INTEREST GROUP REPORT
PALLIATIVE CARE

COVID-19 Pandemic Draws Palliative Care into the ED

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I work in an ED in New York City. As of this writing, NYC has been the hardest hit of the U.S. cities during the COVID-19 pandemic. In some ways, it was inevitable. The city has over eight million residents and is one of the densest areas in the U.S. We use public transportation, gather for entertainment and dining, and have three international airports.

I have worked as the palliative care liaison for my department for several years. We are fortunate to have both a palliative care service and a hospice floor. A palliative care fellow is on call for our hospital 24 hours a day. Still, bringing palliative to the ED on a timeline that worked for the ED was often a challenge. If we called overnight, they would see the patient first thing in the morning. If a patient was actively dying, they would provide recommendations for symptom management over the phone. Occasionally, they would be willing to talk with the family over the phone to help clarify goals of care. Sometimes, the pager didn't get answered. Still, it was much more than other hospitals had access to.

As the number of COVID-19 cases across New York City soared, the palliative care team in our hospital system recognized the exponential need for their services. Some hospitals in the system had no palliative care presence at all. Some of them, like our hospital, had a service, but that service was likely to be overwhelmed. Furthermore, there was concern from the beginning that we might run out of ventilators. While ED and ICU doctors strategized how to use one ventilator on two patients, the palliative care team considered how best to keep those patients who didn't want extraordinary measures from getting on ventilators in the first place. How could we start having these conversations sooner, in the beginning of a patient's hospital stay?

The Palliative Care Department at the main academic center put together a list of communication tips that was widely disseminated but quickly learned that the ED needed more. Shortly thereafter, they established a 24-hour hotline connecting to palliative care-trained attendings and fellows who could have the conversation with the patient, family or health care proxy. As the volume of COVID-19 patients in the EDs increased, though, the calls dropped off. It wasn't that there wasn't a need — it was that with the surge of COVID-19 patients, the ED providers didn't even have time to make the phone call to the 24-hour line. They needed more help. They needed someone on site.

At the same time that the EDs were overwhelmed, some of the hospital system's services had less to do. Elective surgeries and clinics were cancelled. There were doctors who wanted to help. In my ED, we used ophthalmology residents to act as palliative care "runners," serving as in situ palliative care extenders. They would see a patient, determine the decision-makers, get health care proxy paperwork filled out, talk with the family, and connect with the 24-hour line if it was felt that the goals of care were unclear. They also set up iPads for video calls because patients weren't allowed to have visitors. They helped patients and families connect at an incredibly disconnected time.

Redeploying these residents served so many purposes: ED physicians got onsite support, palliative care physicians got connected, and ophthalmology residents got an opportunity to connect to patients and families on a less clinical, more human, level.

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By performing these primary palliative care tasks, these residents provided valuable, patient-centered care during a challenging time. It gave them the opportunity to help during a crisis that they might have otherwise had to sit out. As the volume of COVID-19 patients is waning, plans are being made to re-open clinics and restart surgeries. The residents will go back to their surgical subspecialty training. I will remember how helpful having someone dedicated to primary palliative care in the ED was during the crisis. Their training, done over video, was not difficult and could be recorded and used during another surge of patients. I strongly recommend that this model be considered in EDs that find themselves in similar situations in the future. For more details about the implementation of the 24-hour hotline, see catalyst.nejm.org/doi/full/10.1056/CAT.20.0204. ●