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Research, Practice and Policy in the Covid-19 Pandemic

Palliative care strategies offer guidance to clinicians and comfort for COVID-19 patient and families

The novel coronavirus (COVID-19) has caused a fast-moving, highly distressing global health crisis. Patients of all ages face daunting illness while healthcare systems struggle to meet the growing demand for services. The need for palliative care (PC) is likely to be substantial, and yet, PC specialists are in short supply.[1] PC is specialized health care for patients and families facing serious illness. Incorporation of PC principles into the care of COVID-19 patients and their families can help guide non-palliative specialist clinicians as they respond to the coronavirus pandemic. Alleviation of suffering during crises such as the one we now face is an ethical imperative that PC principles support,[2,3] both for COVID-19 survivors facing days to weeks of distressing symptoms and uncertainty, as well as those who succumb to the disease. We discuss special considerations in applying core PC principles during the COVID-19 crisis as well as targeted strategies to support patients and families.

Principle 1: Alleviate symptoms. Beyond providing life-sustaining treatments in the attempt to preserve COVID-19 patients' lives and function, clinical efforts should also address relief of symptoms. COVID-19 patients often exhibit respiratory symptoms like shortness of breath, which can be addressed by usual nonpharmacological and pharmacological treatments for symptom relief. For example, nonpharmacological treatments such as re-positioning in bed or the use of handheld fans may help relieve symptoms, although use of the latter in inpatient settings may be limited due to risk of aerosolizing viral particles. Pharmacological treatments such as judicious use of opioids and benzodiazepines for dyspnea and anxiety, respectively, could be used carefully for patients with respiratory failure. COVID-19 patients may also experience gastrointestinal, olfactory and hypogeusia/ageusia symptoms for which providers should assess and provide symptom-targeted relief (in the case of gastrointestinal symptoms) or acknowledgement (for changes in smell and taste). Addressing emotional, social, and spiritual needs, normally a priority in PC, may not occur with the usual attention due to the need to limit contact with COVID-19 patients, but efforts to support these likely sources of suffering can and should be made where possible.

Principle 2: Provide patient-centered care. Patient-centered care typically includes collaboration with informed patients to craft care plans that reflect their personal goals. Patient-centered care has been increasingly embraced across multiple specialties with multimodal interdisciplinary care. The COVID-19 pandemic has upended patient-centered care in inpatient units and residential facilities practically overnight due to patient isolation, staffing limitations, and growing concerns over limited resources like ventilators and hospital beds. Moreover, for patients who are on a ventilator or otherwise limited in expressing themselves, family members often serve as surrogate decision-makers to communicate patient preferences. Now, visitation policies have been practically eliminated, further hindering communication and patient-centered care. As the health care system experiences increasing strain, decisions about patient care may be based on resource allocation and protection of others, shifting the focus of care from patient-centeredness to societal good. Under these circumstances, clinicians are especially challenged in making efforts to respect patient preferences. Clinicians can continue to support patients and families by using empathic statements that convey why patient and family preferences may not be possible and by acknowledging the humanity and inherent value of each patient, regardless of age, comorbidity, or other characteristics.

Principle 3: Care for patients and families. Serious illness affects both patients and their loved ones; therefore, care of and communication with both is essential. Communication and family meetings are still critical but now must rely on technology and telemedicine. These approaches are by necessity expanding to implement best practices during the COVID-19 pandemic.[4] Finding the right words to say about prognosis, grief, and loss can be difficult for clinicians, even under normal circumstances. The pandemic will only amplify this problem. PC clinicians and researchers have developed guides for communication during serious illness with tools such as VitalTalk, which recently added specific guidance for communication related to COVID-19.[5] For example, VitalTalk provides suggested language for conversations around poor prognosis or in the face of system-wide triage decisions that may make ICU beds or ventilators unavailable to some patients. Such communication tools can be used by non-palliative specialist clinicians to conduct difficult, yet critical conversations with patients and families during the COVID-19 pandemic.

Principle 4: Use a multidisciplinary team. Members of multidisciplinary PC teams are knowledgeable about the expertise and function of other PC team members and can, to some extent, step into each other's roles as necessary. This "cross-training" is applicable to the current COVID-19 crisis and is already happening as clinicians' usual roles are shifted to meet staffing and patient needs and to prepare for patient surges in hospitals. While non-palliative specialist clinicians can learn to provide primary PC, PC specialists remain essential partners in providing support for patients with COVID-19 and their families. For example, consultation by specialty PC may be needed for patients with intractable symptoms and for difficult goals of care decision-making with patients and families. Telemedicine can support this integration. As is presently the case with all clinicians, the already limited PC specialist pool will be heavily taxed between patient volume and COVID-19-related illness among team members;

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therefore, efforts to expand the reach of PC will likely be necessary, including train-the-trainer models where PC specialists train non-palliative specialist clinicians in PC strategies. Ongoing challenges in time and location for such trainings to occur remain uncertain as front line responders are overwhelmed by patient volume and acuity.

As the medical care of patients with COVID-19 evolves, PC has a role in the treatment of these patients and their families. Not all patients may need or be able to see specialist PC clinicians; however, PC strategies can be adapted for use by non-palliative specialist clinicians during this pandemic. PC principles can support clinicians navigating unfamiliar and distressing decision-making during these uncharted times and may help bring comfort to COVID-19 patients and their families.

Disclaimer

The views expressed in this manuscript are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

Resources

Center to Advance Palliative Care COVID-19 Response Resources
https://www.capc.org/toolkits/covid-19-response-resources/
National Hospice and Palliative Care Organization resources
https://www.nhpco.org/coronavirus

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