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## Clinical Practice

# Grief During the COVID-19 Pandemic: Considerations for Palliative Care Providers

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### Abstract

The COVID-19 pandemic is anticipated to continue spreading widely across the globe throughout 2020. To mitigate the devastating impact of COVID-19, social distancing and visitor restrictions in health care facilities have been widely implemented. Such policies and practices, along with the direct impact of the spread of COVID-19, complicate issues of grief that are relevant to medical providers. We describe the relationship of the COVID-19 pandemic to anticipatory grief, disenfranchised grief, and complicated grief for individuals, families, and their providers. Furthermore, we provide discussion regarding countering this grief through communication, advance care planning, and self-care practices. We provide resources for health care providers, in addition to calling on palliative care providers to consider their own role as a resource to other specialties during this public health emergency. *J Pain Symptom Manage* 2020;■:■-■. © 2020 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

### Key Words

Grief, COVID-19, end of life, loss, communication, self-care, advance care planning

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## Introduction

The COVID-19 pandemic has disrupted usual experiences of grief and modifications of approaches to support grief are needed. Uncomplicated grief encompasses multiple responses—emotional, cognitive, physical, and behavioral—that are common reactions after a loss.<sup>1</sup> We are all currently susceptible to multiple losses daily—loss of financial security, loss of social/physical connections, and loss of autonomy to move freely in the world. Many individuals are also experiencing a loss of physical/mental health and general safety and autonomy. Others are isolated in facilities where, owing to directives to limit physical contact, families are not allowed to visit. For many hospitalized patients, visitors are limited or prohibited, regardless of a COVID-19 diagnosis. For bereaved individuals, funerals and burials are postponed or held remotely, often without presence of

family or the possibility of the warm embrace from loved ones. Social media feeds are full of devastating stories—families denied opportunities to say goodbye before a death, or loved ones saying goodbye over phone/video, uncertain whether each communication is the last. Clinicians are isolating themselves from their own families indefinitely owing to worry about potentially spreading infection. Individuals are urgently updating advance directives and wills, making complex decisions on ventilation and resuscitation, and considering who will care for their children if they die. Grief is inherently a normal part of this myriad of COVID-19 experiences. Here, we provide discussion to help palliative care providers consider important aspects of grief related to the pandemic, how key practices of advance care planning, quality communication, and provider self-care can help mitigate that grief, and the necessary role of palliative

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care in serving as a resource to other specialties amid this pandemic.

### *Grief in Context*

The complex and rapid changes from COVID-19 impact processes which are best understood through a lens of grief (see Table 1). Traditionally, anticipatory grief is the normal mourning that occurs for a patient/family when death is expected.<sup>2</sup> With the number of COVID-19 deaths currently doubling within days,<sup>3</sup> medical personnel are expecting to experience death at unprecedented rates. Viewing maps of global spread, individuals can anticipate the virus coming closer, increasing distress. Experiences of death become more personal as COVID-19 affects communities broadly. Anticipatory grief results from uncertainty as well as trying to make sense of what is coming. In response to these projected numbers, hospitals are preparing and planning for a surge of patients with potential limitations in necessary equipment, such as personal protective equipment, ventilators, and intensive care unit beds. For patients and families, there can be unsettled feelings of not knowing how disease will progress or how they will be impacted by changing hospital and facility policies. These experiences that occur before death have a lasting impact on grief experiences of loved ones and providers alike.<sup>4–6</sup>

In response to the spread of the COVID-19 pandemic, communities have begun implementing large-scale “stay-at-home” orders, which in many cases are mandated by local or state leaders. Hospitals and other facilities are limiting or banning the physical presence of visitors. As deaths occur, the physical, mental, and social consequences of isolation of social distancing may impact the potential for complicated grief (CG). While clinicians should not assume that all patients or family members are experiencing CG now during the height of the COVID-19 pandemic, it is important to understand how current circumstances may set the stage for CG to occur after death. CG can present symptoms such as recurrent intrusive thoughts of the person who died, preoccupation with sorrow including ruminative thoughts, excessive bitterness, alienation from previous social relationships, difficulty accepting the death, and perceived purposelessness of life.<sup>7</sup> Under usual/pre-COVID-19 circumstances, family members of patients who died in the hospital or intensive care unit were at a higher risk for prolonged grief.<sup>8</sup> In one national survey, the dying patient’s inability to say “goodbye” to family before death was significantly associated with CG.<sup>4</sup> Other studies show that severe preloss grief symptoms,<sup>5</sup> lower levels of social support,<sup>5</sup> lack of preparation for the death,<sup>6</sup> and guilt<sup>9</sup> predicted CG and

postloss depression—all relevant factors in facing death in the context of the COVID-19 pandemic.

The type<sup>6</sup> and volume<sup>10</sup> of losses a person experiences also impacts the bereavement process and likelihood for CG. Owing to COVID-19, it is not uncommon for families and communities to experience multiple losses given the methods by which the disease spreads. In one study, among home hospice patients, nearly half experienced high anxiety and/or depression during the last week of life.<sup>11</sup> However, symptom management and quality of care at end of life is generally better in hospice compared to hospital deaths,<sup>8</sup> suggesting that anxiety and depression may be even higher at the end of life in hospitals. This seems particularly likely with additional context that deaths during this time may be complicated by ethical decisions in triaging resources,<sup>12</sup> quick transitions between “ill” and “dying” in previously healthy patients, and limitations in visitors who can be physically present at the bedside. While research cannot yet report on psychologic processing at end of life during social isolation of the COVID-19 pandemic, one can reasonably extrapolate that many are dealing with higher levels of anxiety/depression during this uncertain time. These likely contribute negatively to the quality of the dying experience, which predicts experiences of CG.<sup>6</sup>

Individuals may also feel they are experiencing disenfranchised grief, when grief is not publicly mourned or socially sanctioned by the larger community.<sup>13</sup> For example, when an individual has not followed the social or mandated “rules” to limit exposure and becomes infected or spreads illness to others, feelings of blame, anger, and sadness, among others, will be entwined with their experience of loss of health. This experience is heightened as language used in society and media presents an emotional distance to whom will contract and/or die from COVID-19 infection. Patients can experience intense guilt and self-blame as some perceive only older adults and the immunocompromised are at risk for infection or severe outcomes. Bereaved individuals may grapple with the fact that the person they lost was so much more than a statistic and have difficulty fitting their grief within these societal messages. Disenfranchised grief can also occur when families are unable to grieve in traditional practices of funeral services or being unable to attend a loved one’s burial. Many funeral and burial providers have discontinued services during the pandemic, or greatly limited the number of attendees along with other restrictions, minimizing options families have for mourning the loss of a loved one.

Though much of the grief outlined previously is focused on that of patients and families, the experiences of providers must also be considered. During times of crises, many providers rely on strategies of

Table 1  
Contexts of Grief Amid Rapid Changes/Impact Due to COVID-19 and Recommendations to Mitigate Grief

Changes Due to COVID-19	Impact	Context of Grief	Recommendations
Pandemic/spread of disease	Fear, worry, anticipation of spread Multiple losses in families; communities; long-term care facilities Individuals consider updates to advance directives—considerations for ventilation and resuscitation	<b>Anticipatory grief</b> for community—will someone I love be affected? When will the spread reach MY community? <b>Anticipatory grief</b> for medical personnel—planning for the “surge” Type <sup>6</sup> and volume <sup>10</sup> of losses a person experiences can impact <b>complicated grief</b> . Overall, <b>grief</b> is an inherent part of our experiences due to the breadth of losses individuals are experiencing to “normal” life. Increase in likelihood for <b>complicated grief</b> (CG) for bereaved family based on impact as the following factors are associated with CG—inability to say “goodbye” <sup>4</sup> , preloss grief symptoms <sup>5</sup> , lower levels of social support <sup>7</sup> , lack of preparation for death <sup>6</sup> , guilt. <sup>9</sup>	Preparing patients/families for a likely death is critical part of anticipatory grief work, which can impact likelihood for complicated grief. Utilize <b>communication-</b> based management, including recognizing, responding, and validating emotional responses, to address anticipatory grief. <sup>2</sup>
Social distancing or “stay at home” orders	Loss of financial security, loss of social/ physical connections and support, loss of autonomy to move freely in the world Limitations in visitors or banning physical presence of family at bedside (in hospitals, long-term care facilities) Survivors must quarantine based on exposure to loved one Changes to end of life practices—how patients/family communicate/say goodbye; communication between patients & providers, between families & providers; Delays and limitations to funerals and/or burials	<b>Disenfranchised grief</b> can occur when an individual does not follow social/ mandated “rules” and becomes infected or spreads illness. <b>Disenfranchised grief</b> can occur when families are unable to grieve with normal practices of social support and rituals in burial and funeral services. <b>Anticipatory grief</b> for patients, families, providers—experiences that occur before death have lasting impact on grief <sup>4–6</sup> Quality of the dying experience can impact occurrence of <b>complicated grief</b> in bereaved family. Potential for <b>moral distress</b> or <b>secondary</b> <b>traumatic stress</b> in medical personnel—use of avoidance, compartmentalization can lead to burnout and unresolved grief. <sup>14</sup>	Approach difficult conversations directly and do not shy away from discussing emotions, grief, and overall patient and family distress during <b>advance care planning</b> conversations. <sup>22</sup> During <b>advance care planning</b> , include discussions of desired ritual or spiritual practices and funeral/memorial plans. <sup>25</sup> Connect patients/families to resources to help them consider postdeath planning needs and provide/refer to additional grief support through telehealth services. To enhance the role of <b>self-care</b> in overcoming accumulated stress and grief in providers, practice self-awareness. <sup>28</sup> Some <b>self-care</b> strategies to help individuals cope with stress during an event include the following: being able to take breaks and disconnect from the disaster event, feeling prepared and informed in facilitating their response role, being aware of local resources and services to refer patients to for additional recovery assistance, and having adequate supervision and peer support while facilitating response. <sup>31</sup>
Increase in deaths, overburdening of hospital systems	Ethical considerations—triaging of resources, consideration of DNRs Providers may choose to isolate themselves from personal support systems to limit risk of exposure to family Guilt may be experienced by professionals who are unable to work due to exposure/ contraction of COVID-19		

avoidance or compartmentalization to continue treating patients, which can lead to unresolved grief.<sup>14</sup> It is common for persons helping with response efforts to experience secondary traumatic stress, a stress response that can occur as a result of knowing or helping a person(s) experiencing trauma. Symptoms include excessive worry and fear, feeling “on guard” all the time, recurring thoughts, and physical signs of stress.<sup>15</sup> Within the additional context of challenging ethical decisions and impacts of new policy decisions, moral distress may be another common experience for providers. Moral distress is “the physical or emotional suffering that is experienced when constraints (internal or external) prevent one from following the course of action that one believes is right.”<sup>16</sup> Moral distress is a significant issue facing critical care providers and is associated with burnout, where providers experience emotional exhaustion and depersonalization, or even dehumanization, of the patients and families in their care.<sup>17</sup> Personal challenges away from work, such as decisions to isolate oneself from personal support systems to limit risk of exposure, or feelings of guilt for those who are quarantined due to overt exposure or their own diagnosis, may cause additional grief for providers.

### ***Recommended Practices to Mitigate Grief***

With COVID-19 contributing to increasingly difficult circumstances and the potential for amplified grief, health care clinicians need tools and resources to mitigate that grief for patients/families and to cope with and process grief for themselves. Quality communication, advance care planning (ACP), and provider self-care are three recommended practices that can assist now in addressing this changed landscape of grief. [Table 2](#) outlines relevant resources across these recommended practices.

With the likelihood of fewer (or no) family allowed to visit, clinicians must be open to having honest conversations while exploring ways to offer connection. Helping prepare for likely death is a critical part of anticipatory grief work, particularly because lack of preparedness is associated with postdeath CG.<sup>18</sup> Anticipatory grief work with families is a crucial component in effective ACP<sup>19</sup> as participation in ACP can enhance outcomes for families during the bereavement period.<sup>20</sup> Communication-based management, including recognizing, responding, and validating emotional responses, is one key strategy for addressing anticipatory grief among critically ill patients and their families.<sup>2</sup> Patients and families who are provided opportunities for cognitive and emotional acceptance of death show better outcomes in quality of life for bereaved family members six months after the loss.<sup>21</sup>

In addition, EOL decisions inherently impact the grief experience for all involved<sup>13</sup> and critical decisions are being made daily for individuals facing COVID-19 infection diagnoses. Clinicians must be ready to approach these difficult and uncertain conversations directly and should not shy away from discussing emotions, grief, and overall patient and family distress during ACP conversations.<sup>22</sup> Ideally, ACP conversations should occur early with the goal of avoiding unwanted/unneeded hospitalizations and intensive treatment.<sup>23</sup> However, the rapid clinical decline of moderate/severe COVID-19 infection presents unprecedented urgency in discussing goals of care, especially with older patients with chronic disease.<sup>24</sup>

ACP with patients within weeks/days of life expectancy should also include discussions of desired spiritual practices and funeral/memorial.<sup>25</sup> For caregivers, the unpredictable trajectory of illness, practical and emotional preparedness for death, and coping with fear of unknown factors and a future without the care recipient all contribute to tension between the present and an uncertain future.<sup>18</sup> Connecting patients/families to resources to help them consider postdeath planning needs and providing additional grief support is important. While forced to disengage from traditional funeral and burial services during the COVID-19 outbreak, many are turning online to telecommunication-based alternatives, which can be an effective means of extending services.<sup>26</sup> In addition, many licensing boards have been temporary lifting restrictions on how licensed professionals can facilitate telehealth and remote services.

Health care clinicians are often trained to put aside their own feelings and emotions to put patient well-being and care first. During a time of a crisis, this focus can be amplified, and the concept of self-care may feel counterintuitive. However, dealing with the personal thoughts and emotions that arise during care is pertinent to providing ongoing ethical care for patients and families.<sup>27</sup> This self-awareness, or the ability to attend to the needs of the patient, the overall work environment, and one's own subjective experience can enhance the role of self-care in overcoming accumulated stress and grief in providers.<sup>28</sup> In fact, personal awareness, along with inner and social self-care, is positively associated with a health care professional's ability to cope with death in their professional setting.<sup>29</sup> Self-care is of utmost importance to minimize potential for long-term outcome effects so that providers are able to continue caring for patients during this unprecedented strain on the health care system.<sup>30</sup> Some self-care strategies to help individuals cope with stress during an event include the following: being able to take breaks and disconnect from the disaster event, feeling prepared and informed in facilitating their response

Table 2  
Resource List for Providers Navigating Grief Through the COVID-19 Pandemic

Topic Area	Organization, Author(s)	Title (With Hyperlink)	Purpose/Description
Communication	Vital Talk	COVID-Ready Communication Skills <sup>33</sup>	Practical advice on how to talk about difficult topics related to COVID-19
	Serious Illness Conversations—Kelemen, Altilio, & Leff	Specific phrases and word choices that can be helpful when dealing with COVID-19 <sup>34</sup>	Resources include the following: helpful responses during times of restrictive visiting; guide to virtual family meetings; end-of-life topics that may arise; supporting staff; team support
	SWHPN <sup>a</sup> —Halpern	Working with families facing undesired outcomes during the COVID-19 crisis <sup>35</sup>	Tip sheet of suggestions and considerations when communicating with families
Telehealth guidance	CAPC <sup>b</sup>	CAPC COVID-19 Response Resources <sup>36</sup>	Toolkit includes communication tips, symptoms management protocols, palliative care team tools, using telehealth, among other resources
Advance care planning	Respecting Choices	COVID-19 Resources <sup>37</sup>	Resources include the following: those to help clinicians have conversations about treatment preferences before a medical crisis; tools to support specific treatment decisions in high-risk individuals (CPR, breathing assistance—ventilator, user guide); resources for high-risk individuals and their agents/loved ones
	NHPCO <sup>c</sup>	COVID-19 Shared Decision-Making Tool <sup>38</sup>	Includes information related to likelihood of survival, along with symptoms, statistics and facts. The tool also prompts a “decision point” about advance directives
	Aging with Dignity – Five Wishes	Five Wishes Advance Directive <sup>39</sup>	A complete approach to discussing and documenting care choices; document meets legal requirements for directives in 42 states
Self-care	CDC <sup>d</sup>	COVID-19: Stress & Coping <sup>40</sup> Emergency Responders: Tips for Taking Care of Yourself <sup>45</sup>	Provides tips and resources for reducing stress Includes information on preparing for a response; understanding and identifying burnout and secondary traumatic stress; getting support; self-care techniques; and resources
	AAHPM <sup>e</sup>	Resilience and Well-Being <sup>41</sup>	Includes self-care tips, videos and presentations, articles, and other resources
	University of Buffalo, School of Social Work	Self-Care Starter Kit <sup>42</sup>	Includes foundational information about self-care; self-care assessments, exercises, and activities; and resources for developing a self-care plan (including for use during an emergency)

<sup>a</sup>Social Work in Hospice & Palliative Care Network.

<sup>b</sup>Center to Advance Palliative Care.

<sup>c</sup>National Hospice and Palliative Care Organization.

<sup>d</sup>Centers for Disease Control and Prevention.

<sup>e</sup>American Academy for Hospice and Palliative Medicine.

role, being aware of local resources and services to refer patients to for additional recovery assistance, and having adequate supervision and peer support while facilitating response<sup>31</sup> (see Table 2).

### Conclusion

Grief is an ongoing and important factor of the COVID-19 pandemic that affects patients, families, and medical providers. Some grief processes are novel related to social distancing/isolation, uncertainty/self-blame related to infection, and inability to implement usual burials/funerals. Others are typically experienced near end of life but are occurring on an unprecedented scale that has the potential to have devastating individual/societal effects in the short and long term. Based on their training and expertise in working with patients near EOL, palliative care providers are perfectly positioned to serve as a resource to their colleagues in other specialties.<sup>32</sup> Understanding the complexities of this grief, in addition to accessing and sharing resources for improved communication, telehealth, ACP, and self-care, is an important component to supporting patients, families, colleagues, and ourselves.

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### References

1. Worden JW. *Grief Counseling and Grief Therapy*, 5th ed. New York, NY: Springer Publishing Company, LLC, 2018.
2. Shore JC, Gelber MW, Koch LM, Sower E. Anticipatory grief: an evidence-based approach. *J Hosp Palliat Nurs* 2016;18:15–19.
3. Katz J, Sanger-Katz M. Coronavirus deaths by U.S. State and country over time: daily tracker. *The New York Times*. 2020. Available from <https://www.nytimes.com/interactive/2020/03/21/upshot/coronavirus-deaths-by-country.html>. Accessed March 28, 2020.
4. Otani H, Yoshida S, Morita T, et al. Meaningful communication before death, but not present at the time of death itself, is associated with better outcomes on measures of depression and complicated grief among bereaved family members of cancer patients. *J Pain Symptom Manage* 2017;54:273–279.
5. Romero MM, Ott CH, Kelber ST. Predictors of grief in bereaved family caregivers of person's with Alzheimer's disease: a prospective study. *Death Stud* 2014;38:395–403.
6. Lobb EA, Kristjanson LJ, Aoun SM, Monterosso L, Halkett GK, Davies A. Predictors of complicated grief: a systematic review of empirical studies. *Death Stud* 2010;34:673–698.
7. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub, 2013.
8. 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.
9. Li J, Tendeiro JN, Stroebe M. Guilt in bereavement: its relationship with complicated grief and depression. *Int J Psychol* 2019;54:454–461.
10. Mercer DL, Evans JM. The impact of multiple losses on the grieving process: an exploratory study. *J Loss Trauma* 2006;11:219–227.
11. Kozlov E, Phongtankuel V, Prigerson H, et al. Prevalence, severity, and correlates of symptoms of anxiety and depression at the very end of life. *J Pain Symptom Manage* 2019;58:80–85.
12. Downar J, Seccareccia D, Associated Medical Services Inc. Educational Fellows in Care at the End of Life. Palliating a pandemic: "all patients must be cared for". *J Pain Symptom Manage* 2010;39:291–295.
13. Doka KJ. Ethics, end-of-life decisions and grief. *Mortality* 2005;10:83–90.
14. Gerow L, Conejo P, Alonzo A, Davis N, Rodgers S, Domian E. Creating a curtain of protection: nurses' experiences of grief following patient death. *J Nurs Scholarship* 2010;42:122–129.
15. Centers for Disease Control and Prevention. *Emergency Responders: Tips for taking care of yourself*. 2018. Available from <https://emergency.cdc.gov/coping/responders.asp>. Accessed March 26, 2020.
16. Pendry PS. Moral distress: recognizing it to retain nurses. *Nurs Econ* 2007;25:217.
17. Fumis RRL, Amarante GAJ, de Fátima Nascimento A, Junior JMV. Moral distress and its contribution to the development of burnout syndrome among critical care providers. *Ann Intensive Care* 2017;7:71.
18. Breen LJ, Aoun SM, O'Connor M, Howting D, Halkett GK. Family caregivers' preparations for death: a qualitative analysis. *J Pain Symptom Manage* 2018;55:1473–1479.
19. Lacey D. Nursing home social worker skills and end-of-life planning. *Social Work Health Care* 2005;40:19–40.
20. Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ* 2010;340:c1345.
21. Ray A, Block SD, Friedlander RJ, Zhang B, Maciejewski PK, Prigerson HG. Peaceful awareness in patients with advanced cancer. *J Palliat Med* 2006;9:1359–1368.
22. Wolfe B. *Conversations that matter: stories and mobiles*. In: Rogne L, ed. *Advance care planning: Communicating about matters of life and death*. New York, NY: Springer Publishing Company, 2013.
23. Borasio GD, Gamondi C, Obrist M, Jox R. COVID-19: decision making and palliative care. *Swiss Med Weekly* 2020;150:w20233.
24. Curtis JR, Kross EK, Stapleton RD. The importance of addressing advance care planning and decisions about

- do-not-resuscitate orders during Novel Coronavirus 2019 (COVID-19). *JAMA* 2020. <https://doi.org/10.1001/jama.2020.4894>.
25. Zhukovsky DS. Principles of advance care planning. In: Hui D, Bruera E, eds. *Internal Medicine Issues in Palliative Cancer Care*. New York, NY: Oxford University Press, 2015.
26. Gibson A, Wladkowski SP, Wallace CL, Anderson KA. Considerations for developing online bereavement support groups. *J Social Work End-of-Life Palliat Care* 2020:1–17.
27. Katz RS. When our personal selves influence our professional work: an introduction to emotions and countertransference in palliative and end-of-life care. In: Katz RS, Johnson TA, eds. *When Professionals Weep: Emotional and Countertransference Responses in Palliative and End-of-Life Care*, 2nd ed. New York, NY: Routledge, 2016:3–7.
28. Kearney MK, Weininger RB, Vachon ML, Harrison RL, Mount BM. Self-care of physicians caring for patients at the end of life: “Being connected... a key to my survival”. *JAMA* 2009;301:1155–1164.
29. Sansó N, Galiana L, Oliver A, Pascual A, Sinclair S, Benito E. Palliative care professionals’ inner life: exploring the relationships among awareness, self-care, and compassion satisfaction and fatigue, burnout, and coping with death. *J Pain Symptom Manage* 2015;50:200–207.
30. Butler LD, Carello J, Maguin E. Trauma, stress, and self-care in clinical training: predictors of burnout, decline in health status, secondary traumatic stress symptoms, and compassion satisfaction. *Psychol Trauma* 2017;9:416.
31. Gibson A. An inquiry into older disaster responders’ secondary traumatic stress. Paper presented at the 21st International Association of Gerontological Societies’ World Congress of Gerontology and Geriatrics Meeting. San Francisco, CA. 2017.
32. Powell VD, Silveira MJ. What should palliative care’s response be to the COVID-19 epidemic? *J Pain Symptom Manage* 2020. <https://doi.org/10.1016/j.jpainsymman.2020.03.013>.
33. VitalTalk. COVID-Ready Communication Skills: A playbook of VitalTalk Tips. 2020. Available from <https://www.vitaltalk.org/guides/covid-19-communication-skills/>. Accessed March 29, 2020.
34. Kelemen A, Altilio T, Leff V. Specific phrases & word choice that can be helpful when dealing with COVID19. Available from Serious Illness Conversations website at <https://img1.wsing.com/blobby/go/2ad29bfa-43d6-4d9d-a3fe-a5abe1cb2c1f/downloads/SIC%20COVID%20Guidelines.pdf?ver=1585741689050>. Accessed March 29, 2020.
35. Halpern J. Working with families facing undesired outcomes during the COVID-19 crisis. Available from SWHPN website at <https://swhpn.memberclicks.net/assets/01%20Working%20With%20Families%20Undesired%20Outcomes%20COVID19.pdf>. Accessed March 29, 2020.
36. Center to Advance Palliative Care. CAPC COVID-19 response resources. Available from <https://www.capc.org/toolkits/covid-19-response-resources/>. Accessed March 29, 2020.
37. Respecting choices. COVID-19 resources. Available from <https://respectingchoices.org/covid-19-resources/>. Accessed March 29, 2020.
38. National Hospice & Palliative Care Organization. Coronavirus disease 2019 (COVID-19) shared decision-making tool. 2020. Available from <https://www.nhpco.org/wp-content/uploads/COVID-19-Shared-Decision-Making-Tool.pdf>. Accessed March 29, 2020.
39. Aging with dignity. Five wishes. Available from [https://fivewishes.org/five-wishes-covid-19?\\_cldee=YnNiYXJyZXR0ODFAYW9sLmNvbQ%3d%3d&recipientid=contact-a75e9887ad74e8119436005056a0481a-358d738d3cb941c597982d82cebe8052&esid=7ceac7b8-136a-ea11-94da-005056a0481a](https://fivewishes.org/five-wishes-covid-19?_cldee=YnNiYXJyZXR0ODFAYW9sLmNvbQ%3d%3d&recipientid=contact-a75e9887ad74e8119436005056a0481a-358d738d3cb941c597982d82cebe8052&esid=7ceac7b8-136a-ea11-94da-005056a0481a). Accessed March 29, 2020.
40. Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). 2020. Available from <https://www.cdc.gov/coronavirus/2019-ncov/prepare/managing-stress-anxiety.html>. Accessed March 29, 2020.
41. American Academy of Hospice and Palliative Medicine. Resilience and well-being. Available from <http://aahpm.org/career/resilience-and-well-being>. Accessed March 29, 2020.
42. University at Buffalo School of Social Work. Self-care starter kit. Available from <http://socialwork.buffalo.edu/resources/self-care-starter-kit.html>. Accessed March 29, 2020.