

The Corona pandemic as a challenge for spiritual care

Advice for pastors

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Spiritual Care is an essential part of the care of critically ill and dying patients and their family members. This also applies in the current corona pandemic, in which all those involved are challenged to an unprecedented extent. Chaplains in hospitals, geriatric care facilities and in outpatient palliative care bear responsibility for the maintenance of spiritual care, with and for all those involved. They represent the shared caretaking effort of all health professions and are usually the first point of contact for spiritual care.

0 basics

0.1 According to the WHO, the goal of the care of ill and dying people is to enhance "well-being" and "quality of life" in all dimensions (physical, psychological, social and spiritual). This is especially true in times of crisis.

0.2 All health care professionals are obliged to pay particular attention to their own health and to obey the physical distance to others. If physical contact cannot be avoided, protective clothing is essentially necessary. Basic medical care is a top priority when it comes to distributing protective clothing.

0.3 Being with the dying and saying goodbye to the deceased is more difficult if not impossible by the pandemic. Visits are restricted for hygienic reasons. Due to strict hygiene protection measures, the deceased are moved to closed areas in sealed body bags as soon as they are found to be dead. This not only painfully limits the opportunity to say fare-well to a deceased person, but also religious acts customary for this situation.

1 Care for patients

1.1 Patients who are hospitalized due to COVID-19, suffer to a great extent from isolation, a fear of dying, and rapid disease progression. Restricted or prohibited visits by relatives increase the burden and intensify stress symptoms. Chaplains should work together with health care teams in order to provide for psychosocial and spiritual needs and whole person

care. Technical and digital communication tools such as telephone, face-time, or video call can be used for tele-chaplaincy.

1.2 All patients, especially the dying, should be offered spiritual care in accordance with their belief system and their wishes and needs. However, alternative forms of spiritual care should be offered, if direct interpersonal contact is no longer possible or only to a limited extent. Healthcare chaplains should get in touch with representatives of others than their own religion at an early stage in order to coordinate and discuss needs, possibilities, and limits. It is important to avoid situations of misunderstanding and conflict within the clinic or nursing home.

1.3 In consultation with psychosocial professionals, care should be coordinated in order to enable as many affected people as possible (not just directly to COVID-19 patients) to receive human accompaniment. Spiritual and pastoral on-call service should be included in emergency plans of the facility. Chaplaincy services should be split between COVID-19 patients and other patients in order to meet the special conditions of high infection risks and not neglect any of the groups.

1.4 In case a patient is dying, family should be able to say goodbye. Since corona infected patients will be isolated, direct communication will be complicated by the protective clothing. Restrictions may apply. Nurses may be able to represent the family and religious community by saying a word of blessing as surrogates. Attention, however, should be paid to the (non-)religious patients or members of other faith communities (e.g. – Christian/Jewish –: "The Lord bless you and keep you"; or – secular –: "Go / rest in peace! Be protected on your way! "Or – Muslim –:" The blessing of Allah be with him and his family and peace"). Specific words and rituals can be coordinated in each individual case with family and / or patient.

1.5 Hygiene standards are binding for chaplains. Do not take anything (hymnal, bible, or other artefact) into or out of the room. It is, however, possible to laminate prayers from different traditions and to deposit them on the wards - for use by chaplains or by healthcare staff members.

1.6 Special circumstances in handling the corpse of an infected patient will apply. Find out about requirements at your institution. If direct contact is not possible due to restrictions, relatives should be enabled to a symbolic farewell ritual in the hospital chapel. Please note the permissible size of groups. When first discussing this with family members, ask them what is important to them. Have a photo taken of the deceased person by staff or by yourself. It can be an important document of proof for relatives at a later time, and can be helpful in coping and grief. For this purpose, a protocol to take and document a photo shot must be agreed with the facility. This procedure is covered by the EU data protection regulation, since it is vital information for the persons concerned (Art. 6 Para. 1 GDPR).

1.5 It is helpful if pastoral care proactively informs relatives and patients about specific offers appropriately (e.g. on the website of the institution).

2 Care for loved ones and family

2.1 Relatives, especially in critical situations, should have access to the patient, especially in critical situations and at the end of life. There are, however, limitations in case of patients with COVID-19. Chaplains should speak to the ward and facility management to advocate for sensible and protection oriented regulations for visits. However, you should also address the risks of a visit. Pastors should also listen to the needs of the staff and the clinic.

2.2 Situations may arise in which direct contact with the patient is not possible. In this case, chaplains are particularly needed to offer family support. Where possible, digital messages by relatives / the patient* can be transported by chaplains (e.g. recording of photos or short greetings through mobile camera). Hygiene rules must be strictly observed. For this purpose, a camera / mobile phone / tablet can be put into a waterproof bag (available for underwater photography) to enable thorough cleaning and disinfection.

2.3 Given the risk of infection, the public discussion and potentially mass infections, relatives will be upset. Fears and worries should be taken seriously and should have space when talking to spiritual care givers and chaplains.

2.4 Particular attention should be paid to the needs of people in acute grief. Many questions will arise, as well as a search for meaning and support, and the need to "do something". The possibility of saying goodbye to the dying – both in symbolic and ritual form – has a positive effect on grief. Rituals help to overcome one's feelings of powerlessness. Chaplains should offer creative opportunities to express their relationship with the patient (verbally and symbolically) inside a chapel or in other suitable places (garden, river, etc.), to find comfort in their faith and to connect with their individual spiritual resource system. It may be helpful to light a candle, say a prayer, or write into a book of intercession. Not everyone, however, can or wants to deal with spirituality or rituals in the same way. Open invitations to pray may be helpful.

2.5 Increased death rates and rapid disease progress mean social constraint and uncertainty for grieving relatives. They may be a heavy burden for grieving persons. Information about local grief counseling groups should be provided.

3 Care for healthcare staff

3.1 Healthcare professionals in clinics and care facilities are particularly stressed by the corona pandemic. Increased death rates, especially, mean maximum stress and existential crises.

3.2 Chaplains and psychosocial care professionals can proactively approach staff members, asking about their burden and offering support. It should be borne in mind that "functioning" is of primary importance for the clinic staff. Therefore, such conversations are most likely to take place during breaks or after the end of duty, or at the end of the stress period. Meetings and activities such as mindfulness exercises, guided meditation, joint prayers, and rituals of remembrance of the dead can be supportive and stabilizing.

3.3 Staff members who are burdened beyond their limits because of constant confrontation with existential suffering must be able to express this to their superiors and to be able to take advantage of support measures.

4 Care within nursing institutions

4.1 The care and treatment of people who have been infected with the novel coronavirus or are in (self-)isolation, will have to take place within their institutions and residencies.

4.2 There will be restrictions on visits from outside by relatives, and also among inhabitants. These will increase the level of isolation and feelings of loneliness.

4.3 Chaplains in care facilities should look for ways to stay in contact with residents. Written communication or – where possible – use of digital media should enable communication through messages, chat, recorded readings, or other forms of contact. Technical support should be provided.

4.4 Where devotional services are not possible, spiritual offers should be provided via various communication media.

4.5 Chaplains should participate in the team meetings of the nursing homes, thus contributing to a whole person care.

5 Ethical questions

5.1 As in all clinical facilities, decision-making situations can occur under great time pressure. Chaplains have communicative skills, some also ethical skills, and, if desired, should take part in meetings, especially in connection with decision making on termination of life support.

5.2 It may happen that decisions will have to be made that allow some patients to receive intensive care while others won't ("triage" in connection with the limited use of automatic ventilation or organ transplantation). Intensive care beds may not suffice and some patients will no longer receive curative treatment. For these patients palliative medicine must be provided. Information on ethical guidelines regarding "triage" can be found on the website www.covid-spiritualcare.com.

5.3 Decision-making processes should be accompanied spiritually, especially if they cannot be solved satisfactorily. Difficult treatment decisions can also lead to the phenomenon of 'moral distress'.

5.4 Healthcare professionals and others will make mistakes and feel guilty. Overwhelming situations can create feelings of guilt. A good error management culture and the willingness of chaplains to speak confidentially about guilt, feelings of guilt and shame, are an important, proactive contribution by spiritual care. The offer of confession may also be appropriate. Calling crisis experience by its name, making people aware of tragedy and differentiating actual personal guilt from feelings of lagging behind one's ideals is elementary in order to cope with the burdens of existential crises.

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