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Perspective

Compassionate Communication and End-of-Life Care for Critically Ill Patients with SARS-CoV-2 Infection

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ABSTRACT

Public health strategies recommend isolating patients with SARS-CoV-2 infection. But compassionate care in the intensive care unit (ICU) is an ethical obligation of modern medicine that cannot be justified by the risk of infection or the lack of personal protective equipment. This article describes the experiences of clinicians in ICUs in the south of Spain promoted by the Andalusian Society of Intensive Care SAMIUC, in the hope it will serve to improve the conditions in which these patients die, and to help their families who suffer when they cannot say good-bye to their loved ones.

In the south of Spain, healthcare professionals use daily videoconferencing to improve communication between clinicians, patients, and their relatives who cannot visit them in the ICU. This close communication allows families to see their loved ones and extends communication between healthcare professionals, patients, and their relatives. To allow family members to accompany patients at the end of life, it is possible to adapt public health rules to the epidemic situation.

The SARS-CoV-2 pandemic has placed healthcare professionals in the face of an unprecedented scenario, and has led to patients who are affected by SARS-CoV-2 infection dying alone in hospitals unaccompanied by their loved ones.[1]

Since the beginning of the pandemic in March 2020, the Infectious Diseases Working Group of the Andalusian Society of Intensive Medicine (SAMIUC) has promoted a series of measures aimed at improving communication between critically ill patients in isolation and their family members. Through videoconferencing, healthcare professionals can first provide daily clinical information updates to patients' family members, allowing families to see their loved ones through the screen of mobile phones. When patients recover a level of consciousness and are able to understand their condition and communicate with loved ones, this can be extended to allow communication between healthcare providers, patients, and their family (see figure 1).

From the beginning of the pandemic, the intent has been to prevent ICU units from becoming isolated "radioactive bunkers," and efforts have been made to provide patients with personal objects provided by family members such as photos, radios set to patients' favorite stations, and even letters of encouragement from family members and anonymous volunteers who want to contribute to the care of patients, which are read to patients by the healthcare staff.

Some patients do not overcome the disease, and we adapted clinical and epidemiological

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measures to accommodate their end-of-life situations. At the end of a patient's life, the care plan must be to avoid suffering and respect the dignity of the person.[2] In the ICU, the lack of family and friends at the end of a patient's life must be addressed as an ethical conflict. Quality care in modern medicine must ensure and improve end-of-life care for the critically ill, whether or not the cause of hospital admission was SARS-CoV-2 infection.

Without a doubt, the safety and protection of patients' relatives and the uninfected population are the top priority, which is why they are restricted from visiting patients in hospitals, but the end of life is an extraordinary situation and must be addressed as such. At the end of life, patients' physical, psychological, and spiritual symptoms must be managed effectively; sensitive communication regarding the adequacy of care is mandatory; aligning treatments with patients' preferences and meeting the needs of family members and relatives is a priority.[3] This last aspect must include consideration of family members' offers to accompany patients in their last moments in the ICU. We have established that patients may be accompanied at the end of life by a single family member, after we determine that the family member has no symptoms of infection on arrival at the hospital, and after we explain the situation of terminal illness and the risks the family member assumes when he or she accompanies the patient at the end of life, and after we provide the family member with individual protective equipment that we help put on and later remove. After the patient's death, there is clinical follow up with the family member, who must agree to comply with confinement measures at home, and to alert the healthcare team if symptoms appear in the next 14 days. With these measures we have sought an intermediate course of action that respects the ethical values in conflict: on the one hand, the possible harm to third parties by the risk of infection of the family member; on the other, the dignity of patients as they face the process of dying alone without the company of loved ones.

FIGURE 1. A patient has her first family contact with her son by videoconference after more than three weeks in the ICU of the University Hospital of Jerez. Used with the permission of the patient and family. Photo: Francisco Pérez Domínguez, ICU nurse.

In our short experience in this regard, all of the family members chose to accompany their loved ones as they died in the ICU under these conditions.

In addition to disease prevention, diagnosis, monitoring, and treatment, comprehensive critical care in the ICU requires that adequate palliative care be provided at the end of life. Comprehensive care includes not only the administration of appropriate drugs to relieve pain or dyspnoea, but also the company of patients' family members, as a part of attention to patients' needs, to ensure the most comfortable environment possible. To achieve that goal, comprehensive care gradually gives more importance to caring, rather than to treatments or diagnostic tests, and this caring includes the presence of family members. The caring continues not only while family members accompany patients during the process of dying, but also includes attention to bereavement once patients have died. It is advisable to offer psychological support to family members during this pandemic.

Modern bioethics grew and developed in parallel with intensive care, facing different conflicts, adapting to the times, sharing scarce resources. In the middle of the last century, ethical conflict arose with the shortage of respirators during the polio epidemic in Copenhagen.[4] Unfortunately, we have been on the verge of reviving the worst weeks of that outbreak.[5] Patients' autonomy and quality of life were goals at the end of the last century.[6] Now we must assume the challenge of assisting patients' family members to accompany their loved ones at the end of life while we minimize the risk of infection and maximize patients' dignity as they die in the ICU during the SARS-CoV-2 epidemic. Compassionate care in the ICU is an ethical ob-

ligation in modern medicine, and its absence cannot be justified by the risk of infection or a lack of personal protective equipment. The simple justification is human decency.

NOTES

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2. R.T. Gerritsen et al., "Comparing Quality of Dying and Death Perceived by Family Members and Nurses for Patients Dying in US and Dutch ICUs," *Chest* 151, no. 2 (2017): 298-307.

3. Á. Estella et al., Bioethics Group of Work Spanish Society of Intensive Care SEMICYUC, "Update and recommendations in decision making referred to limitation of advanced life support treatment," *Medicina Intensiva* 44, no. 2 (March 2020): 101-12.

4. J.B. West, "The physiological challenges of the 1952 Copenhagen poliomyelitis epidemic and a renaissance in clinical respiratory physiology," *Journal of Applied Physiology* 99, no. 2 (August 2005): 424-32, doi: 10.1152/japplphysiol.00184.2005.

5. J.L. Vincent and A.S. Slutsky, "Coronavirus: just imagine . . . ," *Critical Care* 24, no. 1 (March 2020): 90, doi: 10.1186/s13054-020-2824-8.

6. T.L, Beauchamp and J.F. Ch*ildress, Principles of Biomedical Ethics,* 5th ed. (New York: Oxford University Press, 2001); M. Angell, "Respecting the Autonomy of Competent Patients," *New England Jounal of Medicine* 310 (26 April 1984): 1115-6, doi: 10.1056/NEJM198404263101710.