

# HEALING THE --- HEALERS

Special Edition  
Hospital Chaplains on Spiritual  
Frontlines during COVID-19

Written Professional Resources - Parts 1-3

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At Odyssey Impact, we believe in the power of personal story to change perspectives, change attitudes, and even to change the world. In responding to the needs of spiritual care providers and faith leaders in COVID-19, we were honored to collaborate with our chaplaincy partner organizations, the Chaplaincy Innovation Lab and the Association for Clinical Pastoral Education (ACPE), to convene conversations and provide resources to spiritual care providers (chaplains) in health care settings.

We are pleased to offer the following topics, reflections, and questions for anyone considering the aspects of providing spiritual care in health care settings during the COVID-19 pandemic. Those exploring the dimensions of pandemic pastoral care in other contexts will find it valuable as well. Uplifted here are spiritual care sub-topics that emerged in David and Shawn's conversation, as well as pandemic-related issues from ongoing national spiritual care dialogues.



For the convenience of chaplaincy educators, students, and residents, all sections are tagged with relevant ACPE Outcomes and APC Competencies. While each of the three filmed zoom conversations is accompanied by a standalone written resource, the content of the three resources do not overlap, and may be considered as a single rich engagement of pandemic chaplaincy topics.

For the creation of this resource, we are grateful to the Rev. Sarah Knoll Sweeney, an ACPE Certified Educator at the Memorial Hermann Health System in Houston, Texas. In terms of pedagogical development, Rev. Sweeney brought to this task her formidable experience as former Chair of the ACPE Curriculum Committee, Founding Convener on Community of Practice for Educators Utilizing Online Options, and Accreditation National Site Team Chair.

# Part 1

## HOSPITAL CHAPLAINS ON THE SPIRITUAL FRONTLINES OF COVID-19

### How Might the Hallmarks of Chaplaincy Change?

#### Adaptivity is more important than ever

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David and Shawn are making time to connect with each other despite *and because of* the overwhelm and chaos in front of them. Being adaptive in the face of rapid change is a hallmark of the healthcare chaplain. For many of us drawn to the vocation of chaplaincy, we recognize in one another a mutual ability and affinity for showing up in any situation to assess, intervene, observe the outcome, and reflect with trusted colleagues on the results. In CPE, we call this the clinical method of learning, the cycle of action → reflection → new action. We revere being alert, responsive, creative, resilient, and we have long privileged learning from experience as well as theory. Many of us signed on because we saw Experience as a teacher informing our tradition.

During our experience of pandemic, this learning-from-experience has been at full tilt. Almost on the hour, new policies reached to reflect new realities; by the time we figured out how to handle one part of this, something seemingly changed, and we were pivoting again. We compared notes on how to use PPE and technology to encourage connection across barriers. HIPAA regulations relaxed for us to meet critical needs and we had to huddle regularly on how to adapt. We chaplains know how to put our heads together on the fly.

For awhile, our anthem as chaplains was: “We were made for a time such as this!” As the weeks wear on, however, new Experiences became our teacher as well, like Fatigue. Our self-care practices had to adapt to the new reality: David and Shawn discuss their own adaptations in a later portion of conversation.

# Changing Understandings of “Ministry of Presence”

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When David reflects on how chaplains are figuring out where to show up physically, he touches on a deeply held conviction among chaplains -- the importance of our ministry of presence. Many chaplains remark that they are drawn to this work because it is so obviously meaningful – to be truly present for others in acute crisis and accompany them with skill and compassion. We learned the concept of ministry of presence in CPE or in pastoral theology courses in seminary, or from the first books we read about spiritual caregiving. Somewhere along the way, we decided that “being present” was the heart of what we do.

Some chaplains have interpreted this as a mandate to our physical presence in the heart of the action. If we are the Presence People, and if we are in any way absent, then we are less than a chaplain. I’ve heard some of my elder colleagues cite their experience during the AIDS crisis, remembering the powerful witness of showing up and physically accompanying the sick, the dying, and the staff through a time of incredible stigma. COVID-19 is a very different kind of dilemma, because of its transmission. Many of us are asymptomatic carriers, visiting patients who, by nature of being a patient in the hospital, have a compromised immune system. Some chaplains have now become patients in the ICU. A ministry of physical presence is also a potential ministry of transmission – to ourselves and others.

Many chaplain teams have not resigned themselves to the mandate of physical presence in light of the risk. We too have joined the ranks of the safer and more creative, telephoning our infected patients and their families, being swift to make contact before someone is ventilated, so that, before they cannot communicate, they know someone is accompanying them through barriers of glass and PPE. We telephone non-infected patients who are trapped in mandatory pandemic isolation, because, as one of our colleagues put so well: “a call is often more intimate than a prayer shouted from 6 feet away.” The staff has shared that seeing you on the floors, even if they are too busy to engage you much, has brought them comfort. Thoughtfully, you choose physical presence with them, knowing two things: you all share high probability as carriers, and that fear is as present and invisible as the virus itself. Chaplains of vulnerable populations (>65, underlying conditions, immunocompromised), or who are otherwise very anxious about their own health or the health of their families, sometimes recognized that their best offering was not physical presence, because they added more anxiety than they could relieve.

# Stretching / Accepting / Testing the Limits of Empathy

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David and Shawn begin their conversation asking how the other is feeling in the midst of their experience. Throughout their conversation, they reach to inhabit one another's perspective, when it reflects and differs from their own. In the history of chaplaincy, we have lifted empathy as a primary approach to connecting with careseekers. We commit to sit with another in their suffering, to feel with them. We strive to put ourselves in the shoes of another, just for a moment, and to see the world the way they see it. In times of heightened and collective crisis, we might wonder about the limits of empathy. Trying on others' shoes all day long will leave our feet sore, squished, and unprotected. It drains more of our energy than we may have for the weeks ahead. And, it turns out, the shoes we most like to try on are the ones that are closest to ours in length, width, and style. It's easiest to get inside the perspective of another if that perspective is most like ours.\* David and Shawn are remarkably similar in many demographic and professional ways; how might a conversation between chaplains of marked differences have demonstrated the stretch of empathy in a crisis involving extreme diversity in race, gender identity, spiritual practices, and class?

Compassion is different. Taking a beat to send our loving-kindness to those we serve is a renewable resource, and moves us to caring action rather than burnout.\*\* I invited my students to practice loving-kindness meditation during their early weeks of the pandemic. While they were washing their hands, I invited them to visualize the careseeker they just encountered in silence, and send them loving-kindness. Then, to send it to the next person who will encounter them — their tech, their nurse, their one single visitor for the day. As the soap went between their fingers, thumbs, and under their nails (I was reinforcing hand hygiene through this practice!), I invited them to send that same love out to the person whose shoes they least wanted to try on right now. As they rinsed off their blessed hands, send one more push of kindness to that difficult, irksome person. I told them: be sure to notice where your own feet are when you shut off the water. Breathe out the kindness that arose from within you. You are a precious renewable resource when you take loving care of yourself.

# Navigating the Moral Stress of Being Essential

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As Shawn and David discuss the quick shifts in role and priority that they are experiencing, they reflect together on what it means to be “essential workers.” In some institutions, chaplains were considered essential and given the freedom to attend to their units’/hospital’s unique circumstances, care for desperately stretched interdisciplinary staff, and visit patients otherwise left alone due to a no visitor policy. Some chaplains were mandated to stay home weeks ago, to reach patients, families, and staff via videoconference or phone. Some cities declared spiritual caregivers essential while particular healthcare institutions in that city did not, and vice versa.

For those considered essential, that freedom can also be deeply unsettling. Even onsite, chaplains face choice after choice: "How closely should I approach the nurse I really want to check in on?" "Is it more connective to call the patient than to shout a prayer at them from 6 feet away?" On the one hand, you know you are a risk vector: stats floated from the CDC and other government official that between  $\frac{1}{4}$  and  $\frac{1}{2}$  of the infected population are asymptomatic carriers, leaving chaplains who have been documented as exposed more than once to take extreme precautions when visiting other ill patients and interacting with potentially asymptomatic staff. Most chaplains have joined nurses and physicians in elaborate rituals of leaving and arriving home: changing in the garage, wearing scrubs to be washed at the hottest possible temperature, removing jewelry and make up, sleeping separately from partners to reduce their risk of infection. For those considered nonessential, or those whose schedules involve making more calls from an office and spending less time on the floors, feelings of guilt or shame can surround their absence.

While nurses’ and physicians’ moral injury focuses on how to delegate equipment and resources to patients in a time of shortage, for chaplains, moral stress revolves around at least two major dilemmas. 1: our potential to transmit the virus as asymptomatic carriers who travel from floor to floor and throughout all parts of the institution and 2: a lack of agreement about whether a chaplain need be physically present in order to be useful, helpful, and caring. Administrators feel this moral stress, both when advocating for chaplains’ to continue visiting patients, and when advocating chaplains be released from the mandate to enter infected patients’ rooms.

David and Shawn reflect on their personal separations from loved ones during the pandemic, reflecting a theological shift in how love is expressed: whereas touch formerly communicated love, now separation is the more loving thing to do. A parallel reflection occurs at the professional and ethical level: where and how is a chaplain most helpful, and least harmful?

# Chaplains as Midwives of Grief

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Whether in person, on the phone, or via videoconference, the conversation makes clear that naming loss and facilitating grief continue to be central to the work of the chaplain. David and Shawn naturally illustrate the truth that we can only accompany others where we have been willing to go within ourselves. As they trace their personal losses and attend to each other's grief, they are freed to accompany their staff, students, and patients through their own loss and grief.

In discussing shifting protocols in visiting infected patients, David also reveals the foundational connection between physical, emotional, and spiritual health in the life of the patient: if the patient is not yet ventilated and visited by a chaplain, their lowered anxiety helps their breathing remain steady while unassisted. This underlying assumption demonstrates the vital role a chaplain may play as the primary attender to a patient's emotional and spiritual needs and resources during any hospitalization, especially vivid in the moment of pandemic.

## Questions for Reflection:

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- 1 How did your institution's designation as essential or nonessential impact your sense of vocation during the pandemic? What became more clear to you as the fundamental nature of your work?
- 2 What theological reflection did you engage as the weeks went on? How have you understood your central beliefs and practices to fuel and motivate your work?
- 3 How might our experiences as chaplains during COVID-19 further nuance our beloved concept of a ministry of presence, incorporating the reality of chaplains as risk vectors, recognizing which kinds of presence brought help or harm?
- 4 How do you understand the difference between empathy and compassion, and how do you work with the strengths and limits of each in your work as a chaplain?
- 5 What has been the most difficult moment of adaptation during the pandemic? How do you find your strength?

## ★ ACPE Outcomes

- 1.8: Use the clinical methods of learning to achieve one's educational goals.
- 2.3: Demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/transformation, confrontation, crisis management, and appropriate use of religious/spiritual resources.
- 2.4: Assess the strengths and needs of those served, grounded in theology and using an understanding of the behavioral sciences.
- 2.5: Manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate professional communication.
- 2.7: Establish collaboration and dialogue with peers, authorities and other professionals.
- 2.9: Demonstrate self-supervision through realistic self-evaluation of pastoral functioning.2.2 provide pastoral ministry with diverse people, taking into consideration multiple elements of cultural and ethnic differences, social conditions, systems, justice and applied clinical ethics issues without imposing one's own perspectives.

## ★ APC Competencies

- PIC1: Be self-reflective, including identifying one's professional strengths and limitations in the provision of care.
- PIC3: Attend to one's own physical, emotional, and spiritual well-being
- PPS2: Provide effective spiritual support that contributes to the well-being of care recipients, their loved ones, and staff.
- PPS4: Triage and manage crises in the practice of spiritual care.
- PPS5: Provide spiritual care to persons experiencing loss and grief.
- PPS10: Formulate and utilize spiritual assessments, interventions, outcomes, and care plans in order to contribute effectively to the well-being of the person receiving care.
- OL3: Understand and function within the institutional culture and systems, including utilizing business principles and practices appropriate to one's role in the organization.
- OL4: Promote, facilitate, and support ethical decision-making in one's workplace.

# Part 2

## HOLDING SPACES FOR FEAR, LOSS AND HOPE

### Understanding Trauma-Informed Spiritual Caregiving

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Both David and Shawn share what they're discovering as they mine their past experiences for wisdom applicable to the here-and-now. In reflecting upon past crises in which they've provided spiritual care, and the collegial communities that supported them through it, they revisit past traumatic moments they hope will guide them in the current moment of communal trauma and anxiety.

There is some debate among chaplains about whether, in this pandemic context, simply showing up to work as a chaplain constitutes trauma. Regardless, trauma-informed spiritual caregiving serves us well in attending to ourselves and those we serve in a time of collective uncertainty, stress, and danger such as this. A review of basic concepts in trauma and brain function is useful: limbic systems, amygdala, fight-flight-freeze. It helps us as chaplains to remember that first responders have override functions; by repetition, they've learned to push past fight-flight-freeze in the same kinds of crises over and over. During chaplaincy education, many students express concern about becoming calloused to suffering and death. However, being ready and capable is not the same as being calloused. Many of us discover that we shift from judging nurses' gallows humor to joining them (out of patient earshot) because we realize this is part of how we were going to get through, too. Things that used to feel like an emergency when we first started have become routine.

But in this pandemic, the contours of "routine" and "emergency" have shifted. "An emergency is a *novel* situation, not something we deal with on a regular basis. Therefore, we don't have a 'mental script' on how to handle it." We're dealing with a *novel* virus, and that means, to various extents for each of us, this is a *novel* emergency. It does not quite feel analogous to our scripts and experiences of previous disasters, crises or emergencies. Shawn recalls his days in CPE during the AIDS crisis, connecting the importance of his peer relationships then to the value he finds in talking with David now. In Houston and other coastal communities, some observed the stockpiling of water and lumber – two major needs for the much more common disaster – a hurricane.

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For New Yorkers, comparisons to September 11th abound, and across media outlets, we hear descriptions of ERs as war zones. But none of these similar experiences quite fit. Being a chaplain to an AIDS patient and to a COVID-19 patient have radically different implications for infection and transmission, and so demand a very different strategy for connection and presence. This lack of a collective memory for how to be a chaplain in a flu pandemic leaves our brains whirring in the background, cycling through fight → flight → freeze, again and again.

## Chaplains as Midwives of Death

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David and Shawn begin anticipating how they will attend to the religious needs of patients separated from loved ones and community spiritual caregivers in the isolation mandated by the pandemic. As they talk, we can feel their devotion to the importance of the chaplain's role in a patient's death. Many of us who are called to deathbeds — spiritual caregivers, chaplains, religious leader types — have ideas about "dying well." Ira Byock's book and the hospice movement laid a foundation for us. This notion that we can facilitate "the good death" has formed many of us in our approach to blessing, praying, and anointing our people as they lay dying. Some of us see end-of-life care as our most vital function, and it turns out most healthcare staff see us that way, too.

In just September of last year, Byock wrote "When people are competently cared for, many can feel a sense of peace — well within themselves and with others — as they leave this life. Preserving this opportunity is the fullest expression of community. Depriving people of the opportunity to die well seems the final social injustice."

As more of us around the country move to Zero Visitor policies for our COVID-19+ patients, we join our medical colleagues in striving for the good death, working to prevent Byock's final social injustice. We pull beloveds up on ipads for the dying to see. We call them from the other side of the glass to offer their comforting words. Per the traditions of chaplaincy, we make do with what we have, advocating for the sanctification of an otherwise horrifically clinical moment. We hold up the staff as they move on to the next bed. We have learned to communicate with our eyes; the rest is behind a mask.

When David reflects on his apprenticeship moment with a CPE student in the morgue, it becomes clear that the deceased patient's son spontaneously moves into the short list of things chaplains sometimes facilitate loved ones to say to the dying person. Chaplains continue to facilitate grieving, even under some of the most bizarre circumstances of our ministry life.

# Adapting to New Tools: Telechaplancy in COVID-19

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When David reflects with Shawn on how he navigated using the phone in the morgue with the patient's son, many of us are thrust back into our own experience strategizing creative spiritual caregiving in the midst of the constraints of the pandemic. Perhaps no innovation became more pressing for us than telechaplancy skills. Spurred by some chaplains being removed from their floors, increasingly stringent no visitor policies, uncertainty about the spread of the disease via droplets and aerosols, and a potential or actual shortage of PPE, chaplains have shifted from automatic in-person visits to all patients to strategies utilizing phone and videoconferencing technologies. David's visit to the morgue captures all of this and invites us to reflect on how we navigate these moments for ourselves.

Telechaplancy is not new in the pandemic, but many who had formerly dismissed it have come quickly to learn its usefulness. The phone and iPad not only help us connect with the patient, they help us connect the patient to their beloveds. Like David and Shawn, we mine our colleagues and Facebook groups for best practices and to share what we are learning on a daily basis. [The Chaplancy Innovation Lab](#) and other organizations are striving to rapidly share and disseminate these best practices for easy access and quick learning. Many, if not most, CPE programs have moved to meeting by videoconference in light of <10 person, 6-foot distance requirements, so Educators are in a parallel scramble to set up and orient to this technology for the education of future chaplains.

Before the pandemic, we often saw our primary role in end-of-life situations as facilitating grief processes among those present. Most chaplains rarely (or sparingly) used technology to connect loved ones otherwise separated. For many of us, the pandemic has invited us to question again the primacy of physical presence in our work. We begin to wonder what relational connections we've neglected to advocate for when a patient faced the end of their life. As the relaxation of HIPAA regulations allowed chaplains to meet these immediate needs with the limited resources at hand, many spiritual care providers have wondered aloud how we've allowed these regulations to needlessly limit us in the past.

For some of us, the new engagement of technology for spiritual care has created fascinating questions (and possibilities), while others hope these questions (and problems) will disappear upon the advent of a COVID-19 vaccine: might some of chaplancy be more efficient and effective via videoconference, or is this just an exception necessitated by this pandemic? When families can gather on a Zoom from across several states and see the patient's face, what do we learn about our ability to facilitate relational connectivity in the patient's life? Which is better, shouting a prayer from 6 feet away or a phone call that could modulate a less-anxious presence and a soothing tone?

## Questions for Reflection:

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- 1 How have your knowledge of and experience with trauma informed your work as a spiritual caregiver during the pandemic?
- 2 What have you observed about your brain and body function during the crisis, both while working and in rest? How does this self-awareness inform your work as a chaplain?
- 3 How has the pandemic changed our ideas about “dying well” and the role of the chaplain? How might this inform the future of chaplaincy?
- 4 How has your facilitation of grief changed during the pandemic? What will you bring with you into your spiritual care practice moving forward?
- 5 What technology are you using during the pandemic that you find useful and effective for ongoing spiritual care practice?
- 6 As telechaplaincy becomes the temporary “new normal,” what has been lost that you now hold even more sacred in your role as a spiritual caregiver?
- 7 At a time when chaplains became even more critical surrogates for loved ones at a patient’s end of life, what have you learned about the creative potential of your role?

## ★ ACPE Outcomes

- 1.2: Identify and discuss major life events, relationships, social location, cultural contexts, and social realities that impact personal identity as expressed in pastoral functioning.
- 1.5: Recognize relational dynamics within group contexts.
- 2.1: Articulate an understanding of the pastoral role that is congruent with one's personal and cultural values, basic assumptions and personhood.
- 1.7: Initiate helping relationships within and across diverse populations.
- 2.4: Assess the strengths and needs of those served, grounded in theology and using an understanding of the behavioral sciences.
- 2.3: Demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/transformation, confrontation, crisis management, and appropriate use of religious/spiritual resources.
- 2.4: Assess the strengths and needs of those served, grounded in theology and using an understanding of the behavioral sciences.

## ★ APC Competencies

- ITP2: Incorporate a working knowledge of psychological and sociological disciplines and religious beliefs and practices in the provision of spiritual care.
- PIC2: Articulate ways in which one's feelings, attitudes, values, and assumptions affect professional practice.
- PPS1: Establish, deepen and conclude professional spiritual care relationships with sensitivity, openness, and respect.
- PPS3: Provide spiritual care that respects diversity and differences including, but not limited to culture, gender, sexual orientation and spiritual/religious practices.
- PPS4: Triage and manage crises in the practice of spiritual care.
- PPS5: Provide spiritual care to persons experiencing loss and grief.
- PPS6: Provide religious/spiritual resources appropriate to the care recipients, families, and staff.
- PPS9: Facilitate group processes, such as family meetings, post trauma, staff debriefing, and support groups.
- OL1: Promote the integration of spiritual care into the life and service of the institution in which one functions.

# Part 3

## COPING, SELF-CARE, AND HOLDING SACRED SPACE

### Creating Space for Coping and Self-Care

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David and Shawn continue their grieving process as they envision a future after the current crisis, imagining engaging in things they miss, like sharing a hug or a beer. They explore briefly how they are coping with the stress and uncertainty presented by the pandemic. These cover unconscious processes, including defense mechanisms like compartmentalization, as well as more conscious coping strategies like continuing to make time for important support networks and when they trade recent binge-watching favorites. Competencies for the professional chaplain include attending to our own well-being, and the pandemic limited former self-care practices for many of us who utilized gyms, gathered socially, and countless others. The chaplain's particular adaptive abilities, usually emphasized in the professional realm, are especially useful when personal self-care routines are constrained and must be revised.

# Acknowledging The Primacy of Staff Care in the COVID-19 Crisis

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As they shift from their own personal care to staff care, we again see the connection between the chaplain attending to their own needs and their ability to attend to others' needs as a result. Shawn shares how he attended to staff and leadership and asks David's input on how to most effectively continue this work. Chaplains who have stayed on the floors but are increasingly restricted in patient care due to lowered census and contact precautions shifted to primarily care for the staff who care for the patients. Rightly so, healthcare workers are the MVPs of COVID-19.

For most chaplains this is a substantial shift in day-to-day focus. We have always cared for staff alongside our patients, families, and visitors. Now, with our halls emptied of all but patients and staff, with contact precautions putting a virtual end to cold-call patient rounding, and with the pandemic stressing our systems to a lifetime high, our care of staff is more critical than ever.

The reality is that there isn't time or space for a lot of long heart-to-hearts. We have to be quick, clever, and creative.

After reviewing the literature from 1981 and 2004, Brown-Haithco wrote in 2012 that staff needs and struggles were much the same. In 2020, in the midst of this pandemic, her list is still right-on in caring for nurses, techs, physicians, administrators, and others still reporting in. In supporting staff during the pandemic, we are noticing :

**Moral Distress:** when their jobs take them against their own ethics, morals, and integrity.

**Compassion Fatigue:** when the overwhelm of the job burns them out of the original energy of their calling.

**High Patient Volume and Acuity / Staff Shortage:** speeding up licensure processes to get retired healthcare workers on the floor means we are gathering all the staff we can for the surge. This novel coronavirus has us catching up to an unfamiliar disease process at unprecedented rates, not to mention that folks are still falling ill and dying for all the usual reasons, just as they were before.

**Lack of Appreciation and Affirmation:** planned applause, bells ringing out, food delivery, and other gestures are all ways we see folks showing love to our IDTs.

**Organizational Change:** bringing on retired staff to formerly cohesive teams, redistributions of staff in a labor pool, new policies each day, rapidly adjusting care protocols, and the backdrop of unprecedented cultural and economic upheaval — I’ve said it before: we’re always ready for change in healthcare, but this has us at our limits. Trying to offer simple solidarity on the way constant change means never finding a routine, loss of sense of control and certainty, simple things being more challenging. We can definitely relate to them here.

## Questions for Reflection:

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- 1 How have your self-care needs and resources changed during the pandemic? What have you learned about what nourishes you that will serve you in the future?
- 2 What do you find your staff teams need more than ever? How might this inform our future relationships with healthcare staff?
- 3 When the acute phases of this crisis subside, what will your shifted priorities be with staff, when there is more time and space to reflect and process all that you and they are experiencing?

### ★ ACPE Outcomes

- 1.7: Initiate helping relationships within and across diverse populations.
- 2.7: Establish collaboration and dialogue with peers, authorities and other professionals.

### ★ APC Competencies

- PPS2: Provide effective spiritual support that contributes to well-being of the care recipients, their families, and staff.
- PPS4: Triage and manage crises in the practice of spiritual care.
- PPS7: Develop, coordinate, and facilitate public worship/spiritual practices appropriate to diverse settings and needs.
- PPS8: Facilitate theological/spiritual reflection for those in one’s care practice.