Getting Ahead of Covid-19 Issues: Dying from Respiratory Failure Out of the Hospital

By Joanne Lynn

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Within the next few weeks, the U.S. will experience a very large number of deaths from Covid-19. The evidence is now plain that these deaths will mostly be of persons over 60 years old. Many will be persons past 80 and younger persons already living with disabilities and illnesses associated with aging. I have been a geriatrician and hospice physician for many years and I've been involved in disaster planning – and I am alarmed that we are not yet thinking ahead. Specifically, we are not

1. Getting plans made ahead for persons at high risk of dying, so we know whether that person wants to endure hospitalization and life on a ventilator if he or she gets a bad case;
2. Being ready to support a peaceful dying in homes and nursing homes for those who otherwise face suffocation;
3. Preparing for prompt and appropriate care of dead bodies; and
4. Developing the ability to test large numbers for immunity, since they could return to work and caregiving.

I know they are busy trying to catch up to today's challenges, but our leaders should be thinking ahead and preparing for these issues. This delay in confronting the issues perpetuates the same problem we had in January, when it was already clear that this virus was so contagious that it would circle the globe. We are way behind in dealing with today's issues, but there is still time to get out ahead on these near-future issues.

Enabling Persons at High Risk to Make Treatment Decisions in Advance

Every one of us at high risk on the basis of age or illness should be setting goals and making decisions about the desirability of hospitalization and ventilator support – yet no one is talking about making and using Covid-19 advance care plans. Every nursing home and assisted living facility should immediately help virtually all of their residents to set goals and make decisions about how they would like to be treated if they have a bad case of Covid-19. These advance care plans should be specific to the threat of Covid-19 in the context of the particular resident's situation. Covid-19 in older adults and seriously ill persons mostly kills by respiratory failure, progressing over a few hours or days from a sensation of breathlessness to a losing struggle to breathe. Only a minority of elderly persons who are put on ventilators survive to leave the hospital, and most have become more disabled from being very sick and mostly immobile. Older adults already living with eventually fatal illnesses and their families might make decisions to avoid all this and accept that a serious case of Covid-19 is very likely the end of their lives.

But someone has to ask them. Someone has to inform the elderly or seriously ill person or his or her surrogate decisionmakers and help them to understand their situation, and then to document their decisions. Having the opportunity to make the decisions ahead of becoming ill with Covid-19 is especially important if they decide not to take the conventional pattern of going to the hospital or refusing a ventilator. These discussions are difficult, and clinicians involved may find the advice for Covid-19 conversations on Vital Talk (https://www.vitaltalk.org/) to be helpful.

However, none of this likely to happen broadly unless the CMS and CDC guidelines start mentioning the urgency of these issues, and professional society advice reinforces the claim. Leaders on television and social media need to be willing to give voice to the merits of having these discussions and decisions now.

Nursing home and assisted living residents are at particular risk because we have no way to prevent outbreaks in facilities. This virus has about a five-day incubation period (https://www.jwatch.org/na51083/2020/03/13/covid-19-incubation-period-update) during which an infected person has no symptoms but can still spread the virus. Someone is bound to bring the virus into some facilities unknowingly. With so many residents who cannot cooperate fully with isolation due to dementia or delirium and the shortages of protective equipment for infection control, the virus is very likely to spread. So, a focus on advance care planning for residents of nursing homes and assisted living centers is urgent, and it is also feasible.

Still, half of our population of seriously ill or disabled elderly people are not in facilities; they are being cared for at home by family, friends or neighbors. So, families or care partners need to have the same conversations and make these decisions. They need guidance and support, too. The same urgency to plan in advance applies to elders being supported in private homes. Families and other caregivers will find helpful suggestions in the resources of The Conversation Project (https://theconversationproject.org/).

One painful aspect of these discussions is that hospitalization and ventilator use may become unavailable to older people if our facilities become overwhelmed. We don't need to dwell on this aspect, but we do need to acknowledge that a decision to pursue fully aggressive medical treatment depends upon those elements continuing to be available.

Making Sure that People Dying without Ventilator Support are Reasonably Comfortable

A person whose care plan is to stay on site and not to use the hospital, or who has no option to get hospitalization, needs to be able to rely upon good symptom management for respiratory distress. Without treatment, respiratory distress is among the most anguishing ways to die. Good care requires supplemental oxygen and providing morphine (or another opioid). Many nursing homes and assisted living centers will have had little experience with supporting people dying with respiratory failure as the cause. Hospice and palliative care practitioners will have the needed skills and experience, especially in knowing how to titrate morphine to relieve air hunger while keeping the possibility open that the person might survive. However, these clinicians need morphine, oxygen concentrators (a machine), personal protective equipment, and time at the bedside. They will be stretched to serve suddenly large numbers of infectious people dying of respiratory failure at home and in facilities. These clinicians need to be on the list of high priority providers and their services need to be acknowledged and valued by leadership. Indeed, nursing homes and assisted living centers need to reach out to their local hospice programs and work out how to work together if their setting is hard-hit. Only if the clinician can promise reliable symptom management can a high-risk patient choose to avoid hospitalization.

The Care of Bereaved Families and Newly Dead Bodies

The rapid loss of a substantial number of older adults has no real precedent, and the situation bars many of the usual supportive behaviors and rituals. Many decedents will have had to die alone, because family was barred from attending for fear of infection. Social distancing prevents final embraces and mutual consoling among family and friends. We can't even gather in religious ceremonies. Supporting

the bereaved will require some new patterns, and we could start identifying the approaches that are helpful.

Obviously, morticians, funeral directors, crematoria, and cemeteries will need to be prepared for a surge of deaths, including many occurring out of the hospital. Stories from other countries of families having to wait for days to have the body removed could be averted with planning now. Again, leaders should acknowledge and value these services and help to make arrangements for their workforce and supplies.

Valuing Immunity: The Benefits of Serologic Testing

We will soon have a substantial number of people who have had their infection and recovered. Nearly all will have rid themselves of the virus within a month. But most will be uncertain as to whether they are immune because they never had a definitive diagnostic test, either because their illness was mild or because the testing was unavailable. Persons who are immune become very valuable to the public. They can return to work, they can visit sick people, they can provide care – indeed, they can be the vanguard of a return toward normal. But they need to know that they are immune, as do their employers, patients, and family members. This calls for development of and deployment of serologic testing, so we can know who is still susceptible and who is immune. We don't yet know how long immunity will last, and the evidence in related viruses is for it waning over a year or two. But in the current year, these people are especially valuable since they cannot be infected and cannot spread the virus (with ordinary hygiene). We need leaders to be calling for development of this testing, funding it, and making plans for deploying it – perhaps first to health care workers.

In Conclusion

The nation is watching the experience in Italy with some horror – but it is over there and not here. We are not yet honestly dealing with the likelihood that some aspects of their experience will be here, in at least some parts of the nation, in the next months. Let's get over our reticence. We will have many deaths. Many will be in nursing homes and assisted living centers and most will be among people who are growing old. When a person is likely to die if he or she gets this disease, we should be clear as to what treatment the person wants. If the person is dying without ventilator support, he or she should have treatment to prevent feeling suffocation. Families and friends should have ways to grieve. Bodies should be able to be removed and buried or cremated promptly and safely. And we should be ready to test for immunity within a month.

These things are foreseeable. Indeed, they are foreseen. It's time for leaders to talk and to put plans in place. Let's get ahead of this pandemic on these issues.