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and provide verbal encouragement and reassurance when necessary. Particularly in COVID-19 patients with concomitant heart failure, all involved health care professionals must adopt a palliative approach that combines objectivity, compassion, and truthfulness, recognizing that heart failure is more di cult to predict than malignancy, and that di cult conversations about end-of-life [8]. Emotional and socio-cultural barriers may have to be overcome to facilitate e ective shared decision-making about future interventions [8]. Discussions about the discontinuation of palliative care or treatment should take into account the patient's current physiological state, existing quality of life, advance directives, and personal wishes and values, including cultural norms and spiritual beliefs [7].

Patients with COVID-19 o en require clinical isolation for preventing the spread of infection, and the most demanding element of this is not being able to be with their loved ones when they die [7]. Such a situation goes against the normative perception of a good death, where the family can comfort their relative and say "goodbye. ey can attend to the patient so that he or she does not die alone, but they cannot comfort the grieving family. Likewise, relatives, community, and faith leaders may be denied access to practices and rituals that some cultures and religions require before and a er death, and funeral rites may be truncated, with only a limited number of mourners allowed to attend. e sight of multiple co ns in a temporary mortuary or strangers wearing PPE carrying the body to the cemetery can be disconcerting for anyone. In such situations, people trying to come to terms with the premature loss of a family member or close friend may exhibit persistent, complicated bereavement with long-lasting negative e ects. Palliative care can also support these people [7].

ere is also a need for psychological support for healthcare professionals involved in the treatment of COVID-19 [7]. Unfortunately, as a result of the extraordinary increase in the number of intensive care unit (ICU) beds for patients requiring invasive ventilation, health care providers may have to make on-the-spot ICU admission decisions based primarily on the ethical concept of distributive justice, prioritizing the allocation of this constrained resource to patients who are considered to have the best chance of survival [9]. In addition, many health care professionals caring for patients with COVID-19 have been reassigned from their normal clinical work environment and are working outside of their usual areas of expertise. Some sta may feel con icted that being reassigned to support COVID-19 patients may compromise the patient care for which they are normally responsible [7]. It is important to ensure that there is a professional support system in place for health care providers.

Conclusion

In this narrative literature review, we reviewed palliative care for patients with heart failure and COVID-19. Although there is no evidence showing the clinical and social bene ts of palliative care for patients with heart failure and COVID-19, we summarized what is needed to provide optimal palliative and end-of-life care for patients with heart failure and COVID-19 complications in this COVID-19 pandemic and post-COVID-19 era.