



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.



An accumulation of distress: Grief, loss, and isolation among healthcare providers during the COVID-19 pandemic

David Ansari

Department of Medical Education, University of Illinois College of Medicine at Chicago, 808 S. Wood St. M/C 591, Chicago, IL, 60612, USA



ARTICLE INFO

Keywords:

Healthcare professionals
Distress
Grief
Loss
Isolation

ABSTRACT

This article draws on the journal entries of 62 healthcare professionals (HCP) in the United States and Canada who participated in the Pandemic Journaling Project (PJP) during 2020–2021. The HCP in this article represented healthcare fields including medicine, nursing, physical therapy, social work, and clinical psychology. In their journal entries, HCP provided accounts of witnessing the death and bereavement of their patients and loved ones; experiencing their own loss of loved ones and important milestones; facing isolation from their networks and places of meaning; and juggling increasing workloads and caregiving activities. I illustrate how these four areas were impacted by guilt, duty, ethical deliberations, and gender disparities. I argue that HCP face an accumulation of distress when they witness grief and face loss without space to process these experiences.

1. Introduction

The COVID-19 pandemic has taken the lives of millions of people around the world and has generated a crisis of grief in its wake. It has also troubled processes of grieving, mourning, and making meaning of loss. As a more encompassing experience than grief, loss interweaves other aspects of our lives into the crisis of the pandemic (Zhai and Du, 2020). Many have been unable to be with their loved ones at the time of their death, ensure that their loved ones' wishes were respected, carry out appropriate and meaningful funerary rites, and, in some instances, they have experienced guilt and uncertainty due to potentially infecting loved ones (Fernández and González-González, 2022; Mohammadi et al., 2021; Pearce et al., 2022). Not only has COVID-19 generated loss, it has also complicated individual and collective ways of grieving, mourning, and processing loss.

Anthropological accounts of grief, loss, and mourning have emphasized their social, long-term, and transformative dimensions (Brison and Leavitt, 1995; Kaufman and Morgan, 2005; Neimeyer et al., 2014; Robben, 2004). Anthropologists who study grief have identified how mourning is an individual and social process that takes place in cultural, religious, economic, and historical contexts (Silverman et al., 2021). The late Sharon Kaufman and co-author Lynn Morgan (2005: 323) noted that the commemoration of the dead profoundly informs the social identity of the living. Mourning is a situated and communicative act that narrates the meaning of the deceased person's life and the status of the bereaved within their communities (Neimeyer et al., 2014). Ritual practices

provide opportunities for healing and the restoration of wellbeing (Hockey et al., 2007). In a different but also unsettling context, Rebecca Crocker et al. (2021) document how the disappearance of migrants along the U.S.-Mexico border has left their bereaved loved ones without closure. The authors ethnographically explored ambiguous loss, a concept coined by family therapist and scholar Pauline Boss, as a lived and embodied experience where a missing loved one is physically absent but psychologically present. Ambiguous loss, as well as these anthropological framings of grief, loss, and mourning more broadly, help us to understand how making sense of loss and finding meaning through grieving have been complicated and rendered incomplete by the pandemic.

Health care providers' (HCP) experiences of grief and loss have also been upended by the pandemic. When families and loved ones could not be present in hospitals, HCP were the last people to accompany isolated patients as they died from COVID and other causes. HCP have witnessed patients suffering and dying alone, often without knowing *why* they were alone (Fernández and González-González, 2022). A surge in the need for bereavement care forced HCP, including those feeling unqualified to provide this kind of care, to take on new responsibilities and skills, often while doing so remotely (Pearce et al., 2021). HCP have dutifully performed this clinical and caring work, frequently in dangerous working conditions, all while expressing fear for their own safety, facing uncertainty about spreading COVID-19 to others, isolating from their families and friends, mourning the loss of their loved ones, and watching mixed reactions from politicians and the public about the gravity of the

E-mail address: daa@uic.edu.

<https://doi.org/10.1016/j.ssmmh.2022.100146>

Received 2 February 2022; Received in revised form 21 August 2022; Accepted 21 August 2022

Available online 9 September 2022

2666-5603/© 2022 The Author. Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

pandemic (Aughterson et al., 2021; Das et al., 2021; Liu et al., 2020; Nyashanu et al., 2020; Rabow et al., 2021). The heavy workloads of HCP have also overshadowed the space they might ordinarily devote to sharing, venting, and checking in with their colleagues (Kotera et al., 2022). Taken together, these perspectives illustrate the intense emotional burden that has befallen HCP that limits their ability to grieve, mourn, and process loss.

The experiences of grief, loss, and mourning has taken a toll on the mental health of HCP. Grief among HCP has been associated with compassion fatigue resulting from the exposure to the traumatic experiences of their patients, as well as burnout, which is characterized by emotional exhaustion, depersonalization, and a low sense of accomplishment (Adwan, 2014; Boerner et al., 2017; Carton and Hupecey, 2014; Lathrop, 2017). Compassion fatigue and burnout among HCP were already concerning prior to the onset of COVID-19, due to witnessing the suffering of their patients and not having space to process what they witnessed (Frajerman et al., 2020; McGibbon et al., 2020; Missouriidou et al., 2021; Rotenstein et al., 2018; Shah et al., 2021). HCP and students in the health professions already had higher rates of mental health problems like depression and suicide ideation than the general public before the start of the pandemic (Ivey-Stephenson et al., 2022; Kelsey et al., 2021; Mata et al., 2015; Puthran et al., 2016; Rotenstein et al., 2016; Shanafelt et al., 2021; Tung et al., 2018). Taken together, these perspectives identify the urgency in understanding how the mental health concerns of HCP—particularly in terms of how they process grief and loss—have been heightened by the pandemic.

The pandemic has made mental health worse for HCP, who have experienced an elevated risk of depression, anxiety, post-traumatic stress disorder (PTSD), substance misuse, and suicide (Di Tella et al., 2020; Greenberg, 2020; Greenberg et al., 2020). These forms of distress are not equally distributed among all HCP: nurses, women, front-line HCP, younger HCP, HCP in areas with higher COVID-19 infection rates, HCP who are gender and sexual minorities, and HCP who are Black, Indigenous, and People of Color have reported more severe forms of distress (Ayanian, 2020; Miu and Moore, 2021; SpoorthySai and Mahant, 2020; Vizheh et al., 2020; Wojcik et al., 2022). These accounts emphasize that the underlying experiences of distress faced by HCP have only been heightened by the pandemic.

These clinical and anthropological perspectives demonstrate that HCP witness and experience loss and grief, demonstrating why palliative care physician Michael Rabow et al. (2021) have characterized HCP as “witnesses and victims both” in a powerful review. In the present article, I drew on journal entries that provided first-hand accounts of what it was like for HCP to be witnesses and victims both. My argument is that HCP experienced an accumulation of distress when they witnessed and encountered grief and loss but did not have the space to process what they witnessed and encountered. This argument was based on entries from the Pandemic Journaling Project (PJP) generated by a subset of PJP participants who identified as HCP (see Introduction, this volume).

2. Methods

The PJP is an online journaling platform launched in May 2020 as an online space where participants worldwide (ages 15 and above) can document their experiences of the COVID-19 pandemic (see Introduction, this volume). The dataset used in this article was generated from a subset of participants ($n = 62$) who responded affirmatively to a prompt in the baseline survey (see Supplement, this volume) asking them if they identified as HCP, such as a nurse, physician, or emergency medical technician. This dataset of HCP participants also included participants' responses to prompts or questions of interest concerning mental health, such as 1) “Some people are feeling intense feelings right now as a result of the pandemic. Is anything making you especially sad, angry, or hopeful right now? If so, what's on your mind?” 2) “If you feel your mental health has changed since the pandemic started, talk a bit about how, and why.” 3) “Has the pandemic disrupted your plans for the future in any major

way? If so, talk about the most significant disruption(s).” 4) “Talk about any major life events, milestones, or other important things in life that have been disrupted by the pandemic.” 5) “Do you feel like your life is going well right now? Has the pandemic changed this? If so, tell us about it.” These are the kinds of prompts and questions that might be posed in other qualitative methods, such as interviews. Journal entries are a particularly rich genre since they allow participants to process, reflect, and share at their own pace, thereby yielding deeper accounts than what might be gathered in the relatively bracketed space of an interview.

Table 1 provides the basic demographics and professional details of HCP participants in the PJP between May 2020 and August 2021, when the data subset was created. The sample included a range of HCP. While participants in this subset responded affirmatively that they were HCP, not all participants responded in a way that would indicate what kind of HCP they were. Rather, some participants elected to share their professional details in their open-ended responses. Doctors and nurses were the most represented professions among those who did provide these details. Doctors indicated specialties including pediatrics and integrative functional medicine, for example, and nurses indicated specialties including palliative care and home health care. Most HCP participants were white women, which reflected the overall demographic composition of the PJP as a whole (see Introduction, this volume). The underrepresentation of minority populations has been identified in COVID-19 research more broadly, and this has been attributed to structural factors, such as limited access to health services and participation in health research, as well as mistrust towards researchers and research institutions (Ettie et al., 2021). Others have suggested that participatory research methods, such as digital storytelling, may enhance the research engagement of underrepresented populations (Fish and Syed, 2021). The PJP is an important example of digital storytelling, yet researchers using these methodologies may still struggle to include underrepresented populations in their samples.

A thematic analysis identified principal themes occurring in the journal entries of HCP. Journal entries were coded and grouped according to sub- and global themes concerning the topics of mental health, stress, and wellbeing. A selection of these themes is presented below.

3. Results

Four salient themes emerged, representing layers of an accumulation

Table 1
Participant demographics and professions.

Participants identified as	Male	5
	Female	55
	Non-binary	2
Age	Under 20	2
	20–30	8
	30–40	21
	40–50	14
	50–60	10
	Above 60	4
Race	White	47
	Black or African American	1
	Asian or Pacific Islander	3
	Mixed	1
	Middle Eastern	1
	Latinx	0
Profession ^a	Nurse	6
	Physician or medical student	6
	Social worker	1
	Psychologist	2
	Psychotherapist	1
	Pharmacist/pharmacy technician	2
	Physical therapist	2
	Direct support professional for people with disabilities	1

^a Not all HCP respondents provided details about their specific profession.

of distress: 1) witnessing patient deaths and the bereavement of patients' loved ones, 2) experiencing their own loss, 3) being isolated from sources and spaces of support, and 4) overwork and caregiving responsibilities. By examining and integrating these themes, I have argued that HCP faced a layering or an accumulation of distress when they lacked the space to process their experiences.

3.1. Witnessing death and bereavement

In their journal entries, HCP recounted the deaths of their patients due to COVID-19. Jessica,¹ inpatient physical therapist, detailed how she accompanied two patients in their final moments when they were separated from their loved ones:

“All too many times I see somebody die from this virus. Like [name removed], a sweet lady in her 80's who I helped up to the chair in the ICU just so she could hear her husband's voice over the phone. She cried when he picked up on the other end. She did not worry about herself and her increasing need for oxygen, she was worried about *his* health, home alone without her. She passed a few days later, intubated, sedated, and alone. And there's the Vietnam vet who has survived unspeakable atrocities and now fights for every breath, prone in his ICU bed, also alone.” (original emphasis) (Jessica, inpatient physical therapist, white woman, 30s, New Hampshire)

Witnessing patients as they took their final breaths alone and isolated from their loved ones was distressing for HCP, especially given the frequency of these deaths. Jessica produced this journal entry at work, before beginning a new shift with 10 other COVID-19 patients, whom she would attempt to get out of bed so that they could walk to look out the window and, as she put it, hopefully summon a smile. These acts demonstrated Jessica's attempts to bring joy to patients in moments of profound vulnerability. While she recounted that this work was rewarding, Jessica stated it was also terrible because of all the death she witnessed. Witnessing death and the suffering of patients are part and parcel of being a HCP, yet HCP have experienced the loss of patients at a greater intensity and without the space to process these losses due to the pandemic.

Mary, a palliative care nurse, detailed a similar situation and the need to work around institutional regulations to ensure a patient would not die alone:

“I cared for an elderly 91-year-old gentleman who had a massive stroke and also had coronavirus ... I had to make a decision whether or not to allow his own unvaccinated daughter into the room prior to removing him from the ventilator ... I finally left the decision up to her, going against some of the hospital's policies. I hope I made the right decision and that she did not get sick. He died a couple hours later, peacefully, with his wife and daughter with him. This consumed my day, yet they were not my only patients.” (Mary, palliative care nurse, white woman, 40s, Tennessee)

Like Jessica, Mary commented on the weight of this singular encounter, while recognizing that she would also attend to her other patients dying of COVID-19. Mary and Jessica's comments indicated how having to move on from the loss of one patient to provide care to other patients limited their ability to process these losses. Mary's actions to provide this elderly man with accompaniment at the time of his death were not without risk, both in terms of contraindications to hospital policy and the uncertainty of whether this man's unvaccinated daughter might become infected. Both Jessica and Mary's experiences illustrate how their actions went beyond or deviated from official guidelines or expectations concerning their practice. These acts were a form of everyday ethics, or ethical dilemmas that they needed to navigate in

order to respond to the unique demands of these clinical encounters and infuse these encounters with joy, dignity, and togetherness. Navigating everyday ethics was an additional form of labor HCP performed that might lead to experiences of moral distress if institutional constraints prevented HCP from doing what they considered to be the morally correct course of action (Brodwin, 2013; McGibbon et al., 2010). In the next section, I illustrate how HCP experienced grief and loss personally in addition to witnessing them professionally.

3.2. HCP have experienced their own loss

The journal entries were also a space where HCP recounted their own experiences of loss, which included mourning lost loved ones, the loss of important milestones, and a collective loss that has spanned the duration and geography of the pandemic. Tricia, who detailed her work with young children with disabilities, provided an account of how losing her mother has generated distress:

“After losing my mother to this disease in December, my world has changed and will never be the same again. My anxiety is through the roof and I have developed panic attacks, which scare me so badly ... This grief is so intense, I feel like I will never be myself again ... Never got to say goodbye to mom, never got to hold her or touch her, and be by her side as she died. She must have been so scared. I hope she understood why no one could be there, but that had to have been so crazy and heartbreakingly hard.” (Tricia, Woman, 50s, Canada)

As readers, we are left hoping that Tricia's mother spent her last moments with HCP like Jessica or Mary who would have gone beyond their official role to bring joy to these final moments. Grieving HCP also continued to provide support to others. Tanya, a direct support professional for people with physical and mental disabilities, spoke to her “duty and honor” to continue providing care despite her own losses:

“... it is my duty and my honor to help everyone through this difficult time and to be at the front lines and helping the public. I have lost my grandfather to COVID-19. That has been very hard on me.” (Tanya, direct support professional, Black woman, 20s, Ohio)

Tanya detailed that this was a very difficult loss for her as she was very close with her grandfather. Elsewhere in their journal entries, both Tanya and Tricia raised concerns about distancing measures and, in particular, when people flouted public health guidelines. Tricia recounted being triggered and angered by seeing anti-maskers and those on social media, in the news, and in person, who, in her words, “don't take the rules seriously” when she—at the time of her journal entries—had yet to hold a funeral to commemorate her mother's life. Like Tanya, Tricia also recounted a sense of desire to help others, yet she found work to be a scary place where the enjoyment she previously experienced was deflated by the pandemic: “I want to help others ... but mentally how do I deal with covid work all day long? Feel like I will break down if that happens.” These perspectives demonstrate how the duty to help others drove HCP to remain steadfast in their work while grieving, yet Tricia's comments suggest there may be a limit to this as she was contemplating early retirement. Tricia and Tanya's experiences demonstrate how the duty to care for others encroached upon their ability to grieve and care for themselves.

HCP also experienced loss when missing out on opportunities and facing disruptions. A clinical psychologist described attending her grandmother's 101th birthday on Zoom, and she lamented that she could not attend in person since she was uncertain if her grandmother would get to celebrate another birthday. A medical student recounted how her board examination, which would determine her placement in a residency program, was consistently rescheduled, making it nearly impossible to study for. These experiences of loss were accompanied by feelings of guilt when sizing up these losses in comparison with the grief experienced by others.

¹ All names of participants are pseudonyms.

HCP like Mary, the palliative care nurse introduced above, detailed an abstract, collective loss that generated grief, sadness, and anger:

“I feel grief for the huge amount of loss that is prevalent in society. The collective grief runs through lanes of traffic, it sits at empty seats at the table, it whispers in the windchimes late at night ... there is a deep sadness in me that some of those lives could have been saved. So many what ifs cross my mind and I have anger at the way this all went down. How could this happen?” (Mary, palliative care nurse, white woman, 40s, Tennessee)

Experiences of loss among HCP were also distinct from the loss they faced prior to the onset of the pandemic because this loss was a collective experience. Anger and sadness, in addition to guilt, shaped how HCP have responded to the losses they encountered and witnessed. These experiences of loss, however personal, as well as the grief HCP have witnessed, contributed to a layering of distress that, as illustrated in the next section, was often encountered alone.

3.3. Witnessing and mourning loss in isolation

Jessica, Mary, Tricia, and the other HCP were managing as best as they could while being isolated from peers and colleagues and support networks. Jessica, the inpatient physical therapist introduced above, lamented that she was unable to visit her aging parents abroad, and that her gym—which was her opportunity to socialize with friends and blow off some steam—was inaccessible. Mary, due to her frequent encounters with vulnerable patients in palliative care, recounted how her fears of infecting others generated isolation:

“Very regularly it has been a struggle to feel safe being around anyone, even my husband. It would break my heart if anyone I've been around ended up with Covid-19 because of me, so I have felt very isolated. Some of my friends have been much more relaxed about restrictions and even though they say they are being safe ... I distrust their interpretations ...” (Mary, palliative care nurse, white woman, 40s, Tennessee)

Tricia, wrought with grief, also faced loneliness and an absence of community:

“My sense of community, friendship and belonging has all but dwindled to nothing. I don't know if it's my anxieties limiting me here, or just that I so deeply long to hug people again and can't connect well without touch? But I feel more alone than ever ...” (Tricia, Woman, 50s, Canada)

Tricia, Jessica, and Mary experienced isolation due to different reasons, but being isolated from people and spaces that provide respite limited how they could process what they witnessed and faced, especially if they wished to process these experiences socially. Indeed, in an article in this volume, Michelle Anne Parsons documented the importance of interacting with acquaintances, strangers, and the physical places that convey belonging. Isolation added another layer to the distress HCP faced, and, as described in the next section, overwork and caregiving responsibilities also prevented HCP—particularly women—from making space to process their experiences.

3.4. Overwork and caregiving responsibilities

Being alone and isolated also occurred when HCP were burdened by overwork and caregiving responsibilities. Morgan, a social worker, shared how her responsibilities of being a single mother and social worker greatly intensified during the pandemic:

“I'm a single mom who had little help before; now there's no help. My kid was having some behavioral struggles; now those are full blown daily disasters. Work was tough working with the homeless as a social

worker; now it feels impossible and I can't ever leave work in time. I felt like I was just barely treading water; now I've been drowning I used to rarely cry; now I am constantly on the verge of tears. I used to feel alone, worrying about me being the only one to put me and my family first; now I know that's the case.” (Morgan, social worker, white woman, 40s, Connecticut).

Morgan was not alone, at least in her experience. Erin, a pediatric hospitalist, was also responding to increasing professional demands and identified a gendered dimension of overwork:

“I am NOT working the 20 hours a week I am being paid to work. I am consistently working 30–34 hours per week ... I harbor enormous feelings of guilt around this. After all, I still have a job, and my job allows me to care for my family. At the same time ... I feel I deserve to be paid for the work I perform, which requires my high level of training/expertise. Is this a typical woman thing to do? I'm certain male colleagues would not necessarily find themselves in a similar situation.” (Erin, pediatric hospitalist, white woman, 40s, Connecticut)

Erin's experience of being overworked took place alongside of caring for three children and maintaining order at home:

“At home, I also find myself in a situation where I am doing more than my fair share. My partner is utterly unable to prioritize or multitask, leaving the majority of the housework to me. It isn't intentional, but it leaves me feeling hurt and unappreciated.” (Erin, pediatric hospitalist, white woman, 40s, Connecticut)

Both Erin and Morgan's perspectives have illustrated a pervasive structural problem in the health professions where women have faced more intense burnout than their male colleagues (Templeton et al., 2019) and where work environments are toxic to women HCP who also have family caregiving obligations (Gauci et al., 2021; Liang et al., 2019; Olsen et al., 2022). What Morgan and Erin's experiences add, however, is that these gendered burdens have been amplified by the pandemic. Their experiences also demonstrate that the space and energy devoted to overwork and caregiving could be used to process the grief and loss they witnessed and faced. Combined with feelings of guilt, these experiences left HCP feeling less deserving and that their concerns about overwork and caregiving were less valid.

4. Discussion

Drawing on the experiences and perspectives of Jessica, Mary, Tanya, Tricia, Morgan, and Erin, I have demonstrated how HCP have witnessed and experienced grief and loss, but their collective experiences reflect an accumulation of distress due to not having space to process this grief and loss. Grieving and processing loss have been upended by COVID-19. The pandemic has prevented many of the social processes associated with grief and mourning, which anthropologists have identified are crucial for the remembrance of the dead and the wellbeing of the bereaved (Crocker et al., 2021; Hockey et al., 2007). Not being able to be with a loved one in their final moments and not being able to commemorate their loss prevent people from mourning in the ways they would under normal circumstances. The disruption of grieving rituals and processes has prevented closure and healing among those who have lost loved ones.

HCP have witnessed and experienced this disruption of grieving processes. As witnesses, they were often the last people present with those who died alone over the course of the pandemic. The end-of-life care they provided included actions that brought joy to those who were dying. HCP also bent the rules to bring dignity and togetherness to those who passed and their bereaved loved ones. HCP engaged in everyday ethics, wherein HCP would act according to the demands of the situation rather than institutional guidelines (Brodwin, 2013; Crocker et al., 2007). HCP would go above and beyond their official role and risked experiencing moral distress when these workarounds that felt right were not possible. As people who have experienced grief and loss,

HCP like Tricia and Tanya identified how HCP were “witnesses and victims both” (Rabow et al., 2021). This article has contributed to anthropological scholarship by demonstrating how the social and contextual features of grief, mourning, and loss were further complicated when considering how HCP approached these features from multiple vantage points. Grieving, mourning, and processing loss have been disrupted by the pandemic, and HCP have been at the front lines of supporting people through these disruptions, all while grappling with their own loss. Since they were often the only ones who could be present at the end of a patient's life, HCP played important roles in the ways that people grieved for their loved ones. The accounts above demonstrate how the presence and practices of HCP provided closure to patients and their families, even though HCP themselves lacked that closure. The accumulation of distress faced by HCP was layered by the demands of practicing everyday ethics, a sense of duty, guilt, and gender disparities.

The loss experienced by HCP did not always involve the loss of a loved one. It involved missing birthdays or facing uncertainty and being unable to amply prepare for a board exam that would determine their professional trajectory. Loss also involved lamenting people in an abstract sense and feeling sadness and anger over individual and political decisions that may have kept more people alive. These experiences were marked by guilt as HCP reflected on the ways they were more fortunate than those they care for. Mary characterized this as *survivor's guilt*: “Feeling hope this week is a blessing, but it is also so very unsettling. And with that hope, comes a form of survivors [sic] guilt ... I need some time to process all these losses I have witnessed.” Feeling guilty about surviving or about one's relative position in the pandemic was a way that HCP downplayed the gravity their experiences.

The ability to process the loss and grief that HCP witnessed and experienced was complicated by isolation—from a community, from loved ones, and from spaces that hold meaning. Being isolated also meant that HCP—and women in particular—carried professional and familial burdens without support. While duty and honor were some of the principles that have guided the care HCP have diligently provided throughout the pandemic, fear, overwork, and exhaustion have left them questioning whether they would be able to carry on.

5. Conclusion

It is well known that HCP experienced burnout, compassion fatigue, and poorer mental health than the general population well before the onset of the pandemic. This article has built upon research on HCP mental health by examining the accumulation of distress that has gone unabated without ample space to process what HCP experience and witness. The PJP represents one kind of space where HCP have been able to share and reflect on what they have experienced and witnessed over the course of the pandemic. The PJP, as well as other accounts of HCP writing during the pandemic (Nagata, 2021; Procaccia et al., 2021), will be an essential archive for HCP to focus on and remember their experiences.

CRedit authorship contribution statement

David Ansari: Funding acquisition, Project administration, Data curation.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

I would like to thank the HCP in the PJP for sharing their experiences of grief, mourning, and loss. I am grateful to Sarah Willen and Katherine

Mason, the principal investigators of the PJP, as well as the PJP Research Consortium, for the opportunity to participate in this powerful project. Additionally, I would also like to express gratitude to Heather Wurtz, Emily Mendenhall, and the anonymous reviewers for their editorial feedback on earlier drafts of this article.

References

- Adwan, J. Z. (2014). Pediatric nurses' grief experience, burnout and job satisfaction. *J. Pediatr. Nurs.*, 29(4), 329–336. <https://doi.org/10.1016/j.pedn.2014.01.011>
- Aughterson, H., McKinlay, A., Fancourt, D., & Burton, A. (2021). Psychosocial impact on frontline health and social care professionals in the UK during the COVID-19 pandemic: a qualitative interview study. *BMJ Open*, 11(2). <https://doi.org/10.1136/bmjopen-2020-047353>
- Ayanian, J. (2020). Mental health needs of health care workers providing frontline COVID-19 Care. *JAMA Health Forum*, 1(4), Article e200397. <https://doi.org/10.1001/jamahealthforum.2020.0397>
- Boerner, K., Gleason, H., & Jopp, D. S. (2017). Burnout after patient death: challenges for direct care workers. *J. Pain Symptom Manag.*, 54(3), 317–325. <https://doi.org/10.1016/j.jpainsymman.2017.06.006>
- Brisson, K. J., & Leavitt, S. C. (1995). Coping with bereavement: long-term perspectives on grief and mourning. *Ethos*, 23(4), 395–400.
- Brodwin, P. (2013). *Everyday Ethics: Voices from the Front Line of Community Psychiatry*. Oakland, CA: University of California Press.
- Carton, E. R., & Hupcey, J. E. (2014). The forgotten mourners: addressing health care provider grief—a systematic review. *J. Hospice Palliat. Nurs.*, 16(5), 291–303.
- Crocker, R. M., Reineke, R. C., & Tovar, M. E. R. (2021). Ambiguous loss and embodied grief related to Mexican migrant disappearances. *Med. Anthropol.*, 40(7), 598–611.
- Das, S., Singh, T., Varma, R., & Arya, Y. K. (2021). Death and mourning process in frontline health care professionals and their families during COVID-19. *Front. Psychiatr.*, 12, Article 624428.
- Di Tella, M., Romeo, A., Benfante, A., & Castelli, L. (2020). Mental health of healthcare workers during the COVID-19 pandemic in Italy. *J. Eval. Clin. Pract.*, 26(6), 1583–1587. <https://doi.org/10.1111/jep.13444>
- Ettie, M., Fofie, H., Razai, M., Crawshaw, A. F., Hargreaves, S., & Goldsmith, L. P. (2021). Ethnic minority and migrant underrepresentation in COVID-19 research: causes and solutions. *cClinicalMedicine* <https://doi.org/10.1016/j.cclinm.2021.100903>.
- Fish, J., & Syed, M. (2021). Digital storytelling methodologies: recommendations for a participatory approach to engaging underrepresented communities in counseling psychology research. *J. Counsel. Psychol.*, 68(3), 271–285. <https://doi.org/10.1037/cou0000532>
- Fernández, O., & González-González, M. (2022). The dead with no wake, grieving with no closure: illness and death in the days of coronavirus in Spain. *J. Relig. Health*, 61, 703–721.
- Frajerman, Ariel, et al. (2020). Burnout in medical students before residency: a systematic review and meta-analysis. *Eur. Psychiatr.*, 55, 36–42.
- Gauci, P., Peters, K., O'Reilly, K., & Elmir, R. (2021). The experience of gender discrimination for women registered nurses. A qualitative study. *J. Adv. Nurs.*, 78(6), 1743–1754. <https://doi.org/10.1111/jan.15137>
- Greenberg, N. (2020). Mental health of health-care workers in the COVID-19 era. *Nat. Rev. Nephrol.*, 16, 425–426.
- Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S. (2020). Managing the mental health challenges faced by healthcare workers during COVID-19. *BMJ*, 368, m1211. <https://doi.org/10.1136/bmj.m1211>
- Hockey, J., Kellaher, L., & Prendergast, D. (2007). On grief and well-being: competing conceptions of restorative ritualization. *Anthropol. Med.*, 14(1), 1–14.
- Ivey-Stephenson, A. Z., et al. (2022). Suicidal thoughts and behaviors among adults aged ≥18 Years — United States, 2015–2019. *MMWR Surveill Summ*, 71(No. SS-1), 1–19.
- Kaufman, S. R., & Morgan, L. M. (2005). The anthropology of the beginnings and ends of life. *Annu. Rev. Anthropol.*, 34, 317–341.
- Kelsey, E. A., et al. (2021). Suicidal ideation and attitudes toward help seeking in U.S. nurses relative to the general working population. *Am. J. Nurs.*, 121(11), 24–36.
- Kotera, Y., Ozakai, A., Miyatake, H., Tsunetoshi, C., Nishikawa, Y., Kosaka, M., & Tanimoto, T. (2022). Qualitative investigation into the mental health of healthcare workers in Japan during the COVID-19 pandemic. *Environ. Res. Publ. Health*, 19(1), 568. <https://doi.org/10.3390/ijerph19010568>
- Lathrop, D. (2017). Disenfranchised grief and physician burnout. *Ann. Fam. Med.*, 15(4), 375–378. <https://doi.org/10.1370/afm.2074>
- Liang, R., Dornan, R., & Nestel, D. (2019). Why do women leave surgical training? A qualitative and feminist study. *Lancet*, 393(1071), 541–549.
- Liu, Y. E., Zhai, Z. C., Han, Y. H., Liu, Y.-L., Liu, F. P., & Hu, D. Y. (2020). Experiences of front-line nurses combating coronavirus disease-2019 in China: a qualitative analysis. *Publ. Health Nurs.*, 37(5), 757–763. <https://doi.org/10.1111/phn.12768>
- Mata, Douglas A., et al. (2015). Prevalence of depression and depressive symptoms among resident physicians. *JAMA*, 314(22), 2373–2383.
- McGibbon, E., Peter, E., & Gallop, R. (2010). An institutional ethnography of nurses' stress. *Qual. Health Res.*, 20(10), 1353–1378. <https://doi.org/10.1177/1049732310375435>
- Missouridou, E., Mangoulia, P., Pavlou, P., Kristotakis, E., Stefanous, E., Bibou, P., et al. (2021). Wounded healers during the COVID-19 syndemic: compassion fatigue and compassion satisfaction among nursing care providers in Greece. *Psychiatr. Care*. <https://doi.org/10.1111/ppc.12946>

- Miu, A. S., & Moore, J. R. (2021). Behind the masks: experiences of mental health practitioners of color during the COVID-19 pandemic. *Acad. Psychiatr.*, *45*(5), 539–544.
- Mohammadi, F., Oshvandi, K., Shamsaei, F., Cheraghi, F., Khodaveisi, M., & Bijani, M. (2021). The mental health crises of the families of COVID-19 victims: a qualitative study. *BMC Fam. Pract.*, *22*(94). <https://doi.org/10.1186/s12875-021-01442-8>
- Nagata, J. M. (2021). Writing through the pandemic and paediatrics. *The Lancet Child & Adolescent Health*, *5*(10), P694. [https://doi.org/10.1016/S2352-4642\(21\)00280-7](https://doi.org/10.1016/S2352-4642(21)00280-7)
- Neimeyer, R. A., Klass, D., & Dennis, M. R. (2014). A social constructionist account of grief: loss and the narration of meaning. *Death Stud.*, *38*, 485–498.
- Nyashanu, M., Pfende, F., & Ekpenyong, M. (2020). Triggers of mental health problems among frontline healthcare workers during the COVID-19 pandemic in private care homes and domiciliary care agencies: lived experiences of care workers in the Midlands region. *UK. Health and Social Care in the Community*. <https://doi.org/10.1111/hsc.13204>
- Olsen, B. C., Barron, S. L., Gutheil, C. M., Blazick, E. A., Mayo, S. W., Turner, E. N., & Whiting, J. F. (2022). Understanding the effect of bias on the experience of women surgeons: a qualitative study. *J. Am. Coll. Surg.*, *234*(6), 1064–1072. <https://doi.org/10.1097/XCS.0000000000000162>
- Pearce, C., Honey, J. R., Lovick, R., Creamer, N. Z., Henry, C., Langfor, A., Strobert, M., & Barclay, S. (2021). ‘A silent epidemic of grief’: a survey of bereavement care provision in the UK and Ireland during the COVID-19 pandemic. *BMJ Open*, *11*, Article e04872. <https://doi.org/10.1136/bmjopen-2020-046872>
- Procaccia, R., Segre, G., Tamanza, G., & Manzoni, G. M. (2021). Benefits of expressive writing on healthcare workers' psychological adjustment during the COVID-19 pandemic. *Front. Psychol.* <https://doi.org/10.3389/fpsyg.2021.624176>
- Puthran, Rohan, et al. (2016). Prevalence of depression amongst medical students: a meta-analysis. *Med. Educ.*, *50*(4), 456–468.
- Rabow, M., Huang, C. H., White-Hammond, G., & Tucker, R. (2021). Witnesses and victims both: healthcare workers and grief in the time of COVID-19. *J. Pain Symptom Manag.*, *62*(3), 647–656. <https://doi.org/10.1016/j.jpainsymman.2021.01.139>
- Robben, A. C. G. (Ed.). (2004). *Death, Mourning, and Burial: A Cross Cultural Reader*. Malden, MA: Blackwell Publishing.
- Rotenstein, Lisa S., et al. (2016). Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: a systematic review. *JAMA*, *316*(21), 2214–2236.
- Rotenstein, Lisa S., et al. (2018). Prevalence of burnout among physicians: a systemic review. *JAMA*, *320*(11), 1131–1150.
- Shah, Megha K., et al. (2021). Prevalence and factors associated with nurse burnout in the US. *JAMA*, *4*(2), Article e2036469.
- Shanafelt, Tait, et al. (2021). Suicidal ideation and attitudes regarding help seeking in US physicians relative to the US working population. *Mayo Clin. Proc.*, *96*(8), P2067–P2080.
- Silverman, G. S., Baroiller, A., & Hemer, S. R. (2021). Culture and grief: ethnographic perspectives on ritual, relationships, and remembering. *Death Stud.*, *45*(1), 1–8.
- Spoorthy, M., Sai, S. K. P., & Mahant, S. (2020). Mental health problems faced by healthcare workers due to the COVID-19 pandemic—a review. *Asian Journal of Psychiatry*, *51*, Article 102119. <https://doi.org/10.1016/j.ajp.2020.102119>
- Templeton, K., Bernstein, C. A., Sukhera, J., Nora, L. M., Newman, C., Burstin, H., Guille, C., Lynn, L., Schwarze, M. L., Sen, S., & Busis, Neil. (2019). Gender-based differences in burnout: issues faced by women physicians. In *NAM Perspectives*. Washington, DC: Discussion Paper, National Academy of Medicine. <https://doi.org/10.31478/201905a>.
- Tung, Yi-Jung, et al. (2018). Prevalence of depression among nursing students: a systematic review and meta-analysis. *Nurse Educ. Today*, *63*, 119–129.
- Vizheh, M., Qorbani, M., Arzaghi, S. M., Muhidin, S., Javanmard, Z., & Esmaili, M. (2020). The mental health of healthcare workers in the COVID-19 pandemic: a systematic review. *J. Diabetes Metab. Disord.*, *19*, 1967–1978. <https://doi.org/10.1007/s40200-020-00643-9>
- Wojcik, H., Breslow, A. S., Fisher, M. R., Rodgers, C. R. R., Kubiszewski, P., & Gabbay, V. (2022). Mental health disparities among sexual and gender minority frontline health care workers during the height of the COVID-19 pandemic. *LGBT Health*. <https://doi.org/10.1089/lgbt.2021.0276>
- Zhai, Y., & Du, X. (2020). Loss and grief amidst COVID-19: a path to adaptation and resilience. *Brain Behav. Immun.*, *87*, 80–81.