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COVID-19 Articles Fast Tracked Articles

What Should Palliative Care's Response Be to the COVID-19 Pandemic?

To the Editor:

COVID-19 is anticipated to spread widely in the U.S. by the end of 2020.[1] Widespread transmission of COVID-19 in the U.S. could translate into large numbers of people needing medical care at the same time. This will push many health systems to the point of rationing limited resources such as intensive care unit beds and life-sustaining machinery, as has occurred in Italy.[2] Patients and their families at the peak of the pandemic will face symptoms, emotional distress, and decision making in the face of uncertainty and limited options. No one is more prepared to handle these needs than providers on palliative care consult teams. However, palliative care consult teams are themselves a limited resource. In this piece, we will outline the challenges palliative care consult services may face in this crisis and suggest some alternatives forward.

Current Palliative Care Specialist Capacity is Limited

Although palliative care has recently experienced growth and increased penetration in the health care,[3] the growth of the palliative care workforce has yet to meet demand. There is an existing shortage of palliative care clinicians (physicians, nurses, and social workers with palliative care specialization). As it stands, many palliative care interdisciplinary teams regularly work at or near capacity,[4] leading many teams to operate using formal triage processes[5] and consultation caps.[6] A massive increase in the number of palliative care consult requests is certain to push most palliative care teams to the point of exhaustion.

Palliative teams generally consist of a physician, nurse practitioner, and/or physician assistant, case manager, social worker, and chaplain. By design, these providers have complementary roles, and there is little to no overlap. Moreover, most teams are small in number; the average 2017 full-time equivalent for a consult service is two for lesser than 150-bed hospitals and 5.5 for greater than 300-bed hospitals.[7] There is little redundancy. Thus, most palliative care teams cannot afford to lose a single team member to a prolonged illness like COVID-19. To best protect this limited resource, is important to keep existing palliative care providers free from COVID-19 if possible.

Use Palliative Care Consult Teams Only When Necessary

The bulk of supportive care for patients with COVID-19 should come from their primary teams. The so-called primary palliative care is the responsibility of every provider caring for a seriously ill patient.[8] This responsibility is only heightened in the context of a pandemic. To help facilitate primary palliative care, palliative care consult teams can help create guidelines or order sets for the management of typical COVID-19 symptoms. Whenever possible, these guidelines should be developed with the cooperation of other services affected by this crisis (e.g., critical care, emergency medicine, and hospital medicine).

Palliative care consult teams should make themselves available by phone for coaching primary teams through the issues relating to seriously ill COVID-19 patients. They should prepare to provide crash courses in palliative medicine to providers on the front line. Teams should consider having talking points at the ready for needs that are likely to arise in the care of COVID-19 patients; such as management of cough, secretions, and shortness of breath; communication of triaging decisions; and management of family grief. If primary teams become overwhelmed with patients, palliative care consult services with the capacity can offset the responsibility of keeping patients' families informed. It is especially important to ensure families are informed when patients take a turn for the worse and/or die; in Italy, there have been instances where families were not informed of their loved ones' passing for days.[9] To facilitate the sharing of communication responsibilities, we recommend scheduled daily card flips with the directors of COVID-19 units in the hospital or the intensive care unit.

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Face-to-face palliative care consultation should be reserved for only those COVID-19 patients for whom primary palliative care is inadequate; that is, when the primary team has done their best to palliate the patient and soothe the family, but efforts have failed.

To ensure the optimal use of palliative care consultation on non-COVID-19 patients, overall palliative care consult criteria may need to temporarily become stricter. Straightforward requests that would normally be entertained to foster good will in an institution may need to be triaged. For example, requests for information about hospice can be handled by unit social workers or case managers instead of palliative care team members. Similarly, requests for early introduction to palliative care (when patients' needs are otherwise being met and their prognosis is robust) may be deferred to a less critical time.

Limit the Number of Palliative Care Providers Exposed to Patients With COVID-19

It is our practice to enter patients' rooms as a team and hold family conferences in patients' rooms. In the context of a highly contagious illness like COVID-19, it makes sense to limit the providers who have direct contact with the patient to the bare minimum (ideally only one provider should enter the room). Of course, palliative care providers should follow all standard precautions and refrain from physical touch, including noninfected members of patients' families. Whenever possible, consideration should be given to interviewing patients or families by phone. Team members with medical conditions that may place them at higher risk (e.g., advanced age, diabetes, immunosuppression, pregnancy) should be kept from entering COVID-19 patients' rooms entirely.

Discourage Existing Palliative Care and Hospice Patients From Coming to the Hospital

Individuals with serious illness should be discouraged from coming to the hospital or any clinic during this pandemic to avoid developing COVID-19. In the context of a pre-existing serious illness and advanced age, the disease is highly likely to be fatal.[10] Palliative teams should develop a plan for managing most outpatient palliative issues by phone or video chat and for encouraging enrollment in hospice earlier than would be the norm.

Individuals with serious illness who become infected with COVID-19 should be encouraged to stay at home with the support of hospice services (if available). If the pandemic intensifies as predicted, older patients with pre-existing serious illness will be the first to be denied life-sustaining care in the event of scarcity. For these patients, hospitalization will provide no benefits above and beyond care occurring in the home.

Following this logic, hospice and home health agencies will see a flood of referrals. Like everyone else, they will likely place limits on face-to-face contact with patients and encourage the use of telephone and telehealth instead. This means that family caregivers will face greater burden, not to mention higher risk for COVID-19 if their loved one was infected. Palliative care providers should give caregivers of COVID-19 patients anticipatory guidance about what hospice will and will not be able to do. Caregivers should be educated about how to avoid acquiring COVID-19 themselves, and how to best use their social network to limit the number of other people exposed.

Prepare for Health Care in the Context of Scarcity

If the current logarithmic spread of coronavirus in the U.S. continues, there will be far more people in need of critical care resources than there are resources available, forcing rationing of resources similar to what occurred in Italy and China.[11] Rationing of health care is antithetical to the American mindset and is likely to provoke intense emotions among patients and families who are triaged. The lack of a clear national consensus as to the criteria used to ration life-sustaining treatment will make decisions appear arbitrary, further compounding the challenge. Palliative care providers may be asked to be the bearers of bad news in this context and will be tasked to help patients and families cope with repercussions. Those palliative care providers who are perceived by the patient and family as part of the "death panel" who decided to not offer life support will have a very difficult time establishing the trust that is necessary to comfort patients and families and help them move forward. For this reason, we strongly recommend that palliative care teams not participate in the crafting of guidelines to ration care or in clinical decision making about the value of life-sustaining therapies for individual patients. More than ever, our patients and families need to view us as neutral. When there are questions regarding individual patients and the value of life support, palliative care providers can encourage the use of case conferences (where multiple experts discuss the specifics of an individual case and craft a recommended course) and ethics consultation.

How to Coach Other Clinicians to Have Difficult Conversations

It is worth remembering that there is an effective evidence-based communication education curriculum—VitalTalk—which can be used in this context

to coach other providers to have difficult conversations.[12,13] Preparing front-line clinicians for how to handle negative emotions will be especially important; in particular, encouraging providers to express empathy and acknowledge emotions by calling them out when patients and families express strong emotions (rather than responding with more clinical detail and medical jargon) can sometimes help diffuse it. Providers should avoid terms like futility, which can promote an adversarial relationship with the family. Providers should reassure patients and families that they will not be abandoned and that patients will continue to receive compassionate care regardless of candidacy for life-sustaining treatment.

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Palliative Care in the Time of COVID-19: Reflections From the Frontline

To the Editor:

When our palliative care unit was closed to make room for COVID-19 patients, we were prepared. The virus had made its way to our shores in Singapore by January 23, 2020.[1] At the initial stages, Singapore, being the hyperconnected city that it is, was the country with the most confirmed COVID-19 cases outside China.[2] We are part of a large general hospital of 1800 beds with a 13-bed acute palliative care unit and a busy inpatient referral and outpatient service. We are also situated next to the National Center of Infectious Diseases where most COVID-19 positive or suspected patients were housed. Consequently, clinicians from our palliative care team were deployed to help fight in this nationwide health care crisis.

Our palliative care attending physicians volunteered to go into the COVID-19 wards together with senior