

Palliative Medicine Offers Lessons for Pandemic Preparedness

Porter Storey, MD FACP FAAHPM

Although no one can predict the future, the similarities between H5N1 influenza and the deadly Spanish Flu of 1918 are disturbing. Certainly in this time of rapid travel and high population density we are extremely vulnerable to a rapidly spreading, deadly disease. Whether it proves to be H5N1 or some other public health emergency, *preparing for a pandemic is imperative.*

Because of the work that we do every day, palliative medicine specialists and hospice and palliative care teams should be particularly active and involved in preparing for pandemics.

We bring a vital perspective to the preparedness efforts; we genuinely care

- for the terminally ill patients who are not likely to get a hospital bed or other scarce medical resource in a time of crisis
- for the large numbers of patients who will be triaged to “comfort care only,” however that is defined
- for our teams and organizations that need to be functioning extremely well at a time of crisis in order to meet these needs
- for our families and communities who will need our support and care at home and need our presence after the pandemic has passed.

Meeting these extraordinary needs poses great challenges on many levels, but *we can prepare for a pandemic.*

Lessons Learned from Palliative Care

As palliative medicine specialists we can help our communities work effectively to provide needed care. Hospices and palliative care teams have provided needed services and coordinated resources for many families in times of personal crises. We recognize the needs of families and volunteers to care for critically ill patients in their homes, in nursing homes or retirement centers, or in hospice or hospital inpatient units. We have already learned to effectively organize resources—financial assets, human

resources, and personal strengths.

We have much to offer our colleagues, who may not be familiar with the management of respiratory failure outside an ICU, with palliating end-stage symptoms, or with helping patients, families, and staff members cope with multidimensional crises. They will need our help in caring for the patients triaged to “comfort care only.” These patients deserve high-quality, humane, compassionate, ethical, and effective care—even if the ICU and other resources are being used by others. Our colleagues may also need our help coping with death and dying. We will all need help from each other to grieve effectively and continue on.

Recommendations

We must become more engaged with our communities, which will be the “center of mass” of our efforts. Interinstitutional, neighborhood, and personal interactions can all be used to heighten awareness, build partnerships, detect particular vulnerabilities, and develop a cohesive action plan. If the priorities and plans are developed by the community, the required sacrifices are much more likely to be forthcoming.

We must expand our educational outreach with presentations, materials, and personal appeals to help our colleagues and institutions increase their skills and competence.

Our patients will be best served by a strong and healthy workforce that feels protected and supported. This kind of workforce will be able and willing to take the risks involved in providing care in this challenging time. We should strongly consider:

Increasing strength and health

- Provide tangible rewards for health-care workers who see their physicians annually, increase their aerobic capacity, increase their flexibility or upper body strength, and move closer to their ideal weight.
- Assist workers in obtaining an additional 3-month supply of their personal medications.

Providing protection and support

- Assist workers in making the necessary child and elder care arrangements so they can be available when schools and most day care facilities are closed.
- Provide training, equipment, and medication to prevent staff from becoming ill, including the following:
 - large supplies of personal protective equipment in all service locations.
 - training in how to avoid contamination from such common movements as hand from keyboard to nose.
 - microbiological testing to ensure that such training and practice are effective.
 - adequate supplies of antiviral medication for prophylactic use by frontline workers.
- Provide extensive preparations to ensure that healthcare workers do not take a deadly disease home to infect their families. These measures could include
 - setting up facilities to allow workers to change into (disposable) scrubs before starting work and to wash extensively and remove these scrubs before leaving the facility. These facilities should be available to both hospital/inpatient unit-based workers and those making home visits.
 - enforcing the use of these facilities and confirming success with microbiologic testing.
- Develop clear policies to describe the appropriately generous compensation that will be awarded to those that take the risks inherent in providing such care.
- Establish clear policies and procedures to reassure workers that should they or their families become ill, they will be first priority for full intensive care efforts.
- Reevaluate insurance coverage to reassure workers that should they die from an occupationally acquired

disease, their families will not suffer financially.

- Because the above preparations are very costly and some staff will not be willing to take the risks involved in hands-on care, every effort should be made to develop means of working from home.
 - Telephone support for patients triaged to “comfort care only” should be developed in conjunction with local hospices and hospital emergency centers.
 - Stockpiling, telephone prescribing, and backup delivery methods for essential pharmaceutical agents should be developed and implemented.
 - Team meetings using internet meeting software should be practiced extensively.
 - Web-based electronic medical record access should be available to all patient care staff.

- Protocols for “speakerphone consultations and hospice admission visits” should be developed and practiced in hospital, nursing home, and home settings.

Pandemic Preparedness Offers Opportunities

Our communities can pull together now so when a pandemic has passed we can recognize heroic contributions to the common good and know that we did all we could. In the process, we might come closer to consensus on just methods of allocating our limited healthcare resources.

Our teams and colleagues can become much more proficient at caring for the gravely ill. Palliative medicine might be widely recognized for the significant contribution it is making, and be supported accordingly.

Certainly we can use this opportunity to muster our personal and organizational resources. We can develop physically,

socially, psychologically, and spiritually to meet this challenge.

Suggested Readings

- ACP Position Paper, The healthcare response to pandemic influenza, www.acponline.org/college/pressroom/pan_flu.htm
- Pandemic influenza working group, University of Toronto Joint Centre for Bioethics. *Stand on Guard for Thee—Ethical consideration in preparedness planning for pandemic influenza*. November, 2005. Available at http://www.nciom.org/projects/flu_pandemic/5-03-06_Thompson.pdf
- Gostin LO. Medical Countermeasures for Pandemic Influenza: Ethics and the Law. *JAMA* 2006; 295:554-556. Available at <http://jama.ama-assn.org/cgi/reprint/295/5/554?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=pandemic+influenza&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>
- Clark CC. In harm's way: AMA physicians and the duty to treat. *J Med & Philosophy* 2005; 30: 65-87.
- Gibson JL, Martin DK, Singer PA. Priority setting in hospitals: fairness, inclusiveness, and the problem of institutional power differences. *Social Science & Med* 2005; 61(11): 2355-2362.
- Kotalik J. Preparing for an influenza pandemic: ethical issues. *Bioethics* 2005; 19(4); 422-431.
- Porter Storey is the executive vice president of the American Academy of Hospice and Palliative Medicine.*