

Social distancing and cancer care during the COVID-19 pandemic

SARS infected 1755 and killed 299 people in Hong Kong in 2003. On receiving the news of a COVID-19 outbreak in Mainland China, Hong Kong, as the closest city, was determined not to let history repeat itself. The government was quick and took major measures which included stringent border controls, health quarantine for inbound

travellers, restrictions on gatherings of more than four people and so on.

In response to the pandemic threat, the hospital authority raised the emergency response level to the highest since 25 January 2020. Under this, all patient visits were suspended (with exceptional cases on compassionate grounds). Non-emergency services were deferred to prioritise resources. Clinical psychologist, social workers and pastoral services were suspended to reduce non-essential contact time.

These major measures proved effective in controlling the outbreaks. However, such strict regulations are a double-edged sword; they created issues for inpatient cancer care—especially in those who are older and require palliative care. Four clinical cases during the COVID-19 period are summarised in table 1 to illustrate the challenges.

These four clinical cases reflected the unanticipated impacts of the extreme measures: communication breakdown between caretakers

Table 1 Four clinical cases to illustrate the challenges of cancer care during the COVID-19.

Case	Challenges	Responses	Lessons learnt
Madam A	Madam A, 73 years old, with metastatic stomach cancer on conservative treatment. Poor appetite; very time consuming for her relatives to feed her. Later admitted for haematemesis and anaemia. Condition stabilised post transfusion. One week after admission had sudden coffee ground vomiting and died. Her relatives were shocked. During the hospitalisation, relatives were not allowed to visit. They questioned if her death was from poor care in the hospital and suspicious that it was due to starvation from feeding difficulty.	To address the concerns, a meeting with oncologist, palliative care doctor and nurse was arranged with Madam A's relatives and bereavement counselling offered. Relatives were encouraged to talk and express concerns. We regained trust by active listening and demonstrating empathy. Medical notes were reviewed. Information about Madam A's death given. Communication gaps, misunderstandings and negative feelings were sorted and settled.	<ul style="list-style-type: none"> ▶ Normally, relatives receive update from the healthcare team during visiting hours. ▶ Relatives who could not accompany patients at the end of life have complex emotions. ▶ Regular updates of patients' conditions to relatives are essential; especially under restriction, for example, updating by phone calls alternate days. ▶ Guidelines should allow more flexible visiting for end of life. For example, relatives must declare any travel history outside Hong Kong or respiratory symptoms before visits; have temperature check before entering; limit number of visitors each time and so on.
Madam B	Madam B, a 96-year-old woman, was admitted for colon cancer complicated with intestinal obstruction and needed total parental nutrition. It was her first hospital admission ever. Unfortunately, she became confused a few days later due to the unfamiliar environment and no visiting from family members.	Investigations (including CT brain, blood tests) were done promptly to exclude reversible causes for confusion. After settling the acute problem, she was referred to palliative care. The confusion improved after transfer to the palliative care unit where relatives were allowed.	<ul style="list-style-type: none"> ▶ Family member reassurance and comfort was the best medicine. ▶ Normally relatives accompany older patients even in the acute hospital. Referral to palliative care less urgent and sometimes delayed. ▶ In the COVID-19 period, no visitors allowed. Settling acute problems efficiently and early referral to palliative care/rehabilitation facilitated family support and this practice should be continued in future.
Mr C	Mr C, a 76-year-old man, had radioactive iodine refractory thyroid cancer and multiple lung metastases. He was admitted for acute renal impairment and pneumonia and needed antibiotics. He was in low mood with poor appetite. This was the deepest separation from his family in his life.	We encouraged Mr C's relatives to use video calls to communicate with him. We educated him on using an iPad. Video conference calls between Mr C, his relatives and clinical psychologist provided remote psychological support.	<ul style="list-style-type: none"> ▶ Even normally relatives may not be able to visit the patients often because of their busy work or schedule. A call from relatives can certainly comfort the patient and show their care. ▶ Use of technology, for example, video calls or telemedicine should be promoted as this can definitely improve the communication between patients, caregivers and healthcare professionals when direct contact is not feasible.
Mr D	Mr D, a 85-year-old man, with lung cancer with multiple lung, bone and liver metastases. He failed three lines of systemic treatment and was on conservative treatment. He was admitted to our oncology ward for bone pain and received palliative spinal radiotherapy. After this, his condition deteriorated day by day. He was dying. Visiting based on compassionate ground—with maximum two people—was allowed. Relatives expressed wish to stay with him throughout.	We introduced them to advance directive and raised the possibility of 'dying-at-home'. Relatives understood the legal procedures and logistics and took Mr D back home. Two days later, he passed away peacefully with close relatives beside his death bed. Relatives were grateful for the arrangement.	<ul style="list-style-type: none"> ▶ Many people in Hong Kong do not accept the concept of dying-at-home. Some even worry if someone dies at home, the price of the apartment will depreciate. Nevertheless, with option of being able to accompany their loved ones, advance directive and home care should be promoted to provide alternative to families.

and healthcare professionals, lack of family support causing patient complications, limited visiting with distress to both patients and relatives, and so on. At the time of writing, two hospitalised patients with cancer committed suicide in 1 month. The reasons for their suicidal ideation were under investigation and unclear if they related to social distancing. Distress screening (recommended in international oncology guidelines) has been used in our outpatient clinics but not yet for every hospitalised patient.^{1 2} Due to these incidents, there is a move to extend distress screening to all oncology patients.

COVID-19 highlighted the deficiencies in our existing system. Yet, it also offered an opportunity to identify our limitations and develop alternative and creative approaches to improve cancer care. The tsunami-like impact of this global pandemic also reminded us about the deepest need of our patients. We should not only focus on physical symptoms or routines, but more importantly should provide psychological support to patients

and caretakers in a holistic, individualised, planned and communicated approach.

Wing Lok Chan ¹, Pui-Ying Patty Ho,²
Kwok-Keung Yuen²

¹Department of Clinical Oncology, LKS Faculty of Medicine, The University of Hong Kong, Hong Kong, Hong Kong

²Department of Clinical Oncology, Queen Mary Hospital, Hong Kong, Hong Kong

Correspondence to Dr Wing Lok Chan, Clinical Oncology, University of Hong Kong, Hong Kong, Hong Kong; lokwingin@hotmail.com

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ORCID iD

Wing Lok Chan <http://orcid.org/0000-0001-9793-9273>

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