

to coach other providers to have difficult conversations.^{12,13} Preparing front-line clinicians for how to handle negative emotions will be especially important; in particular, encouraging providers to express empathy and acknowledge emotions by calling them out when patients and families express strong emotions (rather than responding with more clinical detail and medical jargon) can sometimes help diffuse it. Providers should avoid terms like futility, which can promote an adversarial relationship with the family. Providers should reassure patients and families that they will not be abandoned and that patients will continue to receive compassionate care regardless of candidacy for life-sustaining treatment.

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Palliative Care in the Time of COVID-19: Reflections From the Frontline



To the Editor:

When our palliative care unit was closed to make room for COVID-19 patients, we were prepared. The virus had made its way to our shores in Singapore by January 23, 2020.¹ At the initial stages, Singapore, being the hyperconnected city that it is, was the country with the most confirmed COVID-19 cases outside China.² We are part of a large general hospital of 1800 beds with a 13-bed acute palliative care unit and a busy inpatient referral and outpatient service. We are also situated next to the National Center of Infectious Diseases where most COVID-19 positive or suspected patients were housed. Consequently, clinicians from our palliative care team were deployed to help fight in this nationwide health care crisis.

Our palliative care attending physicians volunteered to go into the COVID-19 wards together with senior

physicians from the rest of the hospital to help with the mounting patient numbers. Our chief advance practice nurse was sent to the frontline virus screening center, and we lost another advance practice nurse to the intensive care unit (ICU) where she used to be from. We had to familiarize ourselves with the donning and removing of personal protective equipment; gowns, goggles, and gloves became the byword rather than morphine and fentanyl. We went back to being general internal medicine physicians, infectious disease nurses, and ICU nurses.

Among other things, we lost our palliative care unit. Many of our palliative care nurses in the unit lamented a loss of their identity, their specialized roles, and commented on how they missed taking care of palliative care patients; vacation leave was also sacrificed in the call for solidarity and to help man the ever-expanding COVID-19 wards. Our art and music therapist could no longer come into hospital to work.

There was also the fear of catching the virus while at work and passing it to colleagues. Or worse, bringing it home to family. Although there was strong government and public support for health care workers, the public was still afraid of coming too close to us. Some of us excused ourselves knowingly from family or social gatherings.

Perhaps the isolation was the worst. We could not hold large group meetings anymore, and the usual staple of multidisciplinary rounds and journal clubs, which we took so much for granted, had to be replaced by virtual meetings. Those who were in the dirty wards usually isolated themselves from the rest of the team and often ate alone. So much of palliative care is about the camaraderie of being together as a team, these regular routines of team meeting provided the peer support that invariably strengthens us from burnout and builds resilience.³

However, it was the patients infected with the COVID-19 virus who suffered the most. They struggled with questions such as *How did I get it?* and *Is this going to get worse or Am I going to the ICU like the other person* and even *Will I die from this?*. These fears and questions are no different from our palliative care patients who suffer and experience these same feelings and emotions. The families suffered along with them. Often anxious, worried, and burdened and because of the no visitor policy in the hospital for this group of patients, they could only contact their loved ones online or on the phone. Many cried in the loneliness of their rooms.

Many of the patients did recover, and this disease certainly does not qualify as a life-limiting illness for many. But the principles of holistic care, which palliative care embodies so well,⁴ still apply. For instance, empowering our clinicians to manage physical symptoms, spending time on the phone (through a stained glass window) to care for their psychological needs, and comforting and encouraging these patients. For those of us who had to move from our usual line of work in palliative care into the frontlines of fighting this epidemic, the echoes of the words of Sheila Cassidy⁵ rings clear and true—that we in palliative care are here, walking through the darkness with you.

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