

# HEALING THE --- HEALERS

**Special Edition**  
Hospital Chaplains on Spiritual  
Frontlines during COVID-19

**Written Professional Resources - Part 1**

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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.

## 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.