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DOI: 10.1017/S1478951520000541

Impacts of social distancing on cancer care during COVID-19 pandemic: Hong Kong experience -- RETRACTED

Short title: COVID-19 in Hong Kong

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Abstract

- While the strict regulations in hospital in Hong Kong effectively controlled the outbreaks of COVID-19, they caused challenges in the care of our hospitalized cancer patients.
- Four clinical cases based on true encounter during the COVID-19 period with mitigations were summarised.
- These four cases reflected the unanticipated impacts of the extreme measures and highlighted the deficiencies of our existing system.
- The pandemics offered us opportunities to explore new ways to improve our cancer care, especially concerning the psychological support to both patients and caretakers.

https://doi.org/10.1017/S1478951520000541 Published online by Cambridge University Press

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Gaining from the heartbroken experience in SARS which infected 1755 and killed 299 people in Hong Kong in 2003, upon receiving news of the outbreak of COVID-19 in Mainland China; Hong Kong, being the closest city to Mainland China, is determined not to let history repeat itself. The Hong Kong Government was quick in response and took extreme measures including stringent border controls, health quarantine arrangements on inbound travelers, restricting gatherings of more than four people, etc.

In response to the threat of COVID-19 pandemic, the Hospital Authority (HA), a statutory body managing all the pubic-funded hospitals in Hong Kong, has raised the Emergency Response Level to the highest "Emergency" level since 25th January 2020. Under the highest "Emergency" level, all patient visits are suspended with exceptional cases on compassionate grounds. The non-emergency services are deferred in order to prioritize the resources to manage the COVID-19 pandemic. Therefore, clinical psychologist, social workers and pastoral services are suspended with the intent to reduce non-essential contact time.

These extreme measures proved effective in controlling the outbreaks and Hong Kong has won accolades globally in curbing the spread of the viruses. However, having strict regulations is a double-edged sword, it raises challenges when managing inpatient cancer patients especially those who are older and require palliative care support. Four clinical cases based on true encounter during the COVID-19 period with mitigations were summarised in Table 1 to illustrate the challenges we faced.

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Table 1:

Case	Challenges	Responding to these challenges	Lesson to learn
Madam A	Madam A, 73 years old, was diagnosed with metastatic stomach cancer and on conservative treatment. She had poor appetite and it was very time consuming for her relatives to feed her. Madam A was later admitted for hematemesis and anemia. Her condition was stabilised after transfusion; however, one week after admission, Madam A had a sudden episode of coffee ground vomiting (the presence of coagulated blood in the vomitus) and passed away shortly after. Her relatives were shocked about her sudden deterioration and death. During her hospitalization, the relatives were not allowed to visit her due to the current visiting restriction. The relatives questioned if Madam's A death was related to poor care in the hospital and extended their suspicion that her death was related to starvation due to prior experience in feeding difficulty.	To address the relatives' concerns, official meeting with oncologist, palliative care doctor and nurse was arranged with Madam A's relatives and bereavement counselling was offered. Relatives were encouraged to talk and express their unsatisfactory and displeasure. We regained their trust by active listening and demonstrating empathy. Medical notes were reviewed. Information about Madam A's death was given. Communication gaps, misunderstandings and negative feelings were sorted and settled.	- In the normal days, relatives could receive update from the health care team during visiting hour. - Because of the strict regulations, relatives are not allowed to visit the hospitalized patients. Relatives who could not accompany patients at the end-of-life usually have various emotions. - Regular updates of patients' conditions to relatives are essential especially under the current restriction, e.g. updating relatives by phone calls every alternate day. - Guidelines should be set to allow more flexible visiting for end-of-life patients. For example, relatives must declare any travel history outside Hong Kong in the past two weeks or any respiratory symptoms before entering hospital for visits; have temperature check before entering ward; limit the number of visitors each time etc.

Madam B	Madam B, a 96-year-old lady, was admitted for colon cancer complicated with intestinal obstruction and needed total parental nutrition. It was her first admission to hospital in her lifetime. Unfortunately, she became confused a few days after admission due to unfamiliar environment and no visiting from family members.	Investigations (including CT brain, blood tests) were done efficiently to rule out any reversible causes for her confusion. After settling the acute problem, Madam B was referred to palliative care. Madam B's confusion improved after transferral to palliative care unit where companion of relatives is allowed.	- Family members reassurance and comfort was the best medicine in this case. - In the normal days, relatives were allowed to accompany older patients for longer hours even in acute hospital. Referral to palliative care seemed not so urgent and sometimes was delayed. - In the COVID-19 period, no visitors are allowed. Settling acute problems efficiently and early referral to palliative care / rehabilitation can facilitate family support and this practice should be continued in the future.
Mr C	Mr C, a 76-year-old gentleman, had radioactive iodine refractory thyroid cancer and multiple lung metastases. He was admitted for acute renal impairment and pneumonia and needed antibiotics injection. He was in low mood and poor appetite. He expressed that was his deepest separation with his family in his life.	We encouraged Mr C's relatives to use video calls to communicate with him. We educated Mr C on using iPad. Video conference call between Mr C, his relatives and clinical psychologist was also set up to provide remote psychological	- Even in the normal days, relatives may not be able to visit the patients often because of their busy work or schedule. A call from relatives can certainly comfort the patient and show their care. - Use of technology e.g. video calls or

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		support.	telemedicine should be promoted as this can definitely improve the communication between patients, caregivers and health care professionals when direct contact is not feasible.
Mr D	Mr D, a 85-year-old gentleman, was diagnosed to have lung cancer with multiple lung, bone and liver metastases. He failed 3 lines of systemic treatment and was on conservative treatment. He was admitted to our oncology ward for bone pain and received palliative radiotherapy to the spine. After radiotherapy, his condition deteriorated day by day. He was at his last days of life. Visiting based on compassionate ground with maximum two people was allowed. Relatives expressed wishes to stay beside patient in his last days of life.	We introduced them on advance directive and raised the possibility of "dying-at-home". Relatives understood the legal procedures and logistics then took Mr D back home. Two days after discharged, he passed away peacefully with close relatives beside his death bed. Relatives were grateful for the arrangement.	- Many people in Hong Kong do not accept the concept of "dying-at-home". Some even worry if someone dies at home, the price of the apartment will depreciate. Nevertheless, with option of being able to accompany their loved ones, advance directive and home care should be promoted to provide alternative to families.

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These four clinical cases reflected the unanticipated impacts of the extreme measures: communication breakdown between caretakers and health care professionals, lack of family support causing patient complications, limited visiting resulting in distress to both patients and relatives etc. By the time we wrote this article, there were two hospitalized cancer patients who committed in recent one month. The reasons for their suicidal ideation were still under investigations and not sure if related to social distancing. Distress screening which has been recommended in different international oncology guidelines including NCCN, European Palliative Care Research Collaborative (EPCRC) and the International Psycho-Oncology Society has been used in our outpatient clinics but not yet to every hospitalized patients.[1,2] Due to the current incidents, there is an urge to extend distress screening to all oncology patients.

The COVID-19 highlighted the deficiencies in our existing system. Yet, it offered us opportunity to identify our limitations and develop alternative and creative approaches to improve our cancer care. The tsunami-like impact of this global pandemic has also reminded us on the deepest need of our cancer patients. We should not only focus on patients' physical symptoms or do everything just as a routine, but more importantly should provide psychological support to both patients and caretakers with suffice accompany time, in a holistic, individualized, planned and communicated care.

Funding: none declared

Disclosure Statement:

The authors have declared no conflicts of interest. All authors have nothing to disclose. All authors received no funding or sponsorship. No financial disclosure. There is no conflict of interest to disclose.

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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