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Editorial
COVID-19: Multinational Perspectives of Providing Chaplaincy, Pastoral, and Spiritual Care

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HSCC: COVID-19

This special issue of *Health and Social Care Chaplaincy* (*HSCC*) considers international responses from chaplains ministering during the first six months of COVID-19. It presents initial research and reflections from seven countries about the provision of spiritual care to patients, families, and staff suffering under the affects of a cruel pandemic. At the time of writing this editorial,[4] the number of COVID-19 cases diagnosed internationally totals

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approximately 22 million; the number of deaths is approximately 800,000. Both figures are rising rapidly, with nearly 33,000 new cases and approximately 1,300 deaths per day.[5]

While some countries, at the time of writing,[6] appear to have impressively kept morbidity and mortality under control (e.g., New Zealand), other countries have fared poorly (the United States, Brazil, the United Kingdom, Mexico, and Italy have sustained the highest number of deaths),[7] and yet other countries, while initially having controlled the virus, have subsequently experienced a second wave of infection (e.g., Australia – mainly Victoria and New South Wales). The situation, however, is constantly changing.

A future question that arises, of course, relates to COVID-19 vaccinations and the ethics of distribution: who will gain access and, perhaps more importantly, who will decide and prioritize that entitlement? There are many uncertainties about vaccination developments, which could represent either the "silver bullet" or simply attractive chimeras. At this stage, however, we cannot know whether a vaccination for COVID-19 is possible, effective, or enduring. Such uncertainty presents the world with unique challenges and existential distress, or even perhaps "death anxiety," as a result of people purportedly developing an irrational fear and response to death accelerated by COVID-19 – which supposedly can be explained by terror management theory (Becker, 1973) and treated using cognitive behavior therapy (Menzies & Menzies, 2020). Yet, as evidenced by the articles in this issue, it is not the *fear* of death per se that is the raw concern caused by COVID-19. The real concern is the loss of love, laughter, friendship, identity, and ultimately loss of contact with kin and community to which people relate, caused by an uncontrollable disease they did not initiate. In addition, as Abel and colleagues (2020) note, COVID-19 is forcing us to rethink our public health priorities regarding end of life care, not only now but into the future.

Furthermore, what began as a health emergency, testing our resources relating to personnel and technology across the world, is now being followed by an unrivalled economic depression, the full extent of which cannot be calculated at present. Many chaplains have been in the thick of the medical response to COVID-19, at patients' bedsides as well as supporting clinical

5. WHO Coronavirus Disease (COVID-19) Dashboard – confirmed cases: Americas, *n* = 7,948,513; Europe, *n* = 3,124,701; South-East Asia, *n* = 1,571,317; Eastern Mediterranean, *n* = 1,429,084; Africa, *n* = 623,851; Western Pacific, *n* = 272,829. Data: World Health Organization, Geneva. Retrieved 23 July 2020 from https://covid19.who.int

6. Editorial date: August 20, 2020.

7. Countries with the highest death rates: US, *n* = 146,192; Brazil, *n* = 82,890; UK, *n* = 45,501; Mexico, *n* = 41,190; Italy, *n* = 35,082. Retrieved 23 July 2020 from https://www.worldometers.info/coronavirus

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colleagues. At the same time, other chaplains are connected to communities which have responded in different ways, not least by providing emotional, religious, and spiritual solace during a time when gatherings have been prohibited in many places. Yet, as noted by Pierce (2003), this is not the first time that chaplains have ministered under such conditions (e.g., Canada: Severe Acute Respiratory Syndrome: SARS). Some chaplains/clergy, however, as a result of their care, have succumbed to COVID-19 and died (Bramstedt, 2020).

COVID-19: Chaplaincy Response

This issue of *HSCC* presents the story of chaplaincy during the initial stages of COVID-19 via case studies, research, and reflections covering a number of chaplaincy domains including acute care, aged care, palliative care, primary care, and mental health care. It also covers a number of regions – namely (in alphabetical order), Australia, England, Italy, Ireland, the Netherlands, New Zealand, and Scotland.

Australia

David Drummond and Lindsay Carey write of an Australian case study using Salmasy's (2002) "bio-psycho-social-spiritual" paradigm to systematically consider the biological, psychological, social, and spiritual care practices implemented by chaplains to ensure the continuity of care within the McKellar Centre aged care facility in Geelong, Victoria – one of two states in Australia that have experienced repeated "lock-downs" due to subsequent waves of COVID-19 cases. The spiritual care practices of chaplains are subsequently considered in greater detail using the WHO Spiritual Intervention Codings (WHO, 2017), indicating that chaplaincy can, with innovation and skill, continue to fulfill appropriate spiritual care interventions even under the difficult conditions of COVID-19 (Drummond & Carey, 2020).

England

Simon Harrison and Julia Scarle present a brief qualitative overview of COVID-19 findings based on a "snapshot" survey of chaplaincy teams in the United Kingdom during April 2020, in order to find out how they were functionally responding during the pandemic. Their exploratory study consisted of 12 questions regarding: (1) chaplaincy teams working shorter/intentionally limited time frames on wards; (2) maintaining on-call response; (3) wearing scrubs; (4) using technology regularly for patient care; (5) offering enhanced or "rebadged" staff support; (6) becoming more

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integrated into staff support networks; (7) being fit tested team members; (8) visiting intensive care unit patients when requested; (9) whether they were well supported by their Trust/Board; (10) whether they believed chaplaincy staffing was/is adequate; (11) whether there were any major obstacles hindering chaplaincy ministry; and (12) whether any local initiatives were developed. They suggest "a need, as a profession, to rapidly take stock and reflect in more depth on our pandemic practice and the potential for long-term changes in practice" as well as the need for systematic research to prepare for the future (Harrison & Scarle, 2020).

Chris Swift sets the preliminary scene in the United Kingdom with regard to aged care, and the changing interaction of chaplains "being there," "virtually being there," and even "being absent." He argues that for many chaplains there has been a mixed economy of presence and absence, where older people in residential care have enjoyed the support of chaplains while their relatives have been contacted remotely. Swift argues that, given the exceptionally high per capita mortality in care home populations, there are wide-ranging implications regarding the type of support needed for residents and staff living amidst unprecedented mortality and illness (Swift, 2020a).

Another UK chaplain, Karen Murphy, considers the issues from a palliative care perspective. She argues that a number of challenges have become evident for chaplaincy and will more than likely continue as a result of COVID-19. These include the effect of social distancing upon bereaved relatives, the challenges of conducting funeral rituals, and the negative after-effects of residual emotions felt by individuals and communities as a result of not being able to properly grieve (Murphy, 2020).

Likewise, Lynn Busfield, a chaplain in the Midlands of England, provides a brief personal reflection on her feelings of being with patients, nursing staff, and paramedics, enduring not only the intensity of working in an expanding intensive care unit but also the challenges of caring for those in "dying bays" who were no longer receiving active COVID-19 treatment. She stays to pray, hear their life story, holding their hand and "just being with people's pain, confusion, and sadness" (Busfield, 2020).

In another personal reflection, Helen Cockell writes of her experience of a unique chaplaincy role, that of caring for bereaved parents and widows in lockdown. She notes their pain and grief, changes to usual mourning practices, anxiety, self-efficacy, the lack of presence and touch, enduring negative capability, and other practical challenges arising from COVID-19. Through it all, and while still maintaining social distancing, Cockell finds a "new way of working, which for me is different, profound" (Cockell, 2020).

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Of all the UK chaplaincy domains, Graham Peacock argues that the greatest changes to chaplaincy have been in the area of mental health care. This article provides a personal reflection describing the effects of COVID-19 on mental health care chaplains, their practices, and their NHS Trusts. It shows that chaplains are adapting to these changes, but at a cost. Peacock reflects upon five areas of concern: (1) personal loss and questioning; (2) deaths and support; (3) being present without being present; (4) new developments with regard to staff meetings, services of worship, and developing new resources; and (5) returning back to normality by engaging differently. His conclusion predicts six possible future implications and responses for mental health care chaplaincy in the United Kingdom, and like other authors in this issue, Peacock anticipates that the changing healthcare landscape will continue to be affected by this pandemic for many years to come (Peacock, 2020).

Ireland

The article by Michael Byrne and Daniel Nuzum highlights an innovative response by healthcare chaplains responsibly practicing social distancing, using virtual video-call technology by way of tablets and/or other mobile devices, and thus providing a sense of pastoral closeness for patients and staff without risking the health of patients or care givers. This response to the challenges of COVID-19 enabled pastoral ministry to continue, and to maintain connection and support between patients and their loved ones who could not be physically present. The use of technology also provided a valuable form of support for staff colleagues (Byrne & Nuzum, 2020).

Italy

Of considerable concern is the review by Katrina Bramstedt, which notes the tragic deaths of numerous Catholic priests across Italy. The data are quite heart-wrenching when one considers that priests were sincerely fulfilling their pastoral duties of providing support, counseling, guidance, and various rituals to care for others, only to contract the virus themselves and lose their lives, fundamentally demonstrating this to be an occupational hazard for the clergy. The tragic nature of this story reminds one of the calamitous effects of the "Black Death" (1665) on the clergy in Eyam, Derbyshire, England. Rather than flee their infected village, the clergy courageously administered various preventative measures to restrict infection, and continued providing ministry in modified ways, until they too died (Byrne, 2012). Bramstedt raises a number of ethical issues with respect to priests undertaking pastoral visits, anointing the sick, performing baptisms

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and the elderly age of priests carrying out such ministry during pandemics – and the need to consider alternative strategies (Bramstedt, 2020).

Netherlands

The article by Iris Wierstra, Gaby Jacobs, and Carmen Schuhmann highlights how some chaplains in the Netherlands have responded to COVID-19 and have already started to reflect on the lessons learned regarding chaplaincy. One very clear lesson is that while chaplaincy may so often be disregarded when life is "normal," the advent of a pandemic results in a rapid increase in the visibility, recognizability, and strengthening of the role of chaplains; however, it also places considerable strain on chaplaincy services and subsequently insufficient support for patients and staff, particularly given the fact that healthcare organizations have undervalued and underfunded chaplaincy services for decades (Wierstra, Jacobs, & Schuhmann, 2020).

New Zealand

Perhaps the most successful industrialized country in the world to deal with COVID-19 has been New Zealand. In summary, a World Health Organization report noted that New Zealand had the advantage of being a high-income island nation with an advanced public health system and a competent government that immediately implemented speedy testing, contact tracing, total isolation (both nationally and internationally), and strategic clinical case management, plus rigorously adhering to (scientifically based) public health guidance and effective public communication (WHO, 2020). New Zealand then turned to the care of other Pacific nation islands in its region. This included procuring supplies and providing training for health staff both within those countries and via remote support. Nevertheless, the immediate and total lockdown within New Zealand had a powerful effect on health services and chaplaincy. Amy Finiki and Kath Mclean, both "Spiritual Pastoral Therapists" (SPTs) at Porirua Hospital, Aotearoa, New Zealand, explain their quick and multi-talented response and creativity during total isolation. The authors provide examples of positive qualitative feedback from staff affirming the contribution of SPT support to hospital staff and assert that regular patient-clients seemed to become less demanding as spiritual care services increased and subsequently gained greater favor among both staff and management (Finiki & Mclean, 2020).

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Scotland

Finally, from Scotland, Sarah Giffen and Gordon Macdonald present an informative report for the Association of Chaplaincy in General Practice regarding spiritual care in England and Scotland during the COVID-19 pandemic thus far. This report will be of interest to the *HSCC* readership, as it describes the effect of the current pandemic on primary care chaplaincy and details the varied responses of GP chaplaincy to this situation. Giffen and Macdonald acknowledge that chaplaincy provision in primary care is a new but growing service, which offers a listening service and significant support for individuals in community settings. There is, however, much still to be learned from each other. Recording the impact of COVID-19 and reflecting on the varied responses and how chaplaincy might move forward is vital (Giffen & Macdonald, 2020). We suggest that this report should also be read along with Giffen's other work, "Why GPs refer to chaplaincy" (Giffen & Cowey, 2020).

Epilogue

Coinciding with the changes thrust upon us by COVID-19, there are a number of points to conclude this editorial that relate to changes affecting the *HSCC* Journal.

HSCC Transition

This is the first issue with Dr. Lindsay Carey as Editor-in-Chief, transitioning from Rev. Meg Burton, who was the Editor-in-Chief for five years and was acknowledged for her outstanding work by Co-Editor Rev. Dr. Chris Swift (Swift, 2020b). Meg will remain in post as a Co-Editor with *HSCC* for a short time. We also welcome a new *HSCC* Co-Editor, namely Dr. Piret Paal (Paracelsus Medizinische Privatuniversität, Austria). It is terrific to have her on board, assisting with the seemingly ever-increasing number of editorial duties.

HSCC Advance Access Online and *HSCC* Twitter

For the first time, and keeping in line with other contemporary healthcare journals, *HSCC* now has "advance access," allowing articles to be made available early – prior to the release of their allocated issue. Given the increase in articles being submitted to *HSCC*, "advance access" is already proving to be valuable, as it means that neither authors nor readers have to wait six months or longer to access publishable manuscripts. It also means

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that, given special circumstances, it is possible to publish resources more responsively when health and social dilemmas arise unexpectedly (e.g., COVID-19). Appreciation needs to be expressed to Tom Fryer from Sparks Publishing Services Ltd. for assisting Equinox in expediting articles to advance access. Another expediting service to note is the reactivation of the *HSCC* Twitter account, which we encourage you to "follow" at https://twitter.com/HSCCJournal (*HSCC*, 2020).

International Impact

You may have noticed that for this special COVID-19 issue a number of abstracts are translated into a language other than English. We wish to thank Jacinda Renae Carey (Spanish), Katrina Bramstedt (Italian), Dr. Joël Ceccaldi (French), and Friedrich van Scharrel (German) for their contributions to this issue. Whenever possible, authors will be encouraged to have their abstracts translated into a language other than English now that *HSCC* has become a journal with an international readership; so much so, in fact, that the Australian chaplaincy association, "Spiritual Care Australia," has now included *HSCC* as an optional bonus alongside its membership registration. We hope other chaplaincy associations follow suit.

Next Issue – Future Chaplaincy

It is planned that the next issue of *HSCC* (9(1)) will consider the future of chaplaincy with regard to the inclusion and role of non-religious spiritual carers (i.e., "secular chaplains," atheists, agnostics, humanists). This will be a challenging issue for the chaplaincy profession across many countries, and may be regarded by some as a betrayal of a long-standing and largely undervalued religious tradition stretching back centuries; a ministry which has proved its utility by continually providing a service in multiple ways (whether appreciated or not) to those of religious faith and to those who profess none (Carey, 2012 ; Swift et al., 2012). It will be important to listen to this perspective, which will no doubt raise considerable points of debate, responses, and rejoinders, but may indeed mark the "beginning of the end" for traditional chaplaincy, or indeed, eventually, perhaps no chaplaincy at all – only time will tell – but for now, let's await the next issue, or perhaps the next pandemic!

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