Integration of palliative care into COVID-19 pandemic planning

Nada Fadul, Ahmed F Elsayem, Eduardo Bruera

ABSTRACT
The COVID-19 pandemic is expected to surpass the healthcare system's capacity to provide intensive care to all patients who deteriorate as a result of the disease. This poses a unique challenge to healthcare teams of rationing care during pandemic when resources are scarce. Healthcare providers will need to acquire new skills in care decision making and effective symptom control for patients who do not receive life-saving measures. In this review, we describe some of the important palliative care considerations that need to be incorporated into COVID-19 pandemic planning. The main aspects to be considered include decision algorithms for rationing care, training on effective symptoms management, alternative delivery methods of palliative care services such as telemedicine and finally death and bereavement support for surviving family members who are likely to be isolated from their loved one at the moment of death.

INTRODUCTION
The coronavirus disease 2019 (COVID-19) pandemic has thus far caused over a hundred thousand deaths globally, mostly in the USA and Europe. While most patients with COVID-19 are either asymptomatic or have mild symptoms, 5% require hospitalisation and 1%–2% need intensive care unit (ICU) admission and ventilator support. Mortality is highest in older adults and patients with chronic medical conditions and malignancies.

By 1 May 2020 in the USA, COVID-19 has been reported in all 50 states, caused over 1.1 million infections and resulted in over 60,000 deaths. Some states bear a higher burden of the disease and its mortality than others do, but as community transmission continues, the impact on states is expected to increase. With the rapidly increasing community transmission in the USA and globally, it is expected that the disease will soon outpace the capacity of the healthcare system, specifically ICU beds and ventilators. Healthcare providers are already faced with difficult ethical decisions of prioritising ICU care and ventilator support for patients who have a higher chance of survival. Integration of palliative care into pandemic planning is crucial in order to equip healthcare providers with the resources needed to prepare for these unforeseen circumstances.

RATIONING CARE WHEN RESOURCES ARE LIMITED
Considering the limited number of ventilators and ICU resources available, the healthcare system will not be able to provide adequate support for all those who experience respiratory failure. Emergency physicians, hospitalists and intensivist will soon be faced with the difficult decision of prioritising ICU care and ventilator support for patients who have a higher likelihood of benefiting from these interventions.

While it is evident that mortality increases with age and with the number of organs involved, there is currently limited data on mortality scores and indexes that can assist physicians in making those decisions. This will lead to a great deal of uncertainty in making such decisions, especially in a healthcare system that has thus far emphasised patient autonomy, curative treatment intent and technological advances to prolong life. The dilemma imposed by COVID-19 will create a paradigm shift in the way healthcare providers handle prioritisation of care, and there is a need for locally applicable guidelines to support them in recommending fore-going ICU care when appropriate. Many European societies have issued criteria to assist healthcare providers in making treatment limitation decisions, equating them to wartime triage and catastrophic medicine principles. These recommendations are based on the ethical principle of utilitarianism-maximising benefit for
the largest number. A recently proposed multiprinciple allocation framework for rationing care during the COVID-19 pandemic in the USA takes into account several factors including likelihood of survival to hospital discharge and likelihood of long-term survival, while prioritising individuals who play an essential role in saving lives such as healthcare workers. Healthcare systems can use these principles to develop and continuously update their own local guidelines.

WITHHOLDING NON-BENEFICIAL TREATMENT

Reports from Wuhan and Washington State showed mortality rates of up to 86% among patients with COVID-19 who required intubation and mechanical ventilation. Given this high mortality rate, many elderly and patients with advanced chronic diseases may choose to forgo intubation and mechanical ventilation. Most physicians receive little to no training on withholding non-beneficial treatment and conducting end-of-life care discussion. In situations when these invasive interventions are likely to cause more harm and discomfort than provide benefit, the ethical principle of non-maleficence can be applied. A recently proposed framework outlines the process for informed assent, which can assist healthcare providers in reaching these difficult decisions, especially in patients who place a higher emphasis on quality of life over longevity.

Goals of care discussion should ideally occur before the patient succumbs to a severe illness in order to lift the burden of decision making from next-of-kin in countries like the USA or the healthcare team in countries like the UK. In a recent article, Curtis et al emphasised the immediate need for clinicians to begin having goals of care and do not resuscitate (DNR) discussions with patients in the community and nursing home settings, especially those who are older or with advanced chronic diseases.

### SYMPTOM CONTROL AND PALLIATIVE INTERVENTIONS

In order to be comfortable with implementing such guidelines, physicians will need to receive training on how to effectively control symptoms such as dyspnoea, pain and delirium in patients who are not candidates for ICU care in order to maintain comfort at end of life. Immediate training on symptom control is essential as lack of comfort can cause distress to patients and caregivers and to the healthcare team leading to burnout and compassion fatigue. In addition, inadequate symptom control may lead to interventions that can increase the risk of disease transmission to healthcare workers such as non-invasive mechanical ventilation for dyspnoea and placement of physical restraints for agitated delirium. Table 1 highlights some potential recommendations on how to palliate symptoms and implement palliative care interventions, especially in DNR patients. It is important to note that while intensive care approach and palliative care approach to patients with COVID-19 have several differences, many of these patients will end up dying in the ICU, and it is important to integrate both approaches in such end-of-life care.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Suggested palliative care approach for patients with COVID-19 and comparison with other approaches</th>
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<tbody>
<tr>
<td><strong>Assessment of symptoms</strong></td>
<td><strong>Face to face during interdisciplinary team rounds.</strong></td>
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<tr>
<td>Dyspnoea</td>
<td><strong>Oxygen not usually given.</strong></td>
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<tr>
<td></td>
<td><strong>Opioids.</strong></td>
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<td></td>
<td><strong>Steroids.</strong></td>
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<td></td>
<td><strong>Palliative sedation in refractor cases.</strong></td>
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<tr>
<td>Delirium</td>
<td><strong>Minimise psychoactive drugs.</strong></td>
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<tr>
<td></td>
<td><strong>Palliative sedation in refractor cases.</strong></td>
</tr>
<tr>
<td>Goals of care and DNR</td>
<td><strong>Discuss with patients and family members in clinics or during hospitalisation.</strong></td>
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<td></td>
<td><strong>Family support/ family meetings</strong></td>
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<td></td>
<td><strong>End-of-life care.</strong></td>
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<td></td>
<td><strong>Bereavement</strong></td>
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<td></td>
<td><strong>Hospice mainly at home.</strong></td>
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<td></td>
<td><strong>Combination of family members and visiting nurses.</strong></td>
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<tr>
<td></td>
<td><strong>Patient dies in the hospital, mainly ICU.</strong></td>
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<td></td>
<td><strong>Family unable to be at the bedside.</strong></td>
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<td></td>
<td><strong>Provided to close family members for up to 1 year from patients death.</strong></td>
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ARDS, acute respiratory distress syndrome; DNR, do not resuscitate; ICU, intensive care unit; PPE, personal protective equipment.
patients. An example of that is compassionate extu-
bation of patients that requires critical care expertise
to minimise aerosol generation during tube
withdrawal and palliative care expertise in order to
minimise respiratory distress. Steroids can be help-
ful in palliating dyspnoea in patients with advanced
cancer,¹⁹ ²⁰ and they have recently been recommended
for patients with COVID-19 and acute respiratory
distress syndrome and on mechanical ventilation.²¹

Another important aspect to incorporate into palli-
ative care planning is support for healthcare providers
dealing with daily losses, including their own.²² Reports
from Italy and China showed that over 4800 health-
care workers had been infected (9% of total cases),
with 24 doctors dead, and 3300 healthcare workers
infected, with 23 doctors dead, respectively.²³–²⁶ In
the first few 2 months of the spread in the USA, over 9000
infections have been reported in healthcare workers
including 27 deaths.²⁷ Caring for own colleagues and
witnessing their death can further add to the distress
faced by healthcare teams and increase the risk for
burnout.

PALLIATIVE CARE DELIVERY METHODS
Pandemics pose a unique challenge to palliative care
services as they result in a surge of patients who
need palliative and hospice care during their end
of life, which can surpass the capacity of palliative
care teams.²⁸ Palliative care programmes will need
to be prepared to be able to handle this surge while
maintaining the health and well-being of their staff.
This underscores the importance of palliative care
providers taking the lead in training primary teams
on effective symptoms control and communication
strategies. Another challenge posed by this pandemic
is the isolation and social distancing procedures
that can negatively impact the effective provision
of holistic interdisciplinary palliative care.²⁹ This is
especially challenging during the current COVID-19
pandemic where healthcare facilities are trying to
conserve personal protective equipment and are
therefore limiting the number of staff who can enter
patient’s room. There is emerging evidence on the
utility of telemedicine in the provision of palliative
care; however, adequate preparation and technical
expertise are needed to effectively implement this in
the acute care setting.³⁰–³⁶ Palliative care and hospice
teams will need to be proactive in identifying, imple-
menting and training on the most suitable remote
platform to deliver services to patients and families.

DEATH AND BEREAVEMENT SUPPORT
Several issues can arise during the death and bereave-
ment process in those affected by COVID-19. Dying
alone in an ICU setting is difficult on patients and
their loved ones. Surviving family members who were
not allowed to be with their loved ones during this
critical time are at high risk for complicated grief.

After death, the body will need to be handled in a
special way to prevent spread of infection. Disposi-
tion of the dead body through burial or cremation,
and other religious rituals such as washing the body
before burial, will need to be done in a sanitary way
to avoid further transmission.²⁷ All of these require-
ments will further complicate the grief process for
surviving family members who are likely to be quar-
tantined themselves. Interventions to deliver bereave-
ment counselling should incorporate online and
virtual reality based methods. During these times
of social isolation, virtual support groups may assist
grieving family members in sharing experiences and
finding hope.³⁸–⁴⁰

FUTURE DIRECTIONS
All of these challenges taken together underscore the
importance of generating evidence-based medicine on
the implementation of palliative care during pandemics.
It is crucial that we learn from the COVID-19
pandemic, and there is an urgent need to document
outcomes. There is also a need for innovative point-of-
care training methods for healthcare providers who are
already overwhelmed by the demands of patient surge.
Such training should balance attending to the well-
being of providers while educating them on palliative
care principles. Such training should balance attending
to the well-being of providers while educating them on
palliative care interventions.

CONCLUSIONS
The COVID-19 pandemic is expected to surpass the
capacity of the healthcare system and will create a
need for integration of palliative care into pandemic
planning. First, there is an immediate need for health-
care provider education on palliative care principles
and how to triage patients when resources are scare.
Second, there is a need for alternative methods for
provision of palliative care such as telemedicine, tele-
counselling and online bereavement support groups.
Finally, we need to learn from this experience and
document outcomes in order to assist the healthcare
system with preparedness for future pandemics.

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