madrid. Retrieved from <https://www.youtube.com/watch?v=5H1fDLI6KNs>
- Chacón-Fuertes, F., Fernández-Hermida, J. R. & García-Vera, M. P. (2020). Psychology in the face of the COVID-19 pandemic in Spain. The response of the collegiate organization. *Clínica y Salud*, 31(2), 119-123. doi: [10.5093/clysa2020a18](https://doi.org/10.5093/clysa2020a18).
- Chakraborty, S. (2020). How risk perceptions, not evidence, have driven harmful policies on COVID-19. *European Journal of Risk Regulation*, 11(2), 236-239. doi: [10.1017/err.2020.37](https://doi.org/10.1017/err.2020.37).
- Chapman, G., & Loewenstein, G. (2020/06/09). *Why Americans are tiring of social distancing and handwashing - 2 behavioral scientists explain*. Retrieved from:

<https://theconversation.com/why-americans-are-tiring-of-social-distancing-and-hand-washing-2-behavioral-scientists-explain-139625>

Cheng, V. C., Lau, S. K., Woo, P. C., & Yuen, K. Y. (2007). Severe acute respiratory syndrome coronavirus as an agent of emerging and reemerging infection. *Clinical microbiology reviews*, 20(4), 660-694. doi: [10.1128/CMR.00023-07](https://doi.org/10.1128/CMR.00023-07).

Cherniss, C. (1981). Preventing burnout. From theory to practice. In J. W. Jones (Ed.). *The burnout syndrome: current research, theory, interventions* (172-176). Park Ridge. Illinois: London House Press.

Official College of Psychology of Madrid (2020). *Guía para un afrontamiento psicológico eficaz del proceso de desconfinamiento: ¿y ahora qué?* Retrieved from <https://www.copmadrid.org/web/comunicacion/noticias/1554/guia-un-afrontamiento-psicologico-eficaz-proceso-desconfinamiento-y-ahora-que>

State Council of Medical Students (CEEM). (2010). *La comunicación de malas noticias*.

Cooke, H. (2000). *Cuando alguien muere: una guía práctica para el cuidado integral al final de la vida*. Oxford; Boston: Butterworth-Heinemann.

Cori, L., Bianchi, F., Cadum, E., & Anthonj, C. (2020). Risk perception and COVID-19. *Int. J. Environ. Res. Public Health*, 17(9). doi: [10.3390/ijerph17093114](https://doi.org/10.3390/ijerph17093114).

Curtis, J.R. (2004). Communicating about end-of-life care with patients and families in the intensive care unit. *Critical Care Clinics*. 20 (3), 363-380. doi: [10.1016/j.ccc.2004.03.001](https://doi.org/10.1016/j.ccc.2004.03.001).

De Pablo, G. S., Serrano, J. V., Catalan, A., Arango, C., Moreno, C., Ferre, F., ... & Fusar-Poli, P. (2020). Impact of coronavirus syndromes on physical and mental health of health care workers: Systematic review and meta-analysis. *Journal of affective disorders*, 275, 48-57. doi: [10.1016/j.jad.2020.06.022](https://doi.org/10.1016/j.jad.2020.06.022).

Department of Health The NHS cancer plan. (2000). Department of Health, London. Retrieved from https://www.thh.nhs.uk/documents/_Departments/Cancer/NHSCancerPlan.pdf.

Dryhurst, S., Schneider, C., Kerr, J., Freeman, A., Recchia, G., van der Bles, A. M., Spiegelhalter, D. & van der Linden, S. (2020) Risk perceptions of COVID-19 around the world. *Journal of Risk Research*, doi: [10.1080/13669877.2020.1758193](https://doi.org/10.1080/13669877.2020.1758193).

Echeburúa, E. (2005). *Superar un trauma. El tratamiento de las víctimas de sucesos violentos*. Madrid, Spain: Psicología Pirámide.

Edlich, R. F. & Kubler-Ross, E. (1992). On death and dying in the emergency department. *Journal of Emergency Medicine*, 10(2), 225-9. doi: [10.1016/0736-4679\(92\)90231-h](https://doi.org/10.1016/0736-4679(92)90231-h).

- Emanuel, E. J., Persad, G., Upshur, R., Thome, B., Parker, M., Glickman, A.,..., and Phillips, J. P. (2020). Fair allocation of scarce medical resources in the time of Covid-19. *N Engl J Med*, 382, 2049-2055. doi: [10.1056/NEJMs2005114](https://doi.org/10.1056/NEJMs2005114).
- Ezquerro, J., Alarcón, A., Álvarez, G., Ancochea, J., Arenas, C., Delgado, O.,..., Hernández, I. (2020). Lecciones del Covid-19: qué ha aprendido el sector sanitario español ante la pandemia. *Redacción Médica*. Retrieved from <https://eventos.redaccionmedica.com/lecciones-covid19/>
- Fallowfield, L. & Jenkins, V. (2004). Communicating sad, bad, and difficult news in medicine. *The Lancet*, 363(9405), 312-19. doi: [10.1016/S0140-6736\(03\)15392-5](https://doi.org/10.1016/S0140-6736(03)15392-5).
- Fallowfield, L., Saul, J. & Gilligan, B. (2001). Teaching senior nurses how to teach communication skills in oncology. *Cancer Nursing*, 24(3), 185-91. doi: [10.1097/00002820-200106000-00004](https://doi.org/10.1097/00002820-200106000-00004).
- Ferrer, R. (2020). La UCI ante las epidemias: organización y gestión de los recursos [Conference 19/09/2020]. I National Congress COVID-19. Spain.
- Villacañes, M., Felix-Alcántara, M., Buiza, C., (31/06/2020). *Impacto psicológico COVID-19 en profesionales sanitarios*. [Communication]. I International Online Conference AETSYS. Spain.
- Fellowes, D., Wilkinson, S. & Moore, P. (2004) Communication skills training for health care professionals working with cancer patients, their families and/or carers. *Cochrane Database of Systematic Reviews*. 2. doi: [10.1002/14651858.CD003751.pub2](https://doi.org/10.1002/14651858.CD003751.pub2)
- Ferrer, R. (2020). Pandemia por Covid-19: el mayor reto de la historia del intensivismo. *Intensive Care Medicine*, 44(6), 323-324. doi: [10.1016/j.medin.2020.04.002](https://doi.org/10.1016/j.medin.2020.04.002).
- Flórez, S. D. (2002). Duelo. *Anales del sistema sanitario de Navarra*, 25 (Suppl. 3), 77-85. Retrieved from <https://recyt.fecyt.es/index.php/ASSN/article/view/5545>
- Fouce, G. (2020, 04, 05). *Una carta y una foto en redes sociales para despedir a un padre y a una madre (Hessling, X. and Escudero, B.)*. Retrieved from <https://www.lavanguardia.com/vida/20200405/48324858741/una-carta-y-una-foto-en-redes-sociales-para-despedir-a-un-padre-y-a-una-madre.html>
- Gala, F. J., Lupiani, M., Raja, R., Guillén, C., González, J. M., Villaverde, M. C. & Alba, I. (2002). Actitudes psicológicas ante la muerte y el duelo. Una revisión conceptual. *Cuadernos de Medicina Forense*, 30, 39-50. Retrieved from http://scielo.isciii.es/scielo.php?script=sci_abstract&pid=S1135-76062002000400004

- Gao, J., Zheng, P., Jia, Y., Chen, H., Mao, Y., Chen, S., et al. (2020). Mental health problems and social media exposure during COVID-19 outbreak. *PLoS ONE* 15(4): e0231924. doi: [10.1371/journal.pone.0231924](https://doi.org/10.1371/journal.pone.0231924).
- García-Vera, M. P. (2020a, 04, 17). *Entrevista en Tribuna Complutense a María Paz García Vera, coordinadora del Servicio de Asistencia Psicológica del Ministerio de Sanidad y del Consejo General de Psicología de España* (Martín, A.). Retrieved from <http://tribuna.ucm.es/267/art4094.php#.X2UsJ2gzZPa>
- García-Vera, M. P. (2020b, 08, 10). *Los motivos psicológicos que explican el rechazo a la protección contra la Covid: falta de empatía... y la "presión social"* (Omedes, E.). Retrieved from <https://www.20minutos.es/noticia/4348818/0/restricciones-impuestas-frenar-coronavirus-gente-fia-experiencia-no-datos/?autoref=true>
- García-Vera, M. P. & Cordero, R. (2020, 03, 30) *El coronavirus aplaza el duelo de las familias* (Segura, M.). Retrieved from <https://www.diaridetarragona.com/noticias/El-coronavirus-aplaza-el-duelo-de-las-familias-20200330-0083.html>
- García-Viniegras, C., & Pérez, C. (2013). Duelo ante muerte por suicidio. *Revista Habanera de Ciencias Médicas*, 12(2), 265-274. <http://www.revhabanera.sld.cu/index.php/rhab/article/view/67>
- Garfin, D. R., Silver, R. C., & Holman, E. A. (2020). The novel coronavirus (COVID-2019) outbreak: Amplification of public health consequences by media exposure. *Health psychology: official journal of the Division of Health Psychology, American Psychological Association*, 39(5), 355-357. doi: [10.1037/hea0000875](https://doi.org/10.1037/hea0000875).
- Gevers, A. (2020, 04, 08). Qué hacen los consumidores en Europa en línea durante el bloqueo. Retrieved from <https://www.comscore.com/Insights/Blog/What-consumers-in-Europe-do-online-during-the-lockdown>
- Gómez, M. (2008). Qué hacen los consumidores en Europa en línea durante el bloqueo. E. Parada (Eds.), *Psicología y Emergencia* (pp. 293-320). Seville, Spain: Desclée de Brouwer.
- Gómez-Batiste, X., Novellas, A., Albuquerque, E., & Schroder, M. (2003). Información y comunicación en enfermos con cáncer avanzado y terminal. *Janus, Medicine and Humanities*, LXV (1495), 1482-1489.
- González, J. (2020, 03, 27). *El difícil duelo tras la muerte de un ser querido por coronavirus* (Martitegui, A.). Retrieved from https://www.niusdiario.es/salud-y-bienestar/coaching/dificil-duelo-muerte-coronavirus_18_2920845186.html.
- González, J. (2013) Atención psicosocial al duelo [Material del aula]. *II Edition psychologist specialist in bereavement processes*, Colegio Oficial de la Psicología de Madrid. Madrid, Spain.

- Harrahill M (2005) Giving Bad News Gracefully. *Journal of Emergency Nursing*, 31(3), 312-314. doi: [10.1016/j.jen.2005.01.006](https://doi.org/10.1016/j.jen.2005.01.006).
- Hernández-Sanz, M. (2020). *Resiliencia de las unidades de críticos en situación de pandemia* [Conference 19/09/2020]. I National Congress COVID-19. Spain.
- Herrán, A., Rodríguez, P. & De Miguel, V. (2019).). ¿Está la muerte en el currículo español? *Revista de educación*, 385, 201-226. Retrieved from <https://sede.educacion.gob.es/publiventa/d/22975/19/0>
- Ho, C. S, Chee, C. Y, & Ho, R. C. (2020). Mental Health Strategies to Combat the Psychological Impact of COVID-19 Beyond Paranoia and Panic. *Ann Acad Med Singapore*, 49(1), 1-3.
- Horowitz, M. & Kaltreider, N. (1980). Brief treatment of post-traumatic stress disorders. *New Directions for Mental Health Services*, 1980(6).
- Carlos III Health Institute (ISCIII). (2020/7/23). *El ISCIII coordina la encuesta de la OMS en España sobre percepción y conocimientos de la COVID-19: primeros resultados*. Retrieved from <https://www.isciii.es/Noticias/Noticias/Paginas/Noticias/EncuestaPercepcionCOVID19.aspx>
- Jiménez, A., Montés, M., & Jiménez, J. (2014).). Postvención en supervivientes al suicidio. En Anseán, A. (Dir.). *Manual de prevención, intervención y postvención de la conducta suicida. 2nd revised edition*. Spain: Mental Health Foundation Spain for the prevention of mental disorders and suicide.
- Kaye, P. (1996). *Breaking Bad News: A Ten Step Approach*. EPL Publications, Northampton.
- Kendrick, K. (1997) Sudden death: walking in a moral minefield. *Emergency Nurse*, 5(1), 17-19.
- Kentish-Barnes, N., Chaize, M., Seegers, V., Legriel, S., Cariou, A., Jaber, S., Lefrant, j., Floccard, B., Renault, A. et al. (2015). Complicated grief after death of a relative in the intensive care unit. *European Respiratory Journal*, 45(5), 1341-1352. doi: [10.1183/09031936.00160014](https://doi.org/10.1183/09031936.00160014).
- Khosravi, M. (2020). Perceived Risk of COVID-19 Pandemic: The Role of Public Worry and Trust. *Electron J Gen Med*, 17(4). doi: [10.29333/ejgm/7856](https://doi.org/10.29333/ejgm/7856).
- Kübker-Ross, E. & Kessler, D. (2005). *On Grief and Grieving: Finding the Meaning of Grief Through the Five Stages of loss*. NY: Scribner.

- Lacalle, M & Barbero, J. (2020, 03, 24). Sin velatorio, sin funeral, sin poder llorar juntos: ¿cómo afrontar el duelo por un ser querido fallecido por coronavirus? (Bousmaha, K.). Retrieved from <https://www.20minutos.es/noticia/4201796/0/duelo-sin-despedida-como-afrontar-situacion/>
- Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N..., Hu, S. (2020). Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019. *JAMA Netw Open*, 3(3), e203976. doi: [10.1001/jamanetworkopen.2020.3976](https://doi.org/10.1001/jamanetworkopen.2020.3976).
- Legido-Quigley, H., Mateos-García, J. T., Campos, V. R., Gea-Sánchez, M., Muntaner, C. & McKee, M. (2020). The resilience of the Spanish health system against the COVID-19 pandemic. *The Lancet Public Health*, 5(5), 251-252. doi: [10.1016/S2468-2667\(20\)30060-8](https://doi.org/10.1016/S2468-2667(20)30060-8)
- Lei, L., Huang, X., Zhang, S., Yang, J., Yang, L., & Xu, M. (2020). Comparison of prevalence and associated factors of anxiety and depression among people affected by versus people unaffected by quarantine during the COVID-19 epidemic in southwestern China. *Medical Science Monitor: International Medical Journal of Experimental and Clinical Research*, 26. doi: [10.12659/MSM.924609](https://doi.org/10.12659/MSM.924609).
- Levinson, W., Roter, D. L., Mulhooly, J. P., Dull, V., & Frankel, R. (1997). Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. *JAMA: the Journal of the American Medical Association*, 277, 553-9.
- Law 41/2002, of November 14, 2002, basic law regulating patient autonomy and the rights and obligations regarding clinical information and documentation. Official State Bulletin (B.O.E). Spain. November 14, 2002.
- Linconao, A. J. (2020). El COVID-19: Escasez de recursos y prioridad médica. Bioética y debate social. Retrieved from https://www.researchgate.net/publication/340116064_El_COVID-19_Escasez_de_recursos_y_prioridad_medica_Bioetica_y_debate_social.
- Lorenzo, S. (2020). La pandemia COVID-19: lo que hemos aprendido hasta ahora desde España. *APS EM REVISTA*, 2(1), 28-32. doi: [10.14295/aps.v2i1.66](https://doi.org/10.14295/aps.v2i1.66).
- Martín, L. & Muñoz, M. (2009). *Psychological first aid*. Madrid, Spain: Ed. Síntesis.
- Maslach, C. & Jackson, S. E. (1981). The measurement or experienced burnout. *Journal of Occupational Behavior*, 2, 99 -113.
- Mazza, C., Ricci, E., Biondi, S., Colasanti, M., Ferracuti, S., Napoli, C., & Roma, P. (2020). A nationwide survey of psychological distress among Italian people during the COVID-19 pandemic: Immediate psychological responses and associated factors.

International Journal of Environmental Research and Public Health, 17(9), 3165. doi: [10.3390/ijerph17093165](https://doi.org/10.3390/ijerph17093165).

McMahon, D. E, Peters, G. A, Ivers, L. C and Freeman, E. E. E. (2020). Escasez de recursos globales durante COVID-19: Malas noticias para países de bajos ingresos. *PLoS Negl Trop Dis* 14 (7), e0008412. doi: [10.1371/journal.pntd.0008412](https://doi.org/10.1371/journal.pntd.0008412).

Mirón, R. (2010). Comunicación de malas noticias: perspectiva enfermera. *Journal of the Spanish Association of Health Communication*, 1(1), 39-49.

Moghanibashi-Mansourieh, A. (2020). Assessing the anxiety level of Iranian general population during COVID-19 outbreak. *Asian journal of psychiatry*, 51. doi: [10.1016/j.ajp.2020.102076](https://doi.org/10.1016/j.ajp.2020.102076).

Monden, K. R, Gentry, L., & Cox, T. R. (2016). Delivering bad news to patients. *Proc (Bayl Univ Med Center)*, 29(1), 101-102. doi: [10.1080/08998280.2016.11929380](https://doi.org/10.1080/08998280.2016.11929380).

Montés, M., Jiménez, J., & Jiménez, A. (2019). *El duelo, estrategias terapéuticas. Apoyo e intervención en duelo por suicidio. 2nd updated edition*. Distance Continuing Education. Consejo General de Colegios Oficiales de Psicólogos. Thirty-eighth edition January-March 2019.

Montesinos, A., Román, A., & Elías, L. (2013). Asistencia al duelo neonatal: diez años de experiencia en una Unidad de Neonatología. *Revista chilena de pediatría*, 84(6), 650-658.

Montoya, J. (2004). *El duelo. Sobre cómo ayudarnos y ayudar a otros ante la muerte de un ser querido*. Colombia: Biblioteca básica de tanatología.

Moore, P. M., Wilkinson, S., & Rivera Mercado, S. (2004). Communication skills training for health care professionals working with cancer patients, their families and/or carers. *Cochrane Database of Systematic Reviews. Issue, 2*. Art. No.: CD003751. doi: [10.1002/14651858.CD003751.pub2](https://doi.org/10.1002/14651858.CD003751.pub2)

Moreno, C., Wykes, T., Galderisi, S., Nordentoft, M., Crossley, N., Jones, N., ..., & Chen, E. Y. (2020). How mental health care should change as a consequence of the COVID-19 pandemic. *The Lancet Psychiatry*, 7(9). doi: [10.1016/S2215-0366\(20\)30307-2](https://doi.org/10.1016/S2215-0366(20)30307-2).

Moriconi, V. & Barbero, J. (2020). *Guía de acompañamiento al duelo*. Madrid, Spain: Colegio Oficial de la Psicología de Madrid.

Moriconi, V. & Valero, E. (2020). El duelo durante la pandemia de COVID-19. *Mente y Cerebro*, 32(103).

- Moriconi, V. (2020). Teorías y técnicas de duelo [Material del aula]. *Acompañamiento al duelo por COVID-19*, Colegio Oficial de la Psicología de Madrid. Madrid, Spain.
- Morillo, I. (2020, 05, 17). Del tsunami a la pandemia: ¿por qué España no se prepara para las grandes catástrofes? Retrieved from https://www.elconfidencial.com/espana/andalucia/2020-05-17/catastrofes-plan-espana-pandemia-tsunami_2597072/
- Moya, M., Willis, G., Paez, D., Pérez, J. A., Gómez, A., Sabucedo-Cameselle, J. M., Alzate, M.,... Salanova, M. (2020). La Psicología Social ante el COVID19: Monográfico. *International Journal of Social Psychology*. doi: [10.31234/osf.io/fdn32](https://doi.org/10.31234/osf.io/fdn32).
- Muñoz, F. A.; Fernández, S.; Parada, E.; Martínez, M. J.; García, A. (2001). Comunicación de malas noticias. *Revista de Psiquiatría Facultad de Medicina Barna*, 28(6), 350-356.
- Nicola, M., Alsafi, Z., Sohrabi, C., Kerwan, A., Al-Jabir, A., Iosifidis, C., Agha, M. & Agha, R. (2020). Las implicaciones socioeconómicas de la pandemia de coronavirus (COVID-19): una revisión. *International journal of surgery (London, England)*, 78, 185-193. doi: [10.1016/j.ijssu.2020.04.018](https://doi.org/10.1016/j.ijssu.2020.04.018)
- Nomen, D. (2008). Los procesos comunicativos. En Nomen, L. (Eds) *Tratando... el proceso de duelo y de morir*. Barcelona, Spain: Pirámide.
- O'Donovan, S. (1999). Reflections on breaking news of a family death. *Nursing Times*, 95(45), 54-5.
- Olagoke, A. A., Olagoke, O. O., & Hughes, A. M. (2020). Exposure to coronavirus news on mainstream media: The role of risk perceptions and depression. *British Journal of Health Psychology*, 25, 865-874. doi: [10.1111/bjhp.12427](https://doi.org/10.1111/bjhp.12427).
- World Health Organization (WHO). (2020a). *WHO Director-General's opening address at the press conference on COVID-19 held on 11 March 2020*. Retrieved from <https://www.who.int/es/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.
- World Health Organization (WHO). (2020b). *WHO Director-General's opening address at the press conference on COVID-19 held on 3 April 2020*. Retrieved from <https://www.who.int/es/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19--3-april-2020>.
- World Health Organization (WHO). (16/03/2020c). *Joint statement by ICC and WHO: An unprecedented call for action to the private sector to address COVID-19*. Retrieved from <https://www.who.int/es/news-room/detail/16-03-2020-icc-who-joint-statement-an-unprecedented-private-sector-call-to-action-to-tackle-covid-19>.
- World Health Organization (WHO). (02/02/2020d). Novel Coronavirus (2019-nCoV): Situation Report - 13. Retrieved from <https://www.who.int/docs/default->

[source/coronaviruse/situation-reports/20200202-sitrep-13-ncov-v3.pdf?sfvrsn=195f4010_6](https://source.coronaviruse/situation-reports/20200202-sitrep-13-ncov-v3.pdf?sfvrsn=195f4010_6)

World Health Organization (WHO). (04/08/2020e). COVID-19 mortality estimate: Scientific note. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/333857/WHO-2019-nCoV-Sci_Brief-Mortality-2020.1-spa.pdf.

World Health Organization. International Classification of Diseases. 11th Revision (ICD-11). Version: 04/2019. Retrieved from <https://icd.who.int/en>.

World Health Organization. International Classification of Diseases. 10th Revision (ICD-10). Retrieved from <http://ais.paho.org/classifications/Chapters/>

Özdin, S. & Özdin, Ş. (2020). Levels and predictors of anxiety, depression and health anxiety during COVID-19 pandemic in Turkish society: The importance of gender. *International Journal of Social Psychiatry*, 66(5). doi: [10.1177/0020764020927051](https://doi.org/10.1177/0020764020927051).

Pacheco, T., Garrosa, E., López, E. & Robles, J. (2012). *Atención psicosocial en emergencias*. Madrid, Spain: Editorial Síntesis.

Pangrazzi, A. (2008). *Conviver com a Perda de Uma Pessoa Querida*. Portugal: Paulinas Editora.

Pakpour, A. H., & Griffiths, M. D. (2020). The fear of COVID-19 and its role in preventive behaviors. *Journal of Concurrent Disorders*, 2(1), 58-63. Retrieved from http://irep.ntu.ac.uk/id/eprint/39561/1/1313636_Griffiths.pdf

Payás Puigarnau, A. (2017). *Las tareas del duelo. Psicoterapia del duelo desde un modelo integrativo-relaciona*. Editorial Paidós. Barcelona.

Perez, V. (2020). La salud mental ante la pandemia de COVID-19 [Moderation conferences, 18/09/2020]. I National Congress COVID-19. Spain.

Petralanda, V. L., García-García, J. A., de Vizcaya, S., & Complicado, D. (2001). ¿Qué es el duelo? *Medicine*, 134(3), 208-215.

Pettinari, C. J., & Jessop L. (2001). "Your ears become your eyes": managing the absence of visibility in NHS Direct. *JAN*, 36(5), 668-75. doi: [10.1046/j.1365-2648.2001.02031.x](https://doi.org/10.1046/j.1365-2648.2001.02031.x).

Probst, D. R., Gustin, J. L., Goodman, L. F., Lorenz, A., & Wells-Di Gregorio, S. M. (2016). ICU Versus Non-ICU Hospital death: family member complicated grief, posttraumatic stress, and depressive symptoms. *Journal of Palliative Medicine*, 19(4), 387-93. doi: [10.1089/jpm.2015.0120](https://doi.org/10.1089/jpm.2015.0120).

- Rabow, M. W & McPhee, S. J. (1999). Beyond breaking bad news: how to help patients who suffer. *West J Med*, 171(4), 260-263. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305864/>
- Raffio, V. (2020, 03, 28). *Coronavirus: una pandemia anunciada pero impredecible*. Retrieved from <https://www.elperiodico.com/es/ciencia/20200328/se-podria-haber-previsto-pandemia-coronavirus-7907323>.
- Razavi, D., Delvaux, N., Marchal, S., Cock, M., Farvacques, C. & Slachmuylder, J. L. (2000). Testing health care professionals communication skills: the usefulness of highly emotional standardized role-playing sessions with simulators. *Psycho-Oncology*, 9(4), 293-302. doi: [10.1002/1099-1611\(200007/08\)9:4<293::AID-PON461>3.0.CO;2-J](https://doi.org/10.1002/1099-1611(200007/08)9:4<293::AID-PON461>3.0.CO;2-J)
- National Epidemiological Surveillance Network (RENAVE). (2020a). *Report No. 32. Situation of COVID-19 in Spain as of May 21, 2020*. Spain: National Epidemiology Center (CNE) and CNM (ISCIII). Retrieved from <https://www.isciii.es/QueHacemos/Servicios/VigilanciaSaludPublicaRENAVE/EnfermedadesTransmisibles/Paginas/InformesCOVID-19.aspx>
- National Epidemiological Surveillance Network (RENAVE). (2020b). *Report No. 43. COVID-19 situation in Spain as of September 9, 2020*. Spain: National Epidemiology Center (CNE) and CNM (ISCIII). Retrieved from <https://www.isciii.es/QueHacemos/Servicios/VigilanciaSaludPublicaRENAVE/EnfermedadesTransmisibles/Paginas/InformesCOVID-19.aspx>
- Ribes, E. (1990). *Psicología y Salud: un análisis conceptual*. Barcelona: Ed. Martínez Roca.
- Rizo Garcia, M. (2015). Interacción y emociones: La microsociología de Randall Collins y la dimensión emocional de la interacción social. *Psychoperspectives*, 14(2), 51-61. doi: [10.5027/psychoperspectives-Vol14-Issue2-fulltext-439](https://doi.org/10.5027/psychoperspectives-Vol14-Issue2-fulltext-439).
- Rocamora, A. (2013). *Intervención en crisis en las conductas suicidas*. Bilbao: Desclee de Brouwer.
- Robles, J. & Medina J. (2008). *Manual de salud mental en desastres*. Madrid, Spain: Editorial Síntesis.
- Rodríguez-Leor, O., Cid-Álvarez, B., Ojeda, S., Martín-Moreiras, J., Rumoroso, J. R., López-Palop, R.,..., & de Prado, A. P. (2020). Impacto de la pandemia de COVID-19 sobre la actividad asistencial en cardiología intervencionista en España. *REC Interv Cardiol*, 2, 82-89.

- Health of Castilla y León (Sacyl). (2020). *Protocol for healthcare professionals for telephone communication of bad news to relatives of patients with coronavirus in last-day care situation*. Junta de Castilla y León.
- Sarabia, C.M, Ortego, M.C & Torres, B. (2013). Topic 5: Communication and dialogue [Classroom material]. *Desarrollo de habilidades y competencias a través del coaching y la inteligencia emocional*.
- Madrid Health Service (Salud Madrid): Hospital Universitario 12 de Octubre. (2020). *Protocol for telephone communication of bad news to relatives of patients with coronavirus in last days situation*. Comunidad de Madrid.
- Sjöberg, L. (2000). Factors in risk perception. *Risk analysis*, 20(1), 1-12. doi: [10.1111/0272-4332.00001](https://doi.org/10.1111/0272-4332.00001).
- Slovic, P. (1992). Perception of risk: Reflections on the psychometric paradigm. In *Krimsky, S., Golding, D. (Eds.), Social Theories of Risk* (pp. 117-178). Praeger: Westport, CT, USA.
- Suquilanda, Q. & Manuel, A. (2016). Como Informar malas noticias en personas con diagnóstico de discapacidad. *IntraMed Journal* 5(7).
- Taylor E. (2007). How best to communicate bad news over the telephone. *End of Life Care*, 1(1), 30-7.
- Tizón, J.L. (2004) *Pérdida, pena, duelo*. Barcelona, Spain: Paidós.
- Tizón, J. (1998). El duelo y las experiencias de pérdida. J. Vázquez (Eds.), *Psychiatry in Primary Care* (pp. 519-540). Madrid: Grupo Aula Médica, S. A.
- Torregrosa, L., Gempeler, F. E., & Silva, J. M. (2020). Conversaciones difíciles en medicina: el profesionalismo y humanismo en el arte de comunicar malas noticias. *Universitas Medica*, 61(1), 74-83. doi: <https://dx.doi.org/10.11144/javeriana.umed61-1.conv>
- Van der Linden, S. (2015). The Social-Psychological Determinants of Climate Change Risk Perceptions: Towards a Comprehensive Model. *Journal of Environmental Psychology*, 41, 112-124. doi: [10.1016/j.jenvp.2014.11.012](https://doi.org/10.1016/j.jenvp.2014.11.012).
- Van der Weerd, W., Timmermans, D.R., Beaujean, D.J., Oudhoff, J. & van Steenberghe, J. (2011). Monitoring the level of government trust, risk perception and intention of the general public to adopt protective measures during the influenza A (H1N1) pandemic in the Netherlands. *BMC Public Health* 11 (575). doi: [10.1186/1471-2458-11-575](https://doi.org/10.1186/1471-2458-11-575).
- Vila, J. (2020). *Closing of the COVID-19 National Congress* [Clausura 19/09/2020]. I National Congress COVID-19. Spain.

- Wang, C., Pan, R., Wan, X., Tan, Y., Xu, L., Ho, C. S., & Ho, R. C. (2020). Immediate psychological responses and associated factors during the initial stage of the 2019 Coronavirus disease (COVID-19) epidemic among the general population in China. *International Journal of Environmental Research and Public Health*, 17(5), 1729. doi: [10.3390/ijerph17051729](https://doi.org/10.3390/ijerph17051729).
- Wilkinson, S.M., Gambles, M. & Roberts, A. (2002). The essence of cancer care: the impact of training on nurses' ability to communicate effectively. *Journal of Advanced Nursing*, 40(6), 731-8. doi: [10.1046/j.1365-2648.2002.02432.x](https://doi.org/10.1046/j.1365-2648.2002.02432.x)
- Wisten, A. & Zingmark, K. (2007). Supportive needs of parents confronted with sudden cardiac death--a qualitative study. *Resuscitation*, 74(1), 68-74. doi: [10.1016/j.resuscitation.2006.11.014](https://doi.org/10.1016/j.resuscitation.2006.11.014).
- Worden, J.W. (2013). El tratamiento del duelo. *Asesoramiento psicológico y terapia* (4th ed.). Barcelona, Spain: Paidós.
- Wright, B. (1996). *Sudden Death: a Research Base for Practice*. 2nd ed. Churchill Livingstone, New York.
- Xiang, Y. T., Yang, Y., Li, W., Zhang, L., Zhang, Q., Cheung, T., & Ng, C. H. (2020). Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed. *The Lancet Psychiatry*, 7(3), 228-229. doi: [10.1016/S2215-0366\(20\)30046-8](https://doi.org/10.1016/S2215-0366(20)30046-8).
- Xiao, C. (2020). A novel approach of consultation on 2019 novel Coronavirus (COVID-19)-related psychological and mental problems: Structured letter therapy. *Psychiatry Investigation*, 17(2), 175-176. doi: [10.30773/pi.2020.0047](https://doi.org/10.30773/pi.2020.0047).
- Xiong, J., Lipsitz, O., Nasri, F., Lui, L. M., Gill, H., Phan, L.,..., & McIntyre, R. S. (2020). Impact of COVID-19 pandemic on mental health in the general population: A systematic review. *Journal of affective disorders*, 277, 55-64. doi: [10.1016/j.jad.2020.08.001](https://doi.org/10.1016/j.jad.2020.08.001).
- Zhou, X. (2020). Psychological crisis interventions in Sichuan province during the 2019 novel coronavirus outbreak. *Psychiatry Research*, 286(April), 112895. doi: [10.1016/j.psychres.2020.112895](https://doi.org/10.1016/j.psychres.2020.112895).

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