Physiotherapist Adaptations to Cancer, HIV/AIDS, and Hospice and Palliative Care in the COVID-19 Era: A Global Perspective Paper

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In the early stages of the COVID-19 pandemic, physiotherapists (PTs) across the globe were required to rapidly adapt clinical practice to provide safe and effective care for people with HIV/AIDS and cancer and those in hospice and palliative care. These rapid decisions included developing criteria for in-person versus remote care and developing equitable platforms for telehealth and telerehabilitation. Most decisions were made with limited guidelines or evidence for practice related to the pandemic. The purpose of this perspective was to provide a synopsis of the experiences of 25 PTs from 16 countries regarding their clinical decisions for (1) rapid adaptation of patient care delivery, (2) evaluation criteria to treat in-person or remotely, (3) utilization decisions for telerehabilitation, (4) determinations for future practice and research needs, and (5) promotion of health equity in an environment rapidly transformed by a highly infectious and deadly disease. (Rehab Oncol 2020;38:145–152) Key words: critical thinking, equity in health care, evidence needs, infection control, telehealth, telerehabilitation

The sudden spread of COVID-19 required physiotherapists (PTs) globally to rapidly adapt clinical practice with limited guidelines or evidence for clinical decisions. On April 25, 2020, the International PTs for HIV/AIDS, Oncology, Hospice and Palliative Care Subgroup (IPT-HOPE) within the World Physiotherapy (WPT) hosted an online networking session for PTs to share their experiences and learn from each other methods to adapt clinical practice during the pandemic. Responses were solicited from PTs serving as Member Organization Liaisons to the IPT-HOPE Subgroup. Other PTs contributed responses during the virtual session and through e-mails after watching the recording of the session. Twenty-five PTs from 16 countries shared their clinical decisions and experiences in this public forum (Table).

The PT contributor practice areas included HIV/AIDS, cancer, and hospice and palliative care. Contributors practiced in all phases of rehabilitation, including intensive and acute care, in-patient and residential care, home care, and private practice, and in academics and research. While some PTs worked at comprehensive cancer centers treating a variety of diagnoses, others specialized in cancers of the head and neck, breast, prostate, hematologic, pediatric, geriatric, lymphedema, and/or neurorehabilitation. The PT practice settings included national institutes for health, national and regional cancer centers, university medical centers and teaching hospitals, a nongovernmental organization for adult and pediatric cancers, and private clinics. Four contributors were educators and/or researchers. Fourteen countries were in the high-middle WPT economic regions and 2 were from low-middle economic regions. The live streaming session was attended by more than 60 PTs globally.3

On April 25, 2020, the known COVID-19 symptoms were mild to severe difficulty breathing, a dry cough,
| Regions        | Countries (Number of PT Contributors) | Facility and Access Status PT Decisions for In-Person Care (Representative Settings/Patients)                                                                 | Cases per 1 000 000 Population | Deaths per 1 000 000 Population |
|---------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------|
| Africa        | Nigeria (3 contacts)                   | Inpatient PTs in regional hospitals with cancer and HIV centers were in lockdown and only treated critical acute referrals. Outpatient PTs only saw people in-person with severe pain greater than 5 out of 10. | 0.55                          | 0.15                          |
|               | South Africa (1 contact)              | Hospital cancer centers and private clinics were in lockdown. Acute and inpatient admissions decreased to <10% with emphasis on post-neoadjuvant oncology surgery and trauma. Outpatient and private practice patients decreased to <20% with emphasis on emergency face-to-face oncology conditions, vestibular rehabilitation, and triage assessment for musculoskeletal trauma. | 4.50                          | 1.33                          |
| Asia Western Pacific | Australia (2 contacts)              | Regional hospital centers for HIV and cancer centers were in lockdown to visitors and nonessential staff. PTs are essential and visit people in acute and inpatient wards. Outpatient PTs see only urgent conditions in-person with strict infection precautions. Most people with cancer and HIV/AIDS self-isolated, so treatments and medications were on hold. A regional HIV center in Melbourne reports that only 9 people were hospitalized with COVID-19 and none had HIV infection. In residential care centers, people received short PT visits in their rooms and the staff were required to have influenza vaccines. | 0.78                          | 3.10                          |
| Japan (1 contact) | Japan (1 contact)                     | The National Cancer Center was in lockdown and in-person visits were only for hospitalized people. Outpatient visits were only for people immediately following hospital discharge. PT visits were significantly reduced for people with cancer and often not sufficient for their needs. | 5.16                          | 2.64                          |
| Saudi Arabia (1 contact) | Saudi Arabia (1 contact)             | The National Cancer Center was in lockdown, but acute and inpatient PTs continue to work. Outpatient departments were closed for 10 d, and these PTs were reassigned to acute and inpatient wards. One walk-in outpatient clinic was open for urgent conditions and supply distributions such as crutches or lymphedema bandages. | 33.60                         | 3.65                          |
| Turkey (1 Contact) | Turkey (1 Contact)                    | The Cancer Treatment Center was in lockdown. Cancer surgical procedures and treatments were cancelled. Acute, inpatient, and outpatient visits were only for necessary individual exercises, with strict infection precautions and no touching people. | 37.02                         | 30.83                         |
| Qatar (1 contact) | Qatar (1 contact)                      | The National Cancer Center was in lockdown. Acute and inpatient PTs continued to work with urgent conditions. Outpatient departments were closed except for urgent conditions and security clearance was required to enter the department. Outpatient PTs were redeployed to the hospital and once there, all PTs were grouped into 2 hospital teams that work different shifts to minimize exposures. | 264.14                        | 3.47                          |
| European      | Denmark (1 contact)                   | The Regional Hospital and Cancer Center was in lockdown but was beginning to meet required guidelines to begin gradual reopening in 2 d. During the lockdown, acute, inpatient, and outpatient cancer rehabilitation was diminished, with only the most critical conditions seen for in-person care. Strict infection control guidelines were enforced and PTs changed uniforms and disinfected equipment between individuals. | 23.65                         | 69.58                         |
|               | The Netherlands (3 contacts)          | A university teaching and research hospital was in partial lockdown. Cancer surgical procedures and treatments were on mostly on hold. For example, for head and neck cancers, surgery was performed but not reconstruction or rehabilitation. For inpatient, only the most critical conditions were seen. Outpatient facilities were closed and oncology research and student PTs clinicals are on hold to reduce the spread of the virus. The number of COVID-19 infections is beginning to decrease, so ICUs are beginning to return to normal. | 47.04                         | 250.31                        |
### TABLE

| Regions | Countries | Facility and Access Status PT Decisions for In-Person Care (Representative Settings/Patients) | Cases per 1,000,000 Population<sup>1</sup> | Deaths per 1,000,000 Population<sup>2</sup> |
|---------|-----------|---------------------------------------------------------------------------------------------|---------------------------------------------|---------------------------------------------|
| Ireland (1 contact) | The Hospital Systems and Cancer Centers were in lockdown until May 5. All outpatient visits were by phone. On the breast care side, we were speaking with postoperative clients with shoulder dysfunction and posting out garments to stable lymphoedema review clients. Palliative care, daycare, and day hospitals were closed for the last month. Hospice is full and COVID-19–free at this time. Outpatient PTs are on-call for weekends at the acute hospital for COVID-19 and were given about 40 h of respiratory upskilling. | 116.85 | 167.89 |
| Sweden (1 contact) | The university hospital systems were in lockdown. PTs in acute, inpatient, and outpatient settings call people by telephone to determine whether they desire in-person, telephone, or video visits. For outpatient PTs, all group activities were closed and only one person at a time was seen in the gym. Inpatient rehabilitation was ongoing, with limited gym access and strict infection control measures. Home care was initially by telephone due to lack of personal protective devices, but now people are triaged by phone and PTs make limited home call visits. | 80.4 | 213.09 |
| The United Kingdom: England (2 contacts); Scotland (1 contact) | University Hospital Trust Systems were in lockdown. Outpatient services across the Trust were suspended to reduce infection risk and free staff for retraining and redeployment to COVID-19 wards. Chemotherapy treatments are delayed, paused, or titrated down; radiotherapy is delayed or compressed into shorter time periods; the duration of hormone therapy for some has increased, and some surgery such as reconstruction/reversals have been canceled or postponed. HIV outpatient rehabilitation programs are closed. | 79.34 | 335.74 |
| North America and the Caribbean Islands | Across Canada, acute and inpatient PTs were mostly working. Outpatient and private clinics in Eastern and Western provinces are slowly reopening and offering combinations of telehealth and some face-to-face consults for people with lymphedema and others who would suffer permanent disability or substandard outcomes. Central provinces are closed and working virtually by offering group classes and individual consultations. Some home care was provided by private practitioners with strict infection risk management guidelines. Cancer wellness and exercise centers were closed and do not anticipate opening until the fall or early 2021. | 47.11 | 60.99 |
| The United States (5 contacts) | For university teaching hospitals in California and Michigan, a private practice setting in Texas, and a PT academic research university, restrictions vary by state. Most hospital facilities were under lockdown with acute, inpatient, and home PT care restricted to people with urgent needs where deferral of treatment carries greater detriments than COVID-19 exposure risks. Most cancer and HIV/AIDS treatments are cancelled, delayed, or altered, and people are self-isolating for fear of infections. Outpatient departments and private practices were primarily closed. Many PTs contacted people by telephone and beginning to develop virtual visits when regulations for privacy and standards for practice were approved. | 64.51 | 154.13 |
| South America | Chile (1 contact) | For a nongovernmental cancer rehabilitation care center, lockdown zones vary by counties, and people with cancer are greatly encouraged not to leave their houses as they are at high risk. PTs continue to work with adults and children with cancer virtually. | 25.84 | 9.10 |

*Abbreviations: ICU, intensive care unit; PT, physiotherapist.*
and fever that could lead to pneumonia, acute respiratory distress, and death. Additional symptoms were reported anecdotally in the cardiovascular, digestive, integumentary, central nervous, visual, and renal systems. In the Netherlands, PTs reported, “At this time, we do not know the specific lung pathology of COVID-19 as it is not simply a chronic obstructive disease. We need to work together with other countries to identify the COVID-19 pathology and its long-term side effects for optimal rehabilitation of individuals with cancer, HIV/AIDS, or in palliative care.”

The purpose of this perspective was to provide a synopsis of the experiences of 25 PTs from 16 countries regarding their clinical decisions for (1) rapid adaptation of patient care delivery, (2) evaluation criteria to treat in-person or remotely, (3) utilization decisions for telerehabilitation, (4) determinations for future practice and research needs, and (5) promotion of health equity in an environment rapidly transformed by a highly infectious and deadly disease.

ADAPTING TO RAPID CHANGE

All the PTs reported being in full or partial lockdown based on the severity of local infection rates. Because of travel restrictions and fear of infections, many people with HIV/AIDS and cancer were self-isolating and not receiving needed care, medicines, and functional rehabilitation. The PTs also reported cancellations or delays in cancer surgical procedures, interruptions or titrating down of chemotherapy with increases in hormonal therapies, and cancellations or shortening of radiation regimens. In the Netherlands, PTs reported, “Head and neck cancers surgeries were performed but without subsequent reconstruction or rehabilitation.”

The majority of contributors reported that “acute and inpatient PTs were only seeing the most critical people in-person and only with universal precautions.” A few countries deemed inpatient PT services were nonessential during the pandemic and PTs were furloughed. Outpatient and private clinics were closed in 6 countries with high infection rates. In 10 countries, PTs reported that outpatient, private clinics, and home care offered restricted services for people with urgent needs where treatment deferral carried greater detriments than infection exposure risk. Decisions for in-person or remote care were made collaboratively with people and their families. In the United Kingdom, Saudi Arabia, Ireland, and Qatar, outpatient PTs were retrained and deployed to COVID-19 wards as needed.

Most hospitals and residential and palliative care centers were closed to visitors, and people were isolated from their families. In Australia, PTs visited residential care centers, but visits were short, and flu vaccines were required for all staff members to enter.

In all settings, PT concerns were expressed about limited evidence for practice adaptations related to COVID-19 in cancer, HIV/AIDS, and palliative care. Experienced PTs relied on established standards, critical thinking, and patient preferences to provide safe and, as effective as possible, rehabilitation care. The rapid adaptations instituted across the countries were remarkably similar despite a lack of prior communications between PTs.

Differences in adaptations to clinical care were found primarily in areas where health resources and adequate infection precautions were not readily available. In Nigeria, “Water was scarce so compliance to hygiene and hand washing proved challenging. Social distancing was not possible as many generations live together, and daily in-person contact was necessary to obtain food and water and go to work. In the community, masks are homemade and do not provide adequate protection. In the hospitals and clinics, Personal Protective Equipment (PPE) was in short supply, and remote communications by telephone or telehealth are not always consistent or possible.” In South Africa, “Only one-third of all people have smartphones and only 17% have computers.”

A few PT guidelines in acute and pulmonary care appeared online and offered suggestions for managing people with COVID-19, but there were few guidelines for PTs working with people in HIV/AIDS, cancer, or hospice care with or without COVID-19 at this time.

EVALUATIVE CRITERIA DECISIONS

Clinical decisions to treat people in-person or remotely were based on the critical nature of their condition, their infection risk, and availability of PPE. Individuals with urgent conditions, where deferral of hands-on care created greater detriments than possible COVID-19 exposure risk, were most often seen in-person. In Nigeria, “In-person care was provided for individuals with pain greater than 5 out of 10 on the numeric pain scale or for new inpatient referrals.” In South Africa, “PTs treated emergency oncology and vestibular conditions in-person and performed triage evaluations for trauma and acute musculoskeletal pathology.” In the United States, “People are seen in-person by a PT only when medically necessary such as severe head and neck lymphedema.”

Since testing kits were limited or unreliable, PTs treated all people as being infected asymptptomatically with COVID-19 and implemented strict infection control guidelines. In the United States, “A patient with neurological degenerative ataxia, and a husband in stage IV lymphoma, requested home visits for balance and gait reeducation. The PT implemented handwashing, wearing masks, and social distancing with education for the patient and family. However, many people with cancer or HIV/AIDS that require in-person care were not seen due to safety concerns for their immunosuppression, or comorbidities like heart disease, hypertension, and diabetes.” When infection control was not adequate, PTs determined whether people could benefit from remote care.

Telehealth was not yet approved or a covered benefit in several countries; therefore, telephone communications were used initially in the lockdown to assess an individual’s needs and provide instructions. Exercise instructions were then sent to people by post or online. In Denmark,
“Oncology postsurgical complication education was provided through telephone visits.” In a private practice in the United States, “virtual e-visits or telephone calls once or twice weekly were used and people demonstrated good improvements. The PTs ability to be creative, flexible, and available with consideration for the individual was important at this time and for the future.” In Ireland, “On the breast care side, PTs spoke by phone to post-op clients with shoulder dysfunction and also posted out garments to women previously in rehabilitation, with stable lymphoedema. The national lymphoedema office published COVID-19 advice for lymphoedema people online for self-education, exercise updates, monitoring self-care, and providing audio-visual recordings. Concerns were In-...tions, triage, continuance of previously established care, and motivation and goal setting. It is not authorized for routine assessment and diagnosis or treatment of musculoskeletal conditions. It is assumed this directive will be reversed following the current health crisis.” In the Netherlands, “Virtual visits were used before the lockdown but now are expanded to include interviews, examinations, patient education, and some exercises, as possible. In pediatric settings, virtual meetings work well for young parents and their children. Some older people, unfamiliar with the technology, occasionally had difficulties. Exercise protocols with pictures and training schedules were also sent by post. Some people came to the gym for examinations, but training was performed online, and this worked well. For people already in treatment, it was easier to transfer them online, as they were familiar with training. New patient contacts were more difficult to begin online, particularly related to the effort or intensity required for training.” In Japan, “Telehealth was used before the lockdown to check activities of daily living and determine whether in-home rehabilitation was required. Since people were afraid to come to the hospital for cancer treatments, PTs were beginning to use telerehabilitation for exercise instructions.”

Other countries began implementing telerehabilitation during the lockdown. In Sweden, “PTs consulted by telephone with people in acute, inpatient, and outpatient care to determine whether in-person or video visits were preferable. PT visits were of increased importance, particularly for people isolated in their rooms with restraining orders for relatives.” In Canada, “Telehealth is used exclusively in provinces in lockdown, except for some home care provided by private practitioners with strict risk management that includes online screening to minimize consultation time and infection exposure.” In Alberta, group classes and individual consults were offered virtually online. In the United States, “Most outpatient PTs and private clinics moved primarily to virtual visits. However, regulations and reimbursements vary by state and payer systems. In general, online visits were useful for baseline screening, education, exercise progression, posture and ergonomics, home safety, and some self-management activities such as gentle stretching or self-massage. Virtual group exercises were motivating for people fluent in their exercises and body mechanics. For some people, the virtual education and movement counseling were sufficient or provided some relief. For others, manual examinations and hands-on treatment were required, particularly for new lymphedema, scar tissue management, and pelvic floor conditions. Most older adults adapt well to virtual technology with basic education and prompts, and virtual visits promoted self-advocacy. Barriers include video quality, equity of online access in some areas, and patient confidence or comfort with virtual visits.” In Ireland, “Telehealth, video and phone calls were used in limited capacities during the lockdown mostly by outpatient PTs.”

In Chile, “Hospitals, residential centers, and outpatient clinics were in lockdown and oncology PTs were using telerehabilitation for every person with cancer, regardless of their stage or treatment. For pediatric cancers, telerehabilitation was used with the parents when the child was young and would not stay in front of the screen for long periods. Parents receive advice and education on exercises to perform during the week, and we noticed that they were more empowered in their child’s rehabilitation. Older children’s e-visits consisted of online exercises and homework activities, which most of them do, as it gives them something different to perform while in quarantine. The PTs found that implementing videogames using sport or dance as homework therapy increased exercise adherence.” In Nigeria, “Telehealth was not always available, but can be used for people with adequate literacy levels for patient education, exercise updates, monitoring self-care, and providing audio-visual recordings. Concerns were Internet access, poor Internet connectivity and coverage, the need to translate materials into local languages, and fears of

IMPLEMENTATION OF TELEHEALTH

The PTs expressed reluctance to use virtual care since hands-on diagnosis and treatment are essential to our professional practice and identity. However, telerehabilitation was a logical, safe approach to care for people at high risk for infection. In addition, since many of our people were self-isolating, remote communications met their preferences for care.

Several PTs used telehealth in a limited capacity prior to the pandemic. In Australia, “Telehealth was available in private practice and approved for 5 conditions, but did not include cancer, lymphoedema, or palliative care. Continued advocacy led to increases in conditions as was clinically appropriate. Our professional association advocated strongly for private health insurance rebates for telehealth.” In South Africa, “Telehealth was within our scope of practice but was extended during the pandemic for screening, reviewing history, verbal subjective assessments, triage, continuance of previously established care, and motivation and goal setting. It is not authorized for routine assessment and diagnosis or treatment of musculoskeletal conditions. It is assumed this directive will be reversed following the current health crisis.” In the Netherlands, “Virtual visits were used before the lockdown but now are expanded to include interviews, examinations, patient education, and some exercises, as possible. In pediatric settings, virtual meetings work well for young parents and their children. Some older people, unfamiliar with the technology, occasionally had difficulties. Exercise protocols with pictures and training schedules were also sent by post. Some people came to the gym for examinations, but training was performed online, and this worked well. For people already in treatment, it was easier to transfer them online, as they were familiar with training. New patient contacts were more difficult to begin online, particularly related to the effort or intensity required for training.” In Japan, “Telehealth was used before the lockdown to check activities of daily living and determine whether in-home rehabilitation was required. Since people were afraid to come to the hospital for cancer treatments, PTs were beginning to use telerehabilitation for exercise instructions.”

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losing our hands-on practice.” In Denmark, “Postsurgical complication education was performed virtually, and musculoskeletal rehabilitation was deemed nonessential. But it is difficult to do telehealth from home while homeschooling and caring for children.” In Turkey, “During lockdown, outpatient PTs perform consults and some cancer rehabilitation online.” In Saudi Arabia, “At lockdown, outpatient PTs called people to assess their needs for hands-on care or instructions by phone. Postoperative cases were given the choice to come to the clinic for sessions or receive instructions by phone. As we passed through this crisis, PTs noticed many people could benefit from a phone call or a virtual session. People were grateful to receive the phone call.”

A few countries plan to implement virtual care in the coming weeks. In the United Kingdom, “Some telephone visits were performed with people in oncology rehabilitation and then supplemented with personalized written exercise programs and handouts. Telehealth is currently driven by tech-savvy PTs, so evidence and training are needed to prepare all health professionals to be efficient and to address inequalities in access to these methods.” In Qatar, “Video consultations were not yet provided but were expected to be rolled out in the coming months. Teleconferencing will begin next week after strict security measures by the Ministry of Public Health are achieved. The health care system covers all residents’ costs. Under this financial system, it was easy to switch to phone or teleconsultations during the COVID-19 situation.”

**PLANNING FOR THE FUTURE**

Moving forward, the primary PT concerns were increased rehabilitation needs, integrating telerehabilitation, research needs, equity in health security, and PT recognition as essential practitioners during the global pandemic.

**Increased Rehabilitation Needs**

The PTs expressed concerns that there will be a high number of people with complex rehabilitation needs from COVID-19, delays in cancer care, or an inability to obtain HIV/AIDS medications. A United Nations report from 155 countries found that 42% of cancer treatments were interrupted during the lockdowns. In the Netherlands, “Outpatient PTs are not expecting to see people with COVID-19 for active training in the near future as they were on the ventilators and in intensive care units much longer than other people so they are much weaker. It may take several weeks of inpatient rehabilitation before they can begin any active training, and that is conditional on the status of their lungs after the infection. Further, we are afraid there will be significantly more disability following lockdown among people with cancer or HIV/AIDS from delays in treatment and the lack of functional rehabilitation.” It will also be necessary to develop efficient alternatives to care in areas where numbers of PTs are not sufficient. Alternative options may include bringing students into the clinics earlier in their education, increased use of group telerehabilitation for patient education, and exercise classes. In Nigeria, “Behavior change interventions like motivational interviewing can also be used to improve adherence.” Finally, moving forward, from Nigeria, “All PTs need to take a basic training course in palliative care.”

**Integrating Telehealth**

In Nigeria, “Moving forward, physiotherapists and our clients need to develop comfort levels for using telehealth related to trust, outcomes, and safety. The PTs will need evidence-based guidelines for rehabilitation practice in telehealth and consistent follow-up for people to realize it is an approved and safe treatment approach and not a consequence of the pandemic. Initially, telehealth should be about developing relationships with people, not remuneration. We currently charge 50% less for telehealth than for our in-clinic fees.” In South Africa, “The experiences with telehealth during the pandemic suggest that it could be a useful adjunct to delivery of care, but cannot replace the inherent gift of diagnostic therapeutic touch. So ultimately, telehealth will have a role, but it will not replace our basic skill set.”

**Research Needs**

In Scotland, “PTs need to take this opportunity to drive telehealth for our oncology populations such as evidence-based prehabilitation to prepare people to be fit for delayed surgery and cancer treatments. Telehealth and telerehabilitation require evidence to develop platforms for physical and mental health support to prepare for what’s to come.” In the Netherlands, “The lack of research on diagnostic, treatment, and outcomes measures among people with COVID-19 and/or with cancer and HIV/AIDS will delay the development of effective methods for patient care.” In Nigeria, “Interestingly, our HIV-infected people were not currently experiencing more serious COVID-19 symptoms and possibly this was due to their antivirals, but evidence was not available at this time to support this.” In Australia, “PTs were eager to learn how COVID-19 presents in people with HIV/AIDS and the implications on rehabilitation. It is suggested that when HIV infection is suppressed virologically, that COVID-19 would present clinically as it would in non–HIV-infected individuals.” Finally, since clinical trials were halted, it was suggested that PTs could subsequently perform post hoc studies such as medical record reviews and case series to begin evidence support for practice, particularly related to cancer and HIV/AIDS outcomes and telerehabilitation.

**Equity and Health Security**

Global public health security is an emerging concept of activities and measures that proactively and retroactively minimize the incidence of events that endanger people’s health and ensure the health of populations across geographical regions and international boundaries. Global
COVID-19 infection and mortality rates are highest among people of color and/or from lower-income areas. In COVID-19 hospital wards, PTs reported care was equitable across races and that disparities in health security before and after hospitalizations contributed to the poorer outcomes among people of color and/or those from lower-income areas. In the United States, “Some people from lower-income areas reported disparities in access to testing, Internet availability, safe transportation, and clean water.” In Nigeria, “Clients come to us for care irrespective of color and background, so we must act as advocates for everyone since they entrust their care to us. In summary, we should not sound naïve like we don’t know such issues arise, but we must speak out as PTs and advocate for equal health care.” As rehabilitation professionals, our primary goal is to improve quality of life through promoting health, improving function, and reducing pain. Therefore, our PT roles as educators and advocates support promoting the moral determinants of health that include equitable access to basic health security in the community.

PTs as Essential Health Care Team Members

While most countries consider PTs as essential health care professionals, many of our fundamental roles in HIV/AIDS, oncology, hospice and palliative, and COVID-19 care may not be known or appreciated. The PTs working in COVID-19 wards were often questioned about their presence in intensive and high-density units by nurses and physicians, and some hospital systems considered rehabilitation a nonessential service during the lockdown. The pandemic conditions became a singular moment for PTs to educate others and advocate for the need of our skills, particularly in critical care on proning teams, and in pulmonary and critical care. In Sweden, “The visibility and appreciation for PTs increased during this time through interactions on COVID-19 care units and news media attention.” Denmark reported, “Extensive and positive news coverage of PT work with COVID-19 people throughout the country.” This positive recognition created appreciation for PTs as essential in acute areas of practice. This recognition can be expanded by educating patients and professionals about our skills and working with our professional organizations to enhance our visibility.

SUMMARY AND CONCLUSIONS

In response to rapid lockdowns created by the spread of COVID-19, PTs around the globe adapted clinical practice to ensure patient safety and to provide high standards of care under the following conditions. Although guidelines for adapting clinical practice related to COVID-19 and cancer and HIV/AIDS care were rare, experienced PTs used standards of practice, critical thinking, and patient preferences to prioritize treatments and develop and expand telerehabilitation. Seasoned clinicians acknowledged the limitations of virtual care but found it a viable option for some patient conditions, particularly patient education, monitoring and progressing established rehabilitation protocols, and promoting a patient’s self-advocacy. It was felt, however, that virtual care will never replace our touchstone skill of hands-on diagnoses and treatment.

In the future, PTs plan to prepare for a large influx of people with complex rehabilitation needs from delayed treatment and paused functional training. The PTs plan to collaborate with investigators to develop evidence for practice, particularly related to treatment outcomes and telerehabilitation. The PTs believe we must advocate for health security, which is an unmet need in rehabilitation for our people of color or with limited incomes. The PTs felt we can use the awareness generated by our professional work during the pandemic to secure our place as essential practitioners in the health and medical care for patients at all levels of practice. Finally, the PTs expressed gratitude for this networking session and acknowledged its value as a means to learn from each other, validate decisions and outcomes, and provide collegial support during uncertain global times. Therefore, networking sessions will continue in the future to support PTs addressing challenging decisions related to safe and effective clinical care.

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