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Original Article

Perspectives of Remote Volunteer Palliative Care Consultants During COVID: A Qualitative Study



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Abstract

Context. A novel remote volunteer program was implemented in response to the initial COVID-19 surge in New York City, allowing out-of-state palliative care specialists to serve patients and families in need. No study has detailed the perceptions of these consultants.

Objectives. To understand the experiences of remote volunteer palliative care consultants during the initial COVID-19 surge.

Methods. This qualitative study utilized a thematic analysis approach. During January and February 2021, we conducted one-on-one semi-structured interviews with 15 board-certified palliative care physicians who participated in the program. Codes and emerging themes were identified through iterative discussion and comparison.

Results. Five overarching themes (with sub-themes in parentheses) were identified: 1) motivations for participating in the program, 2) logistical evaluation of the program (integration, telehealth model, dyad structure and debriefing sessions), 3) barriers to delivery (language and cultural differences, culture of high-intensity care, legal and administrative differences), 4) emotional burden (moral distress, burnout), and 5) ideas for improvements. Notably, participants observed institutional and cultural differences that posed challenges to delivery of care. Many expressed feelings of distress related to the uncertainty and scarcity caused by the pandemic, although volunteering may have been protective against burnout.

Conclusion. This study provides an in-depth look at the experiences of remote volunteer palliative care consultants during the initial COVID-19 surge from the unique perspectives of the consultants themselves. Participants expressed overall positive and meaningful experiences and felt that the model was appropriate given the circumstances. Additionally, participants provided recommendations that could guide future implementations of similar programs. *J Pain Symptom Manage* 2022;63:321–329. © 2021 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

Key Words

Palliative care, volunteer, telemedicine, COVID-19, emergency response, pandemic

Key Message

This article describes a qualitative study that examined the experiences of remote volunteer palliative care consultant physicians during the first COVID-19 surge. The results highlight the benefits and drawbacks of a volunteer telehealth model when implemented as an emergency response and provide guidance for future implementations of similar programs.

Introduction

The COVID-19 pandemic fundamentally altered the ways in which many fields of medicine deliver care, bringing about a number of changes to workflow born from the greater need for healthcare resources and safety precautions to limit the spread of COVID-19.^{1–10} New York City experienced the first major United States COVID-19 surge during the spring of 2020.¹¹

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The surge required New York City's largest hospital, Columbia University Irving Medical Center (CUIMC)/NewYork-Presbyterian (NYP), to rapidly adapt in order to meet the needs of their patient population.^{12,13} The Adult Palliative Care Service at CUIMC/NYP saw an unprecedented seven-fold increase in requests for consultations, outpacing the team's ability to provide care in a time-sensitive manner.¹² As part of the hospital's response, a novel remote Palliative Care Virtual Consultation Program was rapidly designed and implemented, providing specialty-level palliative care for 34 patients at CUIMC/NYP over a period of two months (April 13–June 14, 2020).¹⁴ Physician participants were recruited through social networks (email and Twitter) with the final program roster consisting of 18 volunteer palliative care specialists from University of California, San Francisco (15), Stanford University (2), and Dartmouth–Hitchcock (1). Participants were consulted in high-complexity COVID-19 cases that were selected by the home institution's palliative care clinicians. These cases consisted of patients who were intubated and sedated or otherwise unable to participate in conversation, and thus the purpose of the consult was to help clarify goals of care and support family members who were not allowed to visit the hospital due to COVID-19 restrictions. Demographics, clinical information, and outcomes of this patient cohort are described in this retrospective case series.¹⁵

Qualitative studies have previously investigated patient and provider perspectives on the abrupt shift from in-person practices to telemedicine.^{16–19} Detailed accounts of the implementation of single-institution and inter-institution volunteer-based remote palliative care services during the COVID-19 pandemic have been documented.^{4,19} However, no study has performed an in-depth exploration of the perspectives and experiences of palliative care specialists providing care remotely in the setting of a global pandemic. The aim of this study was to use rigorous qualitative methods to evaluate the experiences of these physicians, examining themes such as motivation for participation, emotional toll, and lessons learned. These findings provide an instructive lens for understanding the role of virtual palliative care in emergent contexts, as well as for informing future efforts to extend remote palliative care services during times of crisis.

Methods

Study Design and Participants

This qualitative study utilized a thematic analysis approach. Fifteen out of 18 physicians who participated in the Palliative Care Virtual Consultation Program agreed to be interviewed for this study. Informed consent was obtained prior to the interview; research

procedures were reviewed and approved by the New York State Psychiatric Institute's IRB.

Three trained qualitative researchers conducted and recorded semi-structured interviews over Zoom during January and February of 2021, consisting of one pilot key informant interview and 14 subject interviews. A semi-structured interview format was chosen to allow for spontaneity and flexibility in providing participants the opportunity to reflect on their experiences and fully explore naturally arising themes. The pilot interview was transcribed both manually and using OtterAI with comparable accuracy; OtterAI was utilized thereafter with a manual inspection to confirm accuracy.^{20,21} During the interviews, participants were encouraged to think out loud while reflecting, and interviewers conducted member checks with participants to improve accuracy and validity. Concurrent note-taking was performed by a second member of the interview team. After each interview, the interviewer and note-taker discussed and recorded their initial impressions of the distinctive themes (active memoing).

Interview Guide

The interview guide was developed in collaboration with the creators of the volunteer program and a qualitative expert consultant. The guide consisted of open-ended questions about the decision to volunteer, experiences while volunteering, observed institutional differences, and suggestions for improvement. The questions were pilot tested during the key informant interview to determine face and content validity. As interviews progressed, the guide was refined to include emerging themes to ensure that crucial aspects of the program were fully addressed, with a final open-ended question designed to capture any ideas that had not already been discussed.

Qualitative Analysis

All interview transcripts were de-identified and coded using an inductive and iterative process in accordance with the prescribed conventions of thematic analysis.²² Five researchers closely read the transcript of the key informant interview to identify initial comments of interest, a practice known as open coding. These comments were identified through one of two ways: 1) they pertained to themes outlined by the principal investigators and drawn from existing literature; and/or 2) they emerged in the interviews as important to the participants. The pilot interview was coded independently by three different researchers to generate a preliminary codebook. Researchers met regularly to discuss themes and reach consensus on codes with referral back to the original transcripts for validation. Investigator and data triangulation were employed to promote validity, as codes were iteratively discussed amongst all investigators and responses from multiple

clinicians were examined to obtain a variety of perspectives and identify convergent themes. The resulting set of codes was synthesized with iterative refinement and finalized through consensus with early transcripts checked and re-coded where necessary (focused coding). The final theoretical model was created by the multidisciplinary research team through iterative discussion of final emergent themes in the codebook.

Results

A total of 15 palliative care physicians (67% female) from three U.S. academic medical centers participated in one 30-minute to one-hour interview over Zoom. The participants ranged from four to 28 years post-graduation and had a mean of eight [standard deviation (SD) 5] years as a Hospice and Palliative Medicine (HPM) board-certified physician. Of note, HPM boards are only offered every other year. Many participants had either inpatient, research, or administrative roles occupying most of their practice. Participants longitudinally cared for between two and 12 patients throughout the program. The mean number of patients cared for by each participant was five (SD 2). The mean duration of follow-up was 15 days (SD 14, range 1–47) and the median palliative care visit frequency (defined as the number of notes filed by participants) was 4.5 (interquartile range six).¹⁵ Participant information and demographics can be found in Table 1.

Five overarching themes (with sub-themes in parentheses) were identified: 1) motivations for participating in the program, 2) logistical evaluation of the program

Table 1
Participant Demographics

Characteristics	Total (%)
Gender	
Male	5 (33)
Female	10 (67)
Years post-graduation	
1–5	1 (6)
6–10	4 (27)
11–15	3 (20)
16–20	4 (27)
Over 20	3 (20)
Years as hospice and palliative medicine board-certified physician ^a	
1–5	6 (40)
6–10	2 (13)
11–15	7 (47)
Majority of practice	
Inpatient practice	5 (33)
Outpatient practice	2 (13)
Research	5 (33)
Administrative	3 (20)
Number of patients taken care of during program	
1–5	10 (67)
6–10	4 (27)
over 10	1 (6)

^aOf note, Hospice and Palliative Medicine (HPM) boards are only offered every other year.

(integration, telehealth model, dyad structure and debriefing sessions), 3) barriers to delivery (language and cultural differences, culture of high-intensity care, legal and administrative differences), 4) emotional burden (moral distress, burnout), and 5) ideas for improvements. Table 2 provides representative quotes that illustrate each theme/subtheme.

Theme 1: Motivations for Participating

Participants expressed a strong desire to help those who were greatly impacted by the emerging pandemic, especially given that their home hospitals were not experiencing a similar surge at that time: “In San Francisco, we barely had a COVID case in the hospital, like it was unrecognizable, compared to what we were experiencing via telehealth in New York.” In addition to providing support for patients and loved ones, many participants emphasized their desire to alleviate the burden of providers at the host institution.

Participants described varying mechanisms of initial discomfort, including anxiety over not being able to deliver satisfactory care and unease while adjusting to delivering virtual care during a public health emergency. Many felt that their involvement was only a small contribution given the overwhelming nature of the surge, leaving them with “intense feeling[s] of wanting to do more.”

Theme 2: Logistical Evaluation of the Program

Subtheme 2.1: Integration into the Program. Most participants reported a smooth and rapid onboarding process with gaining Electronic Medical Record access and becoming credentialed across state lines. Participants valued having a clear point-person at the host institution for overarching integration needs.

Due to the chaotic conditions of the surge, the unique role of the virtual consultants had not been fully communicated to all relevant members of on-the-ground staff. Participants expressed difficulties in coordinating with on-the-ground team members to establish a day-to-day workflow. One participant stated: “It took a little learning to figure out, ‘Okay, who is on the ground already seeing the patient? And what is our role here? And does the on-the-ground ICU team know that we’re here doing what we’re doing?’”

Subtheme 2.2: Telehealth Model. Participants praised the telehealth model for its convenience and flexibility. Use of telehealth allowed multiple geographically dispersed loved ones to join family meetings, facilitating inclusive and comprehensive conversations about goals of care. Additionally, because most participants were in a time zone three hours behind that of the host institution, they could support families “after hours.”

Table 2
Representative Quotations

Theme 1: Motivations for participating	<p>“There are plenty of people like us who don’t rush into the burning building, but in palliative care, that’s sort of where we rush into the burning building. New York was an inferno and it just felt like I have capacity to make a difference, if you’ll just open the door.”</p> <p>“I did have a lot of internal wrestling, ‘Is this helpful?’ Or am I creating extra anxiety for this person, because we’re part of the palliative care team and all the things that they associate with that. But the fact that people kept answering the phone led me to believe that it was helpful to them in some way.”</p>
Theme 2: Logistical evaluation of the program Subtheme 2.1: Integration into the program	<p>“I think interfacing with the non-palliative care team members was a little bit difficult because we were just these disembodied professionals dropping notes, consider this, consider that, and I don’t know if you’re a healthcare provider. But if I saw that in my patient chart, I would be like, ‘Who is this person?’”</p> <p>“‘How is the COVID ICU being run?’ Because there was not much of a clinical onboarding and orientation, I think that piece was a little bit off. It took a little learning to figure out, ‘Okay, who is on the ground already seeing the patient? And what is our role here? And does the team on the ground know that we’re here doing what we’re doing? Or who we are?’ So there were some questions around that.”</p>
Theme 2: Logistical evaluation of the program Subtheme 2.2: Telehealth model	<p>“They are trusting us to a much greater extent that we’re giving them a clear picture of what their loved one looks like, and what their illness is like, and what their prognosis is like. It’s one thing to have the doctor tell you, it’s another thing to see your loved one going from walking and talking to short of breath and in the emergency department, to being on the floor and having an oxygen mask on, to being in the intensive care unit on a ventilator hooked up to continuous dialysis machine and other medications that are being used to support their blood pressure and sedated and not able to respond to you when you ask them to open their eyes or tell them that you’re there. Now that just brings it home for family members in a way that describing it in words over the telephone cannot.”</p> <p>“In terms of the telehealth visits with the actual patient or family member, it became some of the logistics. Trying to find someone on the floor who actually had the bandwidth to hold up an iPad to pull a patient into a conversation. Because nine times out of 10, there wasn’t anyone who actually had the time or the bandwidth to do that. And I just think about the nurses who were just so overworked, who would take the time to do that, that was really amazing. And then I think about a lot of the surgical services, where the residents and students really stepped up to try to do that kind of volunteer work, so they would be the one that would coordinate with us to bring an iPad or something like that into the room and hold it up for the patient. And that was really helpful and hard to coordinate. So like I said, it was mostly the coordinating that became difficult.”</p>
Theme 2: Logistical evaluation of the program Subtheme 2.3: Dyads and debriefing	<p>“Having that sense of community within the volunteer group, where one could ask each other questions and debrief and learn what’s working and what’s not working, and debriefing with palliative care and colleagues on the ground on a weekly basis, joining into their huddle or team meetings, that might just give us a flavor of what’s going on and what’s the culture in their institution, the language they use.”</p> <p>“I worry about how much the distress doing it alone would have weighed on me. Whereas with doing it with a partner, not only did we mostly talk to families together, and then we would always spend time debriefing immediately thereafter. So it was a very protective practice that we put in place where we were able to think, ‘Was that the right thing?’ Sort of giving each other feedback about how the conversation went. ‘Did we say that? Was that right? Should we have done that differently? Do we need to do something differently?’ And sometimes just ‘Wow, this is really hard for this family or this patient.’ So all of that was really helpful and then also logistically, especially as the weeks went by, it was great to know that if one of us wasn’t able to do a call or pick up a new patient on a certain day, that the other one might be able to fill in and do it.”</p>
Theme 3: Barriers to delivery Subtheme 3.1: Language and cultural barriers	<p>“Washington Heights has a big Dominican population. So there’s those cultural complexities as well. And trying to navigate that, trying to do it with a translator [interpreter] while you’re in California, it was just so difficult.”</p> <p>“I think, particularly with the language barrier, this family opened up to us more because she [host institution provider] was able to fluently speak their primary language.”</p>
Theme 3: Barriers to delivery Subtheme 3.2: Culture of high-intensity care	<p>“What became clear to me was that the medical culture at my hospital is very different than the medical culture at [host institution]. And I think there’s a lot of reasons for that culture, right? It’s a really complicated construct. But you know, at my hospital, if I had been a palliative care consultant, on either of the patients I took care of, there’s no question in my mind that my intensivist colleagues who I know and work closely with would have said, ‘Prognosis is bad. This person is probably not going to survive,’ right? That was not what I heard from the intensivist at [host institution], to be honest. Right? What I heard [at the host institution] was, ‘We’re really worried but we don’t really know. We’re not sure. I don’t want to take away hope. . .’ There was a little more resistance to the idea that maybe we need to consider the possibility that this person is not actually going to have a good outcome.”</p> <p>“[My home institution colleagues were] just really surprised by how little palliative care there was at [host institution]. . . they’re really going up, battling uphill, because there’s just such a culture of high intensity care at [host institution] . . . a lot of the [home institution] doctors noted how different the culture was around acceptance of palliative care between [home</p>

- institution] and [host institution] and the differences in the acceptance of and receipt of high intensity care at [home institution] versus [host institution].”
- Theme 3: Barriers to delivery
Subtheme 3.3: Legal and administrative differences
- “There were absolutely different things about New York, not just the patient population we were working with, but the way medicine was practiced. One of the most striking things was what it takes to logistically remove a patient from life-sustaining treatment, and the hoops that one legally must jump through New York, was absolutely eye-opening to all of us in California. I can say that as we were meeting as a team in California, just like, ‘Have you seen it? How do you have to get permission from the hospital, like, why?’ It was just amazing. So that kind of cultural learning as well was fascinating.”
- “There are some things about the way that [host institution] runs as a hospital that just felt completely foreign. Like to get a DNR order, you have to have an administrator sign off. And I was like, ‘What? Like, what are you talking about?’ That’s something that interns do at my hospital all the time. And it’s not a big deal. So there were some things that really drove home for me that this is a different place.”
- Theme 4: Emotional burden
Subtheme 4.1: Moral distress
- “A large part of what we do as palliative care doctors is help patients and families understand what’s going on and prognosticate. If not about survival, about, you know, what to expect going forward. And all of a sudden, I felt like I didn’t know how to do that anymore. . . all of a sudden [it] felt like my ability to help patients, and to help family members understand what might happen with their loved one, was taken away.”
- “In palliative care, you’re not supposed to come in with an agenda, and you’re supposed to sort of guide the patient. And it was this really deep ethical challenge of trying to be with a patient and their family, but then also having this ulterior motive. . . there were patients that were just completely swamping like a bazillion ICU beds, and there was a need to actually try to manage that in some way, manage the scarcity of resources. And so it turned palliative care from just trying to engage with the family to something where there was really an agenda for public health reasons, which is in conflict with what palliative care is.”
- “It’s frustration with people who won’t wear masks or don’t want to get vaccinated. And I think what’s interesting is that a storyline that is sort of being propagated in some media outlets is that this is like, you know, a mild flu. I have family members who say, ‘Well, I don’t know anybody who’s sick. So I don’t understand what the problem is.’ And it’s almost like this total denial about what has happened. Like New York was horrific. And people watched on the news, and people were freaked out about it, but it’s sort of like, as soon as that was over, people just moved on. And I don’t know if that’s because they’re scared, and that was their own defense mechanism. But it is really frustrating. Because once you’ve seen human suffering, and you’ve seen what’s happened to family members, and the ripple effect of that, of these COVID long haulers, and some people that are just dealing with ongoing disability, it is super frustrating.”
- Theme 4: Emotional burden
Subtheme 4.2: Burnout
- “The biggest challenge for me was more actually related to boundary setting. . . It’s like all of a sudden, I’m their main point of contact for some of these people. And trying to navigate that was such a challenge. And I was constantly like, I’m calling too often or calling not often enough and never sort of knowing what that sweet spot was. That was also something new, to discover the burnout.”
- “I was recognizing the deep sacrifice that all of my colleagues were making in the medical community in New York and wanting to step up in the same way. It’s like, ‘Well, if they’re [host institution providers] working back-to-back shifts, can’t I call them [patients’ family members]? After my normal business hours, can’t I stay another half an hour on the phone, even though I want to go spend time with my daughter?’ And I’m trying to figure out how to set those boundaries correctly, because I wasn’t there. And it’s not like we need everyone to be a martyr; like they would want me to spend time with my daughter, even though they can’t spend time with their daughters. So that was another sort of struggle and something I was constantly thinking about, if not explicitly, definitely in the back of my mind.”
- Theme 5: Ideas for improvements
- “I think this is a really exciting opportunity, because there’s so many patients around the country who don’t have access to specialty palliative care who could really benefit from it. And wouldn’t it be neat if we could find a way to harness this model that obviously was deployed in an acute emergency situation. But we could. . . modify and develop it over time, so that it could actually be. . . a prototype that could be utilized more broadly.”
- “This whole endeavor was like a great demonstration that we may not be able to provide perfect textbook-level team-based palliative care in the middle of a crisis, but we can do something which will be of service. . . that makes a good argument for trying to create some sort of a resource that can go to areas of need in future crises. . . with some infrastructure it can be done and can add value, and you can be really far away and still really impact people’s lives. And so I think it just really highlighted this additional way to magnify the impact of palliative care.”
- “As physicians, we really need to, it might not be as popular to say this, but I think we really need to think about the culture of volunteering, and is that actually solving the root cause of some of these problems and workforce and burnout and unmet institutional needs? Are volunteers the right way to solve the problem? It might be in the short-term, but I think in the long-term, we need to think about how we can recruit more physicians into the field. How do we reduce the barriers? How can we improve recruitment and palliative care? What are ways that we can appropriately compensate palliative care physicians for this type of work and actually value the work in order to bring in palliative care physicians from other parts of the country if there’s huge needs like this?”

Despite these advantages, telehealth complicated efforts to build rapport with loved ones. Some participants reported that absence of physical touch and non-verbal cues compelled them to rely more on tools such as silence and supportive language. In addition, the circumstances did not allow for staff at the host institution to easily coordinate video calls in patient rooms: “Trying to find someone on the floor who actually had the bandwidth to hold up an iPad... 9 times out of 10, there wasn't anyone who actually had the time or the bandwidth to do that.” This resulted in participants updating family mainly based on “secondhand” information about the patient’s condition, making it difficult for participants and loved ones alike to fully grasp the patient’s extent of illness. One participant emphasized this by stating:

“They [family] are trusting us to a much greater extent that we're giving them a clear picture of what their loved one looks like, and what their illness is like, and what their prognosis is like. It's one thing to have the doctor tell you; it's another thing to see your loved one going from walking and talking. . . to being in the intensive care unit on a ventilator. . .”

Subtheme 2.3: Dyads and Debriefing. The volunteer program utilized a dyad model in which one to two remote consultants worked as a team; each team followed one to three cases longitudinally.¹⁴ While palliative care is already largely an interdisciplinary and collaborative specialty, this program employed a less common dynamic in which two attending-level participants worked together in a dyad.

Most participants shared that the dyad system was helpful not only in coordinating family meetings and distributing the workload, but also in “shar[ing] the burden” and emotional toll of difficult conversations. Participant pairs would often hold debriefing sessions after a family meeting: “It was a very protective practice that we put in place where we were able to think, ‘Was that the right thing?’ Sort of giving each other feedback about how the conversation went.”

Some participants also met intermittently in larger groups to troubleshoot logistical issues, share advice, and provide emotional support for each other. Overall, most participants enjoyed and valued practicing palliative care within a dyad structure.

Theme 3: Barriers to Delivery

Subtheme 3.1: Language and Cultural Barriers. Due to the host institution’s large Dominican, Spanish-speaking patient population (64.7% Hispanic; 64.7% Spanish as primary language), participants often used third-party phone (76%) or videoconference (24%) interpreters during their consultations.¹⁵ Of note, it was common

for providers at the host institution to use third-party phone interpreters even prior to the start of the COVID-19 pandemic.

Several participants remarked that differences in language and cultural backgrounds added additional layers of complexity to discussions about goals of care: “Communication is always harder when there's a translator [interpreter], because nuances in the language that you use get lost.” Despite these barriers, participants felt that they were still able to effectively provide support and care.

Subtheme 3.2: Culture of High-Intensity Care. Participants perceived palliative care to be less prioritized at the host institution than at their home institutions. Some attributed this to a difference between “East Coast” and “West Coast” culture; others thought that this difference may be a byproduct of the singularity of the surge rather than a reflection of true differences in institutional culture. One participant described observing a “full court press” mindset in many of the host institution ICU providers: “It definitely felt like there was more of an attitude of, ‘You can't not offer a potential life-sustaining treatment’ to patients. . . who were effectively already dead.” Another stated that the “culture of high-intensity care” sometimes made it difficult to manage expectations when conducting goals of care conversations with patients’ loved ones:

“I noticed [renal replacement therapy] being widely used in patients whose prognosis was objectively terrible. And I found myself thinking, ‘Why are we offering this to so many patients? And why don't we talk to patients and their loved ones about the fact that we don't recommend this?’”

Despite these differences, participants generally felt that the host institution palliative care physicians and the participants themselves were “cut from the same cloth,” noting “a lot of synergy” in their approaches.

Subtheme 3.3: Legal and Administrative Differences. Participants expressed bewilderment at the stark differences in laws about medical decision-making between New York State (host institution) and their home states of California and New Hampshire. Many recounted cases at the host institution that required jumping through “far more legalistic hoops” than they were accustomed to, such as requiring administrator approval to withdraw patients from life-sustaining treatments and requiring two physicians (one attending and one PGY2 or above) to approve Do-Not-Resuscitate and/or Do-Not-Intubate orders – the latter of which is “something that interns do at my [participant’s] hospital all the time.” One participant acknowledged that although these more stringent rules could be considered “protections in place for patients,” they also

recognized “the flip side is that it makes it harder to transition somebody to a less. . . life-prolonging aggressive curative pathway.”

Theme 4: Emotional Burden

Subtheme 4.1: Moral Distress. Participants cited causes of moral distress that revolved primarily around the uncertainty and widespread tragedy caused by COVID-19. During the initial phase when so little was known about COVID-19, participants found themselves in uncharted terrain: “All of a sudden [it] felt like my ability to help patients, and to help family members understand what might happen with their loved one, was taken away.” Some remarked that talking to loved ones “every single day. . . who had family members who are dying from COVID” made them “more angry at the lack of masking” among the general public. One participant emphasized that the resource scarcity caused by the pandemic created a situation that contradicts a basic tenet of palliative medicine:

“There were patients that were just completely swamping like a bazillion ICU beds, and there was a need to actually try to manage that in some way. . . And so it turned palliative care from just trying to engage with the family to something where there was really an agenda for public health reasons, which is in conflict with what palliative care is.”

Subtheme 4.2: Burnout

Participation in the program not only created additional time commitments, but also harbored the potential for causing burnout, a common emotion in the practice of palliative medicine that can be further evoked by the challenges of responding to a public health emergency. Most participants described experiencing feelings adjacent to burnout but stopped short of calling it as such. These feelings ranged from occasional stress from the added workload to frustration with the growing pandemic and public response. Some described difficulties with drawing appropriate boundaries between their existing obligations and their desire to help within the program. Moreover, there was a common feeling of “not being in the thick of it,” as participants recognized that their workload and emotional burden were much less than those of their CUIMC/NYP colleagues. Conversely, some mused that their contributions during a time of crisis may have helped to ward off feelings of exhaustion and grief: “It was almost healing for me to have that personal connection, and also to feel like I'm making a little bit of difference.”

Theme 5: Ideas for Improvements. Participants relayed specific suggestions for improvement for a future iteration

of the program. Most also prefaced such statements with caution, understanding that these improvements were not expected during the unprecedented and rapidly evolving nature of the surge. Many participants expressed a need for “more structure” within the program, specifically for further “specification on [their] role in the [host] hospital.” Moreover, a few participants expressed concern over the markedly unequal distribution of palliative care resources in the United States and had varied opinions regarding if similar volunteer programs would serve to improve the landscape. One participant took issue with the “culture of volunteering” in a medical setting, noting that volunteerism may not be the most equitable way to “match services with the need.” Overall, participants felt that the volunteer model was “a prototype that could be utilized more broadly” to bring palliative care to areas in need.

Discussion

Our findings describe important motivational and logistical aspects of a unique remote volunteer palliative care consultation program and highlight specific areas for improvement in future iterations. Overall, participants felt that they were able to effectively provide care through the program, even when performed in emergency circumstances and across state-lines.

Previous literature shows that frontline workers experienced strong feelings of distress and burnout during the COVID-19 pandemic.¹⁸ Palliative care physicians are also known to have particularly high burnout rates.²³ Notably, participants expressed that volunteering remotely during the crisis offered protection against feelings of burnout, although they still endorsed some emotions of helplessness or moral distress. Participants primarily described experiencing distress from an inability to prognosticate and guide family members due to the uncertainty of the pandemic, as well as from witnessing the plight of colleagues on the ground, suggesting that providers feel an ethical obligation to help fellow healthcare workers during a time of need.²⁴ Of note, much of the participants' moral distress stemmed from the conflict between the conditions of scarcity created by the pandemic and a core tenet of palliative medicine, which is to engage openly and honestly with patients and family without an agenda. However, the meaning and fulfillment derived from the ability to help patients, patients' loved ones, and colleagues ultimately seemed to outweigh their emotional burden. Participants also recalled experiencing surprising, and at times unsettling, differences between their home institutions and the host institution with regards to hospital workflow, institutional culture, and laws around end-of-life decision-making that posed challenges to delivery of care,

highlighting the importance of addressing institutional differences as part of the onboarding process.

Participants described specific improvements for future emergency response palliative care volunteer programs. Many stated the need for increased awareness of the volunteer role and more day-to-day integration into on-the-ground teams within the host institution, as well as greater clarity regarding differing institutional practices. Comments regarding equity and availability of palliative care resources were grounded in existing larger-scale calls for palliative care to become more accessible.^{25,26}

These findings provide novel insights into the experiences of the physician participants themselves. The greater importance of this study is evident through the increasing call for palliative care services via telemedicine in the pandemic's wake, as well as for greater inter-institutional and cross-state collaboration and volunteerism.^{10,15,27} While programs like the one described in this study can be utilized more regularly in order to match available palliative care physicians with specific hospitals or regions that have an increased need for palliative care services, close attention must be paid to improving coordination with on-the-ground staff, clarifying differences in institutional practices and culture, and providing emotional support resources. Lessons learned through this study provide important groundwork for future considerations when designing and implementing similar programs.

Limitations

There are several limitations to this study. As qualitative analysis, the research descriptively reports the perceptions of our participants; thus, we are unable to make causal claims. Our sample size was small, and participants were not chosen randomly; we purposely limited our analysis to the palliative care physicians who participated in CUIMC/NYP's remote volunteer program during the initial surge to elucidate the motivators and experiences of this unique population. Our results represent participant opinions 6-8 months after the program ended rather than during the program itself, introducing possible recall bias, though the uniqueness of the experience may have mitigated this bias. Of note, three physicians declined to participate; their perceptions may differ and are not reflected in this study. In addition, we did not interview non-palliative care physicians, who may have had different experiences during the surge. Despite these limitations, we believe that the themes that emerged from our findings can inform the implementation of future remote volunteer programs that cross state and institutional borders.

Registration

None

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at [doi:10.1016/j.jpainsymman.2021.07.028](https://doi.org/10.1016/j.jpainsymman.2021.07.028).

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