

VIEWPOINT

To Face Coronavirus Disease 2019, Surgeons Must Embrace Palliative Care

Zara Cooper, MD, MSc
Center for Surgery and Public Health, Brigham and Women's Hospital, Boston, Massachusetts.

Rachelle E. Bernacki, MD, MS
Department of Psychosocial Oncology and Palliative Care, Dana Farber Cancer Institute, Boston, Massachusetts.

As of mid-April 2020, there have been nearly 2 million confirmed cases of coronavirus disease 2019 (COVID-19), and more than 100 000 people have died.¹ This historic pandemic has upended daily life globally and forced rationing in some of the world's most high-income countries. To stem escalation of COVID-19, the World Health Organization has called for the deferral of elective surgery to divert personnel and equipment to patients with COVID-19. Thus, in the near term, surgical care is largely restricted to patients with the most severe illnesses and patients who are symptomatic and hospitalized (with any condition). Surgeons will also provide surgical and critical care for patients with COVID-19, a life-threatening virus that gives some affected individuals severe dyspnea or the need for a ventilator and thus isolates them from loved ones within days or weeks of onset. The experience in China and Italy warns other countries that the upcoming months will bring immeasurable pain to patients, families, and clinicians.

Palliative care is a humanistic and interdisciplinary approach to care focused on prevention and relief of pain and distress in serious illness, and it is associated with improved outcomes for hospitalized patients and their families.² Palliative care is not restricted to end-of-life care and should be delivered alongside short-term or long-term life-prolonging care. Despite evidence that palliative care improves surgical outcomes³ and the publication of recent practice guidelines for palliative care in surgery,⁴ surgical patients are less likely than medical patients to receive palliative care.⁵ However, COVID-19 presents structural, ethical, and clinical challenges forcing a fundamental reevaluation of how we care for patients. This crisis presents surgeons with an unprecedented opportunity to embrace palliative care to face this pandemic. Four key aspects of palliative care are instructive to surgeons during this crisis: (1) using serious-illness communication strategies to disclose prognosis and establish goals of care; (2) treating total pain, (3) caring for the family unit, and (4) supporting clinicians.

Using Serious-Illness Communication Strategies to Disclose Prognosis and Establish Goals of Care

Because elective surgeries have been postponed, only the patients with the highest-acuity conditions will be on surgical wards, including those who have immunosuppression and the greatest vulnerability to severe COVID-19 infection. Surgeons must hone their skills in breaking bad news, disclosing prognosis (including prognostic uncertainty), and establishing goals of care. Clinicians must have frank discussions with patients about the likelihood of death and disability after cardiopulmonary resuscitation and be vigilant that patients receive

beneficial and goal-concordant treatments, especially given the high risk to health care workers and other hospitalized patients during intubation and other invasive procedures. Difficult conversations with patients and families should establish a shared understanding of the patient's clinical condition, expected clinical course with different treatment choices, and expected long-term outcomes with respect to symptoms, function, and survival. Prognostic uncertainty can be challenging for patients and all parties involved. Although little is known about the long-term outcomes after COVID-19 infection, data regarding long-term functional and cognitive outcomes after cardiopulmonary resuscitation for patients with chronic illness, older patients after intensive care, and others with chronic critical illness can be informative. Code status and health care proxy must be established on admission. Clinicians should discuss and document the patient's therapeutic goals, trade-offs they will tolerate for a desired health outcome, and preferences for life-sustaining treatment. Such conversations can facilitate directing patients toward treatments aligned with their goals. Helpful tools include the "Serious Illness Conversation Guide,"⁶ the best case/worst case communication tool,⁷ and VitalTalk's "COVID Ready Communication Playbook."⁸

Treating Total Pain

Assessment and treatment of physical pain is the predominant approach to pain management in surgery. However, patients with serious illness experience total pain, which also includes psychological, social, emotional, and spiritual components and will be increasingly relevant during a pandemic that causes massive shifts in how people interact with one another. For example, social distancing, school closures, remote work, self-isolation, and statewide lockdowns may cause social pain. Economic uncertainty, food hoarding, and threats of health care rationing and death panels contribute to anxiety and uncertainty about the future. High morbidity and mortality rates associated with COVID-19 lead to existential distress and worries about premature death and contributing to the death or distress of loved ones. For patients with cancer and other serious illnesses, their pain experience can be exacerbated by separation from loved ones and dehumanizing interactions with clinicians characterized by masks, face shields, and gowns.

Ignoring multidimensional aspects of pain causes inadequate treatment and unnecessary suffering. Patients experiencing distress guided by clinicians focused on physical pain may describe generalized pain unabated by analgesics. A person-centered approach should prompt clinicians to address nonphysical and

Corresponding

Author: Zara Cooper, MD, MSc, Center for Surgery and Public Health, Brigham and Women's Hospital, 1620 Tremont St, Ste 2-016, Boston, MA 02120 (zcooper@bwh.harvard.edu).

spiritual aspects of pain, including proactively engaging social workers and chaplains to support overall well-being. Helpful questions include “What matters most to you today?” and “What do I need to know about you to do a better job taking care of you?”

Caring for the Family Unit

Palliative care is rooted in the principle that the family, defined as persons the patient would include in their care team, is the unit of care. Because COVID-19 is highly contagious, restricted visitation from friends and family members produces untold stress for patients with serious illness who are without emotional support and families unable to see or help loved ones, as well as difficulties in keeping families informed about patient care. Patients and families should be given tools to communicate with each other and clinicians. Ensuring patients have their sensory aids (eg, glasses, hearing aids) and making tablets and computers available for family teleconferences with patients and clinicians is essential. Clinical teams should have a structured plan for daily family updates to answer questions and engage family members in care planning. For the patients with the most critical illness, family meetings should occur by teleconference shortly after intensive care unit admission and at regular intervals.

Supporting Clinicians

Palliative care clinicians have long recognized well-being and resilience as essential to maintaining an able workforce. This pandemic has brought on unique personal and professional challenges to clinicians who may be called to operate outside their specialty, work under adverse conditions, and care for colleagues and loved ones who are critically ill and who may harbor concern about harming their family and fear dying themselves. Institutional support is required to help surgical clinicians cope with stress, tend to personal needs, and strengthen personal relationships. The American College of Surgeons website has resources focused on surgeon well-being.⁹

Conclusions

In 2005, the American College of Surgeons called on surgeons to provide palliative care to all patients with serious illness, not just those at the end of life. Nonetheless, misperceptions about palliative care as synonymous with end-of-life care persist. There is an urgent need for surgeons to abandon biases and fully embrace palliative care to optimize care for patients, their families, and colleagues. In the past, surgeons have asked, “Which patients should receive palliative care?” Today we must ask, “Who should not?”

ARTICLE INFORMATION

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