

Telepalliative care during the pandemic: Lessons for the future

Dear Editor,

Mok et al. gave hope for cautious optimism for the acceptance of telemedicine for palliative care—which will be referred to as “telepalliative care” in this article—during the COVID-19 pandemic.¹ Properly organised, telepalliative care can save time, provide flexibility, improve access for patients^{2,3} and possibly reduce the need for hospitalisations. Telepalliative care adoption should continue and be increased to meet the growing needs of an ageing population. It is foreseeable that there may be an increasing demand for palliative intervention arising from better management of illnesses that prolong lifespans, though not necessarily “healthspans”, i.e. the length of healthy years.⁴ This article outlines some of the concerns and benefits of telepalliative care (Table 1).

Table 1. Concerns and benefits of telepalliative care

Concerns and mitigation measures
Concern: Loss of human touch and connection Mitigation: Caregivers/relatives to step in
Concern: Consent and privacy Mitigation: Telepalliative team to be aware of regulations and to implement clear and consistent guidance for practice
Concern: Standards of care and appropriate patient selection Mitigation: Appraisal of needs, patient's wishes, advance care planning, and specialist palliative physicians to provide guidance
Concern: Trust Mitigation: Incremental adoption, blending with in-person care, and willingness to revert to in-person care
Benefits
Harnessing technology in an increasingly technology-savvy Singapore to enhance access and efficiency, thus saving time and cost
Possible reduction in inappropriate care and hospitalisations through enhanced access for clarifications on expectations and goals

Understandably, many lament the loss of a human connection when care is delivered through an audiovisual medium as it fails to capture the nuances of body language. Touching, which instantly conveys support and compassion is fundamental to human thriving.^{5,6} “Skin hunger”, which is our innate need for human touch, can become an unmet need. Touch is one missing element of care during the pandemic, such as for patients who may be apprehensive about going out in public due to concerns ranging from severe weight loss

approaching disfigurement, emaciation and/or odours. Some patients may require external devices that are connected to their persons, which can hamper venturing out and engaging with people outside the palliative care environment. However, caregivers physically close to the patient should be encouraged to fill a “high touch”⁷ role, that is, one that provides personal attention and interaction.

Consent for telemedicine, besides being regulated by the Singapore Medical Council,⁷ is required under the Personal Data Protection Act, as outlined in its recently updated advisory guidelines for photography, video and audio recordings in October 2021.⁸ This may demonstrate heightened awareness for consent and privacy, given that palliative care patients are particularly vulnerable. It is plausible that these patients can be pressured or feel less entitled to assert their right of refusal when telepalliative care is offered. The consequences of saying no, which may be construed to mean less or no care in spite of this not necessarily being the case, may compel them to say yes to telepalliative care. Consent issues can be made more challenging when caregivers, whom patients may depend on to facilitate the telepalliative care process, express preferences that patients feel unable to object to. The patient's final decision therefore should always be sought independently to ensure voluntariness that is free from undue pressure. For patients without mental capacity, the doctor shall make the final decision based on the patient's best interests after considering the views of others involved in the patient's welfare.⁹ The palliative team also has the responsibility to safeguard the privacy concerns of the patient and the security of audiovisual recordings. In spite of this, a major concern and dilemma is the possibility that a wholly informed consent from the patient may not in fact be fully obtained, which could happen in situations where patients are not fully aware or able to fully understand. Solutions, such as a written medical order made in advance and in a period of lucidity by the patient, are needed to resolve this problem.

Standards in telemedicine must meet equivalence of the in-person consultation, and limitations that may affect the quality of care in relation to the specific circumstances should be recognised.⁷ There are several questions that doctors and the palliative care team should examine. What are the acceptable limitations in the

context of telepalliative care? Regulatory scrutiny over the use of controlled drugs such as opioids, especially for non-specialist practitioners outside of institutionalised settings can be both concerning and discouraging. A challenge that presents in an in-person setting may not be mitigated but in fact exacerbated in the telepalliative setting. Specialist palliative physicians should lead to establishing standards and mentorship for non-specialist practitioners who are keen to develop in this area of practice. This will help build their competence, confidence and the much-needed sense of security.

The World Health Organization defines palliative care as “an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.”¹⁰ Some doctors may interpret elements in this, such as in making a “correct assessment”, too literally. This may lead to a convoluted hospital journey of investigations, fluid infusion, artificial nutrition and antibiotic escalation, at the stage when needs are clearly palliative and no longer curative. Few among us would choose aggressive treatment at end of life, though it is unfortunate that patients may be subjected to such a treatment. It is key to learn the difference between doing things “to” patients as opposed to “for” patients.

Anecdotal evidence suggests that demands from families, their lack of death literacy, coupled with doctors’ fear of complaints often make the route of aggressive interventions easier to navigate, rather than one of restraint and moderation. The main issue may be the absence of clear advance planning, which ideally should have been ongoing when a life-threatening diagnosis is made or as a person ages. A realistic appraisal of the needed care and its correct siting will help reduce hospitalisations and conserve resources at the acute care hospitals for complex care, which admittedly can also occur with a palliative route.

Admission for dying is inappropriate when dying with comfort and support is an attainable goal outside of the acute care hospital. Telepalliative care, blended with in-person care outside the acute hospital setting can be part of the solution to minimise inappropriate admissions. Telepalliative care delivery can help to meet the goals of care, clarify expectations and augment support throughout the patient’s journey. Requesting stepped-up telepalliative care, only when necessary, incurs minimum added cost.

Telepalliative care can amplify the difficulties that stem from a lack of trust and confidence. The perception of patients that telepalliative care is undertaken for convenience and cost savings at the expense of patient welfare must be dispelled by a willingness to revert to an in-person encounter if needed.

Moving forward, telepalliative care adoption may need to be incremental to win acceptance as an established future norm. Therefore, at the very least, the initial encounter must be an in-person encounter. Subsequently, “blended care” comprising online/telepalliative and offline/in-person care shall be determined by the patient’s clinical and non-clinical needs, and with guidance if necessary, from specialist palliative physicians.

Finally, there is hope that technical challenges for the elderly, currently often perceived as a barrier, will diminish over time. The increasing penetration of information technology in Singapore may facilitate the narrowing of the “digital divide”—the gap in access to technology by different demographic, regional, socio-economic and other groups—in years to come. Some may even prefer the unique nature of intimacy that the digital age renders, which facilitates focused attention and listening with individuals’ own design of care within the comfort of their homes.¹¹

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