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Viewpoint

The crucial role of nurses and social workers in initiating end-of-life communication to reduce overtreatment in the midst of the COVID-19 pandemic

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Abstract

The large scale and rapid spread of the current COVID-19 pandemic has changed the way hospitals and other health services operate. Opportunity for patient-centred decision-making at end of life is being jeopardised by scarcity of health system resources. In response, the traditional doctor-initiated advance care planning (ACP) for critical illness may also need to be readjusted. We propose nurse-led and allied health-led ACP discussions to ensure patient and family inclusion and understanding of the disease prognosis, prevention of overtreatment, and potential outcomes in crisis times. We highlight known barriers and list enablers and short-term opportunities to assist in the culture change.

The crucial role of nurses and social workers in initiating end-of-life communication to reduce overtreatment in the midst of the COVID-19 epidemic

Medical technology and therapeutic advances have enabled us to prolong life expectancy. However, in older people with advanced irreversible multi-morbidity, prolonging suffering and impairing quality of remaining life may be questionable. The benefits of advance care planning (ACP) in preventing unnecessarily aggressive and futile treatments near the end of life are well known among clinicians. Paradoxically the uptake of ACP remains low and is a challenge globally.

Recent awareness of the need for documentation of patients' wishes has been heightened due to the high infection rates of Coronavirus 2019 (COVID-19) pandemic, with high mortality risk among older people and/or those with underlying chronic conditions. This rapid spread of COVID-19 is placing strain on existing resources and restricting universal healthcare access. Can the urgent end of life decision-making requirements during public emergencies such as restricted access to intensive care [1] or the appropriateness of resuscitation brought on by this pandemic [2] be met? We propose that this time of global crisis is an opportunity to rethink and reform the models of end-of-life care planning.

End of life discussions are usually doctor-led [3] as their role in determining illness severity and in leading decision-making is generally accepted [4]. More often than not these discussions occur during an acute health crisis after a terminal diagnosis is clear, when patients and families are at their most vulnerable helping decide whether to initiate or discontinue treatment [5]. Prognostic uncertainty, time constraints of busy routine practices and limited access to psychosocial support following the breaking of bad news explain the lack of proactive advance care planning amongst doctors. But public readiness changing as recent research suggests that older members of the public more openly recognise the benefits of comfort care and are more willing to become involved in shared decision-making [6].

The rapid pace of COVID-19 and potential for high mortality are removing opportunities for patients and families to plan for future health care. The pandemic presents a challenge of time pressure for decisions because of the unprecedented patient workload resulting in the need to ration stretched resources to people with the best chances of survival [2]. While the concurrent economic crisis unfolds, the ethical dilemma of health care allocation requires urgent attention so end-of-life care discussions including withholding life-sustaining treatments are not delayed. With the extensive media coverage and online information on COVID-19's diagnosis, prognosis, global spread, and shortage of health personnel and medical supplies, the public is becoming aware of the possibility that restricted access to ideal healthcare is imminent. As in other pandemics strict triage protocols for allocating health resources [7] may need to be introduced. Hence, management aligned with the patient's goals, wishes and preferences may no longer be feasible as equity of access to life-saving technology diminishes if the health system is overwhelmed [8]. But there is still a chance to preserve dignity and provide supportive palliative care if end of life discussions are streamlined and widespread.

A strategy for the health system to adequately respond to the challenge of urgent decision-making is warranted. Delegating some of the responsibility of end-of-life discussion on transition from curative to palliative care to other health professionals who feel ready and competent [9] may be one option. Non-medical clinicians can play a supportive role for patients and their families, specifically nurses due to their ongoing interactions with patients and families at the bedside, which builds trust and rapport [5]. Nurses have a unique perspective of the personalised disease trajectory [10], which strengthens credibility for end of life conversations. Nurses currently play three roles in end of life communication including information broker, supporter and advocate. Their role spans from translating technical medical details, to advocating the patient and family's goals with the wider healthcare team [5, 11], through to navigating across the intricacies of the health system, clarifying the need to prevent futile overtreatment. Many perceived and actual, system and professional barriers have been identified

internationally for non-medical staff to become mainstream ACP champions (Table 1). Barriers from level of competency through to system level legislation, can impact on effective engagement of end of life discussions, and in turn can negatively impact on quality of end of life care for patients. But there are also potential solutions suggested both at the internal service level (palliative care and communications training [12], mentoring) and system-wide level (regulation, legislation, accreditation) [4].

ACP nurse-led models of care implemented and evaluated in urban and rural settings [13] have shown promising results with good patient acceptability and understanding of its benefits [14]. Calls have also been issued for an expanded role of allied health professionals including social workers due to their conflict resolution and advocacy skills [15], and advanced communication skills necessary to support this process. Given the chaotic hospital atmosphere, resource scarcity and doctor fatigue, burnout and isolation if infected during the COVID-19 pandemic, the opportunity exists globally, for end-of-life communication to be initiated by nurses and social workers if they are coupled with rapid educational updates and legal safeguards in routine practice (Table 1).

<Table 1 about here>

As an alternative to current models for the health system, a larger proportion of health professionals capable of initiating the conversation on values, preferences and prognostic disclosure such as the inevitable deterioration, could contribute to reduce the chances of over-treatment and deliver better quality of end of life care. The transition might start with expedited legislative amendment for the competency-ready Nurse Practitioners and clinical nurse consultants, especially those already working in palliative care, who are somewhat less impacted by day to day volume issues of COVID-19 having more control over their workload.

With additional training, expanding the role of dedicated social workers into becoming effective initiators of end-of-life discussions during this pandemic may also alleviate the pressure of doctors when consideration by the medical team is to potentially refuse ICU admission or resuscitation. Importantly, consideration must be taken in not overburdening specific individuals within occupational groups such as frontline workers who may be overwhelmed with direct clinical management. These sub-groups should not be charged with the new role or responsibility in the current environment as their levels of distress, anxiety, depression, and insomnia are already known to be high during the pandemic [16, 17].

Among longer-term opportunities it may be worth to consider incorporating palliative care as part of the annual licensure, recognising specialised nurses; [18] placing a greater focus on palliative care in the standard undergraduate curriculum for social workers and nursing to increase confidence and competence in managing these difficult but necessary conversations; and endorsement associated with nursing registration each year in countries where relevant.

The final action moving forward, is having patients and families, hospital executives, residential aged care being supportive of this cultural shift, recognising the value of nurses and allied health workers' potential role in timely engagement of end-of-life discussions. The benefit of embracing this new model of care will be to reduce non-beneficial overtreatment. With the literature suggesting that patients and families are more satisfied and in acceptance of decisions when a nurse is involved [5], we have likely already commenced this positive shift along this journey but this is the time to enact it more widely and normalise it.

Conclusion

The COVID-19 epidemic has placed extraordinary burden on health systems worldwide and has reignited awareness on the need for hastier decision-making near the end of life. This unprecedented

high level of demand for intensive care services which cannot be satisfied may be an opportunity to explore an expanded scope of practice for key members of the broader healthcare team, namely nurses and social workers. They are suitably qualified and intimately familiar with the social and clinical circumstances to take on the role of initiators and facilitators of end-of-life discussions with patients and families. With targeted education, legislative support, and public awareness, it may be possible to implement a change to the healthcare culture that improves understanding of quality end of life care, accepts the role of palliative care and normalise the need to withhold or withdraw futile life-sustaining therapies for people who do not have prospects of survival. Concurrent evaluations of effectiveness are needed.

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Author Contributions

MC conceived the idea, structured the first draft, supervised the process, and refined the last version of the manuscript. CR contributed substantially to the first draft. CR and EL contributed comments and paragraphs into subsequent versions with clinical and intellectual input. All authors approved the final version.

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Table 1. Current barriers and opportunities for non-medical staff engagement in initiating end-of-life discussions

Barriers	Short-term Opportunities
<ul style="list-style-type: none"> • A culture in healthcare that works against any change in role delineation fuelled by social expectation that doctors take the lead on prognostic disclosure and offers of treatment options • Inadequate training and skill for initiating such complex end of life discussions. • Feeling that their input to the conversation is vague and somewhat meaningless • Lack of support as a profession, in having end of life responsibility within their scope of practice • Discomfort about implications due to the uncertainty of whether taking a leading role in end of life discussions could result in potential legal action by patients’ families. 	<ul style="list-style-type: none"> • Accelerated refresher training on communication of bad news and advance care planning • Internal service policies to enable expanded scope of practice for non-medical clinicians and work through the ability for a nurse practitioner to sign off an advanced resuscitation plan (Including in end of life). • Greater protection through broader legislation, expedited law amendments to be authorised and protection to deliver these activities • Public campaign to enhance support for prognostic disclosure, and open discussions on advance care planning by any health professional, and awareness and harms of life-sustaining treatments when potentially futile

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