



# “IT HAUNTS ME”: IMPACT OF COVID-19 DEATHS ON FRONTLINE CLINICIANS IN ACUTE CARE SETTINGS—A QUALITATIVE STUDY

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**Background** The COVID-19 pandemic created unprecedented conditions for clinicians providing end-of-life care in acute care settings, yet almost 2 years since the start of the pandemic, little is known about its impact on clinicians.

**Objectives** To qualitatively explore how clinicians experienced their role as they cared for dying patients with COVID-19 during the pandemic and the impact of these experiences on their lives as health care professionals.

**Methods** In-depth, hour-long interviews were conducted by phone in the spring of 2022 at a single time point with 23 physicians and nurses in critical care and emergency department settings from 2 health systems in California. The goal was to elicit perspectives on experiences with end-of-life care and the long-term impact of these experiences. Clinicians were asked to reflect on the different stages of the pandemic, and interviews were analyzed using a thematic analysis.

**Results** The interviews highlighted 2 primary themes around provision of end-of-life care during the COVID-19 pandemic. First, clinicians described challenges around their clinical duties of providing care to dying patients, which included decision-making dilemmas and professionalism challenges. Second, clinicians described the emotional aspects around end-of-life care situations they experienced, including communication with family members, “being patients’ family members” at the end of life, and various degrees of meaning-making and remembrance of these experiences.

**Conclusions** The findings highlight the sustained and cumulative emotional challenges and burden clinicians are still shouldering more than 2 years after the start of the pandemic. (*American Journal of Critical Care*. 2023; 32:368-374)

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The COVID-19 pandemic upended health care in a multitude of ways. At the beginning of the pandemic, especially in acute care settings, clinicians faced large volumes of very sick patients, many of whom died quickly without available treatment. Lack of knowledge about this novel virus and effective interventions further complicated the uncertainty and difficulty of caring for sick patients, and deaths occurred on a mass scale globally. Over time, these contextual challenges evolved throughout the various surges of the pandemic, yet little is known about the cumulative impact on clinicians of caring for large numbers of dying patients.

In this article, we explore clinicians' experiences around end-of-life situations that arose during the provision of care to dying patients with COVID-19 in acute care settings and the impact of these experiences on the clinicians' lives as health care professionals.

Mixed-methods and qualitative studies conducted during the pandemic in the United States have highlighted an array of challenges experienced by nurses and physicians in acute care settings during the early parts of the pandemic. The challenges experienced include resource limitations,<sup>1-5</sup> patient volume and acuity,<sup>2,6</sup> insufficient staffing<sup>3,4</sup> or changing staffing models for nurses,<sup>7</sup> visitation policies,<sup>2,5,6,8,9</sup> ethical issues<sup>9</sup> and moral distress,<sup>10-13</sup> and resilience.<sup>14</sup> Less is known about clinicians' experiences in providing care to dying patients over the course of this unprecedented pandemic in the United States, despite widespread death. Uncertainty about what was causing death and how to prevent it, fear for one's own safety and the safety of loved ones, and patients dying alone created a uniquely and intensely distressing environment in which clinicians experienced end-of-life issues differently from prepandemic times.

Most studies on clinician experiences during the pandemic have focused on a single point in time in the United States, typically during the first wave of the pandemic in the spring of 2020. Yet the pandemic has continued for more than 2 years, and clinicians are still on the front lines navigating challenging experiences against the backdrop of multiple surges. Here we examine the experiences of physicians and

nurses working in emergency department and critical care settings in the United States who provided end-of-life care throughout the pandemic. We draw upon 23 interviews conducted in the spring of 2022 that elicited clinicians' lived experiences related to end-of-life care for patients with COVID-19 and the impact of these prolonged experiences on the clinicians' lives.

## Methods

We recruited physicians (4 attendings and 7 residents or fellows) and registered nurses (n=12) from 2 large urban, academic medical centers in California to participate in an interview about their experiences as health care clinicians during the pandemic. Clinicians were eligible if they provided patient care during the COVID-19 pandemic in an emergency department (n=6), critical care setting (n=16), or other acute care setting (operating room or post-acute-care unit, n=1). Our contact at each of the health systems provided a description of the study by email to clinicians, who then contacted us if they were interested in participating. This study was funded as part of a larger study on improving clinician mental health and well-being during the COVID-19 pandemic. We report here on the findings from an additional set of interviews designed specifically to understand clinician experiences in-depth during the COVID-19 pandemic.

The interview protocol was strategically developed to guide respondents chronologically through the different stages of the pandemic. Two researchers external to the health system and trained in qualitative research with experience conducting research about end-of-life care conducted the interviews at a single time point in the spring of 2022. The researchers conducted the interviews by phone or video platform (Microsoft Teams); interviews were generally 1 hour

Little is known about the cumulative impact that caring for so many dying patients during the pandemic had on clinicians over time.

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Twenty-three acute care physicians and nurses were interviewed about their lived experiences related to providing end-of-life care for patients with COVID-19 and the impact of these prolonged experiences over time.

long. Participants received a \$50 electronic gift card for participating in the interview.

Interviews were transcribed and deidentified, and transcripts were uploaded to Dedoose, a qualitative

software program for rigorous qualitative coding using thematic analysis.<sup>15</sup> We developed an initial codebook based on emerging themes from the interviews and tested the codebook on a set of 5 transcripts. Once the codebook was finalized, 4 researchers with extensive experience in qualitative research independently coded the remaining transcripts and discussed emerging findings throughout the data collection and analysis process to ensure data saturation.<sup>16</sup> Data were analyzed concurrently with data collection to identify areas for additional probing in the

interviews and to identify when data saturation was reached (ie, when no new themes emerged).

The institutional review boards at the RAND Corporation and the 2 health systems approved the study. The research was conducted in accordance with the COREQ checklist.<sup>17</sup>

## Results

We interviewed 23 clinicians from 2 health systems: 12 nurses and 11 physicians, of whom 7 were trainees. The interviews highlighted 2 primary themes around provision of end-of-life care during the COVID-19 pandemic: (1) challenges around clinical duties and (2) emotional aspects of end-of-life care. The Table presents these 2 themes and illustrative quotes.

### End-of-Life Care Challenges Related to Clinical Duties

*Feelings of Guilt Related to End-of-Life Decisions.* Clinicians, especially physicians, described challenging clinical end-of-life situations and recalled specific difficulties related to dilemmas around making treatment decisions for patients infected with an unknown virus, particularly at the beginning of the pandemic. Clinicians often had to make these difficult decisions quickly and then immediately move on to the next patient because of the sheer volume of patients with a high level of acuity. One physician trainee described challenging end-of-life decisions that they thought of often and even experienced guilt about:

I actually felt that we probably tipped a patient over and caused their demise by giving them fluids, and that was a day I wish I could take back. We were so busy. It was just me and the attending, and I was running around like a chicken with its head cut off . . . and just knee-jerking and placing orders . . . maybe without giving them very careful thought. . . . I guess if you went back and polled the room, half the people probably would have done the same thing. I don't want to beat myself up about it, but I do. That is one thing that I do say, I wish I had paused on that one. (Resident physician)

Similarly, a nurse reflected on the feeling of being overwhelmed and the impact on clinical decision-making around end-of-life care:

The medicine sides were so overwhelmed, and I feel like at some point because they were so overwhelmed, they were so quick to pull the plug and say, "okay, we're going to withdraw care on this one." Everyone was just writing off people sooner. (Nurse)

### Challenges Related to Goals-of-Care Conversations.

In addition, the uncertainty around this new virus made decisions around continuing life-sustaining treatment and the related conversations about goals of care even more challenging for clinicians. Residents (trainee physicians), in particular, described the difficulties in engaging family members in end-of-life conversations and decision-making. Specifically, they noted that they often had to learn how to conduct goals-of-care conversations in the moment because there was no time for formal instruction, creating new pressures compared with prepandemic situations. One resident described trying to determine the optimal timing for engaging in goals-of-care conversations:

No one has given me any workshops or lectures about how to do goals of care, how to share difficult news. . . . So, I had to do my own kind of digging as far as what is the best way to deliver sad news, how you know when is a good time to do goals-of-care discussion so it's not at the last moment right before people are getting intubated. (Resident physician)

Another resident reflected on the change in their comfort level in delivering "bad news" and being forthcoming about the patient's prognosis, within the context of uncertainty around the virus.

**Table**  
Additional quotations grouped by theme and subtheme

Subtheme	Sample quote
<b>Theme 1: End-of-life care challenges related to clinical duties</b>	
Feelings of guilt related to end-of-life decisions	<p>"I just got really sad, and I know families wanted to keep their loved ones alive because in theory this was something that should have been treatable and should have been preventable. But it is hard because some of those people . . . they weren't meant to stay on earth unfortunately. And I'm a little bit jaded to death and work and doing the work I do." (Nurse)</p> <p>"And then we quickly then just kind of move to the next patient and I remember the team leaving and I thought maybe someone should call the family. I would want to know the moment has happened if it was my loved one. So, I told the fellow . . . I'm going to stay back, I'm going to call the family and then [there] was that challenge." (Resident physician)</p>
Challenges related to goals-of-care conversations	<p>"To call someone's family and to tell them that their loved one is sick and to ask them would they want to be put on a ventilator or if their heart were to stop, would they want chest compressions. It's a really difficult conversation to have when their frame of reference is that they were fine the last that they saw them." (Attending physician)</p> <p>"It's especially hard if someone doesn't speak English or they don't understand health care that much. And working through an interpreter over the phone while everyone's wearing a respirator is really difficult. It was difficult to communicate with families. It was difficult to communicate with patients, not native English speakers, with a phone interpreter." (Attending physician)</p> <p>"Explaining [end-of-life care] to families is definitely difficult. When you're able to explain the severity to the family members over the phone, I feel like, in terms of end-of-life care, there wasn't really any issues. But there are definitely some cases where the family members want to keep the patients for code, even though they're . . . they're at the end of the line. They're maxed out on all the vasopressors, they're maxed out on the ventilator, they're on everything. They're just on multiple organ failures and like they can't, they won't make it. And . . . family members still [insist on] full code for various patients. So, there are definitely some cases where the ethics committee is involved. There's definitely a lot of pushback from the family members, in terms of end-of-life care because they don't want to 'give up on their family members.'" (Nurse)</p>
<b>Theme 2: Emotional challenges related to providing end-of-life care</b>	
Being patients' family members	<p>"So, you're kind of put into an uncomfortable situation with really sick patients and I think the toughest thing too I remember is like you never know if you're going to be the last person and talk to them because we wouldn't let family back which was a new thing, you know?" (Resident physician)</p> <p>"I put a lot of people in body bags at that time. Like a lot, like at one point I think we didn't have . . . morgue bags, we had to go get them from other units . . . Like their daughter, son, their mom, they weren't allowed to come see the body. It was just like we zipped him up and they went to the morgue, nobody is allowed to come." (Nurse)</p>
Experiencing vivid memories	<p>"I think . . . my best COVID story that really made me think, . . . you know what, it matters that it's me. I had [a] patient who was really not doing well, and I had seen it so many times that I knew that he wasn't going to make it out of the hospital. And I talked to his daughter, I was working night shift at the time. So I talked to his daughter at like 9 PM and she was like, 'I know it's not going well. And I know we can't visit. Will you call me if he's dying?' . . . [vivid description of patient dying] And then in the morning when it was time to leave, it just feels so strange. I'm never going to see your [patient's daughter's] face. But I feel like you know me, like, you've seen me at the hardest time in my life, and I don't even know what your face is. And I'll always remember your dad. And I still remember his name . . . and always remember that." (Nurse)</p> <p>"I signed more death certificates than I probably ever did my whole career. And there were big semi-trucks down on the loading dock, just stacking in patients. Refrigerated trucks eventually having to set them up at [nearby hospital] because we had just filled up our capacity not only our morgue, but there were two different large semis. So, it was . . . it was super dark." (Attending physician)</p> <p>"I was getting chills because there was a moment where I thought this is like the end . . . I was like, I can't believe that this is actually happening. And I'm here supposed to do something about it and I'm looking at all these nurses and medics and people running around and doctors like going from patient room to patient room. Like really just trying to do their best, but knowing all these patients I'm looking at will probably be dead pretty soon. It was just really . . . a surreal kind of moment where I was like, this is the end almost. So that was . . . a moment that I think about all the time." (Resident physician)</p>
"Blocking out" experiences	<p>"It was difficult to deal with . . . like I blocked this all out." (Nurse)</p> <p>"I think we suppressed a lot of the feelings at the time because we just had to keep going. It was like you just had to. I can't even begin to count the number of patients I watched pass away or death certificates I think I signed off on or families I had to get bad news to. Because there were just so many of them that we just would go from one to another to another." (Attending physician)</p>

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This resident described this change in having goals-of-care conversations in part due to feeling that the medical team was often doing more harm than good for patients:

Initially I would try to put a positive spin on things, and I just realized that was not fair to these family members and there's a reason I have medical training and it is to give difficult news. But also a lot of times I felt like we were doing harm . . . continually coding or doing CPR [cardio-pulmonary resuscitation] on these people. So, by the end, I think I got slightly more comfortable saying, "I don't think your family member is going to pull through this. I think we could focus on comfort." But it was also hard because we didn't really know. (Resident physician)

Relatedly, the inability to communicate in person with family members around end-of-life decision-making because of visitor restrictions was particularly challenging for clinicians and affected how they delivered bad news.

Clinicians also discussed the challenges of providing care later on in the pandemic to patients who did not receive the COVID-19 vaccine, as noted by a fellow who stated:

It was just awful because then you're put in a position as a provider to see someone who's unvaccinated, going to be on their deathbed, and they're begging you like, "Hey I don't want to die, I don't want to go on a ventilator, can you just give me the vaccine now?" And it's too late, the damage is done. (Fellow)

### Emotional Challenges Related to Providing End-of-Life Care

*Being Patients' Family Members.* The backdrop of the pandemic and related contextual factors exacerbated and created new challenges related to end-of-life care, and clinicians were deeply affected by patients' family members being unable to be present at the bedside, especially when the patients were actively dying. The lack of visitation during the early months of the pandemic because of hospital policies not only made communication and end-of-life decision-making more difficult but also placed an additional burden on clinicians. Clinicians were often the last people that patients saw as they died, replacing family members who would typically be at the bedside at the end of life. One nurse discussed how

families said goodbye to dying patients from a screen or glass window:

It's not part of our natural nursing being. We want to get them some kind of closure. And instead people didn't have that. A lot of patients died alone instead of, you know, holding hands with their significant others. It was just they died in a room by themselves. (Nurse)

Similarly, one physician described the emotional impact of becoming the patient's proxy family and the cumulative effect of these experiences over time:

And then, us kind of becoming their family members and sort of living through the death and dying process over and over and over again was extremely hard. I think probably harder on the nurses, the respiratory therapists, than on the docs. (Attending physician)

Clinicians also described situations in which patients "died alone" and the resulting emotional toll on them not only as clinicians but also as human beings. One physician described the burden that they shouldered over time:

And it's kind of like a really big emotional burden on all of us and I'm sure people have heard these things on the news before and everything, but that's kind of the picture I want people to see in their minds, that multiple times a day, people are dying, and this is kind of the scenario and how they're dying. They're dying alone with like a stranger in the room and that burden is put onto the health care provider. (Physician)

*Experiencing Vivid Memories.* Clinicians recalled certain end-of-life situations to various degrees, particularly because we conducted the interviews 2 years after the start of the pandemic. Some clinicians had vivid memories of end-of-life situations and could recall specific patients' names or a long memory of a patient's last few moments, such as playing a certain song at the patient's bedside at the time of the patient's death, as noted in the following quote:

And I just remember talking to his family every single day. . . . [description of clinical circumstances] . . . and finally he passed and I don't know how the family was able to do this, but they were able to come and just see his body from like the window of one of those 4-person rooms. . . . I met

this daughter that I've spoken to for almost every day for a month, in person. And she hugged me and was just like crying to me . . . I can remember exactly the hallway I was in and exactly like what her sweatshirt looked like and what bed he was in. (Resident physician)

Others described how some memories still haunted them, especially given the sheer numbers of patients who died:

I think it was just the disease and the losses and trying to process the number of families that we walked through the death and dying process within a very unusual way, still to this day, haunts me. Just still hearing those families, but I can still hear some of them. I can still see some of them very clearly in my head. I'll never lose that memory because it wasn't the way people should be dying. Dying alone was not how any of us were meant to be. And I think that haunts me the most. (Attending physician)

*"Blocking Out" Experiences.* Other clinicians, however, blocked out memories of end-of-life situations, noting that they moved on and did not think back to these challenging moments because of the emotional pain of these memories. One nurse spoke about emotionally removing herself from the situation after a patient's death:

My defense mechanism is to un-involve myself with the emotional parts of work other [than] when somebody is actively dying because then I usually cry with the family. It's horrible, but I can't think about it too much. (Nurse)

Another nurse even commented that it felt like even though they "didn't go to war," they experienced post-traumatic stress disorder (PTSD). Others described their experiences as "surreal" or "numbing."

## Discussion

Our findings demonstrate how the COVID-19 pandemic created a context in which many patients suffered and were dying and clinicians were challenged by the uncertainty of a new virus, large patient volumes, the need for quick decision-making, limitations on visitation policies, and staff shortages, which further compounded the challenges of providing care to critically ill patients. Although emergency department and intensive care unit clinicians cope with death, dying, and suffering regularly, the COVID-19 pandemic was unique not only for the

reasons just described, but also for the sheer length of time that clinicians have endured an unpredictably altered workload. By drawing on clinician narratives about their experiences at different stages of the pandemic, our findings offer new insights into how clinicians reflected on and made sense of their experiences. In contrast with previous research on clinician experiences during the pandemic, this focus allowed us to elicit clinicians' feelings and perspectives around how end-of-life situations continue to affect them, such as recalling situations that may have been a source of guilt. While some clinicians vividly recalled specific patients who died, others preferred to block out these memories. This article highlights the sustained challenges clinicians experienced related to providing end-of-life care during an ongoing pandemic and the cumulative impact of these experiences, more than 2 years after the start of the pandemic.

Other studies have considered acute stress in providing care to patients in traumatic situations<sup>18-20</sup> or those with intense suffering.<sup>21,22</sup> Clinicians may be at higher risk for burnout<sup>22</sup> and even PTSD<sup>20</sup> and should be screened and prioritized for intervention.<sup>18,20</sup> In fact, some of the clinicians in our study described emotions related to their experiences during the pandemic that may be consistent with PTSD. Although these studies examined the impact on clinicians of brief, albeit hugely traumatic events, the COVID-19 pandemic has been a sustained, unprecedented event, and it is unknown how the pandemic may affect clinicians over time. This unique context underscores the importance of this study by illustrating the cumulative effect of the pandemic on clinicians, while also highlighting the need for additional studies.

Our work offers important lessons that can inform policy decisions both now and in future public health crises. Many clinicians still shoulder trauma from early in the pandemic and need additional support. Although efforts to highlight and tackle clinician burnout<sup>23</sup> are currently underway, our findings truly underscore how important this work is to inform next steps, in particular as related to clinician attrition and suffering. Data are needed on the impact of seemingly straightforward decisions, such as restricting family and visitors, which may have had more far-reaching effects on clinician suffering than was anticipated. Yet few, if any, studies have directly examined the impact on clinicians as an outcome of this ongoing policy.<sup>24</sup> Trainees may also be a particularly vulnerable group who would benefit from thoughtful and proactive support during times of crisis. Ensuring that end-of-life

care and preparedness for crisis standards are included in training and practiced beyond training, along with connection to additional resources by leveraging ever-improving technology, may help to mitigate clinician distress.

We acknowledge that our study had some limitations, including our sample of clinicians from 2 health care institutions in the Western United States. To maintain their anonymity, we did not collect demographic information from the clinicians interviewed. Because interviews were conducted 2 years into the pandemic, we acknowledge the potential for recall bias; however, we do believe that it is important to understand clinicians' retrospective narratives of their lived experiences because the clinicians were still affected by these experiences even 2 years later.

## Conclusion

Through in-depth narratives of clinician experiences of providing end-of-life care to patients and family members in acute care settings during the COVID-19 pandemic, our study highlights the sustained and cumulative emotional challenges and burden clinicians still shoulder more than 2 years after the start of the pandemic.

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## FINANCIAL DISCLOSURES

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## SEE ALSO

For more about the impact of the COVID-19 pandemic on clinicians, visit the *AACN Advanced Critical Care* website, [www.aacnacconline.org](http://www.aacnacconline.org), and read the article by Gee et al, "Beyond Burnout and Resilience: The Disillusionment Phase of COVID-19" (Summer 2022).

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