Recommendations on Palliative Care in the Critically Ill Patient during the COVID-19 Pandemic

Comprehensive intensive care management has consistently integrated compassionate palliative care practices. Data from the Malaysian Registry of Intensive Care 2017 and 2018 shows that about 26% of critically ill patients may die in that same hospital admission and as such will require palliative care.

This aspect of care encompasses early communications with family to elicit patient's preferences, pre-existing quality of life and to address expectations; formulation of treatment plans that is responsive and appropriate; treatment of distressing symptoms and finally delivering comfort measures when the patient no longer responds to intensive treatment by means of withholding or withdrawal of therapy. The principles of care are further elaborated in the ICU Management Protocols released in 2019. They remain valid.

The COVID-19 pandemic has resulted in many health systems coming under great strain and scrutiny. The pandemic in fact serves as a solemn reminder on the importance of having open discussions on the suitability and extent of intensive treatment in certain patient categories. These discussions must be made early but the principles of palliative care i.e. autonomy, beneficence, non-maleficence and justice remain constant.

The rapid deterioration of disease in surge numbers, the overworked and stressed health care professionals and the mandatory containment and mitigation strategies necessitated by public health measures have made the delivery of quality palliative care in the ICU challenging.

Considerations to be Addressed

Under this premise, some considerations must be addressed namely

- Difficulty in communication with the family and between the patient and his / her family.
- Isolation of the patient in a time when the family is most needed.
- Dealing with expectations, frustrations and mistrust by the family.
- High likelihood of complicated bereavement in families of the deceased.
- Distress of health care professionals caring for the terminally ill patient.

Communication Difficulties

These unprecedented times of having to hold important discussions with families by phone often behind the impersonal PPE, without them seeing their hospitalised love ones is a potential for conflict and stress. Suggestions to overcome this include:

- First communication to be made as early as possible.
- Minimum once daily contact at a pre-specified time.
- Having dedicated staff caring for the patient to conduct the conversation.
- Having access to video calls where possible allowing families to see their loved ones. However, this may be too distressing for some families.
- Documentation of conversation.

Isolation of Patient

Loneliness is distressing and disorientating for the patient. The families suffer anxiety from not being able to contact and converse with their loved ones. Consider allowing patients who are awake and communicative to have access to their own personal communication devices. Invite families to suggest ways to use various media (videos, audio recordings) to attend to the needs of the patient. Encourage video/phone calls to relevant people for spiritual and psychosocial support e.g. religious leaders.

Dealing with Conflicts

Conflicts are best minimised by timely, frequent and consistent empathic communications with families. Allow family to have opportunities to ask questions and check the understanding of the conversation frequently as phone communications have limitations.

Complicated Bereavement

Families may not have closure after the deaths of their loved ones. They may suffer guilt, post-traumatic stress disorder and anxiety after the deaths of their loved ones. Psychological support during the mitigation phase may be limited but should be offered by way of counselling services. Consider establishing avenues for online support such as spiritual care teams or platforms for families to share their grief.

Support for Staff

Lastly, we need to acknowledge the difficult conditions the staff caring for the critically ill COVID-19 patients are placed in. The need to deliver far from ideal palliative care can result in emotional distress, helplessness and burnout. Debriefing as soon as possible and as often as needed by senior health care professionals. Continuous efforts by encouraging feedbacks to improve delivery of care can attenuate the distress. Consider rotation or breaks in work schedule.