

# Pediatric Palliative Care When COVID-19 Positive Adults Are Dying in a Children's Hospital

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In March 2020, Montefiore Health System in the Bronx, New York, received an influx of adults who were critically ill with coronavirus disease (COVID-19). The Children's Hospital at Montefiore (CHAM), a 130-bed facility attached to an adult hospital, accommodated adult patients in the PICU, inpatient wards, and post-anesthesia care unit. CHAM pediatric faculty and housestaff were deployed to serve as primary care physicians and subspecialists for these adults (up to 84 years old), anticipating up to 100 patients.

Among many challenges faced was the commitment by the pediatric faculty and staff to find a way to continue family-centered and compassionate care in the face of social distancing rules during the pandemic. Our goal was to preserve the patient's humanity and their relationship to family and friends who were not permitted to visit. There is an ethical imperative to provide palliative care during a crisis when lives will be lost.<sup>1</sup> As a result, we chose to rapidly expand our palliative care capabilities by training frontline medical providers and enlarging our pediatric palliative care presence to serve each adult admitted with COVID-19.

## RAPID EXPANSION OF PEDIATRIC PALLIATIVE CARE

Through deployment, the palliative care presence was expanded from 1 hospice and palliative care board-certified pediatrician (S.E.N) to a team that included 15 pediatricians, 2 nurse practitioners, and 8 psychologists in 3 days. Our standard hospital palliative care team was revised to an in-house consultation team, with all other team members working remotely through televisits (telephone calls) 7 days a week. The telephone-based team was divided into 2 groups: supportive callers and bereavement callers; these assignments did not change for the duration of their deployment (Table 1). Selection for deployment to palliative care was a collaborative effort between the division chiefs and the chairman of pediatrics. Most clinicians selected for this assignment indicated a willingness to participate in the program. Except for 2 pediatric fellows who were deployed as part of the in-house consultation team, the others deployed had work accommodations due to age >65 years, medical

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exemptions limiting their ability for direct contact with patients with COVID-19, and/or their clinic practices being severely reduced in patient volume. Within the first 48 hours of deployment, each person received individual feedback from the palliative care specialist. In some cases, the clinician was not well suited to this deployment because of a mismatch of skill sets. The division chiefs were notified when reassignment needed to occur.

The in-house physician consultation team, expanded to include 2 pediatric hematology and oncology fellows deployed because of their previous communication training, worked in overlapping 12-hour shifts, with overnight phone consultation available from the specialist. Supportive callers, deployed pediatric clinicians and psychologists, made daily phone calls to patients and their families to combat the isolation caused by the illness. They received daily updates by reading the electronic medical record after the primary medical teams completed morning rounds. Their telephonic visits incorporated these updates and were timed to allow for supportive listening during traditional visiting hours that were no longer possible. Within 24 to 48 hours of a patient's death, the bereavement callers (psychologists) contacted the family. They were separate from the supportive callers to decrease moral injury to the deployed clinicians.

None of the deployed individuals had formal palliative care training; thus, a virtual training session occurred before deployment. The goal was to teach basic palliative care assessment tools that could be employed by telephone, addressing the physical, emotional, social, and spiritual aspects of pain likely to be experienced by inpatient adults and their families who were not allowed to visit. To ensure

**TABLE 1** Deployed Pediatric Palliative Care Team

Team Roles and Hours	Responsibilities
In-house consultation team, 7 AM–10 PM plus overnight telephone support	Daily rounding on highest-risk patients Advanced symptom management Complicated advance care planning Medical decision-making support End-of-life care
Supportive callers, noon to 8 PM	Calling each patient and family members daily Basic counseling for anxiety, depression, and fear Screening household members for COVID-19 symptoms, providing related education
Bereavement callers, noon to 8 PM	Acute grief counseling for 3 wk for any family member with first contact within 24 h after death Anticipatory guidance regarding funeral planning and collection of personal belongings Referrals for complicated grief

uniformity of education and style, phone scripts modeled on the work of VitalTalk<sup>2,3</sup> were created and shared as note templates to guide callers through common scenarios. Templates provided guidance for more effective open-ended conversations with patients and their families.

Note writing style in palliative care is markedly different from traditional medical notes and from mental health documentation and thus was taught. Emphasis is placed on directly quoting patients and families, enabling the primary medical team to get to know their patients and families in more depth. Instruction provided by the palliative care team to patients or families was specifically described, allowing the primary care teams to have a transparent view into the palliative encounters. All notes included a designated section in which concerns raised by the patient and their family were communicated to the social work and primary medical teams. This became an essential communication tool connecting in-house and remote team members.

Spiritual and existential pain are most acute during a crisis that involves large-scale suffering and loss of life. A brief spiritual assessment was completed on admission and when

desired, we provided televisit connection with voluntary community chaplains representing many faith traditions. Because clergy were not able to be at the bedside performing rituals associated with the end of life, we had envelopes with prayers available in multiple languages for use by patients and staff.

### CARING FOR EACH OTHER

Deploying professionals with no previous palliative care training to a palliative care team put them at high risk for “second victim syndrome” commonly seen in residents.<sup>4</sup> Because our team was composed of medical providers and mental health providers, we lacked a common language for support. We developed a twice weekly virtual “connect” group that blended the medical debriefing model with a mental health processing group. The goal was to share successes, challenges, and provide feedback on the functioning of the newly expanded team. To build team connection between the remote workforce and the hospital-based physician leads, we created a weekly informal, optional virtual social hour. Because employees are not immune to COVID-19,

we built into our schedule a roster of back-up team members available in case any primary team member needed to leave their assignment because of illness or the stress of a palliative care deployment.

## CONCLUSIONS

The presence of a pandemic does not mean that a children's hospital needs to halt or cut back services. In <3 weeks, CHAM admitted >150 COVID-19 positive adults to our hospital. All received the services of the deployed pediatric palliative care team. Before March 30, there was only 1 palliative care pediatrician providing service to an entire children's hospital. In this new model, 1 specialist was able to provide training and oversight to an entire deployed team and quickly expand services. The team completed >150 new consultations, 700 supportive calls were made, and 38 families received bereavement

counseling over 6 weeks. During calls, families often expressed gratitude for our services.

Our team worked to combat the isolation caused by visitor restrictions, the fear created by an incompletely understood illness, and the heightened demands placed on the standard system of care. This approach may be useful for other children's hospitals that may have similar situations in the near or distant future. Palliative care remains essential to alleviate the suffering of our patients, their families, and frontline providers during this time of great uncertainty and loss.

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## ABBREVIATIONS

CHAM: Children's Hospital at Montefiore

COVID-19: coronavirus disease

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