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# End of Life Decision-Making Challenges in a Latino Patient with COVID-19: Facing Barriers

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**Abstract**

COVID-19 pandemic brought difficult scenarios that patients and families are facing about end- of-life decisions. This exposed some weak areas in the healthcare system where we can continue improve in reducing disparities and emphasizing advance care planning from a primary level of care. We present a case of challenges in end-of-life decision-making in a Latino patient.

**Keywords**

COVID-19, end-of-life decision-making, advance care planning, code status

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## Introduction

The coronavirus disease 2019 (COVID-19) pandemic overwhelmed healthcare systems worldwide leaving us to face the challenge of shortages of healthcare resources with increased number of patients on the brink of life and death. This exposed weak points in our healthcare system, like the structural racism (Garcia et al., 2021; Bailey et al., 2017) and the community mistrust (López-Cevallos et al., 2014) that was magnified during the pandemic. This situation strained the already existing barriers for minorities including in end-of-life decision-making. We present a case of challenges in end-of-life decision-making in a Latino patient.

## Case

A 64-year-old Hispanic male with a past medical history of squamous cell carcinoma of the lung unknown stage, history of COVID-19 infection 2 months prior in October 2020, bilateral pulmonary embolism on apixaban and recent hospital admission due to generalized body weakness arrived at the hospital via air ambulance after an out of hospital cardiac arrest (OHCA).

On the day of admission, which happened to be Christmas day, the patient awoke short of breath and was given oral lorazepam and oral morphine by his family. Later in the evening, family found him unresponsive and called 911. The emergency medical responder found the patient in cardiac arrest with asystole and proceeded to do cardiopulmonary resuscitation, intubation, and placed an intraosseous line with a total of epinephrine 4 mg administered. Upon arrival to us at the hospital, he was in ventricular tachycardia, ACLS protocol was continued, and a central line was placed. He was given another epinephrine 1mg intravenous, defibrillation 200 joules twice and was started on norepinephrine drip intravenous. The time to Return of Spontaneous Circulation (ROSC) was 5 minutes and downtime was unknown.

After ROSC, on physical exam he was hypothermic, intubated, tachycardic with decreased breath sounds on bases and not withdrawing to painful stimuli. Laboratory test showed anemia, thrombocytopenia, hyponatremia, hyperkalemia, hyperglycemia, transaminitis, and a positive SARS-COV-2-PCR (Table 1). The chest x-ray showed a large right pleural effusion with pneumothorax. Lower extremity venous Doppler was negative for deep vein thrombosis.

The patient did not have advance directives and three family members identified as decision makers, all

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**Table 1.** Laboratory Results on Admission.

| Blood analysis (abnormals bolded) | Result (abnormals bolded) | Reference range |
|---|---|---|
| White blood cell | 5.6 | 4.8–10.9 th/uL |
| **Hemoglobin** | **6.9** | **11.6–15.9 gm/dL** |
| **Hematocrit** | **20.4** | **34.1–47.5%** |
| **Mean corpuscular volume** | **58** | **84–96 fL** |
| **Platelet count** | **96** | **146–388 th/uL** |
| **Sodium** | **123** | **132–143 mmol/L** |
| **Potassium** | **6.4** | **3.5–5.1 mmol/L** |
| **Chloride** | **92** | **98–107 mmol/L** |
| Carbon dioxide | 29 | 21–31 mmol/L |
| **Creatinine** | **0.6** | **0.7–1.3 mg/dL** |
| **BUN** | **55** | **7–25 mg/dL** |
| **Calcium** | **6.8** | **8.6–10.3 mg/dL** |
| **Glucose** | **202** | **70–113 mg/dL** |
| **AST** | **451** | **13–39 IU/L** |
| **ALT** | **241** | **7–52 IU/L** |
| Alkaline phosphatase | 96 | 34–104 IU/L |
| **Albumin** | **1.9** | **3.7–4.9 gm/dL** |
| **Total bilirubin** | **1.4** | **0.2–1.2 mg/dL** |
| **Troponin** | **0.05** | **0–0.04 ng/mL** |
| **BNP** | **867** | **0–100 pg/mL** |
| **pH** | **7.29** | **7.35–7.45** |
| **pCO2** | **49** | **35–48 mmHg** |
| pO2 | 101 | 83–108 mmHg |
| FiO2 | 100 | % |
| **HCO3** | **23.6** | **18–23 mmol/L** |
| SARS-CoV-2 PCR | **Detected** | **Not detected** |

of whom identified Spanish as their preferred language. A primary physician fluent in Spanish discussed code status with the patient's family. We explained that the prognosis was poor based on his comorbidities, OHCA and unknown downtime. We described that if the patient were to have another cardiac arrest despite current measures, his chances for meaningful survival would be poor. The family confirmed understanding using the teach-back method yet decided to keep him full code, stating "*Es luchador*," translating to "he is a fighter."

Overnight, the patient required escalation to four vasopressors: norepinephrine, vasopressin, epinephrine, and phenylephrine. He was transfused one unit of red blood cells and started on dexamethasone 6 mg intravenous daily.

On hospital day 2, his oxygen saturation decreased to 76% on Fio2 of 100% on the ventilator. The intensivist performed a right-sided thoracostomy for the effusion and pneumothorax. Patient's family was updated and stated they would still want the patient to remain full code and that they were waiting for a miracle to happen. Later that day, patient showed no improvement and updates were given to the family who request a video-call to see the patient. The family decided to discontinue life-prolonging treatments after this, and the patient passed away 2 hours after decision was made. No palliative care team was involved during this admission.

## Discussion

The unprecedented situation with the COVID-19 pandemic has brought difficult scenarios for patients and their families facing end-of-life decisions (Pattison, 2020). Latino communities appear to have more cultural barriers for end-of-life decision-making. In the city of McAllen in South Texas, 85.3% of the population is Latino (U.S. Census Bureau, 2019) and barriers include language, religious beliefs, extended family structure and low socioeconomic status (Shen et al., 2016).

Our patient was an example representative of the Latino community which has a family centered approach for making decisions about a relative, in this case, without advance directives. Furthermore, the burden due to the lack directive caused emotional distress in the family and more harm to the patient with invasive procedures. At the beginning, based on their beliefs, the family decided a full code status. As days went by and more invasive measures continued, they noticed that despite treatment he was not going to recover. Due to the visitation restrictions with COVID-19, we resorted to a video-call with the family and during this they realized his chance of survival would be poor and it would be in the patient's best interest to pursue with the discontinuation of life-prolonging treatments.

The case showed us areas for improvement, starting with having advance care planning (ACP) conversation to respect the patient wishes. Ideally it should be done prior to or at a diagnosis of a terminal illness and, according to the Patient Self-Determination Act, ACP discussion should be encouraged by health care providers (U.S. Government Accountability Office, 2015). Unfortunately, disparities exist among communities with studies showing that white Americans were more knowledgeable about ACP in comparison to African American and Latino (Kwak & Haley, 2005). Early engagement in ACP has shown that patients tend to die in their place of preference, most of them at home, when compared with those without it who passed away in the ICU (Shen et al., 2016).

Our patient did not have an ACP conversation despite his cancer diagnosis and his code status was unknown by the family. Unfortunately, Hispanics are less likely to have a do not resucitate(DNR) order or have no code status in comparison with whites (Degenholtz et al., 2002; Eleazer et al., 1996). Furthermore, a study in advanced cancer patients showed that only 22.4% of Latinos had a DNR order versus 50.4% of whites (Shen et al., 2016).

The patient code status initially was a full code resuscitation despite explanation in their preferred language to the family about the poor prognosis of a patient with an OHCA and unknown down time. An OHCA meta-analysis showed that the rate of survival on hospital admission was 22%, with a survival rate at hospital discharge of 8.8%, and 1-year rate survival of 7.7% (Yan et al., 2020). The patient's likely poor outcome and lack of ACP increase his chances of dying in the ICU which has been shown to increase emotional burden and psychological distress of family members (Wright et al., 2010; Fumis et al., 2015).

Our patient died alone on a ventilator, like so many with COVID-19, and we are left to question whether this case could have been prevented with ACP. This causes psychological, physical, and financial distress in patients and family where this distress can be reduced with ACP. Further emphasis should be done at a primary level of care to emphasize ACP conversation in the Latino community.

## Conclusion

The covid-19 pandemic brought to light health disparities with end-of-life care, especially in minority populations. In the US, it exacerbated end-of-life challenges that the country was already facing. Our patient case showed us many areas where we can prevent unnecessary harm to the patient at the end of their life by including earlier discussion on ACP, overcoming community mistrust, and recognizing healthcare disparities faced by the Latino community.

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