



## Reflections on palliative conundrums related to COVID-19 care in a resource-limited setting: a narrative review

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### Abstract

The third wave of the COVID-19 pandemic in Sri Lanka resulted in a rapid rise in incidence and mortality, and overburdened the resources of the free health care sector. This narrative written by a junior doctor who worked at a COVID-19 high dependency unit in Sri Lanka, brings to light the unique palliative care and humanities dilemmas that occur when rising demands of health care surpass the resources of the system. The article will discuss issues of palliation, end-of-life care and family-centred issues in critically ill patients with prolonged hospital stays. It will also discuss the impact of a pandemic on the mental health of front-liners offering both critical and palliative care, which in turn inevitably affects all aforementioned entities. The author suggests strategies to reduce the consequences of these dilemmas on patient care, through improvement of institutional availability of essential health resources based on correct identification of need, equal distribution of frontline work and accessible institution-based services to prevent burnout among health care workers.

**Keywords:** Palliative medicine. COVID-19. End-of-life. Care.

### Introduction

Sri Lanka was affected by the third and worst wave of the COVID-19 pandemic from April to October 2021. Not only did the number of COVID-19-affected patients exponentially rise during this wave, but the number of critically ill patients rose to a level previously unforeseen. The third COVID-19 wave amounted to a total of

483,063 cases in a country that has a population of 21.5 million and the number of deaths due to COVID-19 during this period exceeded 12,000 [1,2].

Sri Lanka, having primarily a free health sector, continued to provide free health care to citizens during the pandemic, and when the health service was required to cater to crushing numbers of critically ill COVID-19 patients, the system soon came close to crashing. Hospital beds were overrun by the daily rise in the number of patients, which was more than 2500 on several occasions [1]. Limitations in resources and reduced healthcare worker (HCW) to patient ratios led to problems in the delivery of patient care, as expected during a pandemic.

This article discussed issues related to palliation of COVID-19 patients, end-of-life care for critically ill COVID-19 patients, family-centered issues due to restricted visits, and the impact of the pandemic on the mental health of frontline workers simultaneously offering both critical and palliative care.

### Narrative

The author was a junior doctor at a COVID-19 high dependency unit (HDU) at the National Hospital of Sri Lanka, Colombo (NHSL). Up until April 2021, NHSL had been an intermediate care center, that would only hold COVID-19 patients until transfer to a designated COVID-19 hospital could be arranged. However, as designated COVID-19 hospitals became overrun with the rising numbers, NHSL was converted to a treatment center, and within a month, ten COVID-19 wards and two COVID-19 HDUs had been opened up through the conversion of general medical wards.



Staff, mostly in the way of junior doctors were mobilized from other units and were supervised by respiratory physicians offering their services voluntarily. Oxygen outlets were set up for each bed in the two HDUs and equipment for the functioning of the HDUs was gradually procured, mostly by way of donations. A greater portion of the daily round at the HDU was spent making decisions about critical care and palliative care. Decisions would be made to determine which patients need escalation to intensive care units, and which patients would have a cap put on their ceiling of care due to reasons of both illness severity and inevitable pandemic-related resource limitations.

### Issues Related to Palliation of COVID-19 Patients

An article by Janssen in 2021, pointed out that COVID-19 patients and their families have needs spanning all the domains of palliative care: physical, psychological, social, and spiritual [3]. Addressing each of these domains had its own set of challenges. The physical need for palliation was mostly about easing off the inevitable shortness of breath. This was identified and managed through the use of benzodiazepines, opioids, and the correct use of respiratory support modalities. While this was perhaps the domain easiest to identify and treat, it was not without its own set of challenges.

The staff was constantly met with large numbers of critically ill patients and the initial primary goal would be stabilization of vital parameters with a tendency to overlook symptoms requiring palliation. Challenges in managing the physical domain of palliative care were the need for critical care taking precedence over palliation of symptoms, lack of training and guidelines during the initial period of the pandemic on how best to alleviate these symptoms, and initial hesitation among health staff to use the above drug classes due to known effects of respiratory depression.

The remaining three domains of psychological, spiritual, and social needs were interlinked and far more difficult to identify and manage. The challenges to effective communication during the care of these patients perhaps contributed to challenges in these domains. Communication among staff and patients was hindered due to the use of personal protective equipment (PPE), as was the communication between patients and family members due to restrictions on visiting.

Patients rarely got to see the faces of the HCWs who cared for them during one of the most nerve-racking illnesses of their lives. The experience of having been spoken to and cared for by individuals covered from head to toe, with disguised identities

certainly made the whole experience cold and impersonal, and did little to ease the fear that patients felt being in an HDU. A suggestion was put forward to have reusable identity tags with photos on the PPEs of HCWs, but unfortunately, this idea never materialized into reality.

About enabling support from family, it must be mentioned that centers that were previously designated COVID-19 treatment units, allowed family members to visit or see their loved ones through a screen. However, due to the rapid conversion of normal wards to COVID-19 wards/HDUs at NHSL, it took some time for these arrangements to be safely allowed. On a positive note, allowances were arranged in time at the NHSL COVID-19 HDU, and the author believes that this played a part in easing the mental burden on both the patients and their loved ones - family members of terminally ill patients were allowed to visit them, whilst being in personal protective equipment and certain patients were allowed to have a by-stander with them throughout the day. This was a step forward in providing more humane health care.

Unfortunately, the author feels spiritual needs were not adequately addressed due to logistic constraints. Spiritual leaders could not freely visit patients as in a normal ward, and audio broadcasting of spiritual passages/chantings was not possible due to patients of various faiths receiving care in the HDU.

Additionally, a new, yet expected occurrence encountered during the pandemic was the number of acute stress reactions in patients who witnessed several deaths occurring around them. The open ward with beds laid in an unobstructed view of each other, allowed patients with awareness to notice the instances when another patient would deteriorate and require intubation/cardiopulmonary resuscitation or instances when terminally ill patients would gasp for hours on end before succumbing to illness. This was an inevitable affliction that was a result of the layout of the HDU that afforded no privacy, and a lot of these patients required psychiatric support in this regard.

### Family-Centered Issues

The negative psychological impact on the family members of critically ill patients has long been recognized and termed post-ICU care syndrome-family (PICS-F) [4]. Factors identified to contribute to PICS-F are poor communication with the managing team and having a loved one who was close to death [5]. In the current context, these factors were exceedingly relevant to the families of patients. It was made worse by the added fear people grapple with due to the negative connotation of COVID-19, the helplessness due to



restrictions placed on family visits, and the fact that they may themselves be placed in quarantine outside their homes.

As a large number of patients who were admitted to the HDU were older and less tech-savvy, both voice and video calls with loved ones were at a minimum. Encounters between family and healthcare workers occur via phone or face-to-face, in those who have had time to come out of quarantine. News of the death was generally broken via a phone call, which coldly removes the human connection that is necessary for such news to be broken gently. All this undoubtedly contributed to anxiety and distress among family members of critically ill patients [5].

### Issues Related to End-of-Life Care

As previously mentioned, the revised decision to allow family members to see terminally ill patients, say goodbye, and allow closure was a positive change implemented during the third wave. Another decision to ensure dignity at the end of life was the decision to withdraw respiratory support in terminal patients who would be struggling fruitlessly against a tight oxygen mask and the use of sedation with benzodiazepines or opioids to allow a peaceful death [5].

### Impact on Health Care Workers

It was stated previously that the system was at its breaking point during the third COVID-19 wave. The HCWs caring for COVID-19 patients bore the brunt of this affront. Working longer shifts and having to care for patients while wearing uncomfortable PPEs took a physical toll on HCWs. But the emotional toll was not second to this. Factors contributing to this were the distressing sight of patients struggling to breathe, witnessing death in proportions not seen before, and the disconcertment of having made trade-offs to provide equitable care. Taken together, these led to physical and emotional burnout among healthcare workers. This was made worse by the knowledge that front-line work was not equally divided. Several of the non-COVID-19 related wards were more amply staffed than the COVID-19 care units and the burden of COVID-19 care fell on the junior doctors [6].

The staff of the HDU remained committed to their work throughout the third wave, but on countless occasions, they had to support each other through the burdens of long shifts, fear of transmitting the disease to their families, witnessing death and suffering, and the dejection of the knowledge that work was unequally allocated to junior staff.

A study done to assess the mental health status of doctors during the first COVID-19 wave in Sri Lanka, in

which a sample was drawn from NHSL showed that 76.7% of doctors were psychologically distressed [6]. Another study assessing the psychological experiences of doctors during COVID-19 showed that more than half experience symptoms of depression and anxiety, and amongst those working with COVID-19 patients, heavy workload and poor occupational safety contributed to said results [7]. However, there are no studies as yet assessing the impact borne by front liners during the most critical wave of the COVID-19 pandemic, which may perhaps show more grave results.

A significant number of healthcare workers tested positive for COVID-19 themselves, resulting in overburdening of the well staff, and patient-care related duties were taken care of by doctors, nurses, and orderlies alike, without the relatively sharp demarcations of responsibility that usually exist. Help was available to front liners in the way of a helpline, though the overburdened system demanded that they continue with their duties as per usual, to avoid interruptions to ward and HDU-based work. This naturally begs the question of whether health care was compromised as a result of the compromise, the well-being of health care workers was undoubtedly subjected to.

### A Way Forward

The challenges to palliative care noted during the COVID-19 pandemic were the precedence of critical care over palliative care due to large numbers of quickly destabilizing patients, lack of proper guidelines and training on palliation in the initial stages of the pandemic, barriers to communication due to the need for PPEs and healthcare worker burnout. Several strategies suggested following the first COVID-19 wave in Sri Lanka by Brabakaran et al, such as institutional disaster preparedness and health professional education remain more relevant than ever [8]. The author suggests the following steps to improve the palliative care of patients in times of pandemic:

1. Institutional policies to prevent burnout among healthcare workers:
2. Equal redistribution of health care staff for front-line work- equal distribution of front-line work amongst all HCWs at the institution, will ease both the physical and mental fatigue that front-liners feel as a result of their work.
3. Easily accessible counseling and psychological services for HCWs
4. Subsidies for HCWs by way of providing meals while on the job, groceries, etc. as was the practice in certain countries. It must be noted that free transport to and from work was



available to HCWs at NHSL during the pandemic.

5. Education of front liners regarding the ethical dilemmas they will have to inevitably face and equip them with the knowledge and skills to overcome these.
6. Education of HCWs regarding the importance of communicating with the families of critically ill patients and equipping them with the skills to communicate effectively and sensitively.
7. Making allowances for family members to see and visit their loved ones, especially those who are terminally ill.

## Conclusion

The third wave of the COVID-19 pandemic brought to light several dilemmas in palliation and humanities. Issues about providing the best medical care amidst limited resources became compounded by burnout among healthcare workers as work demands rose to previously unforeseen levels. While these problems may not be wholly defeated, there are lessons to be learned from them, that may soften the blow on the healthcare workers and foster better, more humane medical care for patients.

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