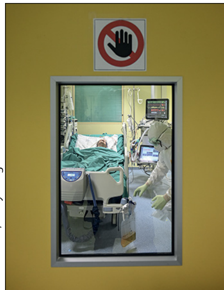
Palliative care and the COVID-19 pandemic



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Palliative care services are under-resourced at the best of times. The 2017 *Lancet* Commission on Palliative Care and Pain Relief described the widespread lack of access to inexpensive and effective interventions as a travesty of justice. And these are not the best of times. As health systems become strained under COVID-19, providing safe and effective palliative care, including end-of-life care, becomes especially vital and especially difficult.

Some doctors, short of resources, might have to decide who can receive critical care and who cannot. For patients who won't survive, high-quality palliative care needs to be provided at least. But COVID-19 makes this more difficult. Time is short when patients deteriorate quickly, health professionals are overworked, isolation is mandated, and families are advised not to touch or even be in the same room as loved ones. This scenario will be compounded most in low-income and middle-income countries where shortages of both critical care and palliative care services are greatest. Continuing community-based palliative care is also harder to do safely. Many patients who need it are at heightened risk from COVID-19, protective equipment is running short, and surging deaths could overwhelm usual service provision.

WHO has issued guidance on how to maintain essential health services during the pandemic, highlighting immunisation, maternal care, emergency care, and chronic diseases among others, but there was no mention of palliative care. This was an oversight. Indeed, palliative care ought to be an explicit part of national and international response plans for COVID-19. Practical steps can be taken: ensure access to drugs (such as opioids) and protective equipment, consider a greater use of telemedicine and video, discuss advance care plans, provide better training and preparation across the health workforce, and embrace the role of lay carers and the wider community.

A pandemic is a cause and powerful amplifier of suffering, through physical illness and death, through stresses and anxieties, and through financial and social instability. Alleviation of that suffering, in all its forms, needs to be a key part of the response. ■ *The Lancet*

For the ***Lancet* Commission on Palliative Care and Pain Relief** see https://www.thelancet.com/commissions/palliative-care

For **WHO's guidance** see https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak

The gendered dimensions of COVID-19

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See **Comment** page 1175

SARS-CoV-2 does not discriminate, but without careful consideration, the global response to the COVID-19 pandemic might. Demographic data from small studies are already informing political decisions and clinical research strategies. Women and men are affected by COVID-19, but biology and gender norms are shaping the disease burden. The success of the global response—the ability of both women and men to survive and recover from the pandemic's effects—will depend on the quality of evidence informing the response and the extent to which data represent sex and gender differences.

Global Health 50/50 tracks sex-disaggregated infection and mortality COVID-19 data from the 39 most-affected countries. Some countries, including the UK, the USA, Russia, and Brazil, have yet to report such data. From those that have, it is unclear whether women or men are more likely to become infected, but more men are dying from COVID-19. Adverse outcomes of COVID-19 seem to be associated with comorbidities, including hypertension, cardiovascular disease, and lung disease. These conditions are more prevalent in men and are linked to smoking and drinking alcohol—behaviours associated with masculine norms.

Women carry a different kind of burden from COVID-19. Inequities disproportionately affect their wellbeing and economic resilience during lockdowns. Households are under strain, but child care, elderly care, and housework typically fall on women. Concerns over increased domestic violence are growing. With health services overstretched and charities under-resourced, women's sexual and reproductive health services, as well as prenatal and postnatal care, are disrupted.

The European Association of Science Editors and other organisations urge all involved in collecting COVID-19 data to follow guidelines (eg, CONSORT, STROBE) and include age and sex in demographic data. We echo this call and encourage a gender focus in all research efforts. Obscuring sex and gender differences in treatment and vaccine development could result in harm. Incomplete reporting compromises meta-analyses. Addressing the health needs of men and women equally will help societies recover and resist future human tragedies. ■ *The Lancet*

For the **Global Health 50/50 COVID-19 sex-disaggregated data tracker** see http://globalhealth5050.org/covid19/

For the **statement by the European Association of Science Editors** see https://ease.org.uk/publications/ease-statements-resources/ease-statement-on-quality-standards/