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COVID-19 Content

Global Palliative Care Education in the Time of COVID-19



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Abstract

The coronavirus disease 2019 (COVID-19) pandemic has highlighted the need for health care providers skilled in rapid and flexible decision making, effective and anticipatory leadership, and in dealing with trauma and moral distress. Palliative care (PC) workers have been an essential part of the COVID-19 response in advising on goals of care, symptom management and difficult decision making, and in supporting distressed health care workers, patients, and families. We describe Global Palliative Education Collaborative (GPEC), a training partnership between Harvard, University of California San Francisco, and Tulane medical schools in the U.S.; and two international PC programs in Uganda and India. GPEC offers U.S.-based PC fellows participation in an international elective to learn about resource-limited PC provision, gain perspective on global challenges to caring for patients at the end of life, and cultivate resiliency. International PC colleagues have much to teach about practicing compassionate PC amidst resource constraints and humanitarian crisis. We also describe a novel educational project that our GPEC faculty and fellows are participating in—the Resilience Inspiration Storytelling Empathy Project—and discuss positive outcomes of the project. *J Pain Symptom Manage* 2020;60:e14–e19. Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.

Key Words

Global health, international health, medical education, pandemic, humanitarian crisis, COVID-19, coronavirus, palliative care

Key Message

Now is the time to educate health care workers on practicing palliative care during humanitarian crises. Our model of reciprocal learning with international palliative care experts offers an excellent way to achieve this.

Introduction

The coronavirus disease 2019 (COVID-19) pandemic has made stark the interconnectedness of peoples and nations. Health care providers responding to the pandemic within their own contexts have been quick to share challenges, experiences, and innovations with the global health community. Even before COVID-19, there was a movement toward

building a global health workforce and aligning educational initiatives with this goal, as evidenced by the creation of the 2016 World Health Organization (WHO) Global Health Workforce Network.¹ As a result, many American residencies and fellowships had begun incorporating global health into their educational programs through away rotations, dedicated lecture series/curricula, and specialized research offerings. Because of the global nature of COVID-19, we expect demand for education on global health to rise sharply after the pandemic, as trainees identify this as a core training need.

Within the field of palliative care (PC), global health is an emerging focus of interest. The WHO has identified PC as an ethical mandate for health care systems worldwide, and studies have highlighted the high burden of health-related suffering globally,

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Accepted for publication: July 18, 2020.

even before COVID-19.^{2,3} In this active COVID-19 pandemic, the field of PC has been called on to advise health systems on acute symptom management, urgent goals of care, ethics surrounding the allocation of limited resources, supporting distressed and overwhelmed health care workers, and creative and technological innovations related to communicating with isolated patients and families. With expertise in addressing physical, psychosocial, and spiritual needs during times of normal human crisis, PC teams have much to contribute in helping other health care workers improve human connectedness and in supporting patients and families to deal with stress and fear.

These PC skills in highest demand are core to those practiced by global PC practitioners. As humanitarian crises increase in intensity and duration, the need for trained global PC practitioners who understand how to operate in settings of resource scarcity and during humanitarian crises is clear and pressing.⁴ Recognizing the need for trained global PC practitioners, our schools designed the Global Palliative Educational Consortium (GPEC).

Global Palliative Educational Consortium

Until 2017, there were no dedicated global health training programs within PC fellowships. Although many institutions employ individual providers practicing global palliative medicine in silos, we recognized the need to build a mentorship community for trainees and design robust clinical experiences in global palliative medicine. Thus, we formed the GPEC partnership between the University of California San Francisco, Harvard, and Tulane universities to train and mentor PC fellows in global health. We formed reciprocal partnerships with two international PC programs: Department of Medicine, Makerere University School of Medicine PC Unit in Kampala, Uganda, and Pallium India, a national charity based in Kerala, India. These centers have established leading PC programs outside high-income countries, with experts in global PC and experience in responding to acute and protracted humanitarian crises: for example, Pallium India's response to the devastating 2018 Kerala floods⁵ and Makerere's PC support for South Sudanese refugees residing in the Adjumani camps.⁶ Both programs had a long-standing practice of inviting health care educators to provide teaching and expressed interest in a formalized program that would meet their needs. They are intricately involved in decisions around fellow oversight and evaluation and educational content by and for fellows. They codesign fellow projects to ensure they impact patients and health care providers in the country and align with their programmatic values.

The core GPEC curriculum, which spans one academic year, consists of pre-elective training before departure, a one-month clinical elective in either Uganda or India, a global health and resiliency curriculum throughout the year, and continuous senior and near-peer mentorship.

Pre-Elective Training

Before each elective, fellows participate in predeployment remote meetings with U.S.-based mentors to review both organizational planning (e.g., housing, travel, safety, and visas) and clinical planning (e.g., setting clinical expectations, identifying lecture topics and projects). On site, fellows meet regularly with in-country mentors.

In early shared design of the fellowship, Pallium India highlighted a critical need to culturally orient the fellows, ensuring awareness of local history, political trends, and economic challenges that impact patient care. They identified a trusted University of Iowa faculty member, frequently on site at Pallium India, to introduce fellows to South Indian culture and to the values and priorities of Pallium India's work. This faculty member also performs hospice and palliative medicine fellowship entrustable professional activities with fellows to set expectations and perform evaluations.

Ugandan-based faculty staff identified a similar need for cultural competency: they introduce fellows to Kampala life and the structure and logistics of Mulago Hospital; clarify goals for the clinical rotation; and structure the fellows' time to be compatible with local needs and priorities. They specify fellow-provided lecture topics based on team interest and send fellows out to additional sites for continued outreach, prioritizing patient needs in multiple settings.

Fellows communicate with PC team members in English, which is the academic language in both sites, and use PC team members for translation for much patient interaction.

Clinical Elective in Uganda or India

The cornerstone of the GPEC fellowship is the one-month clinical elective. One month was identified by our international partners as the minimum time needed to develop an understanding of key cultural differences and the specific contexts of the local health system to be able to participate meaningfully in clinical care and relationship building with the PC teams.

In Uganda, fellows spend two weeks working in Kampala with the Makerere Palliative Care Unit, an interdisciplinary team of physicians, a clinical officer (equivalent to physician assistants and nurse

practitioners), nurses, a social worker, and volunteers. Fellows are based at an academic center with trainees and research projects and see patients in two inpatient hospitals and one cancer center. Fellows participate in rounds and provide teaching and journal club on topics identified by the teams as priorities. Requested topics have included methadone, chronic noncancer pain, lymphedema, end-of-life care, and critically evaluating research articles. Fellows also spend one to two days per week with the nongovernmental organization Hospice Africa Uganda, providing home-based hospice care to patients in and around Kampala. One week is spent in Nagalama performing home-based PC visits in a rural site with a team of local palliative providers.

In India, fellows are based at Pallium India, where they work with an inpatient PC team consisting of multiple physicians, nurses, social workers, and a psychologist. They also participate in home-based PC visits with teams consisting of one physician, several home nurses, and periodically a PC psychiatrist. During their elective, they provide requested lectures for PC certification courses for multispecialty practitioners seeking PC certification throughout India. They also offer lectures to the local team of doctors, nurses, and social workers on an array of topics, including grief and resilience, advanced pain management with methadone and ketamine, and complex pain syndromes.

To receive feedback from our international partners, and continuously improve, we are currently interviewing focus groups of international site leaders to optimize remote/telemedicine collaboration in the coming year.

GPEC Curriculum

Fellows participate in Zoom-based regular virtual meetings throughout the year. Didactic topics include global PC 101, establishing global partnerships, access to essential medications, opioid legalization and access policies, resiliency and wellness in global medicine, and the role of PC during pandemics. Didactics are delivered both by U.S.-based faculty and practitioners from the local sites.

In addition, there is a core resiliency curriculum. This intervention is undertaken by a psychotherapy-trained chaplain with experience working with health care providers experiencing trauma. These meetings include an assessment of the fellow's current resiliency tools and identification of gaps as well as help processing experiences. In Year 2 of the program, we initiated a written narrative medicine exercise to assist in debriefing and encouraged dissemination. To date, one fellow from Year 2 published a poem in the Pallium India newsletter after the clinical elective in India, and a second prepared a piece for submission.

Resilience Inspiration Storytelling Empathy Project

Recognizing the importance of resilience support, the Pallium India team, with several invited members of GPEC, designed a resilience program for health care providers globally who are affected by the COVID-19 crisis. The program, called RISE (Resilience, Inspiration, Storytelling, and Empathy), uses the art of storytelling to create a supportive online community willing to share and listen to experiences of health care workers in this challenging time. Members of our U.S. team were invited to collaborate on these sessions as part of a group of 16 facilitators from different parts of the world, including India, South Africa, and the U.K. Members come from varied backgrounds, including pediatric PC, mental health, theater and performance arts, and critical care.

These storytelling sessions occur once a week over Zoom with the same core group of listeners, an assigned facilitator, an assigned storyteller, and a therapist who can offer a trauma-informed response. There is a somatic and/or experiential activity before each story, a group debrief after each story, and an individual debriefing for the storyteller after the Zoom session. Although RISE does not position itself as an interventional program, it does have clearly defined and stated objectives (Table 1), terms of engagement, and documentation frameworks designed to safeguard its participants and enhance resilience. All the RISE sessions are guided by principles of trauma-informed response, as described in *The Oxford Manual for Palliative Care in Humanitarian Crises*.⁴

RISE participants completed an anonymous survey regarding their perceptions of the storytelling sessions. Twenty-two participants completed the survey (92% response rate), and responses were overwhelmingly positive (Table 2). Most respondents strongly agreed or agreed that participation in RISE had enhanced their meaning-making within a shared awareness of a trauma-informed response ($n = 19$; 86%), and that it had promoted understanding ($n = 19$; 86%), empathy ($n = 20$; 91%), and the capacity to listen in the context of a humanitarian crisis ($n = 21$; 95%). Seventeen (77%) survey respondents reported that they have used and shared the lessons they have learned in the RISE project in their clinical practice.

Discussion

With our international partners, we developed a robust PC training program, which brings significant and reciprocal benefits to all parties. The partnership has led to further shared opportunities including mutually beneficial academic collaboration. For

Table 1
RISE Project—Objectives

1. Counter isolation and provide safety, intimacy, connection, and community among anyone associated with the delivery of health care in the context of a humanitarian crisis and beyond.
2. Work with imagination through the art of storytelling to promote empathy and understanding.
3. Explore our capacity to listen generously and to witness and explore the potential of listening as a form of healing.
4. Enhance resilience and meaning-making within a shared awareness of trauma-informed response.
5. Promote self-guided reflection on emotional and lived experiences.
6. Share lessons learned during the development of and participation in RISE with the wider world.

RISE = Resilience, Inspiration, Storytelling, and Empathy.

example, our U.S.-based GPEC institutions supported Pallium India, at their request, to write pediatric PC pain management guidelines and develop a bedside point-of-care ultrasound training program for

paracenteses. When some of our U.S.-based team authored the *Oxford Manual for Palliative Care in Humanitarian Crises*,⁴ our international partners collaborated on several chapters.

Practitioners with experience working in varied resource-limited and humanitarian settings are in high demand as a result of the COVID-19 pandemic. Through the experience of living and working within a setting with less health care resources, our fellows develop new and adaptable skills relevant to dealing with PC in humanitarian crises such as pandemics. Our global partners have much to teach the fellows about agility and resiliency. Pallium India, in collaboration with PalliCovid Kerala (an informal group of physicians), released an e-book on holistic PC guidelines for COVID-19, aimed at all health care workers as they respond to the pandemic, but especially those operating in situations of resource scarcity.⁷

Table 2
RISE Project—Participants’ Perceptions (n = 22)^a

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
RISE has helped me to counter isolation in the context of a humanitarian crisis and beyond	9 (41)	5 (23)	8 (36)	0	0
RISE has provided psychological safety in the context of a humanitarian crisis and beyond	11 (50)	7 (32)	3 (14)	1 (5)	0
RISE has provided a space for intimacy to develop in the context of a humanitarian crisis and beyond	13 (59)	8 (37)	0	1 (5)	0
RISE has provided connection and community in the context of a humanitarian crisis and beyond	17 (77)	4 (18)	1 (5)	0	0
RISE has allowed me to work with imagination through the art of storytelling to promote empathy	12 (55)	8 (37)	1 (5)	1 (5)	0
RISE has allowed me to work with imagination through the art of storytelling to promote understanding	10 (45)	9 (41)	2 (9)	1 (5)	0
RISE has allowed me to explore my capacity to listen generously and to witness and explore the potential of listening as a form of healing	18 (82)	3 (14)	1 (5)	0	0
RISE has enhanced my resilience within a shared awareness of trauma-informed response	10 (45)	6 (27)	5 (23)	1 (5)	0
RISE has enhanced my meaning-making within a shared awareness of trauma-informed response	10 (45)	9 (41)	3 (14)	0	0
RISE has promoted self-guided reflection on emotional and lived experiences	18 (82)	4 (18)	0	0	0
I have shared lessons learned during the development of and/or participation in RISE with the wider world	5 (23)	12 (54)	2 (9)	3 (14)	0

RISE = Resilience, Inspiration, Storytelling, and Empathy.
^aWhere data do not equal 100% because of rounding.

Experience practicing in a resource-limited setting trains one's mind to be agile and brainstorm creative solutions. It is challenging to conceive of other ways to practice medicine if one has always practiced in a stable environment with relatively infinite supplies. Practicing within a context where ordering a particular medication or imaging study might impact the availability of that resource for other patients introduces providers to the challenges of practicing within resource-limited contexts. We teach our fellows that the vast majority of the world exists in a constant state of resource limitation, humanitarian triage, and sometimes morally challenging decision making.

Global PC, and in particular that practiced in humanitarian crises, also calls for rapid decision making and action. The process of quickly incorporating information, weighing outcomes, and making decisions without the input of large committees and careful calculation are unique skills that must be learned and practiced. In contrast, the default response in much of our health care system is to proceed cautiously, with an abundance of bureaucracy. These impulses must be evaluated and sometimes even fought during times of crisis, and those capable of moving quickly, thoughtfully, and compassionately amidst resource constraints and sometimes high stress should be empowered.

In addition, practitioners trained in global PC have the potential to predict possible outcomes and issues before they arise, enabling systems to plan. Global PC practitioners are well versed in the scarcity of medications, supplies, personnel, and morale that can occur in crises. Ensuring these individuals have leadership positions in health care administration empowers systems to plan ahead at the onset of a crisis.

Health care providers working in humanitarian crises already face a high risk of trauma exposure and moral distress, which can lead to burnout and physical and mental health issues.^{8,9} Those dealing with COVID-19 in many countries have suddenly found themselves in distressing situations making decisions where demand for health care has outstripped supply. The COVID-19 pandemic is revealing an increased need for individuals trained in resiliency techniques and in recognizing the impacts of trauma. Resiliency should be a core curricular component of any global health training program. It is a specific focus of GPEC, through our organizing debriefings, resilience-themed lectures, individual counseling sessions, narrative medicine projects, and the RISE educational initiative.

Finally, our fellows come to understand that the scope of PC is also wider in most low-income or middle-income countries because disease-specific

treatment does not reach patients adequately or early enough. Although following the definition of PC as outlined by the WHO,¹⁰ in the context of countries like India and Uganda, the term life threatening is defined broadly, and does not only apply to mortality risk. Life-threatening diseases like paraplegia threaten life by limiting it to within four walls. In high-income countries, there is a parallel care system that takes care of people with such conditions. In many low-income and middle-income settings, such conditions are brought into the fold of PC and require innovation and adaptation.

Conclusion

With the rising need for global PC skills, both abroad and at home owing to the current pandemic, the field of PC must respond by building our future workforce, in reciprocal partnership with international programs. As a specialty, we are poised to provide expertise to our colleagues and health systems in how to prepare for these events as well as how to provide high quality and creative care when they do occur. We have much to learn from our international colleagues, many of whom are already well versed in practicing compassionate PC amidst resource constraints and during humanitarian emergencies. It is critical to acknowledge that the skills needed to act efficiently and compassionately are unique and must be taught. Moreover, it is vitally important to protect providers and patients from long-term trauma and treat those who do experience serious harm from these experiences. We must prepare now by training the next group of PC providers to support our nation and world through the pandemics still to come. Our model of reciprocal learning with international PC experts offers one way to achieve this.

Disclosures and Acknowledgments

Thanks to Dr. M. R. Rajagopal, Rev. Denah Joseph, Harsh Sahni, Dr. Preeya Desh, Dr. Mhoira Leng, Dr. Ann Broderick, Dr. Thomas Reid, Lucinda Jarrett, Claire Morris, Dr. Charu Singh, Dr. Randi Diamond, Dr. Bethany-Rose Daubman, Dr. Chitra Venkateswaran, Dr. Kathleen Doyle, Dr. Elisha Waldman, and the late Rev. Dr. Peter Yuichi Clark. Thanks to the GPEC and RISE participants.

James Harrison is supported by the Agency for Healthcare Research and Quality under award number K12HS026383 and the National Center for Advancing Translational Sciences under award number KL2TR001870.

The authors declare no conflicts of interest.

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