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**Author(s): | Dr Eve Namisango | Dr Emmanuel BK Luyirika**

**Title: The role of palliative care in response to fatal viral epidemics: A case for covid-19**

The COVID-19 pandemic poses a global health security crisis to health systems worldwide. This crisis is even more concerning in resource limited settings whose health systems are already constrained. Using epidemiological indicators, [statistical models predict](#) that cases in Africa are likely to soar, close to what has been witnessed in Europe. Covid-19 has had a gross multi-sectoral negative impact, challenging the progress towards achieving Sustainable Development Goals. COVID-19 patients face multi-dimensional symptoms spanning physical, psycho-social and spiritual/existential domains. The health workers suffer anxiety, burn out and are at high risk of indisposition and death arising from contracting the often fatal disease. Families equally grapple with being able to support their loved ones through the crisis in what has been described as the “scientific manner”, which is characterized by minimal or no physical interaction and resulting suffering in isolation for the patients. In this blog, we argue that palliative care, underpinned by a patient-centred and compassionate approach with a focus on the patient, family and health workforce welfare, has a key role to play in the response to this pandemic. It is worth emphasizing that palliative care is not synonymous with end of life care.

Palliative care relieves symptoms and suffering, regardless of one’s COVID 19 status or final health outcome and is inclusive of end of life care. Therefore, in line with [WHO recommendations](#), health systems in the African region should consider integrating palliative care into their COVID-19 response plans to optimize outcomes of care and protect the health workforce. In the subsequent sections, we highlight areas that palliative care can support in the COVID-19 response pared to the challenges at hand.

Patients experience complex and distressing symptoms such as breathlessness and pain. Palliative care professionals have extensive experience in the management of such symptoms and can thus support the training of health workers in the implementation of the symptom management guidelines and in-patient care. Furthermore, COVID-19 patients who experience severe symptoms require intensive care, yet most African health facilities have limited capacity to provide such care. [Care must be taken in triaging and selecting patients who may benefit from this service, given that higher mortality has been observed in ventilated patients and in intensive care units generally](#). Palliative care experts have honed this triage skill. Continuity of care for patients with co-morbidities should be sustained to maintain good health and welfare in these populations. Unnecessary hospital visits can be avoided by providing home/community-based care, a role palliative care is very well placed to support, given the expertise gained from the extensive use of home/community-based models to deliver health services.

Quarantines and social isolation are key disease containment approaches in public health preventive strategies in the COVID-19 response, which are lauded as effective interventions for controlling the spread of the infection to vulnerable populations in the communities. That said, isolation disrupts patient and family connectedness and social interaction, and exacerbates psycho-social, spiritual/existential distress to the already

vulnerable patients and families. Documented [psychosocial, and spiritual/existential concerns that come with fatal viral epidemics](#) include:

1. Effect of quarantine or isolation which negatively impacts on self-esteem, and is associated with loss of autonomy, stigma and discrimination.
2. Anxiety associated with the threat to human integrity and uncertainty around the outcome of the illness.
3. Lack of advance care planning services for those that may wish to set in place plans in case of death.
4. Lack of quality end of life care with an opportunity to be with their loved ones in the last moments of life.
5. Complicated grief which may arise from bereavement disruptions and failure to get good closures at the death of their loved ones.

These concerns are typical of what palliative care experts encounter daily and have mastered the science of meeting patient, family and health workers' needs to maintain an equilibrium amidst the crisis. Palliative care service providers should however be supported by governments and partners to leverage on mhealth technologies to deliver this care and support given that physical interaction may not be an option in many instances. This is how we can cope with the widespread shut down of religious/spiritual/existential services for patients and families. Palliative care teams can bridge this gap by supporting the adaptation of technology led mechanisms for social interaction which make it possible for family members to voice/video call their loved ones, who may be isolated.

Response to COVID-19 calls for multi-dimensional care to patients, families and suspected and probable cases. Besides the patients, the suspected and probable cases equally face psycho-social morbidity due to anxiety, uncertainty, stigma, discrimination, loss of autonomy and interrupted access to sources of livelihoods. Though the ethos of palliative care encourages physical presence and contact in the case of epidemics, palliative medicine can learn from the practice of tele-consults, and still be able to guide these deep conversations over voice or video calls to establish goals of care, patient preferences, etc.

Lastly, we must be mindful of the fact that confirmed, probable or suspected case status is difficult news, which must be conveyed to patients or suspected patients and their families in a very sensitive manner to mitigate potential psycho-social and existential/spiritual distress. Again, palliative care experts are accustomed to breaking bad news using evidence-based sensitive approaches. They are also accustomed to engaging in difficult conversations around death, and uncertainty. Indeed, many guidelines have been developed to support this need and palliative care teams can train and orient fellow health workers at the forefront of fighting COVID-19 to deliver better on this mandate. Once more technology-led innovations are required to support the dissemination of these materials and virtual training which could be self, or group led.

Palliative care helps mitigate the sense of failure and negative psychological impacts for patients, families, and health providers when they experience or witness pain and suffering that they can do little to alleviate. This is a useful strength, and much needed in the COVID-19 response. This also feeds into the resources available to manage health worker burn-out and should equally be prioritized.

We advocate for the recognition of the significant role of palliative care in alleviating human suffering and continued funding for hospices and palliative care services. Moreover, the medical fraternity does not yet have all the evidence to know what symptoms will linger for longer or what complications will arise months and years after patients have been discharged from emergency care programmes.

Critical palliative care interventions that must be part of the COVID-19 response include:

- Use of innovative technology led communication solutions to enable patients to communicate with their

loved ones and for families to receive personalised medical updates about the wellbeing of their loved ones; to mitigate against patients suffering in isolation.

- Provision of Personal Protection Equipment to palliative care providers, both institutional and community-based providers and training them on their use.
- Re-training and re-education of patients, families and palliative care providers in the context of COVID-19 to ensure continued provision of services.
- Integration of palliative care research into the COVID-19 responses to generate hypotheses and robust evidence to inform evolving interventions.
- Ongoing follow up of discharged COVID-19 patients to offer ongoing counselling, support and rehabilitation as may be needed.