

PSYCHOGERIATRIC NOTE

Death and dying are not dirty words: palliative care and the older person in the COVID-19 pandemic

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More than 1 year into the COVID-19 pandemic, the death toll remains staggering. Notably, older age increases the risk of developing severe illness and requiring hospitalization from COVID-19, and most deaths are among persons aged 65 years and older, with just under 50% accounted for by nursing home deaths.¹

As these staggering figures continue despite vaccination development, society is being confronted with the limitations of modern medicine and the misperception that we can forestall death. COVID-19 has forced our hand. We need to think and talk about death and dying, particularly with our older patients, their families, and carers. This is an opportunity to inspire change, as one geriatrician has noted:

... the outsized impact of COVID-19 on elders has laid bare medicine's outdated, frequently ineffective or injurious approach to the care of patients who are the planet's fastest-growing age group and the generations most often requiring health care.^{2(p4)}

This ineffective or injurious approach has long been the bane of our clinical existence as old age psychiatrists caring for patients who are least likely to receive a 'good death'. By a good death we mean a death that is self-determined according to personal preferences and needs.³ It is now more important than ever for those working in older adults' mental health services to consider end-of-life issues and actively incorporate philosophies of palliative care into psychiatric practice. However, like many clinicians who consider patient death as a failure, some old age psychiatrists struggle with death as an adverse outcome in health cultures focused on risk management, suicide prevention, and recovery. Yet the most vulnerable from COVID-19 are the same patient population we care for: patients who are older, frail, cognitively impaired, with medically complex conditions, and who are socially isolated and lack psychosocial support.

In this letter, we underscore the importance of palliative care in caring for older patients with serious mental health conditions, at risk of serious illness from COVID-19, yet at the same time at risk of having palliative care needs neglected and their voices unheard.⁴

SYMPTOM MANAGEMENT

The goals of palliative care are to reduce symptom burden, relieve suffering, and provide comfort. Standard protocols for symptom management of COVID-19 infection include antipyretics for fever, oxygen and opioids for dyspnea or respiratory distress, opioids and non-opioids for pain, anti-emetics for nausea and vomiting, anticholinergics for excessive secretions, anxiolytics for anxiety, and psychotropic medications when necessary for delirium, mood, and sleep difficulties.⁵ Non-pharmacological management with calming, cool wipes, and considered use of the prone position are equally vital.⁶ Importantly, our skills as communicators and psychotherapists can be used to full effect in addressing understandable anxiety and depression in this context. Further, the interdisciplinary team approach is fundamental to holistic psychological, social, and spiritual support.

ADVANCE CARE PLANNING (ACP)

Discussions of death and dying, put off for so long, now confront us daily and can no longer be avoided. Severe outcomes of hospitalizations, ICU admissions, and high mortality with COVID-19 mandate advance care planning (ACP). Serious proactive conversations need to be had with patients and families regarding (i) clinical course, trajectory, and prognosis of COVID-19 disease; (ii) defining and articulating preferences for life-sustaining measures in critical illness such as resuscitation, ventilation, and other aggressive interventions; and (iii) open and honest

discussions about allocation strategies in settings with scarce resources.⁷ This is an opportunity to properly embed ACP in everyday practice, something we have struggled with since the inception of the concept, fuelled by death anxiety and death denial shared by patients, families, and clinicians alike.

CAREGIVER SUPPORT

The palliative care philosophy includes caring for the patient and family as a single unit. In addition to the burden of care, caregivers themselves can become ill with COVID-19, experience stress, anxiety, and social isolation. Further, they are often restricted from access to the dying person. Facilitating access to carers—by whatever means—is essential. Palliative care and hospice teams help support caregivers by providing additional assistance with providing physical care, psychosocial, spiritual, and bereavement support, and respite care.

These issues are all the more complex for cancer patients with COVID-19, rendered by uncertainties about antiviral and anticancer treatment in this setting complicated by the need to provide relief for often rapid escalation of symptoms which often compromise decision-making.⁸ Regardless, the same principles remain prime, namely providing holistic and compassionate care and connection with family while maximizing autonomy by respecting will and preferences.

In summary, palliative care is a critical component in caring for older individuals and their caregivers in the context of the COVID-19 pandemic. Early incorporation of key components of palliative care will help optimize quality of life and achieve a good death. These unprecedented times have made us realize our powerlessness, yet we as physicians have not lost our power to minister and give voice to patient wishes. Death is a reality; it is time to talk.

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DISCLOSURE

The authors have no potential conflicts of interest to disclose.

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