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COVID-19, decision making, and palliative care

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Advance care planning (ACP) and medical indication

The primary goal of ACP in the context of COVID-19 is to avoid unwanted hospitalizations and intensive care treatment, which would unnecessarily burden these health care provisions and may aggravate the need for rationing (triage). In order to achieve this goal, it is of utmost importance to explore and document the patient's preferences clearly in an emergency document (e.g. the Swiss version of Physician Orders for Life Sustaining Treatment, termed "[Ärztliche Notfallanordnung](#)", ÄNO).¹

Patients who are currently treated by specialized palliative care teams will, in most cases, not be eligible for intensive care treatment in the case of a COVID-19 infection. This is also true for most patients in nursing homes, according to the [triage criteria of the ASSM](#).²

Several palliative and nursing home patients have already established advance directives. It is important to document the patients' wishes and make the documents available for an acute situation. Patients with decision-making capacity should be informed of the risk of a COVID-19 infection and asked about their preferences, which should be documented in the charts.

Importantly, the residents/patients and their families should be informed that, even if they express a wish for hospitalization and intensive care in the case of severe COVID-19 disease, this wish may not ultimately be put into practice if there is a lack of medical indication or if scarce resources need to be rationed. Advance directives demanding "maximum treatment" are not legally binding according to current Swiss law, and can be overridden by the lack of medical indication.

The clinical options for these patients in the case of COVID-19 disease are the following:

- If they have a benign course, they continue to receive the usual care.
- If they have a severe course, which can ensue with a delay of several days, the treating physician will decide on the medical indication for a hospital transfer with curative intent (for palliative or nursing home patients this will be the case only in a minority of cases). The patient will of course have the right to refuse the transfer.
- If the medical decision is to offer palliative care, then it has to be decided whether this should take place in a hospital setting or in the nursing home. This will depend:
 - o On the severity and complexity of the patients' symptoms and their additional care needs
 - o On the nursing home/ambulatory care capacity of delivering quality palliative care (nursing presence? mobile palliative care team support available?)
 - o On the availability of hospital/palliative care unit beds
 - o On the patient's wish



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A major advantage of a decision based on the medical indication, particularly in a context of rationing of resources, is that it takes the weight of the decision away from the family and the health care proxy, thus reducing the risk of complicated bereavement. For all the other cases, ACP and shared decision-making are reliable tools to relieve the burden on patients and families. Psychosocial and spiritual care of the patient and especially the family is of paramount importance in these situations (see also the documents on the newly established [Covid-19 Spiritual Care website](#)).³

The role of palliative care in triage decisions due to COVID-19

The COVID-19 pandemic, at its foreseeable peak, is likely to surpass the capacity of the Swiss health care system, particularly with regard to ICU beds (ICU stays are usually longer than a week). If no effective treatment is found quickly, triage decisions might have to be taken concerning access to hospitals and ICUs. To maximize numbers of lives saved, the triage should give best possibilities to those patients who have the highest probabilities to benefit from intensive care.

A framework for such decision has been published by the SAMS and the Swiss Society for Intensive Medicine (see above). It is not the scope nor the competence of palliative care specialists to add a different set of triage criteria to the already existing ones. Rather, this document strives to define the ways in which palliative care can contribute to better patient care in such a triage context. Based on clinical experience with COVID-19 so far, particularly in Ticino, the following general principles can be established:

1. All COVID19 patients with a significant risk of dying should have access to early palliative care

Any triage policy, be it at the local, cantonal or federal level, must underline the pivotal role of palliative care for those patients whose triage decision is not to offer life-sustaining care, as well as for their families and HCPs. It is an ethical imperative to provide high-quality palliative care for all patients who are likely to die from COVID-19, especially given their high symptom burden (dyspnea, anxiety etc.) and the significant distress of their families, which is compounded by visit restrictions.

2. Prevent triage discussions by clarifying goals of care with the patients and healthcare proxies in advance, especially in nursing homes (advance care planning)

See above for details.

3. Triage decisions should involve a palliative care specialist

As triage decisions are complex, they should never rest on a single person, and should involve an interdisciplinary team consisting e.g. of an intensive care physician, an internist, and a palliative care specialist.

4. Psychosocial and spiritual care of patients, relatives and health care professionals (HCPs) are of paramount importance

The burden of triage is manifold: feelings of abandonment by the patient and family (which can lead to complicated bereavement), moral distress for the involved HCPs (which can lead to burnout). The availability of qualified psychosocial and spiritual support, including in particular bereavement services, is essential.



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