

In the COVID 19 pandemic, many clinicians and care teams are having to adapt their care and work in crisis situations unlike ever before. Care delivery is rapid-paced, meaning that clinicians and care teams must react rather than proactively consider actions. The palliative care team must utilize the resources within their settings to mobilize care for patients who are very sick. Increased patient volumes mean the team must quickly adjust, placing additional strain on the team. High individual anxiety levels may cause higher anxiety on the team. Many clinicians have intense feelings in situations that feel out of control.

This pandemic is all-encompassing and may prompt many emotions and distress. Understanding the sources of distress allows individuals and teams to address and improve overall team and individual wellness. The following scenarios are common sources of distress for the team member and the team.

### **1. Redeployment to a new setting without context for the team, its culture, or climate**

Palliative nurses, physicians, social workers, chaplains, nursing assistants, and administrators are being redeployed to other teams or units. They may receive no orientation to the unit or have no prior relationship with their new team members. Common feelings of distress for palliative care team members include:

- Feelings of inadequacy in role and expertise
- Anxiety and distress due to lack of connection and support
- Distress about doing things “right” with the new team within unknown rules
- Frustration if working with a colleague(s) who lacks expertise and are closed to coaching

### **2. Providing goals of care discussions by phone and video without context of family**

With restrictions on visitors, health care has transitioned to telephone and video conferences. This results in loss of physical presence. Many palliative care clinicians are providing telehealth and telephone calls, often without much practice or training. Moreover, older adult patients may be less facile in telehealth. Common feelings of inadequacy may be present with the palliative care team or clinician due to:

- Sense that conversations feel stilted
- Inability to “read” the family as they cannot see them
- Awkward cadence or feeling that conversations are clumsy due to technology and delay of voice or pictures
- Interruptions due to drops of internet service
- Distractions from background noise or lack of privacy

### **3. Dealing with emotional aspects of COVID-19 care delivery**

Palliative care is often about physical presence, particularly during periods of intense suffering or during the dying process. The clinical care of COVID-19 is particularly intense as it requires aggressive treatments for rapidly progressive decompensation particularly from respiratory compromise, infection, and renal failure. In the acute care setting, it can be hard to witness the disappearance of the patient within the machinery of the ventilators, dialysis units, poles for intravenous medications, and vital sign

monitors. The result is the distress over seeing intense care with a high rate of mortality. Common feelings of distress among palliative care team members include:

- Intense grief over the suffering of patients
- Ambivalence participating in aggressive care that may seem nonbeneficial
- Responsibility for causing suffering for patients with aggressive COVID -19
- Guilt for not being able to do enough

#### **4. Making clinical decisions on PPE and resource utilization**

Palliative care is being present to the patient with serious illness. However, in many settings, palliative clinicians must consider the use of PPE within their visit. They may need to delegate a task to the person going in the room because the unit may be bundling tasks. Or they may have to decide how to best treat a patient based on medication availability, rather than best practice. Common feelings of stress among palliative care team members include:

- Sense of providing inadequate care
- Frustration of the inability to adhere to quality palliative care delivery
- Sense of injustice that PPE and resources are guiding care

#### **5. Coping with the intensity of working in the COVID-19 environment**

These are extraordinary times where a virus is so virulent. A patient who needs acute management rapidly declines with significant symptoms and distress. Many palliative care team members are witnessing difficult situations, and many clinicians try to put on a brave face. Some clinicians who have been on the front line may feel on the brink of emotional collapse. Common feelings among palliative care team members include:

- Not wanting to bother other members of the team to talk about the stress of working in the COVID-19 pandemic
- Lack of time to debrief about what the care looks like or difficult cases
- Feelings of being an imposter as the public is labeling health workers heroes
- A sense of “survivors guilt” since patients are dying, and the clinician is still alive

#### **6. Witnessing the loneliness of a patient with COVID -19**

Visitor restrictions means many patients are suffering or dying alone which is the antithesis to the goals of palliative care. Often, patients may decline so quickly in a hospital there is not time for loved ones to travel to the hospital. In long-term care facilities, fear of exposure and trying to protect other residents results in isolation. The result is that there is a lack of the presence of people important to the patient, the inability for face-to-face closure at end-of-life and the inability for the team to have their own closure with family. Common feelings of angst among palliative care team members include:

- Sorrow over witnessing patients consistently being alone at the end of life
- Grief and loss for the patient and inability to effectively support or mourn
- Inadequacy for not having the bandwidth to be substituted family members
- Guilt or urgency to make sure patients are not alone even with a busy case load
- Heartache for the loved ones of the patient who could not be there

## Steps for Proactively Addressing Distress

- 1) Recognize how you have helped the palliative care team and the organization care for patients with COVID-19.
- 2) Give you and your team the credit for the difference you made in the care of many patients.
- 3) Continue with the small gestures that make a difference to patients: holding their hand, massaging their hands and feet, and communicating with respect whether they are conscious or not.
- 4) Acknowledge that the COVID-19 pandemic has brought extraordinary times and that everyone is doing the best they can with their resources (human and physical).
- 5) Do not suffer alone - these are common feelings and many other people are feeling distress – and so it is important to share the distress.
- 6) Seek out other palliative care team members.
  - a. Talk to your team members in your support meetings.
  - b. Seek out your program leader to talk about distress and resources for support.
  - c. Initiate debrief meetings with the palliative care team, organizational colleagues, or healthcare colleagues.
- 7) Focus on the difference you have made to patients, families, co-workers, and the community.

## Helpful Tools and Links

Palliative Care Team Health and Resiliency During the COVID-19 Pandemic:

<https://www.capc.org/documents/791/>

Decompress Podcast by VitalTalk <https://podcasts.apple.com/us/podcast/decompress/id1506861758>

World Health Organization Mental health and psychosocial considerations during the COVID-19 outbreak. March 18, 2020

<https://www.who.int/publications-detail/mental-health-and-psychosocial-considerations-during-the-covid-19-outbreak>

NY Health Grief and Loss in the Workplace During COVID-19 April 15, 2020

<https://www1.nyc.gov/assets/doh/downloads/pdf/imm/workplace-grief-and-loss.pdf>

Institute of Health Media Team. What to Do and Say to Support Psychological Safety During the COVID-19 Pandemic

April 10, 2020 <http://www.ihm.org/communities/blogs/what-to-do-and-say-to-support-psychological-safety-in-times-of-crisis>

CAPC Monograph: Strategies for Maximizing the Health/Wellness of Palliative Care Teams

<https://www.capc.org/documents/98/>

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