

Chaplain in the Midst of the Covid-19 Pandemic

Those of us chaplains are quite familiar with the phrase “lessons seminary never taught me.” Facing the Covid-19 pandemic, I can say something similar about our CPE training: “Lessons my CPE training never taught me.” In this brief article, I would like to share a couple of things that I have learned from being on the front lines with other healthcare workers as a chaplain.

1. I find it helpful to see myself as a military chaplain rather than a hospital chaplain in the Covid-19 context even though I have never been a military chaplain or received military chaplaincy training. Borrowing the method of the Systems-Centered Theory which was introduced to me by Meigs Ross, consider three aspects: role, goal, and context. My role is a military chaplain in the healthcare context where all medical staff often express themselves to be soldiers fighting for their patients against Covid-19. My goals are to help these medical soldiers recharge, undo their anxiety and fear, and send them back to their battlefield.

2. In order to meet these goals, it is crucial to set up a basecamp. In this clinical setting, it's a respite room or a recharge room created for staff only. This is the place where staff take a break, feel safe, and literally recharge themselves. I set the room capacity to be less than 5 people. Refreshments should be provided consistently. This can be perceived as institutional support to staff. At least sweets or drinks should be there at all times. You can decorate the room in a way that makes staff feel relaxed and safe. Soothing music can be played, but not too loud. Sometimes, staff just want to stay in silence or talk to each other casually.

3. Challenges

1. Institutional support: I work at two sites: Site A and Site B. At Site A, I didn't succeed in securing and creating a respite/recharge room for staff support. Sadly, no institutional support. So, I wanted to create it from bottom up but no support from nursing managers either even though staff expressed its need. At Site B, I didn't have to do anything because their volunteer office and patient experience team took charge. They created and decorated all the rooms, set up a refrigerator, and brought refreshments.
2. Consistency of refreshment support: how to provide refreshments can be an issue since this crisis is a marathon. Site B depends on donations from local restaurants, yet there is a social concern since restaurants are currently not making any profit. Can hospitals help them rather than ask to be helped? This is a larger question to think about.
3. Functioning more as a military chaplain whose professional training I haven't received, I find the task of helping staff recharge to send them back to their patients or battlefield emotionally challenging. Walking through units and briefly checking in with them is my way to show my solidarity with staff. A military chaplain, according to some unknown resources, stood in the middle of the

battle, holding the crucifix. Even nowadays, military chaplains do not carry weapons as we do not physically interact with patients with the Covid-19.

4. Spiritual interventions: Spiritual interventions vary, depending on each individual chaplain's skills and specialty.

1. Exploring their current experiences can be most helpful. We don't want to go too deep into their emotions. That may be necessary if their shifts are over and we want to provide an After Action Review (which is often called "hot-wash" or "time-out"). The goal is around how we help the staff pay attention to the moment rather than to explore their mixed feelings. Asking them about their families who are concerned about them wouldn't be a good idea, which, though, is a great topic to discuss after their shift. Ask how they are doing physically, mentally, and spiritually in the moment. Undo any anxiety or fear, especially, of infection or exposure. Remind them of safety guidelines. As long as they are prepared with proper PPEs, they're safe. As long as they follow their safety protocols, they're safe. We never want to explore, or at worst trigger, anxiety or fear. The goal is to help them recharge and send them back to their patients.
2. Exploration of anger: While I stay away from anxiety and fear as a topic to talk about, discussing their anger can be useful. We don't want to shy away from the national shortage of PPEs and their dissatisfaction with their hospital leadership. No censor and confidential communication to clergy privileged: in the State of New York, clergy or chaplains are "not allowed to disclose a confession or confidence made to him [her or them] in his [her or their] professional character as spiritual advisor." (NY CPLR § 4505 (2012))
3. A short meditation: I find a short meditation to be an effective spiritual intervention for staff. It shouldn't be too long (< 5 min). Help staff stop thinking and feeling so that they can simply be in the moment, experiencing a sense of their own being. This seems to help staff center and ground themselves.
4. Prayer for protection: If staff are open to prayers, saying prayers of protection, healing, and blessing would help them.

6. Tele-chaplaincy for patient care and family support: It matters what goals this tele-chaplaincy seeks to achieve. Is it to provide emotional and spiritual support? What script is being used? There appear to be pros and cons.

1. Pros: Patients and families may appreciate chaplains' phone calls and their spiritual interventions (e.g. emotional and spiritual support & prayers). It seems to work better when chaplains actually have a relationship with patients in the past. They can match our voices with our faces. Interestingly, tele-chaplaincy may work better for patients and families whose preferred language is not English that chaplains can benefit from phone interpreter services.
2. Cons: Reaching out to families via phone can be alarming, particularly during this time of uncertainty. We call them to help reduce their anxiety and fear for their loved ones, not to increase them. One obvious assumption that cannot be ignored is that families want to know how patients are doing. For me, that would

be the most important information I would like to receive from the hospital. Facts matter in this case, and the HIPAA regulation and our role as a chaplain do not allow us to provide medical facts. On the other hand, calling patients should be carefully thought out since most patients with covid-19 suffer from shortness of breath.

This tele-chaplaincy takes a different approach compared to that of the call center. The call center, usually run by Patient Services, handles all the in-coming calls from families. Its goal is to simply provide the room status of patients (nothing medical) and calm them. The message they convey to worrying families goes something like this after verifying the caller's relationship with a patient by asking a patient's DOB or four digits of medical record number from the caller: "Your loved one is in this room now. Doctors will reach out to you if there's any news. Remember no news is good news." While I don't know how effectively this tele-chaplaincy can be utilized, it should be in conjunction with the call center. Both parties (one proactively calling families and the other receiving calls from families) belong to the same institution after all.

7. Some practical tips: Debrief as often as possible with other chaplains. Experiment with different strategies every day and see what best serves staff needs. Set daily goals with expectations that goals will be changed day to day and plan ways to meet your adjusted goals. Teamwork is more needed than ever during this time.

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