VIEWPOINT

Palliative Care for Patients With Cancer in the COVID-19 Era

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With early studies suggesting that patients with active cancer are particularly susceptible to COVID-19, the current pandemic is forcing palliative care health care professionals to better define our identity as a field.[1] With social distancing requirements, should we minimize patient contact to keep our patients and ourselves safe? As a relatively new specialty, are palliative care consults a luxury that we can hold off on to avoid overburdening the medical system? Are we essential medical personnel, or not?

Over the last decade, benefits of early palliative care have been well established. In fact, the American Society of Clinical Oncology suggests that every patient with advanced cancer see a palliative care team within 8 weeks of diagnosis.[2] This has resulted in referral to palliative care as early as diagnosis and growth in outpatient palliative care services.[3] Now, in the face of this pandemic, palliative care professionals face new demands and needs. It challenges our identities as clinical health care professionals. Hospital systems and palliative care teams are urgently reestablishing best practices for their patients, themselves, and their own families while balancing the risks and benefits of doing so.

Through ongoing national conversations, palliative care practitioners are asking whether we should be adding exposure risk to the patients we see, who are often the most vulnerable. As a field, we must not shrink away by decreasing services provided. Instead, our care can still be provided in creative ways that remain consistent with the core of how we practice outside these unique circumstances (**Table**). The challenges of this pandemic can essentially be considered for 3 populations: outpatients, COVID-19–positive inpatients, and COVID-19–negative inpatients.

As many people are sheltering in place, telemedicine has become an integral strategy to provide early palliative care in the ambulatory setting. Newly updated US Drug Enforcement Administration regulations allow palliative care professionals to continue writing new and refill opioid prescriptions using telemedicine. Prescriptions for new patients require both audio and video assessments. For return patients, video assessments are not necessary. Goals of care can be addressed using telemedicine to ease patient or caregiver distress and to prevent hospitalizations. Telemedicine has hidden advantages; video visits allow practitioners to see patients' home environments—information that is unavailable in traditional clinic visits. However, we have also found that it can be difficult to rapidly establish trust with new patients. Being present, validating emotions, responding to questions, and using communication tools should continue to be implemented for virtual visits. Patients may even be more willing to have these conversations with someone other than their oncologist.[4] Anecdotally, we have observed that patients at higher risk of poor outcomes if exposed to COVID-19 are becoming more proactive about advance care planning. Before adopting this as the norm, health care professionals should remember that at least 1 randomized study of weekly palliative care teleconsultations vs usual in-person palliative care visits showed significantly more anxiety and higher distress in the telehealth group.[5]

In the inpatient setting, palliative care practitioners are using telemedicine creatively for patients with and without COVID-19 because personal protective equipment is limited and family/caregiver visitation is restricted. Patients with critical illness are dying alone, and families/caregivers are distressed as they grieve for their loved ones from a distance. For patients with COVID-19, clinical decline can be rapid, providing little time for families/caregivers to make difficult decisions. Video visits address 2 barriers: (1) they provide a form of face-to-face communication and (2) they allow multiple health care professionals to engage patients/families/caregivers simultaneously, which can be a challenge in person. These tools allow us to continue providing early palliative care services, which are necessary now more than ever. Patients, despite COVID-19 status, require advance care planning and may be more likely to have these conversations with growing fears of limited medical resources and prolonged isolation.

Normally, palliative care professionals spend a significant amount of time providing patients/families with emotional support using therapeutic presence and touch. We can still provide this care but need to be efficient to have a similar influence while limiting physical contact. Time and availability are resources that other health care professionals may not be able to give when otherwise overwhelmed, and frankly, telehealth takes longer. It can also worsen the digital divide when computer-savvy families can participate in telehealth while others can only manage a phone visit. Psychosocial support is necessary to address both the fear of contracting COVID-19 and the emotional burden during diagnosis. During survivorship, guilt and posttraumatic stress disorder may develop. With a specialized and diverse skill set, interdisciplinary palliative care teams have resources to address these challenges.

Palliative care practitioners also offer expertise in management of complex symptoms, including dyspnea, anorexia, and delirium. Symptom management saves lives, simply put.[6] Palliative care comanagement of these symptoms lessens the burden of patient care on primary teams. Delivering excellent symptom management also provides emotional relief for staff having to care for patients with COVID-19 without a cure. Instead of sending our patients to inpatient hospice, we can provide comfort care in the hospital. This protects hospice personnel who would otherwise have to see these patients, obtain hospice admission consent, and

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Table. Palliative Care Challenges When Caring for Patients in the COVID-19 Era

Cohort	Management challenge	Potential solutions
Outpatient	Opioid prescriptions when sheltering in place	• Allow telemedicine (new visits: audio and video required; return visits: phone, email only acceptable) • Apply for free temporary medical license granted by states for quick access until December 2020
	Hospice referrals	• Confirm hospice is accepting new referrals; limited PPE may limit admissions
	Preventing hospitalizations	• Establish GOC early; identify resources to remain at home; specify worrisome symptoms; educate caregivers about safe practices; identify office support during/after hours
	Difficulty establishing rapport with telehealth for new patients	• Be present and patient; validate/respond to emotions and uncertainty (NURSE; "I wish" statements)
	Telehealth technical difficulties	• Use alternative video options (Zoom, Skype) and phone connection without video
		• Ensure technical support is available
	Patient/caregiver mistrust with physical distancing	• Partner with trusted professionals; use video; validate fears and anxiety; keep families up to date
Inpatient, COVID-19 positive	Primary clinicians overburdened	• Implement daily palliative care clinician check-ins with ICU and ED teams
	High management burden for primary care clinicians (rapid decline with significant symptoms)	• Have palliative care clinicians take over care of patients at the end of life
	High fears and anticipatory grief from active COVID-19	• Address COVID-19 complications (intubation, ECMO) and GOC • Provide COVID-19–specific symptom and management guidance • Consult nationally developed resources (eg, CAPC conversation guides[a])
	Frequent symptom medication adjustments at end of life with limited PPE	• Conduct phone assessments directly with patient, if possible • Schedule medications normally as needed, even if the patient is opioid naive • Place infusion boxes outside the room (extended tubing)
	Hospice referrals	• Confirm hospice accepting new referrals; limited PPE may limit admissions
	High fears and anticipatory grief from potential COVID-19	• Discuss early GOC specific to COVID-19 • Support safe discharge as soon as possible
Inpatient, COVID-19 negative	Preventing infectious spread between COVID-19–positive and COVID-19–negative patients	• Divide teams, if possible (in-person solo; group rounding video and phone)
	Guilt related to being ill but not infected with COVID-19	• Provide inpatient interdisciplinary team support/counseling and outpatient referrals if needed

Abbreviations: CAPC, Center to Advance Palliative Care; ECMO, extracorporeal membrane oxygenation; ED, emergency department; GOC, goals of care; ICU, intensive care unit; NURSE, naming, understanding, respecting, supporting, exploring; PPE, personal protective equipment.

[a] Available at https://www.capc.org/toolkits/covid-19-response-resources/.

complete regular clinical assessments. It is essential before making the referral to hospice that we know the hospice is accepting new patients, has enough personnel, and has enough personal protective equipment. In both of our environs, this changes day to day.

Finally, palliative care professionals have a history of supporting colleagues in other disciplines. Now, more than ever, we should take the lead in emotionally supporting them, many of whom are equally afraid and overworked. This includes caring for our interdisciplinary teammates—nurses, chaplains, social workers, and pharmacists. We need to protect our interdisciplinary team and palliative care trainees by not duplicating efforts, which includes dividing patient lists and not rounding as a large interdisciplinary team, but rather seeing patients independently. Group rounding and sign-out can be performed through phone or video methods instead of in person.

Even in this pandemic, palliative care is not a luxury; it is a necessity. In these troubling times when we have to be cognizant of our patients' and our safety, we should not hold back on providing palliative care services. In an era of ventilator shortages and tough choices, it is time for palliative care practitioners to lean into patient care in creative ways that will define and solidify our identity as a field.

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