Letter

A "Good Death" During Coronavirus Disease 2019: Outdoor Terminal Extubation Facilitates Safe Family Presence for a Dying Patient

Introduction

Among the heartbreaking consequences of the coronavirus disease 2019 (COVID-19) pandemic is the large number of patients who have died alone as a result of hospital policies that restrict or prohibit any visitors for admitted patients. These visitor restrictions apply to both patients with COVID-19 and without COVID-19. They are necessary to limit contagion but carry the untoward effect of inflicting additional emotional and psychological duress for patients, families, and clinical staff. These effects are more profound in the case of a dying patient.

For some end-of-life patients, discharge to home hospice may allow them to be with their loved ones during the dying process. However, for the critically ill, ventilator-dependent patients with a plan to transition to comfort-focused care through a terminal extubation, options are limited to honor their preferred place of death. Prior literature describes successful at-home terminal extubation to honor preferred place of death.[1–3] During the COVID-19 pandemic, at-home terminal extubation is a viable option that would allow multiple family members to be present. However, at-home extubations can be prohibitive in patients with hemodynamic instability, an unacceptable distance from hospital to home, or a home unsuitable to accommodate comfort care.

We describe the case of a critically ill patient for whom transition to home was not feasible. We provided an outdoor terminal extubation on a secluded area of the hospital lawn, facilitating family presence while maintaining pandemic safety precautions. To our knowledge, this is the only reported outdoor extubation used for the purpose of facilitating family presence in the setting of pandemic restrictions.

Case Description

The patient was a 25-year-old woman with metastatic Ewing's sarcoma. She was being treated with cyclophosphamide and topotecan when she presented with hypoxic respiratory failure secondary to left hydropneumothorax, multifocal pneumonia, and extensive bilateral pulmonary metastases. She tested negative for COVID-19 and was cared for in the medical intensive care unit. Her hospital course was complicated by refractory septic shock and progressive respiratory failure.

An extensive goals of care meeting occurred on hospital day 15 with her father, also her surrogate decision maker. He understood that she was very close to death, did not want her to suffer, and requested transition to comfort. We provided support for his anticipatory grief surrounding his only child's death. We also addressed his hopes and worries surrounding transition to comfort. He expressed devastation that she would be unable to say goodbye to their close-knit family owing to hospital visitor restrictions, which allowed only 1 family member at the bedside of a dying patient. The full, meaningful family included her stepfather, aunts, and uncles.

An at-home terminal extubation was not possible owing to the long distance to her home and the father's fear that he could not live in a home where his child had died. We then offered the option of terminal extubation on the hospital's lawn, to allow her full family to be with her throughout the process. He expressed excitement and gratitude at this ray of hope in a time of darkness.

The engineering department worked quickly to make the required exterior site alterations to create a feasible space on a secluded area of the lawn. Carpenters built a ramp for stretcher egress, hung a curtain for discretion, and arranged a family sitting area. Hospital security placed personnel in strategic locations to protect the family's privacy.

Our multidisciplinary clinical team, including nurses, a respiratory therapist, pharmacist, and physician, created a medication travel pack, given lack of access to a PYXIS while outside the hospital. Nursing staff hung a new hydromorphone infusion before leaving the intensive care unit. We packed additional

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comfort supplies including absorbent pads, emesis bags, moistened wash cloths, and nasal cannula.

When all were ready, our team moved her, still ventilated, along with the comfort medications and supplies, to the designated area on the lawn. The palliative social worker met the family at the parking garage and walked them to the outside lawn. The family wore face coverings and upheld social distancing guidelines.

After each family member had spent time at the bedside, the family signaled their readiness for extubation. She was extubated outside and died comfortably within an hour of extubation, surrounded by her father and eight loving family members.

Discussion

The COVID-19 pandemic has posed significant challenges to the provision of quality end-of-life care. For hospitalized patients, strict visitor restrictions have further hampered our ability to fulfill end-of-life wishes. This can be devastating for patients and families, inflicting additional distress at an already difficult time.

Palliative literature has shown that the majority of patients prefer to die at home,[4] although only 30% of patients actually do.[5] For bereaved family members, death occurring outside the hospital is associated with better perceptions of end-of-life care.[6] Families of patients who die in the hospital or intensive care unit have been shown to be at increased risk for prolonged grief and post-traumatic stress disorder when compared with home hospice deaths.[7]

Offering death outside the hospital is not always feasible; critical illness, and particularly mechanical ventilation, is often seen as precluding it. The present pandemic has only magnified the obstacles.

Here, we suggest an innovative way to improve end-of-life care during a time of strict visitor restrictions owing to a pandemic. Now, when the family cannot come to the patient, we offer a way to bring the patient to the family. Once transferred to a private area on the hospital lawn, she was surrounded by family and allowed a place of death outside the hospital.

The family expressed tremendous gratitude for the chance to be present during their loved one's death. The medical staff was proud to offer the patient a creative "good death"; facilities and security personnel took pride in this very rare chance to tangibly affect patient care. Since this occurred, our institution is moving to creating a permanent outdoor space where terminal extubations can be more often offered.

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References

1. Clemency BM, Grimm KT, Lauer SL, et al. Transport home and terminal extubation by emergency medical services: an example of innovation in end-of-life care. J Pain Symptom Manage 2019;58:355–359.

2. Gupta N, Harrop E, Lapwood S, Shefler A. Journey from pediatric intensive care to palliative care. J Palliat Med 2013;16:397–401.

3. Noje C, Bernier M, Costabile P, Klein B, Kudchaker S. Pediatric critical care transport as a conduit to terminal extubation at home: a case series. Pediatr Crit Care Med 2017;18:e4–e8.

4. Bell CL, Somogyi-Zalud E, Masaki KH. Methodological review: measured and reported congruence between preferred and actual place of death. Palliat Med 2009;23:482–490.

5. Centers for Disease Control and Prevention. CDC Wonder home page. Available from https://wonder.cdc.gov. Accessed September 20, 2020.

6. Wright AA, Keating NL, Ayanian JZ. Family perspectives on aggressive cancer care near the end of life. JAMA 2016;315:284–292.

7. Wright AA, Keating NL, Balboni TA, Matulonis UA, Block SD, Prigerson HG. Place of death: correlations with quality of life of patients with cancer and predictors of bereaved caregivers' mental health. J Clin Oncol 2010;28:4457.