Original Article

# COVID 19: The New Normal in the Clinic: Overcoming Challenges in Palliative Care

**Deepa Kerketta Khurana, Saveena Gulati Raheja, Madhu Dayal, Dimple Pande, Usha Ganapathy**

Department of Anaesthesia and Intensive Care, Palliative Pain Clinic, VMMC and Safdarjung Hospital, New Delhi, India

## Abstract

**Background and Aim:** In the wave of COVID-19 pandemic, the whole world has come to a standstill. This led to a major setback for cancer patients jeopardizing their treatment plans. This study analyzes the coping mechanisms of running outpatient and inpatient palliative care services in these COVID-19 times – the New Normal. **Materials and Methods:** An observational study was conducted in the pain and palliative care unit at a tertiary care hospital, India. The data were collected from March 23, 2020, to May 22, 2020, of all patients coming to the clinic and inpatient referrals. Using manual and electronic records, demographic data was collected along with clinical data. Additional data were compiled with special attention to the patient's pain and its management. **Results:** Despite complete lockdown and initial low patient load, we saw a progressive increase in the number of patients coming to the clinic. A total of 108 patients visited our clinic (65 male and 43 female), of which 78% of the patients were from Delhi. The median age was 43.94 years (range 6 years to 76 years). We had 33 new and 75 old registered cases coming. The main reason was new-onset pain because of noncompliance of drugs; the opioid stock finished with the patient. We saw a very high number of patients requiring strong and weak opioids. Proper personal protection and social distancing helped in preventing crossinfection. None of our staff or patients fell ill during this time. Communication skills were modified to convey feelings and empathize patients. Telemedicine using phone and video calls was used and found to be useful. **Conclusion:** We share our experience and challenges of providing palliative care in our clinic which can be modified as per the individual requirements in other setups.

**Keywords:** Communication, COVID-19, pain clinic, palliative care, telemedicine

## Introduction

Cancer patients are the most vulnerable group to COVID-19 infection.[1] Since the outbreak of novel coronavirus, the world has come to a standstill. The lockdown which was implemented from March 22, 2020, brought enormous changes not only in the way of life but also in treatment preferences in hospitals in India. This led to a setback to the treatment plans for cancer patients.[2] The cessation of chemotherapy sessions, radiotherapy sessions, cancellation of surgical plans, and limited access to pain management and palliative care, all were jeopardizing. The World Health Organisation (WHO) had issued guidelines on how to maintain essential health services during the pandemic, highlighting maternal care, emergency care, immunization, and chronic diseases among others, but there was no mention of palliative care.[3]

Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi, is one of the biggest central government-run tertiary care hospitals. With the COVID-19 outbreak, all elective surgical cases and outpatient clinics were curtailed to divert the workforce toward the newly opened COVID intensive care unit and wards, with only functional emergency services.

After taking hospital administration into an agreement regarding palliative care as essential services, we continued to provide outpatient as well as inpatient services for the maximum benefit of patients.

With the expectation of COVID19 staying for long and suggestion of opening restrictions by govt authorities,[4]

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**Address for correspondence:** Dr. Dimple Pande, A2/165, Ground Floor, Safdarjung Enclave, New Delhi, India. E-mail: anaesthesia.mamc@gmail.com

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it is high time that we need to find solutions to live with the pandemic. This article describes our experiences and challenges regarding providing hospital-based palliative care with suggestions for the vision of future palliative pain clinic.

### Objectives

1. The purpose of conducting this study was to analyze the coping mechanisms of running outpatient and inpatient palliative care services in these COVID-19 times – The New Normal
2. To assess the needs of patients coming to the clinic in the current situation
3. To analyze the compliance of staff and patients to the new way of running the outpatient department (OPD).

## Materials and Methods

An observational study was conducted in the pain and palliative care unit under the umbrella of the Department of Anesthesia and Intensive Care at VMMC and Safdarjung Hospital, New Delhi. The data was collected from March 23, 2020, to May 22, 2020, of all patients coming to pain and palliative care clinic and bedside pain management referrals. The WHO step ladder is being used in cancer pain management.[5] We have been following the Ministry of Health and Family Welfare, WHO, and Indian Society of Anesthesiologist[6] guidelines for running OPD, written for pain and palliative care clinic.

### Data collection

The data was collected for 2 months post lockdown that is from March 23, 2020, to May 22, 2020. The data was collected from the electronic record-keeping, "Doxper APP,"[7] and the manual data records in our clinic. The data was analyzed for demographics, sex, diagnosis, age distribution, new cases, acute pain management referrals, WHO step ladder status, morphine requirement, referrals to fever clinic, and COVID infection among staff and patients.

## Results

The data was analyzed using Microsoft Excel. The total number of patients who visited the pain and palliative clinic was 108. The observed male:female ratio was 65:43 [Figure 1]. The median age was 43.94 years with a range of 6 years to 76 years. Eighty-four patients belonged to Delhi, and the others were from Uttar Pradesh, Haryana, and Bihar [Figure 2].

There were 33 new cases and 75 old registered cases [Figure 3]. They were mainly referred from the medical oncology, Radiation oncology, and the ear, nose, and throat department. Some cases were referred from other departments such as cancer surgery, hematology, plastic surgery, orthopedics, respiratory medicine, and casualty.

About 37% of the patients with head-and-neck diagnosis made the major load coming to the clinic with chief complaints of pain, oral thrush, wounds, and maggots [Figure 4].

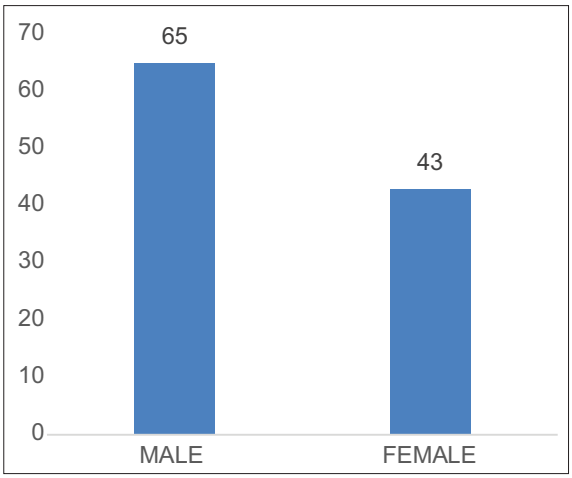


**Figure 1:** Sex distribution among all patients

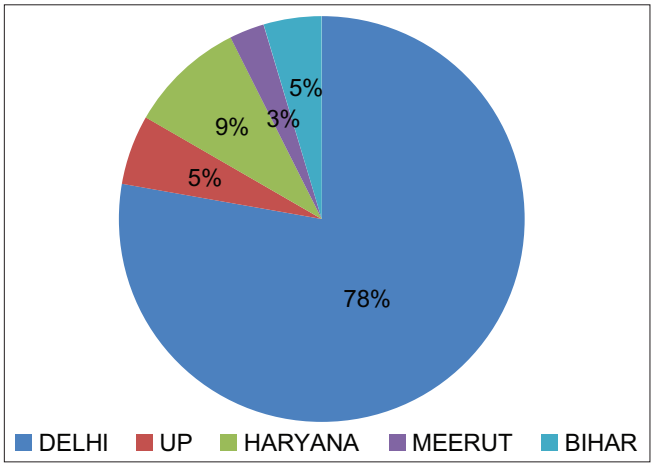


**Figure 2:** Statewise demographic distribution

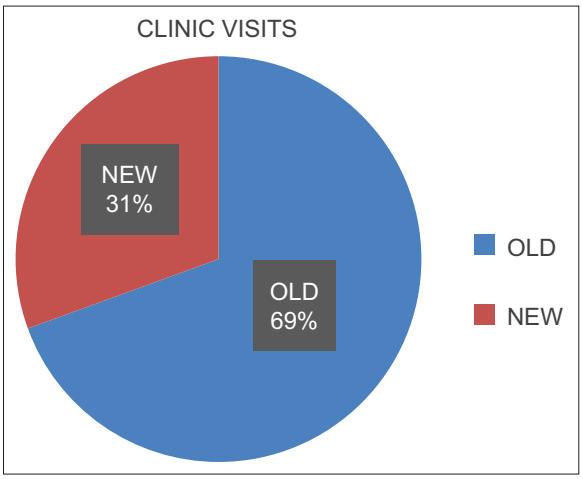


**Figure 3:** Total registrated cases

Seventeen patients came to the clinic with a visual analog scale of >8. The reasons for acute pain include new-onset pain, noncompliance of drugs, the opioid stock finished with the patient.

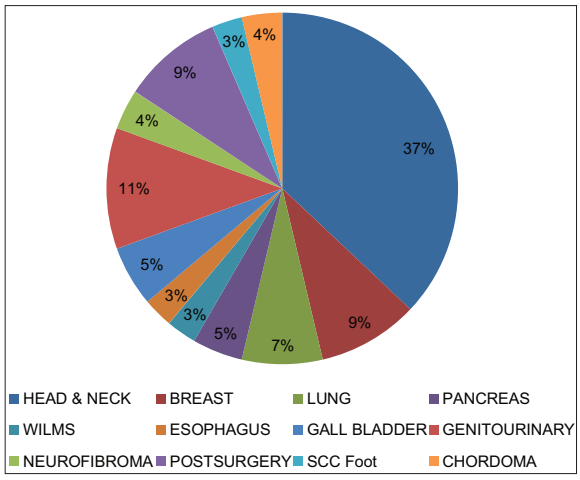


**Figure 4:** Distribution of patients according to the diagnosis

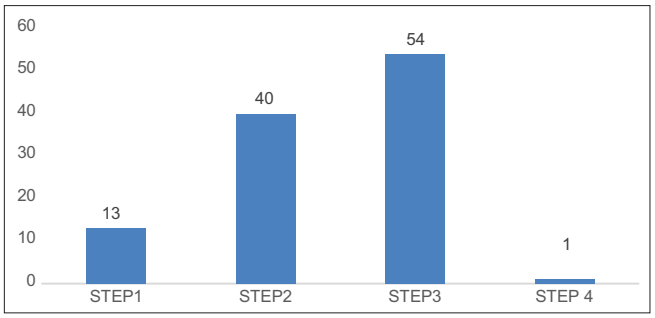


**Figure 5:** Patient distribution by the World Health Organization step ladder for cancer pain management

We saw a very high number of patients requiring strong and weak opioids [Figure 5]. Fifty-four patients were requiring Morphine with 30 mg and 60 mg as maximum daily morphine requirement [Figure 6]. Some of the patients were put on morphine by the primary team and were referred to us for dose escalation and optimization.

## Discussion

During COVID-19 pandemic, there are many reasons for psychological burdens not only for the patient but also for the physician. There are multiple reasons including uncertainty of future, anticipation of infection, social distancing leading to social isolation and loss of mental support. Also financial problems and difficulty in commuting due to lockdown add to their burden.

However, in spite of the total lockdown, we saw a footfall of 108 patients which was one-fourth of the census of the previous 2 months but still significant. The number of male patients was more as compared to females. The difference in the age of patients coming to the pain clinic was wide, i.e., 6 years to 76 years with a median age of 43.94 years. Although the recommendation in COVID 19 times suggests avoiding travel of children below 10 years and adults above 65 years, still, we saw their attendance in our clinic. The main reason for their visits includes new-onset pain, need for change in the treatment plan and finished opioid stock.

The movement in Delhi was difficult and it was even more difficult to cross state borders which were under heavy security with restrictions. We saw 84 patients belonging to Delhi, and the rest were from other states like Uttar Pradesh, Haryana, and Bihar. The patients from outside Delhi were staying with their relatives or staying in hospital premises. The cost of traveling intrastate becomes very high. We offered financial help to the patients, kits for personal hygiene, and dressing material.

The challenge was to run clinic simultaneously protecting patients as well as staff during this time.

Personal protective equipment (PPE) comprising N95 mask, glasses/face shield, and gloves was worn by staff sitting in the OPD [Figure 7], and PPE kit was worn when visiting a patient in the ward [Figure 8].

Personal and environmental sanitization was done regularly. Patients were checked for temperature by a noncontact thermometer, and hands were sanitized before entering the clinic; the mask was mandatory for patients and accompanying person. Social distancing was ascertained by limiting the staff by posting one doctor and nurse for a day. The patient was made to sit on a stool 1 m away with an artificial barrier placed in between patient stool and doctor table [Figure 9]. The patient stool was tied to the nearby furniture to maintain the gap. None of the patients and staff visiting the clinic during these times fell sick.

Lessons learned:

- This new way of patient management is now a part of the new curriculum, i.e., to live with the virus
- The agony of pain and suffering of these patients brought them to the hospitals, which is very much evident by the requirement of opioids
- We had made a provisional change regarding dispensing drugs for a longer duration with vigilance
- Proper personal protection and social distancing can prevent coronavirus infection
- Learning proper donning and doffing with a buddy
- Rational use of PPE kit
- Medical staff were compliant in following protection and social distancing
- Patients and their relatives initially found wearing the mask difficult, although a constant reminder in the form of posters, instructions, and providing them with face mask and small hand sanitizer helped us in enforcing these manners
- Implementation of government policy regarding providing palliative care at primary health care is still deficient. This leads to a need for traveling across states just for pain management. Creating a telephonic network among the palliative care physicians helps in referring patient and information exchange
- Communication skill is an art behind those mask and glasses. The use of eye contact, expressions, pitch of voice and hand gestures should be emphasized.

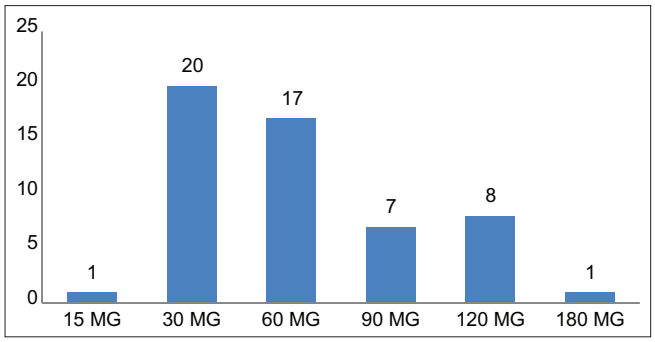


**Figure 6:** Distribution as per the daily morphine requirement

**Figure 8:** Use of personal protective equipment kit

## Modifications needed in the current situation to provide palliative care

### *Screening for cancer patients*

Separate entrance for cancer patients should be made.[8] Cancer patients should be screened and specific questions related to symptoms of COVID-19 should be asked. History of fever cough, cold, diarrhea, and whether living in a containment zone should be asked. The temperature should be checked by a noncontact, infrared thermometer.

### *Communication skills*

Before you start the conversation, tell the patient that you are going to wear a mask and protective glasses for the safety of both.

Good communication involves verbal and nonverbal communication. The present situation is hampering our most important tool in treatment. As per the guidelines, a clinician using N95 mask, face shield, and social distancing makes the verbal communication part very difficult while talking, reflecting, and summarizing.

Utilizing the nonverbal communication had never been so important as in today's situation. The nonverbal communication[9] skill which comprises 80% of the whole communication includes facial expression, eye contact, tone and intonation of voice, body posture, gestures, physical

**Figure 7:** Palliative clinic use of personal protective equipment

**Figure 9:** Social distancing

appearance, and the use of space should be used to the maximum. Touch can be used only in an appropriate manner and after wearing double gloves.

Keep the contact time, reflection and summarizing part to a minimum.

### *Telemedicine*

We had used video conferencing for our patients who were not in a physical condition to come to the clinic and found it very useful.

Telemedicine, a known method of delivering medical services, now becomes a critical technology to deliver palliative care.[10] It has many advantages including maintenance of social distancing, saving travel time, convenient and save resources like PPE.

### *Telemedicine setup*

Calton *et al*. have suggested certain practical tips to start telemedicine setups, such as patient considerations and clinician considerations.[11]

- Patients need access to a smartphone, tablet, or a computer with audio and a camera as well as a data plan or Internet connection

- Patient considerations – Coach patients on telemedicine communication etiquette
- Clinician considerations
    - Create a therapeutic telemedicine environment through the following techniques:
- Choose a quiet space which is private with good lighting.
- Use a laptop or desktop computer.
- Look at the camera to ensure good eye contact.
    - Pay even closer attention to subtle comments made by patients, caregivers and their body language
    - Look for unique opportunities and use the technology creatively.

## Conclusion

We share our experience and challenges of providing palliative care in our clinic which can be modified as per the individual requirements in other setups. Our articles also emphasize the future vision for palliative care clinics in this COVID-19 pandemic with the need for more further studies and widespread implementation.

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Nil.

### Conflicts of interest

There are no conflicts of interest.

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