COVID-19 Articles Fast Tracked Articles

Bereavement Support on the Frontline of COVID-19: Recommendations for Hospital Clinicians

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Abstract

Deaths due to COVID-19 are associated with risk factors which can lead to prolonged grief disorder, post-traumatic stress, and other poor bereavement outcomes among relatives, as well as moral injury and distress in frontline staff. Here we review relevant research evidence and provide evidence-based recommendations and resources for hospital clinicians to mitigate poor bereavement outcomes and support staff. For relatives, bereavement risk factors include dying in an intensive care unit, severe breathlessness, patient isolation or restricted access, significant patient and family emotional distress, and disruption to relatives' social support networks. Recommendations include advance care planning; proactive, sensitive, and regular communication with family members alongside accurate information provision; enabling family members to say goodbye in person where possible; supporting virtual communication; providing excellent symptom management and emotional and spiritual support; and providing and/or sign-posting to bereavement services. To mitigate effects of this emotionally challenging work on staff, we recommend an organizational and systemic approach which includes access to informal and professional support. J Pain Symptom Manage 2020;60:e81–e86.

Key Words

Bereavement, grief, coronavirus, pandemics, palliative care, family caregivers

Introduction

At the time of writing, there have been over 190,000 deaths globally from COVID-19, with an estimated 0.95 million people bereaved. Although the true impact of COVID-19 is as yet unknown, considerable levels of grief and bereavement will follow.

Bereavement is a natural part of the human experience but can be intensely painful and negatively impact physical and mental health. Approximately one in 10 bereaved adults develop prolonged grief disorder (PGD),[1] which involves intense symptoms of grief that endure for more than six months after loss, separation distress, intrusive thoughts, and feelings of emptiness or meaninglessness.

Wallace et al. describe the types of grief associated with the COVID-19 pandemic and provide useful general guidance for its mitigation.[2] Here, we review bereavement risk factors in COVID-19, provide evidence-based recommendations for how to support bereaved relatives (Table 1), and highlight additional resources (Table 2).

Dying in Hospital, Advance Care Planning, and Communication

Most deaths from COVID-19 currently occur in hospital. Advance care planning (ACP) discussions would ideally have been documented before admission and revisited in hospital.[3] However, if ACP has not yet occurred, where possible these discussions should be initiated with patients and families to assist with parallel planning (preparing for the worst while

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hoping for the best)[2,4] (Table 1). ACP aims to understand patients' unique perspectives on what gives life meaning and helps ensure care is consistent with their values. This includes helping patients avoid unwanted or nonbeneficial high-intensity treatments.[5] Planning for future care also prepares family members for the death of their relative and leads to better outcomes after death.[6]

Some of the most critically ill patients with COVID-19 are admitted to and may die in intensive care units (ICUs). While for some patients this will be clinically appropriate and in line with their preferences, among surviving relatives, ICU bereavement is associated with poor mental health outcomes including PGD (5%−52%), post-traumatic stress disorder (PTSD) (14%−50%), and depression (18%−27%).[7–9]

Whether or not a patient dies in ICU, we know that clear, complete communication by health care providers improves bereaved relatives' satisfaction with end-of-life care,[6] and that families appreciate proactive, regular, and sensitive communication and accurate information.[6,10,11] Conversely, poor communication with relatives is associated with PGD.[7]

Specific communication strategies that increase family satisfaction include the following: empathic statements assuring nonabandonment, assurances of comfort, and provision of written information.[12] Conversation analytic research has identified communication practices useful in end-of-life care[13] and has been incorporated in COVID-19 training (Table 2). Family conferences informed by the "VALUE" mnemonic have been found to lessen bereavement burden.[10]

In COVID-19, communication at the bedside is challenging, as health professionals need to wear personal protective equipment (PPE). The depersonalization of protective clothing and communication through a mask and visor is testing, particularly when a patient is frail or hearing impaired; however, guidelines and flashcards are now available (Table 2). Regular telephone communication is vital, with Swiss guidance recommending twice-daily calls to family members when a patient is seriously ill or dying, and families being told when a patient is "sick enough to die."[14]

Table 1
Evidence-Based Recommendations for Mitigating Poor Bereavement Outcomes in Relatives

Before a Patient's Death
• Early advance care planning discussions and parallel planning with patients and families
• Timely, proactive, and sensitive information provision and communication with families, guided by the VALUE mnemonic: value and appreciate what family members say; acknowledge family members' emotions; listen to their concerns; understand who the patient was in active life by asking questions; elicit questions from family members
• Where possible, assign a specific contact person for each patient to help ensure continuity of care and timely communication with families before and after death
• Follow expert guidance on tele-communication and communication with PPE (see Table 2)
• Specialist palliative care collaboration, referral, and advice; use triage and remote communication where needed
• Optimize symptom management
• Where possible, allow and facilitate a family member to visit a deteriorating patient
• Facilitate virtual communication using smartphones, tablet computers, and other technology. Enlist donations to source tablets, smartphones, and charging devices (patients are often admitted to hospital with their phones but not chargers). Dedicated equipment with appropriate applications can then be loaned to patients and families in COVID-19 areas.
• To avoid distress, be cautious about virtual communication when a patient is actively dying
• Ensure patients and families have access to emotional, psychological, and spiritual support, including access to chaplaincy
After a Patient's Death
• Some families may want mementoes or keepsakes (e.g., locks of hair, handprints, etc.). Local practice may vary; in the U.K., these can be taken at the time of care after death, but not at a later date, placed in a sealed bag and not opened before seven days.[41]
• Ensure an involved clinician is available postmortem to speak and listen to family members, discuss what happened, and answer questions via telephone.
• Identify relatives who may be at particular risk of poor bereavement outcomes (e.g., due to social isolation) for enhanced follow-up and support.
• Enlist the support of allied health professionals from other specialties within the hospital, whose workload may have decreased during the pandemic, to help provide psychosocial support to bereaved families.
• Create a COVID-19 bereavement leaflet which signposts relatives to local bereavement support available via e-mail, telephone, mobile apps, Web forums, Web chats, and virtual peer support, and where to get faith-specific advice. These should be given to the family as soon as possible after the patient's death.
• Send a personalized condolence letter. The best timing of a condolence letter is not currently known; however, it should be personalized, not make commitments that cannot be met and include information regarding further support.
• If needed, provide a list of local support services which may be able to provide practical help and support to people who are suddenly vulnerable due to a bereavement and may be self-isolating.
• Provide up-to-date information and guidance on arranging a funeral or other religious ceremony and registering a death, with suggestions and resources for future ceremonies. Funeral poverty may be a concern for many relatives, so signposting toward organizations who can advise on this issue may be helpful.
• Consider providing bereavement support evenings and/or culturally sensitive bereavement services for relatives after the immediate crisis.

Table 2
Resources

Advance care planning in COVID-19	Respecting Choices (US): https://respectingchoices.org/covid-19-resources/#planning-conversations Compassion in Dying (UK): https://coronavirus.compassionindying.org.uk/making-decisions-about-treatment/
COVID-19 communication	Center to Advance Palliative Care (CAPC) COVID-19 Response Resources—includes communication guidance from VitalTalk, the Serious Illness Program and others (US): https://www.capc.org/toolkits/covid-19-response-resources/ Discussion of unwelcome news during COVID-19 pandemic: A framework for health and social care professionals, E-learning for Health (UK) https://portal.e-lfh.org.uk/LearningContent/LaunchFileForGuestAccess/611123
Telephone communication	Patient Safety Learning (UK). Talking to relatives: A guide to compassionate phone communication during COVID-19. 2020. https://www.pslhub.org/learn/coronavirus-covid19/tips/talking-to-relatives-a-guide-to-compassionate-phone-communication-during-covid-19-r2009/
Communication via PPE	CARDMEDIC − Flashcards for communicating with patients in the ICU during the COVID-19 pandemic. 2020. https://www.cardmedic.com/
Information leaflets for hospital admission	Editable leaflets to provide to patients and families (Europe): https://erj.ersjournals.com/content/early/2020/04/07/13993003.00815-2020
Supporting staff	Strategies for Public Service Personnel Leadership (Canada): https://www.cipsrt-icrtsp.ca/covid-19/strategies-for-psp-leadership/ King's Fund (UK): Responding to stress experienced by hospital staff working with COVID-19 https://www.kingsfund.org.uk/audio-video/stress-hospital-staff-covid-19

Telephone communication is understandably difficult, particularly when breaking news of a death, but there are resources to support staff (Table 2).

Palliative care, whether generalist or specialist, plays a central role in responding to COVID-19. Specialist palliative care involvement in the emergency department reduces hospital length of stay and ICU admission,[15] whereas in the ICU, it decreases hospital and ICU stays.[16] Early palliative care consultations also improve bereaved relatives' perception of the quality of end-of-life care.[17] However, as specialist palliative care is a limited resource, consultation and referral will need to be triaged,[18] with input focused on supporting and coaching primary teams, often digitally or via telephone.[19]

Patient Isolation, Family Access, and Virtual Communication

An additional risk factor for poor bereavement is the need to isolate patients to control the spread of COVID-19. Restricted access to a patient and not being able to say "goodbye" are distressing to relatives[9] and associated with PGD and PTSD in bereavement.[7]

If relatives are not in a high-risk category, in quarantine or unwell themselves, it is therefore recommended that access be granted for short periods.[14] Ideally, patients will have single-occupancy rooms to allow quiet and privacy to spend time with relatives.[11] However, for many relatives, visiting may pose a significant health risk. There may also be shortages of PPE for relatives or a lack of staff to assist relatives with donning PPE, particularly where testing of health care staff is insufficient.

It is therefore also recommended that clinical teams help enable patient-family communication via virtual means, following infection control guidelines for devices—particularly if an in-person visit is not possible (Table 1). However, Swiss guidance does not recommend virtual contact between patients with COVID-19 and their families when a patient is actively dying[14]; previous studies have found an association between relatives witnessing death in ICU and higher rates of both PGD and PTSD.[7,8]

Symptom Management

The breathlessness[4] associated with COVID-19 may also be problematic for bereavement. Severe shortness of breath in patients can be highly distressing to relatives.[9] Among bereaved caregivers, the perception that a patient could not breathe peacefully is associated with a higher risk of PTSD, and a patient dying while intubated is associated with both PGD and PTSD.[7] Conversely, there is evidence that withdrawal of life-prolonging interventions and extubation before death increase satisfaction among bereaved family members[12]; withdrawal should be clearly explained and in the context of good symptom control.[20]

Emotional and Spiritual Distress

Patients who are seriously ill with COVID-19 and their families are inevitably anxious, afraid, alone, and in need emotional support, yet this is an area in which hospital care has been found lacking.[11,21] In addition to considering pharmacological and non-pharmacological interventions,[4] attending to the tenor of care is key. Care for the patient and family should provide for physical comfort, autonomy, meaningfulness, preparedness, and interpersonal connection[22] and be mindful of the "ABCDs" of

dignity-conserving care (attitudes, behaviors, compassion, and dialogue).[23] Care must also respect cultural and religious diversity, and staff require cultural competence to provide appropriate support to families whose cultural and faith background is different from their own.

Bereaved family members may question why they have survived when their loved one did not, feel guilt over possibly transmitting the disease and a loss of coherence or meaning, and mourn the loss of future dreams and hopes.[4,24] Relatives' perception of whether a patient received emotional support at the end of life is a determinant of their experience of bereavement.[21] Greater attention to the dying patient's emotional well-being helps limit relatives' distress.[9] Showing respect and compassion and comforting bereaved relatives mitigate poor outcomes and dissatisfaction.[6] All frontline staff should be able to provide the basics of culturally sensitive bereavement support and signpost to specialist services.[25]

Access to spiritual support at the end of life is important for many patients and families, whether or not they are religious, but this is an aspect of care somewhat neglected in acute hospitals.[26] As in humanitarian crises, spiritual care during COVID-19 will include helping individuals face and overcome fears and find hope and meaning; attending to existential suffering; addressing feelings of punishment, guilt, unfairness, and remorse; assisting when people need to confess or reconcile; and offering grief support and death preparation assistance.[24] While chaplains play a crucial role in the team and have specialist skills, "spiritual first-aid," based on skilled listening and expressing kindness and compassion, can also be provided by other staff.[24]

Grieving in Isolation and Bereavement Support

A common impulse for those experiencing grief is to seek comfort in the arms of family, friends, and community. Yet in the context of COVID-19, bereaved family members may have limited social support due to physical distancing requirements and be forced to grieve alone. Loss of social and community networks, living alone, and loss of income are known to exacerbate psychological morbidity in bereavement.[7,27]

Health and social care professionals, and those supporting the bereaved informally, can encourage those who are grieving to express their grief and reach out to others, online or via telephone, letters, or videos. Although these methods cannot replace face-to-face conversation and physical affection, they nevertheless enable connection in the interim.

While family, friends, and existing networks are the foundation of bereavement support, and for many people the only support needed, formal bereavement services play a central role in supporting individuals and families. Poor bereavement outcomes are associated with being a female relative, a spouse, older age, trauma, and lower educational attainment, socioeconomic status, and social support.[28–30] Awareness of these risk factors can guide information provision and support.

A systematic review of bereavement support in adult ICU identified several interventions: a personal memento, a handwritten condolence letter, a post-death meeting, storytelling, research participation, use of a diary, and a bereavement follow-up program. Although evidence for effectiveness was weak, all interventions were well accepted by families.[31] Bereaved relatives report that they prefer hospital staff make contact with them after the death of their family member.[11] A personalized condolence letter can help to humanize the medical institution but might also highlight the absence of further support[32]; hence bereavement leaflets sign-posting to services are also important.[11] While the best timing of a condolence letter is unclear, it is crucial that letters avoid making commitments (e.g., to provide further information) which cannot be met.[33] Organized bereavement support evenings can be a form of comfort and have a positive impact on relatives' grieving process.[34]

Another way a pandemic such as COVID-19 disrupts the process of bereavement is by impacting families' ability to hold funerals and other ceremonies.[2,25] Funerals play a key role in mourning, bringing together those who remember the deceased to celebrate their life, and creating a supportive network for the bereaved family. Restrictions during the pandemic mean that funerals carried out in this time are unlikely to match the wishes of the bereaved or the deceased. However, it is possible to adapt funeral services using online methods to ensure important people are included, even if attendance is not possible (Table 2). After the crisis, relatives can hold ceremonies to remember their loved one, and culturally sensitive bereavement services held in hospitals may be helpful for closure and to show respect for the dead.[11]

The Impact of Deaths From COVID-19 Among Staff

In the COVID-19 pandemic, the ICU has been described as the "frontline of a war" against the disease, with clinicians the "soldiers in the trenches." While war metaphors have limitations, we know from the experiences of clinicians in China, Italy, and Switzerland that care of patients with COVID-19

results in major ethical dilemmas and a psychological toll on the health care teams caring for them, in part due to limited resources.[14,35] Frontline staff are at risk of secondary or vicarious trauma, as a result of repeated empathic engagement with sadness and loss,[36] as well as moral injury,[37] resulting from actions, or the lack of them, which violate one's moral or ethical code. This can lead to depression, anxiety, and post-traumatic distress.[38]

We recommend that health care leaders and organizations take responsibility and ensure staff are prepared for the emotional consequences of their work and that resources, guidance, and training are in place to safeguard health care providers' health.[37] Self-care strategies and individual "resilience tools" such as mindfulness and reflective practice are insufficient; resilience should not become another responsibility of staff working in traumatic conditions but requires an organizational and systemic response.[39] Organizations should actively monitor frontline staff, facilitate effective team cohesion, and implement strategies to support teams' day-to-day work, including informal debriefing and peer support. Single-session psychological debriefing approaches should be avoided as they may cause additional harm.[40] Leaders and organizations should also make professional sources of support readily available; this includes formal bereavement counseling, which can enhance awareness about vicarious traumatization and encourage adaptive coping strategies.[36]

Conclusions

COVID-19 brings new challenges and difficulties in caring for patients and their loved ones, and supporting staff. Evidence suggests several risk factors for poor bereavement outcomes in COVID-19, including severe breathlessness, patient isolation, and disruption to relatives' social support networks. Understanding the risk of trauma and moral injury to staff in the current pandemic is essential for the early identification and prevention of harm. Drawing on best available evidence, we have made recommendations for mitigating negative effects on bereaved relatives and health care professionals. These include proactive, sensitive, and regular communication with family members alongside accurate information provision; enabling family members to say goodbye in person and supporting virtual communication; providing excellent symptom management and emotional and spiritual support; sign-posting to bereavement services; and supporting bereaved relatives to adapt funerals and seek appropriate bereavement support, as well as consistent leadership and support for health professionals in the frontline.

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References

1. Lundorff M, Holmgren H, Zachariae R, Farver-Vestergaard I, O'Connor M. Prevalence of prolonged grief disorder in adult bereavement: a systematic review and meta-analysis. J Affect Disord 2017;212:138–149.

2. Wallace C, Wladkowski SP, Gibson A, White P. Grief during the COVID-19 pandemic: considerations for palliative care providers. J Pain Symptom Manage 2020. (In Press).

3. Billings JA, Bernacki R. Strategic targeting of advance care planning interventions: the goldilocks phenomenon. JAMA Intern Med 2014;174:620–624.

4. Bajwah S, Wilcock A, Towers R, et al. Managing the supportive care needs of those affected by COVID-19. Eur Respir J 2020;55:2000815.

5. Khandelwal N, Long AC, Lee RY, McDermott CL, Engelberg RA, Curtis JR. Pragmatic methods to avoid intensive care unit admission when it does not align with patient and family goals. Lancet Respir Med 2019;7:613–625.

6. Heyland DK, Rocker GM, O'Callaghan CJ, Dodek PM, Cook DJ. Dying in the ICU: perspectives of family members. Chest 2003;124:392–397.

7. Kentish-Barnes N, Chaize M, Seegers V, et al. Complicated grief after death of a relative in the intensive care unit. Eur Respir J 2015;45:1341.

8. Kross EK, Engelberg RA, Gries CJ, Nielsen EL, Zatzick D, Curtis JR. ICU care associated with symptoms of depression and posttraumatic stress disorder among family members of patients who die in the ICU. Chest 2011;139:795–801.

9. Probst DR, Gustin JL, Goodman LF, Lorenz A, Wells-Di Gregorio SM. ICU versus non-ICU hospital death: family member complicated grief, posttraumatic stress, and depressive symptoms. J Palliat Med 2016;19:387–393.

10. Lautrette A, Darmon M, Megarbane B, et al. A communication strategy and brochure for relatives of patients dying in the ICU. N Engl J Med 2007;356:469–478.

11. Ó Coimín D, Prizeman G, Korn B, Donnelly S, Hynes G. Dying in acute hospitals: voices of bereaved relatives. BMC Palliat Care 2019;18:91.

12. Hinkle LJ, Bosslet GT, Torke AM. Factors associated with family satisfaction with end-of-life care in the ICU: a systematic review. Chest 2015;147:82–93.

13. Parry R, Land V, Seymour J. How to communicate with patients about future illness progression and end of life: a systematic review. BMJ Support Palliat Care 2014;4:331–341.

14. Tanja F-S, Nancy P, Keller N, Claudia G. Conservative management of Covid-19 patients – emergency palliative care in action. J Pain Symptom Manage 2020.

15. Grudzen C, Richardson LD, Baumlin KM, et al. Redesigned geriatric emergency care may have helped reduce admissions of older adults to intensive care units. Health Aff 2015;34:788–795.

16. Aslakson R, Cheng J, Vollenweider D, Galusca D, Smith TJ, Pronovost PJ. Evidence-based palliative care in the intensive care unit: a systematic review of interventions. J Palliat Med 2014;17:219–235.

17. Kaufer M, Murphy P, Barker K, Mosenthal A. Family satisfaction following the death of a loved one in an inner city MICU. Am J Hosp Palliat Care 2008;25:318–325.

18. Powell VD, Silveira MJ. What should palliative care's response be to the COVID-19 pandemic? J Pain Symptom Manage 2020.

19. Fausto J, Hirano L, Lam D, et al. Creating a palliative care Inpatient Response plan for COVID19 – the UW medicine experience. J Pain Symptom Manage 2020.

20. Keenan SP, Mawdsley C, Plotkin D, Webster GK, Priestap F. Withdrawal of life support: how the family feels, and why. J Palliat Care 2000;16(Suppl):S40–S44.

21. Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. JAMA 2004;291:88–93.

22. Proulx K, Jacelon C. Dying with dignity: the good patient versus the good death. Am J Hosp Palliat Care 2004; 21:116–120.

23. Chochinov HM. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. BMJ 2007; 335:184.

24. Yuichi Clark P, Joseph DM, Humphreys J. Cultural, psychological, and spiritual dimensions of palliative care in humanitarian crises. In: Waldman E, Glass M, eds. A Field Manual for Palliative Care in Humanitarian Crises. Oxford: OUP, 2019.

25. Leong IY, Lee AO, Ng TW, et al. The challenge of providing holistic care in a viral epidemic: opportunities for palliative care. Palliat Med 2004;18:12–18.

26. Physicians. RCo. End of life care audit-dying in hospital: National Report for England. London: Royal College of Physicians, 2016.

27. Kun P, Han S, Chen X, Yao L. Prevalence and risk factors for posttraumatic stress disorder: a cross-sectional study among survivors of the Wenchuan 2008 earthquake in China. Depress Anxiety 2009;26:1134–1140.

28. Milic J, Muka T, Ikram MA, Franco OH, Tiemeier H. Determinants and predictors of grief severity and persistence: the Rotterdam study. J Aging Health 2017;29:1288–1307.

29. Thomas K, Hudson P, Trauer T, Remedios C, Clarke D. Risk factors for developing prolonged grief during bereavement in family carers of cancer patients in palliative care: a longitudinal study. J Pain Symptom Manage 2014;47: 531–541.

30. 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.

31. Efstathiou N, Walker W, Metcalfe A, Vanderspank-Wright B. The state of bereavement support in adult intensive care: a systematic review and narrative synthesis. J Crit Care 2019;50:177–187.

32. Kentish-Barnes N, Cohen-Solal Z, Souppart V, et al. "It was the only thing I could hold onto, but…": receiving a letter of condolence after loss of a loved one in the ICU: a qualitative study of bereaved relatives' experience. Crit Care Med 2017;45:1965–1971.

33. Kentish-Barnes N, Chevret S, Champigneulle B, et al. Effect of a condolence letter on grief symptoms among relatives of patients who died in the ICU: a randomized clinical trial. Intensive Care Med 2017;43:473–484.

34. Walsh T, Foreman M, Curry P, O'Driscoll S, McCormack M. Bereavement support in an acute hospital: an Irish model. Death Stud 2008;32:768–786.

35. Lai J, Ma S, Wang Y, et al. Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. JAMA Netw Open 2020;3:e203976.

36. Cook D, Rocker G. Dying with dignity in the intensive care unit. N Engl J Med 2014;370:2506–2514.

37. Williamson V, Murphy D, Greenberg N. COVID-19 and experiences of moral injury in front-line key workers. Occup Med (Lond) 2020. https://doi.org/10.1093/occmed/kqaa052.

38. Williamson V, Stevelink SAM, Greenberg N. Occupational moral injury and mental health: systematic review and meta-analysis. Br J Psychiatry 2018;212:339–346.

39. Humphreys J, Joseph DM. A trauma-informed response to working in humanitarian crises: focus on provider. In: Waldman E, Glass M, eds. A Field Manual for Palliative Care in Humanitarian Crises. Oxford: OUP, 2019.

40. Brooks SK, Rubin GJ, Greenberg N. Traumatic stress within disaster-exposed occupations: overview of the literature and suggestions for the management of traumatic stress in the workplace. Br Med Bull 2019;129:25–34.

41. Lawrie I, Murphy F. COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care: Role of the specialty and guidance to aid care. Association of Palliative Medicine, 2020.