

Palliative Care in a Pandemic

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Abstract

A contagion is a serious health consideration for anyone but is of even greater concern for people predisposed to infection. When a novel contagion becomes pandemic, the potential adverse consequences for individuals, their communities, and local and national health care systems become globally significant and urgent. In both new and ongoing pandemics, health care professionals are challenged to look beyond prevailing practices of care and to innovate new, more effective approaches, curative and palliative. Indeed, although public and clinical attention may focus on curative care, innovative palliative care offers unique and often overlooked benefits—particularly in the context of widespread contagion. Recognizing these potential advantages of palliative care requires a broadened understanding of this special form of care. Accordingly, this article on palliative care in a pandemic begins with a re-examination of the definition of palliative care before discussing the application and utility of innovative palliative care in circumstances of rampant contagion.

Keywords: Palliative care; Pandemic; Contagion; COVID-19; Coronavirus; Chronic disease

Part 1. What is Palliative Care?

Palliative care can be understood from four perspectives: first, through operational definition, and then by considering palliative care's scope, patient population, and practical use.

A Broader Definition of Palliative Care

Origin of "Palliate": The origin of palliative care is often associated with the hospice movement founded by nurse-physician Cecily Saunders in the 1960s (Garcia-Bacquero, 2018); however, palliative practice itself is far older. The word "palliate" entered the English language in the 15th century, and today the verb has two medical definitions. The first and broader meaning of *palliate* is "to reduce the intensity or severity of (a disease)"; the word's second, more restricted meaning is "to ease (symptoms) without curing the underlying disease. The distinction between these two meanings is important—particularly, as we shall see, in the context of contagion. Unfortunately, palliative care's relatively recent association with hospice has led both the general public and many health care providers to narrowly view palliative care as non-curative end-of-life care. As a result of this narrow view, valuable opportunities for the application of palliative care are frequently overlooked.

Reasons for Use of a Broader Definition

Given the practical limitations that result from a restricted view of palliative care, the following discussion of palliative care in a pandemic uses a broader but nuanced definition: to reduce the severity of a disease and/or its symptoms for the primary but not necessarily exclusive purpose of reducing suffering. We use this more comprehensive definition of palliative care for three reasons. First, the specialty of palliative care has multiple aspects and benefits for which incurability—a criterion for the use of palliative care in its restricted definition—is not requisite. Second, for many patients, precise determination of incurability is difficult if not impossible, and to overlook or deny palliation for patients merely because impending mortality cannot be definitively determined would be ethically untenable. Third—and of particular relevance for a population threatened by a lethal contagion—palliative care offers important disease-inhibiting and preventive benefits that are generally not provided by curative care. Among these benefits are closer and safer monitoring and treatment of patients who are the most vulnerable to

the contagion.

Consequences of the Use of the Broader Definition

Our use of the broader, nuanced definition of palliative care has several consequences. First, according to this definition, health care may sometimes be simultaneously curative and palliative. Second, the broader definition affirms that palliative care is not the exclusive purview of palliative care specialists. All health care providers, including those focused on curative care, can and do frequently provide palliative care. On the other hand, it is important that providers who are not palliative care specialists as well as the general public are aware of the unique competencies that palliative care specialists beneficially apply within their scope of advanced training and practice. Third, every patient should be viewed as a possible candidate for palliative care. The legitimacy of this assertion can be better understood by examining the possible applications of palliative care. Fourth, palliative care can be provided in the context of hospice or pre-hospice care, but palliative care is not synonymous with either of these forms of care—or with "end-of-life" care or "terminal care." Fifth, the provision of palliative care is not restricted to hospitals; rather, palliative care is provided in a broad range of venues, including both clinical and community settings. The uses of palliative care in diverse settings can be understood by considering the broad scope of this special form of care.

Palliative Care Providers

Providers of palliative care see patients—ranging from pediatric to geriatric—who are among the most vulnerable and medically complex patients in a health care organization's patient population.

Current Utilization of Palliative Care

As the recognition of palliative care has increased among providers and in the general public, the use of this service has also increased. It

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can be surmised that many patients, with diverse diagnoses, do not receive a palliative care consultation but would benefit from it.

Lack of Public Awareness of Palliative Care

Although awareness of palliative care has increased in recent years, the majority are still largely unaware of the nature and benefits of palliative care. For example, a recent survey of 800 adults residing in New York state found that 70% of the respondents were unaware of palliative care (Shalev, 2018). This finding suggests that a large majority of individuals in the general public do not know the scope of the support that palliative care offers. Being knowledgeable about palliative care is especially valuable for patients who live with chronic disease and for their family members (Hagan, Xu, Lopez, & Bressler, 2018).

Inadequacy of Current Utilization of Palliative Care

Data on hospitalized patients' rates of referral to palliative care services provided internally within a hospital or externally outside the hospital are scant. However, extant evidence suggests that health care providers' and organizations' utilization of palliative care is far from adequate. Hagan, Xu, Lopez, and Bressler (2018) note that approximately 90 million Americans live with a serious illness and that the large majority of this population would clearly benefit from multiple aspects of palliative care. In fact, actual usage of palliative care services is quite low: according to Lane et al. (2019), palliative care consultations are provided to fewer than 5% of hospitalized patients. Moreover, in addition to being generally underutilized, palliative care may also be limited qualitatively. For example, in reviewing U.S. Census Bureau data on over 15,700 U.S. nursing homes, Stone (2019) found that palliative care in nursing homes was largely suboptimal [1].

Consequences of Inadequate Use of Palliative Care

Potential consequences of insufficient use or deficient palliative care are numerous. Patients may experience physical symptoms that are not well managed. Poorly addressed pains, anxiety, shortness of breath, or nausea (among other symptoms) diminish quality of life. Patients who are insufficiently supported by palliative care may not have an accurate or thorough understanding of their disease state(s). This lack of knowledge may engender fear in patients as their health declines or as their care needs increase. Comprehensive palliative care addresses the patient's emotional and existential needs; in contrast, partial or fragmented palliative care does not assist the patient in these areas. As a result, the patient may be left lonely, depressed, anxious, or isolated. The insufficient use of palliative care may result in poor communication between the patient and the patient's health care team. Providers may not communicate between themselves regarding individual patients and instead may rely on patients to convey information that they, the patients, may not fully understand themselves. Without comprehensive palliative care, the patient misses out on advocacy [2].

Need for Increased Awareness of Palliative Care

The quantitative and qualitative deficiencies in palliative care underscore the need for increased awareness of palliative care options on the part of providers and increased referral of patients to palliative care services. To this end, Hagan, Xu, Lopez, and Bressler (2018) assert that the nursing workforce must be trained in palliative care. Nurses who know the full range of palliative care's potential benefits for patients and their families are well positioned to offer this service to patients both in and outside of the hospital. These nurses can make a valuable contribution by promoting palliative care—for example, to enhance symptom management and communication between the patient and their physicians.

A Deeper Look at Palliative Care

A common misconception of palliative care is that it is essentially the same as hospice care or as pre-hospice care. The misunderstanding that palliative care is offered only within a hospital setting is common as well. Palliative care is sometimes thought to take the place of curative care.

General Description of Palliative Care

Palliative care is an interdisciplinary approach to enhancing supportive care. The health care support provided by palliative care uses an interdisciplinary approach. Palliative care is provided by physicians, nurses, social workers, therapists, and pastoral care. Palliative care staff visits patients and their families in a hospital setting or in the place of their residence. The focus of palliative care is to alleviate or manage physical symptoms and provide individualized disease process education. Palliative care staff anticipates future symptoms and health care needs to enhance the patients desired quality of life. Ideally, palliative care staff can visit the patient over many months' time, or longer, to assess for any changes in abilities or worsening of a disease state. Palliative care promotes open communication between the patient and their physicians. Patients who are visited by palliative care staff find less of a need for unplanned access to medical care (emergency room visits, physician visits, or hospitalizations; CAPC, 2020) [3].

PC Enables Closer Monitoring

Palliative care enables closer monitoring of patients. Routine visits provide regular physical assessments and changes are reported to the physician in real time. Monitoring includes reviewing medications, and changes in the medications, and compliance. Dietary needs and compliance are reviewed. Changes in care needs are noted and reported to the physician. Palliative staff visits occur more frequently than the patient sees their physicians. The open communication that palliative care staff promotes ensures that changes are reported before the patient finds themselves in the need of an emergency room visit or hospitalization.

PC Nurses Identify Patients' Care Goals

A key function of palliative care is the identification of patient's care goals. The palliative care nurse visits the patient as often as needed and has time to explore goals of care. The nurse can discuss the patients desired quality of life in relation to proposed medical treatments. This allows the patient to determine what interventions best supports their care goals. Knowledge of previously stated care goals assists the provider in aligning the medical care that best supports this. The patient may give direction that they would want any medical intervention offered to them or the patient may state that they desire limited or minimal medical intervention. Patients who want limited intervention are visited at home and their symptoms are managed in place, avoiding the need to go to the hospital for these same measures.

Pc can Facilitate Identification of Symptoms and Problems and Reduce Need for Intensive Care

The addition of a plan for palliative care to the patient's general treatment plan can enable providers to identify previously unrecognized symptoms and problems and to reduce the need for intensive care (Narsavage, Chen, Korn, & Elk, 2017).

PC supports patients: Incorporating palliative care into a patient's medical encounters (e.g., in physician visits, in emergency room visits, and during hospitalizations) well in advance of the patient's having an acute need offers the education and symptom management related

to anticipated future issues to the patient in the patient's place of residence.

Nurses' Palliative Care Functions in a Nursing Home, Community, and Health Care System

Non-palliative care nurses: Nurses who do not specialize in palliative care may offer visits to their patients' place of residence for a limited time. Visiting home nurse services are ordered by the physician for a limited time based on the patients' needs and inability to easily travel to appointments. The patient's insurance carrier authorizes the number of visits allowed. This may vary depending on the patient's geographical location and insurance provider. Additional nursing visits would need to be requested by the nursing staff if they thought they were needed. A non-palliative care trained nurse can discuss disease progression, but they typically do not have the time availability that a palliative care nurse does. Non-palliative care nurses also may not feel as though they are authorized to discuss end of life issues with the patient that they are visiting. During visits, non-palliative care nurses may blood for lab tests, assess, and dress wounds, and monitor physical well-being after discharge from the hospital or a skilled nursing facility. Guidelines for the appropriateness of general in-home visits are specified by the patients' insurance companies [4].

Palliative care nurses: A palliative care nurse who conducts visits at a nursing home or elsewhere in a community can triage patients, mediate concerns, manage symptoms, and monitor the effect of a contagion on patients' overall health and underlying disease processes. Managing health concerns can reduce patients' exposure to a contagion in a setting such as physicians' offices, emergency rooms, and hospitals. Palliative care providers respond to patients' questions about symptoms and work as liaisons between patients and their physicians. Palliative care nurses also help to optimize the utilization of a health care system's valuable resources. For example, expected, routine issues can be addressed without the need to access the emergency room. Each visit by the palliative care nurse would educate the patient about their individual health care needs and the importance of monitoring changes from visit to visit. The patient is also offered contact information to talk about concerns or noted changes between visits from the palliative care nurse. Thus, if a patient with CHF gains weight overnight, palliative care nurses can visit and assess the patient and, if appropriate, recommend that the patient be given a prescription for a diuretic "as-needed" (i.e., PRN). Equipment that is needed for monitoring weight, vital signs, blood glucose levels, etc. is recommended by the palliative care nurse. The patient or their caregiver is educated on their use with a return demonstration to ensure understanding. Each visit from the palliative care nurse would review written documentation of the values being monitored.

PC Nurses vs. Home Visiting Nurses vs. Transitional Care

PC services support the medical community: In addition to providing symptom management and aligning care with patients' care preferences, palliative care service also supports the medical community. Visits outside of the physician office or hospital, and communication to the physician regarding these visits, enable the provider to be informed about the state of health of their patients. Palliative care nurses specialize in symptom management. The palliative care nurses are trained either through education devoted to hospice and palliative care issues or through mentoring with other palliative care or hospice nurses. The palliative care medical director also advises the nurse as needed. Medications or other non-pharmaceutical interventions needed to control symptoms may be used in an off-label manner. The recommendations made by the palliative care nurse and continued in

home monitoring enable the primary care physicians to focus on their other patients. Palliative care clarifies current and future medical care preferences and enhances communication between the patient and all their physicians [5].

Nursing home to emergency department: In a nursing home that has limited staff; a patient's symptoms may become so severe that the staff feels compelled to send the person to a hospital's emergency room. When a patient in a nursing home is visited by a palliative care provider, the nursing home staff understands that they can contact the palliative care nurse for medical issues that the patient is experiencing. Addressing a patient's symptoms when they are first recognized can reduce the likelihood that the nursing home will later need to send the patient to the emergency room.

Palliative care and aging: Palliative care educates patients about expected changes that result from aging. Today, the population of Americans who were born between 1946 and 1964—the baby boomer generation—comprises an estimated 93,000,000 people. Many members of this generation are diagnosed with chronic illnesses, and many of these older adults would benefit from palliative care in their overall plan of health care. We must ask our older patients whether they know what palliative care is, what it offers, and how it can assist them. Many in this generation are highly involved in exploring and choosing their health care options. They want information. In contrast with their parent's generation, baby boomers want to direct their health care.

PC and symptom management: Palliative care is focused on the patient as an individual, their own set of symptoms, their unique diagnosis, their societal support, and emotional state. Palliative care is offered while the patient is continuing to seek curative care, in many instances. Palliative care specializes in symptom management associated with each diagnosis. A service that can support the patients care is vital. The effects of COVID-19 on those with underlying comorbidities are known to increase the likelihood of demise.

Description of Vulnerable Patients

Part 2. Palliative Care in a Pandemic

For people who need palliative care, the advent of a new contagion can pose unique challenges. To understand the impact of a contagion on patients requiring palliative care, we must first consider the unique nature of this special form of care. Clearly, for such patients, environmental exposure to a contagious infection in many cases may be hazardous, especially if the infection is both severe in impact and virulent. For compromised patients who could potentially be exposed to an aggressive pathogen, palliative care can play a vital role in mitigating the elevated risk of exacerbated illness. For example, palliative care enables patients in medically precarious conditions to obtain medical care in their safest environment—their home. In addition, an interdisciplinary palliative care team can help to ensure that the patient's prescriptions are filled and that the patient is maintaining her or his state of health. This palliative care support can enable the patient to avoid potentially contaminated environments (e.g., pharmacies, emergency rooms, waiting rooms, and the hospital as a whole).

Reducing Patient Exposure to Other Patients with Disease

For over 150 years, since the advent of medical bacteriology, health care professionals have recognized as axiomatic that a exposure of one person to a second person who is ill with an infectious disease can result

in the first person's acquiring the second person's infection (Blevins & Bronze, 2010).

Impact of a Contagion on a Health Care System with Inadequate Palliative Care Resources

As our experience with the COVID-19 pandemic has demonstrated in cities and countries worldwide, the large and increasing proportion of populations that consists of older adult is itself a health vulnerability for nations and their local communities. Indeed, a sudden spike in a population's incidence of a contagion such as COVID-19 can potentially overwhelm an unprepared medical system (Bedford et al., 2020). Among specific concerns, an unexpectedly large onset of a contagion could render an unprepared community health care system incapable of providing urgently needed additional palliative care services. Furthermore, as we have seen in hospitals that have been overwhelmed by COVID-19 patients, an overwhelming of a hospital's emergency and intensive care services—both curative and palliative—could result in an overwhelming of the hospital's treatment capacity as a whole. The single most important strategy for reducing the likelihood that a hospital system and its staff will be overwhelmed by sharply elevated care demands would be to reduce vulnerable patients' exposure to virulent contagions (CDC,????). Monitoring patients in their own residence could potentially to accomplish this end.

Palliative Care Delivery

Home visit vs. telehealth: During a viral pandemic, palliative care can be readily provided either via home visit or telehealth technology. Both approaches to palliative care delivery confer important unique benefits. Many patients like the convenience of telehealth, and for both providers and provider organizations, telehealth increases the efficiency of palliative care delivery. In addition, for both patients and providers, the use of telehealth in delivering palliative care can result in cost savings. On the other hand, some of the most vulnerable patient subpopulations in need of palliative care lack access to the technology that telehealth requires; this lack of technology (or lack of skill in using technology) is a manifestation of "technology disparity." Moreover, telehealth itself has its own technological limitations: in telehealth consultations, providers cannot auditorily assess lung sounds, visually assess peripheral edema, or conduct other important sensory-dependent assessments that require the provider's hands-on, in-person engagement. On the other hand, routine telehealth visits eliminate ~~reduce~~ visited patients' exposure to contagion. Although the palliative care nurse is quite cognizant of infection control, there may be an associated risk to the patient for in-home visits. As a result of these home visits, the televisiting provider and everyone (patients, visitors, and staff) are further protected from exposure. Telehealth eliminates this risk. In an emergency, such as a contagion, the patient's knowledge and direction can be conveyed immediately to the other members of the patient's health care team. Staff members will know that a prior discussion about potential issues will have been conducted with the patient and the patient's family—either in the hospital or in the patient's home. Advance care documents that are completed by the patient are provided to the patient's physicians and medical facilities that they frequent and become part of their medical record. A review of the medical record by the medical staff will reveal the patient's priorly stated wishes.

Home visits: A viral pandemic reinforces the importance of visits to patients within their home to reduce exposure to the virus. Physical assessments and notification of changes to the patient's physician lowers the risk of infection by a viral contagion while maintaining

continuity of care. Medical issues or concerns can be addressed at the time of the visit, rather than the patient becoming ill enough that they require an emergency room visit or hospitalization.

The Role of Palliative Care in the Context of Contagion

For people whose risk for environmentally acquired infection is elevated by a contagion, palliative care can confer many benefits. Patients seen by a palliative care service in their place of residence can enjoy their medical care coming to them. The reduction of the need to venture into the community allows these vulnerable patients to avoid others who might be ill or carriers of the virus. The visits in the patient's home can be viewed as extreme social distancing. These are the most vulnerable among us who must be protected to avoid illness and possible demise. Palliative care visits also address the social isolation that quarantined people experience. People are social and suddenly depriving someone of the activities and people they enjoy can cause anxiety and depression. Palliative care visits allow the patient to interact with somebody to discuss any mental health issues that they are experiencing. If enough care providers in a community are knowledgeable about their patients' ultimate care goals, the providers can collectively help to avoid cities, towns, states, and a nation's health care system's being deluged by seriously ill patients or those with chronic disease states.

Description of Vulnerable Patients

In the context of a communicable disease, vulnerable patients cannot tolerate exposure to an infection that could further compromise their already precarious state of health. Such patients know they are chronically ill, and most understand their risk of infection. However, physicians and nurses should not presume that these individuals are necessarily nearing death. Some vulnerable patients are immunocompromised but otherwise stable. Some have cancer but otherwise are fairly healthy overall and are tolerating their treatment well. Some are children with a congenital condition that renders their health fragile but otherwise stable within their environment, meaning that they are considered status quo in their abilities and symptom burden. Some are dialysis patients with weakened immune systems who are actively engaged in family life and careers. Some are older adults (defined here as adults 65 years of age or older) who have experienced minimal declines in functionality but are otherwise valued contributors to their communities' quality of life. All of these patients must be supported and protected when infection is rampant. In addition to these patients whose health is relatively stable and who benefit from palliative care, it goes without saying that people who are nearing death and who choose to not to enter hospice care can also benefit from palliative care—for example, from the symptom management and emotional support that palliative care provides [6].

Infection

The list of diseases that predispose a person to infection is lengthy. Each bodily system includes diagnoses for which this predisposition is true. Neurological diseases are associated with risks of pneumonia from aspiration. Patients with a neurological disease will eventually ambulate less, increasing the likelihood of associated skin breakdown and possible urinary infections related to incontinence. Cardiac patients become fatigued easily as their disease progresses; one consequence of this fatigue is reduced ambulation with the expected associated skin and infection risk problems. Diabetes increases the overall risk of infection because one's blood glucose level is elevated. In addition, the neuropathy that is associated with long-term poor control of elevated glucose can result in open areas that, without vigilant foot inspection,

can easily become infected. For patients with a chronic progressive disease such as those mentioned above, and also for many patients with acute illness, a new contagion may present an additional serious threat. Moreover, that viral threat may be greatly magnified for individuals living in a closed environment such as a skilled nursing facility or other institutional setting. A consideration of the potential impact of a rampant contagion leads to startling conclusions. Patients who already have elevated risk for infection, poor endurance, reduced appetite, and elevated need for physical care—and who then contract a viral contagion—can realistically become very ill, requiring hospitalization, or even die. For these patients, palliative care could reduce the incidence of environmental exposure to a virus and to subsequent infections (e.g., pneumonia, sepsis).

Patients in Nursing Homes

Today, 1.4 million Americans reside in 15,700 nursing homes, and 85% of these nursing home residents are older adults (Stone, 2019). Furthermore, this percentage of older adults in nursing homes is expected to rise as America's older adult age group increases. For these adults, the introduction of a contagion into their nursing homes can result in a devastating loss of life—as witnessed during the current COVID-19 pandemic. Palliative care offers the ability to visit these people in their nursing homes when they may be required to remain there. This mandate can result in nursing home residents' missing their routine physician visits. Depending on the disease state, lack of assessment can lead to worsening of symptoms [7].

Older Age and Health in the Context of Viral Infection

In comparison with the world's population as a whole, America's population is collectively older: in 2019, older adults constituted 16% of the U.S. population; in comparison, the older adult population constituted only 9% of the world's total population (World Bank Group, 2019). Many American older adults are diagnosed with chronic diseases or may have suffered an acute event. As an individual patient's chronic disease progressively worsens over time, the patient requires more assistance. During a viral pandemic, the protection of older adults with chronic or acute disease is critical for mitigating the elevated potential for loss of life.

Pandemic-related Challenges for Patients

Emotional Impact: The isolation and overall fear of infection during a pandemic affects the emotional health of the individual (Soysal, Aydin, Isik, 2020). This is seen in the rising suicide rates in the general, healthy public as well as those with chronic illness (Jurblem, Ng, Castle, 2020). Chronic illness, by itself, can increase the risk of infection (Wang, Li, Wan, 2020). Forced isolation prevents normal access to social, religious, and family contact. People who live in nursing homes have felt this emotional isolation acutely (CITATION). They have not been able to visit with friends and family members as they had in the past. In many cases, these individuals are confined to their rooms for safety and as a result are very lonely (CITATION). Visits to medical appointments may be via telemedicine. With stringent infection control protocols, PCs can visit to monitor changes in health status while providing emotional support (Soysal, Aydin, Isik, 2020).

Economic Impact

With the recent COVID-19 pandemic have come the well-publicized curtailment or closure of businesses, adverse impacts on entire industries, and accompanying constraints on the economy as a whole and on individuals' employment and financial well-being; as a consequence, a large proportion of the nation's population has been

struggling (CITATION). Some may have found themselves needing to move in with other family members to conserve funds. This would be anticipated to have an economic impact on all parties involved. A loss of income by one or more members of a family can exert strain on other members of the household, especially those who were already living on a limited budget. For patients who are adversely affected by pandemic-caused financial loss, palliative care visiting by a social worker can include identification of available community resources and other avenues for help. This can include heat assistance, food, health insurance, or alternative housing.

Drug diversion: Palliative care has long been valued for monitoring drug diversion in a private home. The recent current COVID-19 pandemic has been accompanied by increases in drug abuse, overdoses, and domestic abuse. People who are accessing palliative care for symptom management may have been prescribed narcotics or other potentially addictive medications in order to increase perceived quality of life. The staff from palliative care who visits the patient's home can monitor drug use, create plans for avoiding drug diversion, and notice who is living or visiting in the home. It is not unheard of that someone who is prescribed these types of medications has them stolen.

Spiritual impact: The isolation that results from mandated isolation has multiple effects. People who find solace and support through practicing their religion may really struggle when their places of worship are closed or are mandated to reduce attendance. If a palliative care program is interdisciplinary, the program will offer pastoral care, this need can be addressed. Spiritual distress can be associated with emotional angst as well. If the person who is receiving palliative care visits is also contemplating end of life issues and decisions, a spiritual support offers unique support. As addressed previously, the social isolation that results from mandated stay-at-home orders can compound any isolation and emotional distress that an individual might have been experiencing prior to the stay-at-home requirement. In people who had a pre-existing mental health condition such as depression or anxiety, that condition can potentially be exacerbated by loneliness and lack of routine human contact. Routine, established palliative care visits offers a source of contact. A palliative care visiting staff could alert a mobile mental health service that there is a need to assess this patient in their home if symptoms are worsening. If mobile psyche if not warranted, the social worker can offer some limited in-home counseling and assessment.

Contagion, Specific Disease Considerations in Palliative Care

One of our chief concerns with COVID-19, respiratory distress, can be devastating to patients who already have an underlying disease. For this patient population, limiting exposure to a potentially deadly pathogenic organism can save lives.

Respiratory distress: For patients with underlying respiratory disease, acquiring a viral infection that is known to cause increased shortness of breath and pneumonia can cause the patient to be sicker than other people might be without a chronic respiratory diagnosis. Compromised pulmonary function, at baseline, is further complicated by a viral contagion that is known to cause pneumonia.

COPD: Hospitalized patients with COPD need palliative care (Narsavage et al., 2017). Some patients with COPD may have even more symptoms than do patients with lung cancer. Sixty-five million people worldwide have moderate-to-severe COPD; 5% of deaths in the global population are attributed to this disease⁴. For the population of people with COPD, symptom burden of the disease is greater than that of people with lung cancer.

Cancer: As a result of having cancer and consequent treatments, patients with a cancer diagnosis can be immunosuppressed. For patients with cancer, the potential benefits include a discussion of their particular disease, ultimate goals of care, symptom management while they undergo treatment, and completion of advance care documents. These patients live with increased number of symptom complaints—namely fatigue, depressed appetite, dyspnea, cough, anxiety, and pain. Escalating symptom consequences from cancer treatments often necessitate the patient's having increased access to health care services (Narsavage et al., 2017). Palliative care services are underutilized by people who have cancer and a concomitant non-cancer diagnosis (e.g., diagnoses of cardiac or pulmonary illness; Lane et al., 2019). For patients with cancer, a viral infection can be devastating; yet, despite the obvious value of palliative care for these patients, only 10% of them receive a palliative care referral (Narsavage et al., 2017). By inference, the 90% of patients with cancer who do not receive a palliative care referral are unable to use the symptom management and education that palliative care provides. This same palliative support is beneficial to any patient with any disease state. In the instance of a serious contagion, such as the COVID-19 virus, palliative care providers' knowledge of their patient's care goals can help align current and future medical care to the patient's acceptance. For example, if a patient is known to have an advanced lung disease diagnosis, the patient may opt out of ventilator support. Or, this same person may elect to avail themselves of ventilator support for a period.

Recommendations

Promoting awareness of palliative care: In general, abundant findings of research on palliative care substantiates the value and need to educate both health care professionals and the general public—especially older adults—about the full range of palliative care services. For medical and adjunctive care professionals (e.g., physicians, nurses, social workers, and spiritual support professionals), such education should be provided in the professionals' training schools as required material or as an elective course. Palliative care education for the general public should be presented in a variety of contexts: during patient-provider conversations in public service presentations older adult centers, and in pamphlets in physician offices.

Recommendations for Providers

As health care providers, we know that a clear understanding of our patients' current state of health, including understanding of the likely progression of both primary illnesses and comorbidities, is essential. In the context of a contagion, this understanding will inform our assessment of the patients' vulnerability to infection. Every patient with a chronic illness or a new life-altering diagnosis should be offered a palliative care consultation to complete advance care planning and to make recommendations for any symptoms they may be experiencing. Saliiently for this generation, many older adults are highly involved in exploring and choosing their health care options. They typically want information. In contrast with their parent's generation, baby boomers want to direct their health care. In a patient's initial palliative care consultation, we must ask our older patients whether they know what palliative care is, what it offers, and how it can assist them. Next, patients and their family members can benefit greatly from thorough palliative care discussion of their disease(es)' progression. In this discussion, patients should be encouraged to contemplate and identify their requirements and preferences regarding their desired quality of life. Patients should also consider how aggressive they would want their providers to be should the providers recommend intensive and possibly prolonged uncomfortable medical care—especially if the outcome

of such care would be uncertain. Should the patient contract a viral infection, the palliative care discussion should include consideration of whether extreme life support measures align with the patient's ultimate care goals. Such measures might include ventilator support, the use of off-label medications, and dialysis—all of which are potentially uncomfortable and have uncertain outcomes. Patients should complete an advance directive to explicitly outline their wishes and discuss their wishes with their family and/or a proxy. If the patient has a completed advance directive, she or he should review it for pertinence periodically or in event that they receive a new diagnosis. As an essential component of palliative care, palliative care providers should ascertain whether a patient possesses advanced directive and power of attorney documents. For patients who have completed these documents, providers should advise the patient to provide a copy to each hospital they are affiliated with as well as any physicians they see. For patients who lack these essential documents, providers should encourage the patients to complete the documents and, whenever possible, providers should assist their patients in doing so. Existing advance care documents should be reviewed by the palliative care provider to ensure relevance and continued accuracy. Providers should ask the patient if they have any questions regarding any part of their medical care that has not been answered to their satisfaction and present the answers that they require.

Follow-up Consultations

Palliative care follow-up discussions can discuss the new diagnosis in relation to their stated wishes. Providers must be prepared to accept the possibility that a patient may feel that a provider-recommended treatment may not be in alignment with the patient's quality-of-life preferences or other considerations. Providers can feel frustrated when the patient declines a proposed treatment or requests very aggressive testing and treatments when the provider does not think that the patient will achieve a benefit. If the patient is well educated about the consequences of their decision, then the provider knows that the patient knows what any intervention will entail for them. Extremely complicated scenarios can be referred to the institution's ethics committee. There may be underlying reasons for why the patient, or their proxy, is making such decisions. There may be unresolved familial conflicts, financial considerations, among many that compels the patient or their proxy to make the choices that they do. All medical staff should be mindful of the story of the patient as an individual.

Recommendations for Provider Institutions

For reasons that are now painfully obvious in the context of the COVID-19 pandemic, it is incumbent upon health care organizations to develop their inpatient-outpatient PC programs in advance of a contagion. The availability of a robust palliative care program for patients at risk for an exacerbation of their disease in their place of residence is imperative. Seeing patients in their home substantially decreases the patients' exposure to contagions in any hospital setting for these already compromised people. This could reduce emergency room visits and hospital utilization. Identification of patients with diseases that elevate the patients' risk for mortality should prompt a referral to palliative care services for long-term support. The availability of a robust palliative care program for patients at risk for an exacerbation of their disease in their place of residence is imperative. Providing palliative care to compromised patients in their home substantially decreases the patients' risk of infection in a hospital setting. This support from a palliative care service improves the patient's overall quality of life while living with their chronic disease.

Recommendations for the General Public

A commonsense approach for wellness is essential. When a threat of contagion is high, we can protect ourselves and others by adhering to basic hygienic practices: washing hands, staying home if one becomes ill, cleaning commonly touched surfaces, and being respectful of people who are particularly vulnerable to the contagion.

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