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A Qualitative Study of the Role of Palliative Care During the COVID-19 Pandemic: Perceptions and Experiences Among Critical Care Clinicians, Hospital Leaders, and Spiritual Care Providers

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Abstract

Background: Palliative care offers a unique skill set in response to challenges posed by the COVID-19 pandemic, with expertise in advance care planning, symptom management, family communication, end-of-life care, and bereavement. However, few studies have explored palliative care's role during the pandemic and changes in perceptions and utilization of the specialty among health and spiritual care providers and hospital leaders. **Objective:** To explore the utilization, perceptions, and understanding of palliative care among critical care clinicians, hospital leaders, and spiritual care providers during the pandemic. **Design:** We conducted a qualitative study employing semi-structured, in-depth interviews. **Setting/participants:** We conducted the study at a tertiary academic medical center in Boston, Massachusetts, USA. Between August and October 2020, we interviewed 25 participants from 3 informant groups: (1) critical care physicians, (2) hospital leaders, and (3) spiritual care providers. **Results:** Respondents recognized that palliative care's role increased in importance during the pandemic. Palliative care served as a bridge between providers, patients, and families; supported provider well-being; and contributed to hospital efficiency. The pandemic reinforced participants' positive perceptions of palliative care, increased their understanding of the scope of the specialty's practice, and inspired physicians to engage more with palliative care. Respondents indicated the need for more palliative care providers and advocated for their role in bereavement support and future pandemic response. **Conclusion:** Findings highlight evolving and increased utilization of palliative care during the pandemic, suggesting a need for greater investment in palliative care programs and for palliative care involvement in public health emergency preparedness and response.

Keywords

palliative care, COVID-19, pandemic, qualitative research, critical care, health personnel

Introduction

As of August 2021, there have been over 39 million COVID-19 cases in the United States (US), 640 000 deaths in the US, and 4.5 million deaths worldwide.[1] In addition, the pandemic has strained healthcare resources across the US, raising questions about how to ration care,[2] and threatening the well-being of frontline health providers, who have experienced higher rates of stress, depression, and anxiety.[3,4] Meanwhile, hospital visitation policies have separated patients from their families.[5,6] In March and April 2020, the pandemic gripped the Northeastern US in particular, with New York, New Jersey, Massachusetts (MA), and Pennsylvania reporting some of the highest COVID-19 deaths in the country.[7]

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The surge in critically ill patients amid a backdrop of limited healthcare resources during the COVID-19 pandemic aligns with palliative care providers' expertise in caring for patients with serious illness, discussing goals of care, and concentrating on patient values in decision-making. Palliative care can relieve burdens on healthcare providers and improve care satisfaction and quality of life for patients and families.[8,9] Furthermore, early goals of care conversations led by palliative care may help prevent unindicated and unwanted life-sustaining treatments for COVID-19 patients.[10] Palliative care was also optimally positioned to contribute to healthcare provider well-being during the pandemic, offering skills for coping with suffering, death, grief, and burnout.[11] To our knowledge, there have been no qualitative studies using in-depth interviews to explore changes in perceptions of palliative care and its role among physicians, hospital leaders, and/or spiritual care providers during the first months of the COVID-19 pandemic.

The goal of this qualitative study was to better understand changes in the utilization, perceptions, and awareness of palliative care among physicians providing critical care, hospital leaders, and spiritual care providers in a tertiary care academic medical center in Boston, MA, during the initial months of the COVID-19 pandemic.

Methods

Study Setting, Population, and Design

We conducted this study at Tufts Medical Center, a tertiary academic medical center in Boston, MA, with interviews taking place between August and October of 2020. The Tufts Medical Center Division of Palliative Care, which was established in 2017, consists of 3 full-time physicians, a nurse navigator, a social worker, and an administrator. The team provides both adult and pediatric care. We conducted a qualitative study using semi-structured in-depth interviews with 25 key informants from 3 groups—physicians who provided critical care during the first 5 months of the pandemic from 5 specialties (pulmonology/critical care, anesthesiology, pediatric critical care, surgical critical care, and cardiology), hospital leaders (individuals who oversee daily hospital operations and quality of care), and spiritual care providers from the hospital (i.e., chaplains) and community (i.e., a community minister). We selected these 3 groups in order to obtain a holistic picture of palliative care's role during the pandemic. With respect to the physician group, we focused on critical care providers given that intensive care units were particularly impacted in the early months of the pandemic. We used purposive sampling to recruit all participants. Recruitment occurred via email and participants were provided with an outline of the study's aims and procedures. 41 individuals were contacted and 25 agreed to participate. Interviewees were not compensated for their participation.

Data Collection

We developed in-depth interview guides for each study group, which explored participants' perceptions of palliative care's role during the COVID-19 pandemic and any changes since the onset of the pandemic. Through interviews with physicians, we further explored their experiences working with the palliative care team in the clinical setting and any anticipated adaptations to their practice patterns as a result of lessons learned during the pandemic. In our interviews with hospital leaders, we focused on the value of palliative care from an administrative perspective. Finally, during interviews with spiritual care providers, we explored intersections between palliative care and spirituality. Following provision of verbal consent, one of our research team members (EE) conducted and audio-recorded all interviews on videoconference calls between August and October 2020. The interviewer was a female medical student taking a gap year to serve as a research assistant. She did not have previous qualitative research experience and was trained in qualitative methods by 2 other team members (LV and TS). TS observed and provided feedback on 2 initial interviews. The interviewer was not known to any of the participants prior to the study. Participants were only aware that the interviewer was a medical student. Interviews lasted approximately 35 minutes and were transcribed verbatim by the interviewer. Field notes were not made during or after the interview. Repeat interviews were not carried out and transcripts were not returned to participants for review.

Data Analysis

Saturation of major themes was reached across the 3 study groups. We used thematic content analysis to code and analyze transcripts.[12] We developed a preliminary code list based on the interview guide structure. Two of our research team members (EE, KM) used the preliminary codebook to independently code 2 transcripts from each of the 3 study groups. The researchers reconciled their coded transcripts and made modifications to the codebook. Using the finalized codebook, 1 researcher (EE) independently coded the remaining transcripts; 3 transcripts were double-checked for accuracy by a second team member. Transcripts were coded using Dedoose qualitative analytic software (version 8.3.45; Los Angeles, CA). We reviewed and discussed code reports to identify key themes related to COVID-19. Participants did not provide feedback on findings. In the results section, we only present salient findings that were consistent across 3 or more participants. Quotations are identified by the participant's role. To improve readability, we removed non-verbal utterances and colloquialisms from quotes. We used the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist to guide our report.[13]

Ethical Considerations

This study was approved by the Tufts Health Sciences Institutional Review Board.

Results

Demographics

Demographic characteristics of the 25 study participants (15 physicians, 5 hospital leaders, and 5 spiritual care providers) are outlined in Table 1. Approximately two-thirds of all participants were male. Among the physicians, 5 (33%) were pulmonary/critical care specialists, 4 (27%) were anesthesiologists, 3 (20%) were pediatric critical care specialists who provided adult critical care during the pandemic, 2 (17%) were surgical critical care specialists, and 1 (7%) was a cardiologist who provided critical care during the pandemic. Among the spiritual care providers, 4 (80%) were hospital chaplains and 1 (20%) was a minister. The mean years of experience in participants' roles was 9 years among hospital leaders, 11 years among physicians, and 30 years among spiritual care providers.

Three key themes emerged from interviews with our study groups: (1) palliative care contributions during the COVID-19 pandemic, (2) changes in perceptions and practices related to palliative care due to COVID-19, and (3) recommendations for palliative care's role in the future. The themes are summarized in Table 2 and described further below.

Table 1. In-Depth Interview Participant Characteristics at a Tertiary Care Academic Medical Center in Boston, Massachusetts, 2020 (N = 25).

Gender identification n (%)		
Male		16 (64%)
Female		8 (32%)
Refused to answer		1 (4%)
Role n (%)		
Physician		15 (60%)
Pulmonology/critical care		5 (33%)
Anesthesiology		4 (27%)
Pediatric critical care		3 (20%)
Surgical critical care		2 (13%)
Cardiology		1 (7%)
Hospital ceader		5 (20%)
Spiritual care provider		5 (20%)
	Chaplain	4 (80%)
	Minister	1 (20%)
Years of experience mean (SD), range		
Physician		11 (8), 1-30
Hospital leader		9 (6), 4-20
Spiritual care provider		30 (8), 22-40

Table 2. Key Themes and Subthemes Emerging From Interviews.

Theme	Subtheme
Palliative care contributions during the COVID-19 pandemic	Increased need for and utilization of palliative care
	Serving as a bridge between patients, families, and care providers
	Supporting other care providers with workload, emotional burden, and well-being
	Supporting hospital as a whole by helping to ensure efficient resource utilization
Changes in perceptions and practices related to palliative care due to COVID-19	Reinforced positive perceptions of palliative care
	Recognized scope of palliative care practice
	Anticipated changes in practice patterns
	- More open to consulting palliative care
	- Consults on wider range of patients
	- Earlier consults
Recommendations for palliative care's role in the future	Need for growth in palliative care capacity
	Pandemic planning/preparation
	Bereavement support

Palliative Care Contributions During the COVID-19 Pandemic

Subthemes and salient quotes related to palliative care contributions during the pandemic are presented in Table 3. Respondents noted that palliative care served many of its traditional functions during the pandemic, including navigating goals of care discussions and providing end-of-life care; however, there was increased need for and utilization of such services.

Respondents also noted that palliative care served as a bridge between patients, families, and providers. Critical care physicians relied on palliative care to provide clinical updates, answer questions, and respond to families' fears and anxieties.

Palliative care also helped to reduce clinicians' workload and emotional burden by taking responsibility for time consuming and draining tasks and extended direct emotional support to providers. Respondents noted that there was comfort in knowing that palliative care was there to validate decisions and offer expertise.

Respondents indicated that palliative care also supported the hospital as a whole. Hospital leaders, in particular, noted that palliative care helped to ensure the efficient use of resources during the early months of the pandemic and contributed to the development of crisis standards of care in preparation for potential resource shortages. Palliative care helped to ensure that health care resources were optimally utilized in large part by clarifying goals of care. According to respondents, goals of care discussions helped to prevent unindicated and/or unwanted interventions, reduce hospital lengths of stay, and facilitate transitions out of critical care settings.

Table 3. Palliative Care Contributions During the COVID-19 Pandemic.

Subtheme	Quote
Increased need for and utilization of palliative care	[Their role] increased exponentially in importance [during COVID] for several reasons. We had a lot of patients with sudden onset of… critical illness and realities about end-of-life… I saw them as crucial, in an exaggerated way being really necessary for the clinicians as a support and as a consultant, much like the pulmonologist or anybody else and the respiratory therapist, just because of the threat to life, and decision-making and how to live those last few moments and days (Hospital Leader)
	[Palliative care providers] were more engaged in more patients. There seemed to be a lower threshold of engaging them. In fact, it kind of was like everyone had permission to just engage them all the time, which I thought was actually fabulous (Physician)
Serving as a bridge between patients, families, and care providers	The most striking difference for the pandemic, which continues, is that when patients become incredibly ill and or die, their family members are not able to be present. And so I think that palliative care served as a bridge between the family members who were physically remote by necessity from their dying loved ones (Physician)
	The ICU docs were honestly very busy dealing with ventilators and low oxygen and high blood pressure and strokes and sort of the strictly medical…diseases they were trained to treat… and even though part of that is often conversations with family, updating people, educating families, you know, palliative care augmented, expanded training on how to have those conversations, how to deal with difficult conversations, how to rapidly de-escalate a high-tension situation so that you can communicate (Hospital Leader)
Supporting other care providers with workload, emotional burden, and well-being	I think the moral distress that the respiratory therapists, nurses, and physicians, and, you know, techs and everyone else that I'm leaving out, felt during the pandemic was really, really tough and I always joked, you know, that the palliative care team was helping the providers as much as they were our patients and their families. You know, I'm not sure how it worked on each individual level but knowing that there were also other team members who were helping address emotional pain, spiritual needs, and, you know, was a great relief for the providers who felt so taxed that they were not able to do that. So I think that it relieved a lot of moral distress that many of us were facing (Physician)
	I think that knowing that they were there and that I could hand off this immense responsibility… was a tremendous burden off of my shoulders (Physician)
	I think support of the team was tremendous. They came in, they sat in on rounds, you know, they were available to talk to faculty and nurses and house staff and even if they didn't, just having them there and listening in, how they approached things was valuable to the staff (Physician)
	So the role of palliative care was… to really always be looking at building resilience and refueling the teams and gaining perspective on the reality with a healthy view. And also perhaps allowing people to grieve whatever they needed to grieve, whether that was a loss of normalcy in their life, whether that was a loss of somebody personally in their lives… And also I saw the team as really helpful in gaining perspective in developing coping skills that folks could utilize at home, so folks like me and the care team at frontline and the leaders and the housekeepers to just help us be healthy as much as possible during and after this (Hospital Leader)
	They have been present. I saw them… reaching out to some staff who have been overwhelmed and start the conversation about feelings of the doctors and nurses... And so that was great to see that the [palliative care team] was trying to start conversation… to help [clinicians] to open up, to have some support (Spiritual Care Provider)
Supporting hospital as a whole by helping to ensure efficient resource utilization	A rapid identification of goals of care. That's how we're engaging the palliative care services. To facilitate transition towards hospice care and identification of the location of hospice, whether it can happen at home or in a facility or here in the hospital, you know, could shave days off a length of stay, especially in the very valuable ICUs (Hospital Leader)
	We've never had a conversation with our patients that 'this might help you, but it might help that person more so I'm going to help them first'. And so all specialties, you know, especially ICU, ER specialties are having to think about how to have that conversation and I think the palliative care teams and palliative care specialty, you know, has already done a very good job publicizing some scripts, some tools to have, to start that conversation. And so if, you know, if we get to the point where we're at surge capacity and we're getting close to running out of these scarce resources, having the palliative care team at the forefront to help educate the rest of us on how to have those conversations either with or without them, I think it is going to be essential (Hospital Leader)

Changes in Perceptions and Practices Related to Palliative Care due to COVID-19

Subthemes and quotes related to changes in perceptions and practices due to COVID-19 are presented in Table 4. Members of all 3 respondent groups expressed that their experiences during the pandemic reinforced their positive perceptions of palliative care.

Some physicians also shared that their experience during the pandemic expanded their understanding of palliative care's scope of practice and 2 physicians expressed that the pandemic reminded them that palliative care offers more than end-of-life care.

Table 4. Changes in Perceptions and Practices Related to Palliative Care Due to COVID-19.

Subtheme	Quote
Reinforced positive perceptions of palliative care	We've always felt that they were very helpful in end-of-life situations in the ICU and I think, you know, in my experience every time they get involved it's just always a positive thing…It's a nice reminder to try to use them a little bit more and… it's an essential part of the sort of multidisciplinary approach to an ICU patient's care…So I think it didn't really change necessarily, but it reinforced my…positive thoughts about their involvement in my patients' care (Physician)
	Well I don't think [my perception] evolved. I said, 'thank heaven we have that service running'… I think had it not been built up to the degree it was, I think we would have lost some ability to help some of these patients (Hospital Leader)
	I don't think [my perception] has evolved…because I have found it, for many years, many years I have been aware of the importance of palliative care and the need for it to be introduced early in a person's disease process. So I've been an advocate of palliative care (Spiritual Care Provider)
Recognized scope of palliative care practice	They expanded what our understanding was during COVID, of how they can help us, us as a provider, you know, how they can help the medical team, how they can help provide additional support for the family that…it's less about comfort care and end-of-life and it's more about a broader type of support (Physician)
	I think what it has kind of enlightened me that…how comprehensive they are in their approach… I think they really understand the values of the person and the families and they have much more insight into that than our insight… I tend to think of myself as an attending who speaks to their patient or the patient families,… very often and still I think…the palliative care perspective enlightened me about my patients…and their values, which I think it's, I just didn't realize that they know to that extent, they know the,…personal values of each patient and their families (Physician)
Anticipated changes in practice patterns	I think what I've started doing is I've started calling palliative care a little bit earlier than I might have otherwise. You know, get them involved early on in the conversations about goals of care, long before we're talking about transitions of care and end-of-life care. But as we continue to, you know, meet with families, talk about their critically ill loved ones, having palliative care involved just as a support service for patients and especially for their families, I think is an area I'm going to be kind of using palliative care folks more (Physician)

In addition, most physicians anticipated changes in their practice patterns as a result of their experience during the pandemic. Five physicians said that they will be more open to consulting palliative care in the future, 5 commented that they will consult on a wider range of patients, and 6 said that they will try to consult palliative care earlier in a patient's course.

Recommendations for Palliative Care's Role in the Future

Subthemes and salient quotes related to palliative care's role in the future are presented in Table 5. Most physicians and hospital leaders indicated the need for more palliative care providers generally and in preparation for future pandemics. Respondents suggested that palliative care capacity could be increased by hiring more personnel and/or making creative use of existing resources, such as by re-deploying care providers from other departments to palliative care when needed.

Respondents also commented on the leadership role that palliative care could play in pandemic planning and preparedness in the future, including involvement in pandemic mitigation meetings, taking a leadership role in designing and implementing provider wellness programs, and leading palliative care integration efforts within the local healthcare system.

Twenty-four of 25 participants believed that palliative care should offer bereavement services. Participants highlighted the importance of bereavement generally and during the pandemic, both for families and healthcare providers. Likely given their greater familiarity with the topic, spiritual care providers offered concrete suggestions for ways that palliative care could engage in bereavement support, including facilitating grief support groups and organizing hospital-wide memorial services.

Discussion

In this study, we examined palliative care's role during the COVID-19 pandemic as perceived by critical care physicians, hospital leaders, and spiritual care providers. Study participants recognized palliative care's unique contributions during the pandemic and advocated for their central role in future pandemic preparedness efforts. Respondents indicated that their experience during the pandemic reinforced their positive perceptions of palliative care, helped them recognize the specialty's scope, and inspired them to engage more with palliative care.

Since its formal recognition as a specialty in 2008,[14] palliative care has often been equated solely with end-of-life care, even by members of the medical community.[15] In contrast, respondents in our study recognized palliative care's contributions beyond end-of-life care and indicated intentions to consult and collaborate with palliative care more often and on a wider scope of patients in the future. Two recent studies showed that emergency department and critical care physicians similarly recognized palliative care's contributions during the pandemic, including leading goals of care discussions, facilitating family communication, and navigating challenging family dynamics.[16,17] Our study adds to this

Table 5. Recommendations for Palliative Care's Role in the Future.

Subtheme	Quote
Need for growth in palliative care capacity	I think the pandemic, at least initially, in the medical intensive care Unit…showed how routine involvement in every case is a very worthy goal and has some clear benefits…I think that if we had endless resources, would I have palliative care round with us, would I have them introduced to every single patient in the unit? Yeah, I think that's a great idea. So it just showed…when we buckled down and really had them involved with every case, there was value but again, that was short-lived because that model could not be rolled out to the other units (Physician)
	We have an increased need [for palliative care] and not enough people to provide it (Hospital Leader)
	Whether it's the team bigger or more supported underneath, I have no idea, but I know that's a goal of the organization to see if we can further support palliative care. I think it's a lean machine. And so, you know, in order to have them have enough bench strength to have consultative services when they're needed and to have the time to spend with the clinician's team, there's a lot of need… We're not getting any less complex cases. There is only growing needs of decision-making. I also think that there's growing knowledge of palliative care in the community, so patients and families actually want more options offered. So it's almost a consumerism aspect as well. So I think we've done a fine job and we should be doing a better job investing in palliative care (Hospital Leader)
Pandemic planning/ preparation	Maybe having palliative care in some of those settings as fundamentals, so they're not an extra but they're fundamental in the process of planning our surge planning, our weekly meetings, our team meetings, our review of last week (Hospital Leader)
Bereavement support	I actually think…I of the nicest things I saw done is…in the midst of a pandemic, particularly a pandemic with the substantial burden of mortality in the critically ill, offering bereavement support to caregivers, so like to the nurses, to the docs so that,…even if it's just once at I time point sort of acknowledging,…just taking a moment and acknowledging that hey, fifty people died in our ICU over the course of an 8 week. That's crazy. That never happens. I think that's an opportunity, both sort of bereavement support for families, but also bereavement support for caregivers…health care providers (Physician)
	We postponed a lot of mourning and a lot of ritualized services because of the virus, so the idea of doing…bereavement, meaning in the part of it that's memorializing with services and rituals, I think that's going to serve even a more crucial, that'll be important, really important for people that never had a chance to gather (Spiritual Leader)
	I think we have an individualistic society and we have a patient-centered focused health care system, but a lot of the morbidity that's experienced during the death and dying process or just…extreme critical illness is assumed not by the patient, but by the patient's family. And I think largely our system doesn't address that. But I think…families…, we can't alter whether a patient lives or dies many times, but we can alter how families feel with the process and the process doesn't stop when they die, it many times is just in its beginning. And so I think that bereavement services for families would be a crucial part of any palliative care service (Physician)

evidence, providing rich context, by pointing to the growing recognition of the scope of palliative care and its contributions beyond end-of-life care. Still, while such findings are encouraging, more data are needed to determine whether the pandemic contributed to long-term and large-scale changes in physician and administrator attitudes toward utilization of and investment in palliative care.

As highlighted by participants in our study, palliative care served as a reliable bridge between providers, critically ill patients, and families. This unique role has recently been reported elsewhere in the US.[17] Restrictive visitation policies separated patients and families while, as noted by our respondents, high physician workloads made it difficult for critical care providers to maintain pre-pandemic communication standards. As experts in family-centered care and communication, palliative care is a natural fit for filling this gap.

Respondents also highlighted palliative care's potential role in implementing and leading hospital-based bereavement programs, both during and beyond the COVID-19 pandemic. Bereavement support is especially important in the context of COVID-19. Low levels of social support, guilt, feeling unprepared for death, and being unable to say "goodbye" have been heightened during the pandemic and have been shown to increase the risk of complicated grief.[18] Without intervention, complicated grief can negatively impact work performance, contribute to increased tobacco and alcohol use, and increase risk of suicidal behavior.[19,20] Among healthcare providers, grief following a patient's death may correlate with emotional exhaustion, burnout, and reduced job satisfaction.[21,22] Strategies for addressing grief include helping patients and families prepare for death through advance care planning, responding to and validating emotional reactions, addressing anticipatory grief, and on the part of healthcare providers, being aware of personal grief reactions and engaging in self-care.[18] Such interventions are within the scope of palliative care specialists' practice making them particularly well-qualified to establish and lead hospital bereavement efforts, instruct care providers on how to support bereaved families, and counsel providers in coping with their own grief.

In addition, respondents emphasized the role that palliative care played in providing emotional support to clinicians during the pandemic. Recent studies show higher rates of stress, depression, and anxiety among frontline care providers.[3,4] Despite

encountering serious illness and death regularly in their practice, evidence indicates that palliative care providers experience lower rates of burnout as compared to other clinicians.[23,24] Palliative care providers may be uniquely qualified to respond to clinician psychological distress and provide tools and strategies for responding to suffering and death, including not viewing a patient's death as a personal failure and working in interdisciplinary teams.[11]

Hospital leaders, in particular, highlighted palliative care's role in ensuring efficient resource utilization during the pandemic. According to the Center to Advance Palliative Care, practical benefits of palliative care include hospital cost reduction by helping to limit unnecessary interventions, intensive care unit utilization, and readmissions and improving care quality and patient and family satisfaction.[25] The fact that hospital leaders in our study indicated several of these benefits suggests that hospital administration recognizes palliative care's contributions and their willingness to invest in the service. Hospital leaders' recognition of palliative care's benefits is particularly important in ensuring that the field continues to grow.

Participants identified the need for more palliative care providers and contributions that palliative care could make to future pandemic responses. In an editorial published in *The Lancet* in April 2020, authors highlighted the need for palliative care during a pandemic and called for palliative care to be included in national and international COVID-19 response plans.[26] Palliative care expertise is needed when it comes to developing plans for rationing care if necessary, managing symptoms, providing bereavement support, and responding to isolation and suffering among patients, families, and care providers.[27,28] Such expertise is not only valuable during a pandemic, but also in preparation for and response to other public health crises, including local epidemics, natural disasters, wars/conflicts, and mass casualty events.

Strengths and Limitations

Our findings should be considered in light of several limitations. First, although our findings are likely transferable to other academic medical centers, both in the US and abroad, it is unclear whether they are applicable to community and/or rural hospital settings with lower access to palliative care. An additional study is planned to explore this topic in community care settings within a healthcare system in Northeastern Massachusetts. Second, this study does not capture patient and family perceptions of palliative care during the pandemic. Third, the diversity of our respondents may be limited given that we did not collect race, ethnicity, or age data.

Despite these limitations, our study has several strengths. To our knowledge, this is the first qualitative study using in-depth interviews to explore physician, hospital leader, and/or spiritual care provider perceptions of palliative care and its role during the COVID-19 pandemic. Additionally, we captured in real time participants' reflections in the midst of the pandemic as opposed to relying on retrospective reflections. Finally, while there was a notable overlap in the ideas and opinions expressed by physicians, hospital leaders, and spiritual care providers, each group offered a unique perspective thus creating a more holistic picture of palliative care's role during the pandemic.

Conclusion

Findings from this qualitative study suggest that palliative care made valuable contributions to patient and family care, provider well-being, and hospital efficiency during the COVID-19 pandemic. The pandemic reinforced positive perceptions of palliative care, increased understanding of the scope of the specialty's practice, and inspired critical care physicians to engage more with palliative care. Findings point to the need for greater investment in palliative care programs and palliative care involvement in public health emergency planning and response. In the setting of a global pandemic, these findings have relevance on an international scale, pointing to changes in perceptions of palliative care and opportunities for palliative care growth that are likely transferable to other academic medical settings around the world. Still, further research is needed to assess comparability in other settings and determine the pandemic's impact on palliative care providers themselves.

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Data availability

The data that supports this work are deposited at Tufts Medical Center and available by request from the first author.

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Supplemental Material

Supplemental material for this article is available online.

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