

## Hospital Chaplaincy during the Covid-19 Pandemic

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### Abstract:

The text deals with the experience of Czech hospital chaplains in 2020. Specifically, it concerns the period during the spring and autumn waves of the pandemic caused by the spread of the SARS-CoV-2 virus which leads to a viral disease known as covid-19. The article builds on data obtained through an online questionnaire and subsequent ten interviews with hospital chaplains. The results of the research are presented in four thematic blocks: chaplain and institutions, chaplain and staff, chaplain and patient, and the chaplain himself. Based on a qualitative analysis of the data, we conclude that the pandemic affected the self-concept of many chaplains. It mainly depended on their effectiveness, that is, the possibility of applying their skills, in the hospital during the pandemic. In many cases, the pandemic crisis has accelerated the development of relations with the institution and staff, for better or worse. The position of the chaplain in the hospital before the outbreak of the pandemic proved to be crucial. The work with patients themselves did not usually undergo a fundamental change; the chaplains often functioned here as a substitute for forbidden visits. At the end of the article, we present some practical recommendations resulting from our data.

**Keywords:** hospital chaplain, spiritual care, hospital, pandemic, covid-19

### Introduction

The article is the first attempt to capture the experience of Czech hospital chaplains in 2020, as this period was fundamentally marked by a new situation associated with the pandemic of the viral disease covid-19.<sup>1</sup> Our goal is to describe and interpret subjectively perceived changes (if any) in the role of chaplain during the spring and autumn waves of the pandemic. We also deal with the impact of the pandemic on the chaplain's work with patients and we try to identify potential problem areas or, conversely, sources of support for the chaplain's role. Although Czech spiritual care in hospitals began to develop under different names and in different ways from the second half of the 1990s and more systematically after 2000,<sup>2</sup> it has become more clearly structurally

1 For the sake of readability, we will use generic masculine as, for example, a 'chaplain' or 'patient' in the text, although we are talking about both men and women. The term 'Czech' means chaplains throughout the Czech Republic. In the text, we also talk about 'pandemic' and 'covid'. When using these terms, we refer to the mass spread of a viral disease known as covid-19 during 2020.

2 Cf. Jana MARYŠKOVÁ, 'Nemocniční kaplanství v poločase', *Caritas et veritas* 5/2015, pp. 12–15.

rooted only in recent years.<sup>3</sup> The current pandemic thus caught the Czech hospital chaplain in the institutionalisation phase pointing out some neuralgic points of this process. Especially, the level of acceptance of the hospital chaplain in the hospital and the willingness to really perceive him as part of the hospital team has become evident.

## Theoretical Basis

### The Pandemic from the Point of View of Social Sciences

The worldwide spread of the covid-19 viral disease and the measures associated with it are a new, unexpected, and unpleasant experience for today's modern society. Although it is only a year-old issue, it is already evident that the global dimension of the pandemic is rapidly and fundamentally changing human communities and individual lives. Many aspects of human existence – such as freedom of movement, social relations, or intimate closeness – are losing their position as a matter of course.<sup>4</sup> New circumstances generate widely experienced uncertainty, instability, fear, and anxiety. From a sociological point of view, a new type of virus has entered human lives as 'the other'. It is a sudden and inevitable companion that is dangerous and, moreover, invisible.<sup>5</sup>

In connection with the pandemic, social scientists point out the weakening of social ties. It is happening either because of forced isolation or because of voluntary separation, as every other person automatically becomes a risk.<sup>6</sup> The negative aspects of the pandemic, like other crisis situations, mainly affect social groups already weakened, isolated, and at risk of poverty. In this case, this is primarily the elderly.<sup>7</sup>

However, Steve Matthewman and Kate Huppertz also talk about the rise of altruism and social reciprocity. They see every social crisis as a publicly shared threat which creates solidarity and produces energy for positively motivated action as well.<sup>8</sup> In today's as well as hypothetical post-pandemic worlds, resilience and courage, but also compassion, hope, and empathy acquire new dimensions and meaning.<sup>9</sup>

At the same time, however, the fact that a pandemic places a disproportionate burden on the healthcare system around the world cannot be overlooked. According to Terry R. Bard, a pandemic is also a challenge. One should think about the value of human life and its meaning, both at the individual level and in the wider social context. In this context, Bard notices the growing interest in the spiritual dimension and health of man, both in the media space and in clinical practice.<sup>10</sup> But what does it all mean for the spiritual care providers in hospitals?

### Hospital Chaplaincy (Not Only) During the Pandemic

Not long ago, hospital chaplaincy and chaplaincy institutions in general began to receive more

3 Cf. Jiří Rajmund TRETERA, 'Vážná potřeba institucionalizované duchovní péče v lůžkových zdravotnických zařízeních. Úvaha na základě několika osobních zkušeností', in: *Církev a stát 2017*, ed. Jaroslav BENÁK, Brno: Masarykova univerzita, Právnická fakulta, 2017, pp. 9–17.

4 Cf. Steve MATTHEWMAN and Kate HUPPERTZ, 'A sociology of Covid-19', *Journal of Sociology* 4/2020, p. 675.

5 Cf. Raewyn CONNELL, 'COVID-19/Sociology', *Journal of Sociology* 4/2020, p. 746.

6 Cf. Paul R. WARD, 'A sociology of the Covid-19 pandemic: A commentary and research agenda for sociologists', *Journal of Sociology* 4/2020, p. 729.

7 MATTHEWMAN and HUPPERTZ, 'A sociology...', p. 677.

8 Ibid., p. 677.

9 Cf. WARD, 'A sociology...', p. 731.

10 Cf. Terry R. BARD, 'COVID-19 and a New Normal?', *Journal of Pastoral Care & Counseling* 4/2020, p. 81.

attention within the area of the social sciences. Studies from different parts of the world point out, above all, that the role of chaplain in the institution is something exceptional and different, but, at the same time, it is increasingly detached from traditional religious-institutional ties.<sup>11</sup> Thus, spiritual rather than religious care is sought, which is Christian, secular, and religiously pluralistic at the same time.<sup>12</sup> Even if a bit delayed, this search for a chaplainic identity (known from abroad) is present in the current institutionalisation of hospital chaplaincy in the Czech Republic. In short, it can be described as the tension between Christian (Church) pastoral care rooted in Christianity and human spiritual care in general. The latter, as Menke writes, ‘lies mainly in the area of human and existential accompaniment associated primarily with listening. The religious element is marginal.’<sup>13</sup>

After years of ambiguity, the institutional framework for the provision of spiritual care in health care facilities in the Czech Republic was set out in *Dohoda o duchovní péči ve zdravotnictví* (Agreement on Spiritual Care in Healthcare). It was concluded in 2019 between the Czech Republic (specifically the Ministry of Health), the Czech Bishops’ Conference, and the Ecumenical Council of Churches in the Czech Republic.<sup>14</sup> The text of the agreement defines spiritual care in health care as ‘a non-medical service to all patients, healthcare professionals, and inpatient facility visitors which addresses their personal, existential, spiritual, ethical, and moral issues and needs’. The text also states that ‘this service has a consistent non-evangelising character’. The agreement stipulates that spiritual health care may be provided by authorised persons only, i.e., by hospital chaplains. It sets out binding qualification requirements for this service, including, in particular, university theological education, completion of the Hospital Chaplain course, and authorisation given by the Church. Chaplains are sent to do their job by the Czech Bishops’ Conference and Ecumenical Council of the Churches in the Czech Republic. Important points also include the provision that ‘the chaplain provides spiritual care on the basis of a legal relationship (in particular labour law) with a health care provider’. Thus, the hospital chaplain is understood on the one hand as an ambassador of the Church(es), and as an employee of the hospital on the other hand. Hospital chaplains are part of a medical facility, and their external attributes often merge with the hospital environment. At the same time, though, they come to the hospitals on behalf of one of the registered Christian churches, with a different educational background (theological education), from another environment, and with different experience. However, this ambivalent relationship is not specific to the Czech Republic. It seems to be connected with hospital chaplaincy as such. McSherry et al. describe this ambivalent role of a chaplain as “‘in but not of’ the institution’.<sup>15</sup> Despite this significant institutional shift in the profession of hospital chaplain in the Czech Republic, the job is still looking for its face and identity. In some hospitals, chaplains are commonly accepted; in others, there is no awareness of them. Also, the scope and form of employment in

11 See, for example, Julia MARTÍNEZ-ARIÑO and Mar GRIERA, ‘Catholic Chaplains in Public Institutions: Contextual Opportunities and Institutional Inertia in Spanish Hospitals and Prisons’, *Journal of Religion in Europe* 2–3/2018, pp. 147–156. Also: Kees DE GROOT, ‘The Institutional Dynamics of Spiritual Care’, *Revista de Estudos da Religião* 1/2010, p. 27; Frances NORWOOD, ‘The Ambivalent Chaplain: Negotiating Structural and Ideological Difference on the Margins of Modern-Day Hospital Medicine’, *Medical Anthropology* 1/2006, p. 21.

12 Janet Betty ECCLES, ‘The Chaplaincy Experience: Negotiating (multi-faith) Time and Space in a Northern English General Hospital’, *Journal of Pastoral Care & Counseling* 3/2014, p. 1.

13 Monika MENKE, ‘Nadkonfesní rozměr služby nemocničních kaplanů v ČR’, in: *Církev a stát 2017*, ed. Jaroslav BENÁK, Brno: Masarykova univerzita, Právnická fakulta, 2017, p. 28.

14 © Portál poradních orgánů, pracovních skupin a odborných komisí Ministerstva zdravotnictví, (online), available at: <https://ppo.mzcr.cz/workGroup/65>, cited 2<sup>nd</sup> February 2021.

15 Wilfred McSHERRY, Adam BOUGHEY and Pater KEVERN, “Chaplains for Wellbeing” in Primary Care: A Qualitative Investigation of Their Perceived Impact for Patients’ Health and Wellbeing’, *Journal of Health Care Chaplaincy* 4/2016, p. 152.

the hospital vary. In some places, chaplains are full-time hospital staff, in others, chaplain teams are made up of people with a part-time job or with other work arrangements (contract for work, agreement on work activity). In some hospitals, chaplains operate without an employment relationship with a medical facility and are paid for by the church. For the hospital, they are, in fact, volunteers. For many chaplains, spiritual service in the hospital is a secondary activity in addition to their main occupation (e.g., in a church, education, social services, etc.). There is also a lack of a unified idea about the involvement of chaplains in multidisciplinary teams. The hospital chaplain is theoretically understood, on the basis of the bio-psycho-socio-spiritual paradigm, as an equal part of a multidisciplinary team. Unlike doctors, nurses, clinical psychologists, and health and social workers, though, the chaplain is not a healthcare professional. His actual involvement in the team with regard to, for example, the protection of patients' personal data is therefore complicated. The identity of the hospital chaplain ranges between the idea of a 'priest coming to the believers to provide them with the sacraments' and a 'volunteer who will help to fill the time spent in the hospital'. There is a lack of a clear understanding of who a hospital chaplain is, what he does, and what he may be good at.<sup>16</sup> This is related, among other things, to the high degree of secularisation of the Czech environment. Hospital chaplains enter such an environment while representing traditional religious beliefs (Christianity) and traditional religious institutions (Church). They also declare, though, that their ministry has a supra-religious and supra-denominational dimension and it is for 'patients of all faiths'.<sup>17</sup> Whether their role in the Czech hospital environment is accepted and whether the hospital chaplains themselves are able to offer their service clearly was also highlighted by the crisis situation caused by the ongoing pandemic.

The pandemic crisis directly calls for a new appreciation of the chaplain's role in health care facilities. However, published research on the situation of hospital chaplains during a pandemic is still minimal at this time. In one of the few professional essays on this topic published so far, the American chaplain Ann Riggs reflects on her own experience. Among other things, she perceives a shift in the demands of patients and families. She was used to dealing with feelings of frustration, fear, and sorrow. Now, she notes a demand for shorter and more formal prayers and liturgies. Her 'phone visits' are also appreciated by patients. At the same time, however, she mentions that, contrary to her expectations, the staff use her services very little. They are not interested even though (or precisely because) they are facing increased tension and chaos.<sup>18</sup>

The website of the European Research Institute for Chaplains in Healthcare (ERICH) offers one way to look at this topic at the moment. Among other things, it functions as a signpost for the national websites of hospital chaplain associations and reveals a wide portfolio of issues that are addressed across the states in the field of hospital spiritual care. ERICH also published on its website the preliminary results of its study. The aim of the study was to find out how hospital chaplains manage to provide spiritual care during a pandemic and to identify key changes in their usual practice.<sup>19</sup> The online questionnaire asked about current working conditions and their

16 Cf. © Bohumila BAŠTECKÁ, Ondřej DOSKOČIL and Hana JANEČKOVÁ, 'Nemocniční kaplan-ka: Kdo to je, co dělá a s čím může pomoci', *Sociální práce / Sociálna práca* 3/2020 (online), page numbers not given. available at: <https://socialniproce.cz/nemocnicni-kaplan-ka-kdo-to-je-co-dela-a-s-cim-muze-pomoci/>, cited 2<sup>nd</sup> February 2021.

17 © Asociace nemocničních kaplanů, (online), available at: <https://www.nemocnicnikaplan.cz/>, cited 2<sup>nd</sup> February 2021.

18 Ann K. RIGGS, 'The COVID-19 Context Calls for a Broader Range of Healthcare Chaplaincy Models: An Exploratory Translational Study Utilizing Evolutionary Psychology and Social Neuroscience Loneliness Research', *Journal of Pastoral Care & Counseling* 4/2020, p. 259.

19 © European Research Institute for Chaplains in Healthcare, 'International Survey of Chaplain Activity and Experience during Covid-19 Pandemic', (online), available at: <https://www.pastoralezorg.be/page/international-survey-covid-19/>, cited 2<sup>nd</sup> February 2021. An article summarising this research should be published in the first half of 2021 in the *Journal of Pastoral Care & Counseling*.

change over the past year. In total, researchers received 1,657 responses from around the world. Among the results collected are the most interesting findings: (1) the greatest decline in the clarity of the chaplain's role occurred during March 2020, (2) in general, chaplains had relatively little access to patients (less than 10% of them were able to see covid patients), and (3) chaplains were most annoyed by the separation of family members from the dying and also the lack of protective equipment. The findings from the qualitative part of the questionnaire were expressed in the following spirit: 'Although we say that chaplains are integral team members, chaplains were not part of the discussions about both COVID and non-COVID patient care management at the outset. The attitude of leadership and nursing seemed to be that EVERYONE besides doctors and nurses would spread COVID, so everyone besides doctors and nurses must be excluded from encountering COVID patients.'

The preliminary conclusions of the ERICH survey presented here served as inspiration for our own research. Its results are presented in this text. The summary of the results from the ERICH questionnaire allowed us, above all, the initial categorisation of our own questions. Last but not least, we were interested in how, that is, to what extent, the Czech experience will differ or resemble the international one.

## Methodology, Research Set, and Data Collection

The research is based on a qualitative research strategy. A self-designed questionnaire with mostly open-ended questions and subsequent supplementary semi-controlled interviews were used (see below).

Our research set included providers of spiritual care in Czech and Moravian hospitals who are members of the Association of Hospital Chaplains and the Catholic Association of Hospital Chaplains in the Czech Republic and expressed interest in participating in this survey. They are official providers of spiritual care in health care facilities, although they do not always meet all of the criteria defined for the designation 'hospital chaplain' in the 2019 Agreement on Spiritual Care in Health Care (Dohoda o duchovní péči ve zdravotnictví in Czech). However, for the sake of clarity, we use the term hospital chaplain in the whole text as the collective designation for all types of official providers of spiritual care in hospitals. The first author himself works as a hospital chaplain and did not participate in the research as a respondent.

For the purposes of the survey, we constructed the questions which were inspired by the ERICH survey and were based on our own experience and our previous partial research and studies.<sup>20</sup> Four main thematic areas were identified: (1) the chaplain and his institution, (2) the chaplain and his patients, (3) the chaplain among the staff, and (4) the chaplain himself. We were mainly interested in the change observed in these individual areas during the spring / first wave (March – May 2020) and the autumn / second wave of the epidemic (from October 2020 until now – possibly with recognition of a third wave from December 2020 to January 2021). However, like our respondents and readers, we are aware of the fact that the situation is constantly evolving and cannot be considered closed. Therefore, we primarily focus on 2020 as an unprecedented and dramatically unfolding time period.

20 Cf., for example, BAŠTECKÁ, DOSKOČIL and JANEČKOVÁ, 'Nemocniční kaplan-ka...'; and also Andrea BELÁŇOVÁ, 'Byt kaplanem v Česku: Zdroje nejistoty a nacházení opory', *Český lid* 1/2018, pp. 25–43.

Data collection took place in two steps. In the first step, we created an online questionnaire with open-ended questions. In the second step, we contacted those who were interested and offered them the possibility of an online interview. The data obtained by both methods were processed together and form the basis for this text.

The anonymous questionnaire was created and distributed in online form only. In the first part, we found out the gender (options: man / woman / I do not want to state it), the length of the chaplain's practice in years, church affiliation, the size of hospital (approximate number of beds), the form and extent of employment relationship with the hospital, and the location of the hospital (options: Prague / regional town / district town / other place).

In the second part, it was possible to write freely formulated answers to the following questions:

- 1) Please describe how these elements (your position in the hospital, the organisation of your work, the scope of the service, the place of operation, etc.) changed during 2020.
- 2) Please describe whether and how your work with patients changed, e.g., patient typology, forms, and intensity of contact, etc.
- 3) Please describe if and how your position in the hospital team and cooperation with the medical staff changed.
- 4) Please describe if and how you felt changes with regard to yourself, e.g., new emotions, level of self-confidence, and identification with the role of chaplain, etc.
- 5) Here you can list anything that you may relate to the topic of Chaplains and Covid-19 for which you did not find space in the above questions.

Considering questions 1–4, we were also interested in whether and how the respondents felt the difference compared to the time before the covid-19 pandemic and whether they noticed a difference between the first and second waves of the disease (spring and autumn 2020).

The questionnaire was disseminated through the personnel networks of the Catholic Association of Hospital Chaplains in the Czech Republic (KANK) and the Association of Hospital Chaplains (ANK) and reached all members of these professional organisations. Distribution took place at the end of December 2020 and the beginning of January 2021 (23 days in total).

In total, we received 39 responses from 20 women and 18 men. One of the respondents chose the answer 'I do not want to state it'. The average experience was approximately six years, ranging from 1 to 17 years. Three years of experience was the most common case. The church affiliation of the chaplains was as follows: 21 respondents, the most, stated their affiliation with the Roman Catholic Church. There was also the Czech Brethren Evangelical Church (eight respondents), the Seventh-day Adventist Church (five respondents), the Czechoslovak Hussite Church (two respondents), the Brethren Church (one respondent), the Greek Catholic Church (one respondent), and the Silesian Evangelical Church (one respondent).

The size of the hospital where the chaplains worked was 530 beds on average, ranging from 70 to 2,200 beds. A total of 15 chaplains from the research sample worked in a hospital in a regional city, 13 in a district city, 7 in Prague, and 4 of them stated another place. The form of employment relationship with the hospital varied greatly in our research group. It varied from an employment relationship with the church, where the chaplain acted de facto as a volunteer in relation to the hospital, to a full-time job in the hospital. It was usually a contract for work, respectively an agreement on work activity combined with another main job.

Respondents had the opportunity to leave contact details and to complete a questionnaire with

an interview with one of the researchers. This opportunity was used by 16 respondents. All of these were contacted and asked for an interview. A total of 10 semi-structured interviews were conducted in the online environment. The interviews lasted 60 minutes on average. Most of them were recorded on the basis of the consent of the respondents. During the interviews, the researchers tried to develop the topics listed in the questionnaire and also to create an overall personal reflection of the past year in relation to the chaplaincy profession. Notes from the interview were recorded. Later, they were included in the corpus of data obtained by the questionnaire. The data were processed according to the principles of qualitative analysis. Both authors performed open coding at the same time. Then they compared their results and consulted it repeatedly.

An important aspect of this work for us is the anonymisation of respondents. For this reason, nowhere, except in this chapter, do we provide information about the municipality or region, the gender of the respondents, or the specific church affiliation. We believe that this data is not key with regard to our topic and we try to prevent the possibility of identifying a specific chaplain in this way. As already mentioned, this is also the reason why we choose the generic masculine for all participating chaplains in the text. An exception to this rule [editor's note: this is pertinent to the Czech version of this article] is the direct illustrative quotations of the participating respondents, where the preservation of masculine and feminine grammatical forms is preferred in order to preserve the authenticity of the statements. Given the comparable number of men and women involved, and when omitting all other identifying information, we do not consider this an issue considering their anonymity. The correction of typos and the adjustment of wording that could lead to the identification of respondents are the only interventions that are made in their statements; otherwise, they are transcribed completely authentically, including quotation marks, etc. The following section summarises the main findings from both parts of the research. In each pre-defined area, the most strongly represented topics are elaborated, both with regard to their frequency in the questionnaire and the issues accentuated during the interviews. We use italics to indicate key terms (codes) to which respondents' answers can be assigned.

We also try to distinguish between the spring and autumn waves if the data correspond. Considering the questionnaire, individual respondents are marked with the abbreviation HC (hospital chaplain) and numbers 1–39 according to the order of answers in the table. Direct quotations from personal interviews are then marked HC-I (hospital chaplain – interview) and numbers 1–10.

## Results

### **The Chaplain and the Institution: 'People Know More about Our Service'**

Even before the start of data collection, we defined the relationship between the chaplain and the institution as the first significant topic based on previous experience and research. All respondents answered the question, and we summarise and interpret their answers in the following paragraphs.

Considering hospitals, the pandemic brought, first and foremost, changes in the organisation, both in relation to the operation of the institution and in terms of the division of labour. Especially during the first wave, fear or even panic prevailed in hospitals, and procedures were devised ad hoc. If the chaplains stated any change (seven respondents stated that there was no change), it was new restrictions. Many hospitals chose the simplest way to deal with it and banned chaplains from being present. In some cases, it was an absolute ban coming from the management ('The

hospital management rejected my services at the Easter period and beyond due to a ban on visits, HC21). Hospitals chose the approach of ‘cancelling or closing of the unnecessary’. This made the chaplains feel bitter: ‘it is said that man is body-mind-soul, but, suddenly, it was not important in this situation, it was just a theory’ (HC16-I).

In other hospitals, the access was restricted. The exception was patients in the terminal stage, the ‘on-call’ procedure (typically, it was the sacrament of anointing the sick mediated by a Catholic priest), or the chaplain was admitted to selected wards only. In general, these restrictions brought a certain limit to the chaplain’s free movement around the hospital (to which he might have been accustomed), and greater dependence on communication with management and staff, which was reflected in their relationship (see next chapter). However, this new setting can also have its advantages from the chaplain’s point of view: ‘I often have to contact the management about what I can or cannot do. This way, I can be more visible. I think it benefits spiritual service’ (HC24).

An interesting aspect of these restrictions was the narrowing of the spiritual services to sacramental acts and the emphasis on the Roman Catholic conception of chaplaincy. As mentioned above, some hospitals allowed patients to see the chaplain when they were terminally ill only. This axiomatic connection of the chaplain with the theme of *death and dying* is another recurring theme in the questionnaire and in the interviews. We will touch on it later in the subchapter Chaplain and the Patient. The topic of service in covid wards is also related to dying. While some chaplains were banned from visiting covid patients throughout the year (typically: ‘the chaplain is probably someone extra there, perhaps in terms of hygiene and constant dressing’, HC31-I), others could come at the patient’s request. Here, too, the chaplain’s relationship with the institution before the pandemic seems to play a role.

In the new, ‘pandemic’ regime, the relationship that the chaplain had already established with the institution became more pronounced, both in terms of labour law and at the level of personal conduct. Non-contracted chaplains found themselves in a generally worse situation. In the words of one chaplain, they often ‘do not even have their own slippers in the hospital’ (HC1-I). Behind this image lies the message that the hospital often overlooks or does not address the chaplain’s need for his own space (even if it was just a small locker for storing personal belongings or the possibility of using a changing room). The pandemic then, in some cases, took this impediment to the extreme (see a complete ban on visiting); but it certainly does not apply to all chaplains universally. On the contrary: some chaplains took advantage of the supportive relationship with the hospital and during the pandemic had the opportunity to enjoy certain benefits that were reserved for medical staff. It was either the acquisition of a specific status which allowed the chaplain to enter an otherwise closed department (methodological instructions, inclusion in the team), or to access the insufficient protective equipment, financial bonus for work in the covid department, or the possibility of free testing and vaccination. Chaplains value such gestures very much, as they have a symbolic meaning for them. It is a kind of recognition of their role by the institution.

The change in the organisation of work went hand in hand with *the change in the content of the chaplain’s activities*. Some chaplains mentioned new features which had been added to their portfolio of activities – mostly the kind of activities which could help overworked staff and bring some relief. For example, it could be accompanying patients to the examination rooms, helping with cleaning and storing material, or even organising babysitting (of children of medical staff).

*The difference between the waves* was relatively significant in the case of the relationship with the institution. Spring restrictions and fears were mostly replaced by autumn friendliness to the chaplain and the search for his services (for example, ‘In the first wave, we were getting to know



each other. In the second one, I was already a full member of the team,' HC3; or 'In the spring, chaplains were among the first to be dismissed as unnecessary. In the autumn, it was different. Especially in case of the pressure on patients without visits, the work of the chaplains was perceived as important. It was also important that, as chaplains, we walked among covid patients. We took risks just like the others,' HC16). Spring restrictions were often lifted in the autumn. For example, the chaplains' regular visits were renewed. Many chaplains stated that they were more visible during the second wave ('People know more about our ministry,' HC17), and interest in their ministry was greater: 'I could not do my work for a while during the spring. During the autumn, though, there was more interest in our work, even in the time of covid' (HC35). It should be added that eight respondents stated that they did not feel any change.

In some cases, it may have helped that the chaplains suffered from covid themselves and, after their recovery, they were no longer a threat to patients: 'During the first wave, they originally did not want to let me go anywhere in the hospital. After a negative test result, though, they allowed me to visit one ward. There is less of a concern during the second wave. It is also due to the fact that I have suffered from this disease already' (HC26). At the same time, however, the second wave, although assessed as more organised and based on experience, is also perceived as having been more exhausting for the entire hospital, which also affects the chaplain: 'I still feel certain limitations in my work. I get it. There is nervousness in the workplace, and paramedics are exhausted. Everything is in motion, the situation changes almost from day to day' (HC26).

### **The Chaplain and his Patients: 'Less of Being There and More Telephoning'**

We named another research area as the Chaplain and Patients. We are trying to capture in it the fact whether and how the work of chaplains with patients has changed as a result of the pandemic, for example, typology of patients, forms of contacts, intensity of contacts, etc.

A topic that appeared explicitly or implicitly in the responses of almost all participants in our survey was the *ban on visits or restricted visiting*. This was a decisive factor not only in terms of the organisation of work and the chaplain's relationship with the hospital, but also in the process of searching for new forms of contact with patients. It was a completely unusual situation for hospital chaplains, because they were deprived of the basic tool of their service, that is, their physical presence at the patient's bedside. The prohibition or restriction of visits of relatives and close patients is encountered by hospital chaplains during annual flu epidemics, but their service is usually not significantly affected by that, and they continue to perform their activities in the normal way. In the current pandemic, however, the ban on visits or restricted visiting affected (mostly in the first wave) almost all hospital chaplains in our research group, regardless of the length of their work in the hospital or the form of employment relationship with it. The ban on visits thus significantly reduced the number of patients to whom spiritual care was provided. At the same time, respondents often stated that the visit ban was not applied to the provision of spiritual care to *dying patients*. The image of a hospital chaplain as someone whose inherent competence is to accompany people at the end of life comes into play: 'Visits to patients were considered other visits, i.e., forbidden. Exceptions were patients in the terminal stage of the disease or patients who requested a visit of the chaplain through a doctor' (HC2). Paradoxically, in some hospitals, they only allowed a Catholic priest to visit dying patients, although he is de jure in the role of a visitor coming to the medical facility, while the hospital chaplain, who is a hospital employee, did not have access. This reflects the Catholic emphasis on the need for the sacramental provision of the patient (the anointing of the sick), which cannot be provided by a chaplain who is not a priest. On

the other hand, the chaplain is obliged to arrange a visit of a clergyman at the patient's request: 'Mediation of the visit of the priest was always possible if the administration of the sacrament of the anointing of the sick was concerned' (HC15). 'During the first state of emergency in March, the ban on entry was also applied to me as a hospital chaplain – a woman. The priest could continue to visit patients but only those in the terminal stage... Some departments do not let me go there even now. Of course, they let the priest in if he is visiting dying patients' (HC29). It is remarkable how naturally some Catholic hospital chaplains accept the limitations of their activities, and, at the same time, they perceive the presence of priests as necessary. If during the pandemic in some hospitals the only permitted spiritual care was a priest's visit to the dying, it is understandable that the presence of a hospital chaplain can sometimes be prejudiced as a harbinger of imminent death. Therefore, it is not required or is even rejected by non-religious patients. This happens despite the fact that hospital chaplains are often lay people who, paradoxically, may be better accepted by non-religious patients than hospital chaplains from the clergy.

Chaplains who were allowed to visit patients even during the pandemic also saw their service as a *substitute for forbidden visits* of loved ones or volunteers: 'Patients were very saddened by isolation and separation from their loved ones. They suffered emotionally. Some were grateful for conversations with me and the nurses, with anyone' (HC31).

At the same time, some chaplains from our group stated that the *intensity of contacts* with patients increased during the pandemic. However, some perceived intensity as a higher number of interventions in patients, while others perceived it as a greater intensity of the relationships: 'Certainly, the intensity of contacts increased in comparison to the pre-covid period and the spring. Before Christmas, I went to see some people every day. This can, of course, be largely attributed to the ban on hospital visits or their restriction' (HC26). 'My work has not changed much in terms of the programme. On the other hand, in terms of the intensity of the relationship considering patients in hospitals and clients in homes, it has changed. Relationships have become warmer and, in homes, even more anticipated' (HC6).

The most significant change in the service of hospital chaplains was brought about by the very emergence of a new category of *covid patient*. Even in the existing discourse, hospital chaplains have used different designations for certain categories of patients requiring a specific approach, such as a geriatric patient or an oncology patient, but categorising patients by type of disease has never played such a role for hospital chaplains as in this situation. In the community of hospital chaplains, two groups were formed soon, namely those who are allowed to provide care in the *covid wards* and those who were denied access to these wards. This was also the most frequently described change between the first and second waves of the pandemic in the group of hospital chaplains who we examined: 'In the autumn of 2020, it was also possible to visit patients in covid wards' (HC1). 'It was not clear if they would let us to see covid patients. This was no longer the case with the second wave and everything was fine' (HC10). 'The second wave is completely different, they let me into any covid department without any problems' (HC32). However, there were also hospital chaplains who were not allowed to visit covid patients even during the second wave of the pandemic, despite the fact that they were hospital staff, and, until that time, they had not yet encountered such restrictions, that is, a ban on visits to certain patients or no access to certain wards. In any case, the covid patient appears here as a new type of patient and a symbolic dividing line between different categories of staff.

Service regarding covid patients changed the habits of many chaplains. Visits are shorter, more intense, and contact is limited by protective equipment ('spacesuits'). It is often a one-time contact:

‘The difference is with covid patients. It is about the frequency of visits (we often manage only one), the atmosphere of the visit, and of course the conditions for the visit. If a patient perceives the severity of his condition, conversations with him tend to be very intense’ (HC39).

In many cases, the pandemic also changed the *typology of patients* with whom the chaplains came into contact. While in the pre-pandemic period these were predominantly long-term sick patients (a typical hospital ward for chaplains is the aftercare ward), some chaplains noted a greater share of their work in seriously ill and dying patients. This was connected to their greater involvement in caring for patients in the second wave: ‘The nature of the work is completely different from the time before covid’ (HC13). ‘During the second wave, the composition of patients shifted even more significantly towards patients in a serious condition with a poor prognosis’ (HC30). ‘During the pandemic, there were acute patients, patients with more serious diagnoses who required much more time and energy’ (HC34).

In connection with the care of covid patients (but not exclusively), the topic of *protective aids* appears with a high frequency. On the one hand, they are presented as possible causes of the restriction of spiritual service in their initial shortage in the spring, and, on the other hand, they represent a new distinctive feature of the chaplain’s affiliation with the institution. Protective aids thus become a means which enables one to visit covid patients, but, at the same time, hospital chaplains perceive them as a *communication barrier* between him and the patients or a source of *physical discomfort* or *time limitation* of the visit: ‘I do not want to give any time limits, but after all, there is a bit of a pressure. I know that this suit costs around two thousand crowns, so I try to see more patients. It would seem silly to me to see only one of them and then throw it all away again. So I try not to prolong the conversations’ (HC17-I).

In addition to protective equipment, other material elements entered the work of the hospital chaplain. Due to the limited visits, some chaplains chose *new forms of contact*. It was especially the use of modern communication technologies which had not yet played such a role in the chaplain’s activities. In most cases, respondents mentioned *telephone calls* with patients or arranging phone calls or video calls of patients with their loved ones: ‘I tried to pay more attention to staff and outpatients and to set up the provision of spiritual services via social networks and the telephone’ (HC4).

Participants in the survey also record other changes in the *topics of conversations* with patients. They note the greater thematisation of suffering, dying, and death in interviews with patients and staff. Some mention the growing religious needs of patients, others the higher presence of existential and spiritual topics in interviews: ‘The form of the conversation changed – people felt more insecure and afraid of the future. I felt the difference compared to the time before the pandemic’ (NK29). ‘I think the pandemic has intensified awareness of the fragility of human life, the value of interpersonal relationships and encounters. Interviews are shifting from hospitalisation to topics that concern the patient’s values and spiritual resources’ (HC38).

Chaplains also mention the impact of the pandemic on *patients’ mental state*. They notice social isolation, loneliness, insecurity, fatigue, lack of information and fear: ‘People are already exhausted and tired and staff, of course, too. I see the greatest damage to people’s psyche. Many elders have died in serious conditions with covid, but many have not – people are now very afraid. They have inaccurate and biased information and their psyche suffers terribly’ (HC5).

### **The Chaplain among the Staff: ‘Soft Indications That They Do Me a Favour’**

We consider the topic of the chaplain’s relationship with the medical staff to be equal in importance.

According to the work agreements in the hospital, which apply also to the chaplain, his service is intended not only for patients and their loved ones, but also for medical staff. The idea then arises that, in times of pandemic crisis, this activity will become more important. Therefore, we were very interested in how the chaplains themselves perceived a possible change in the relationship with staff during both waves of 2020.

The responses to this question were basically of two kinds. The nature of the response largely depended on the way in which the hospital responded to the pandemic, how much space it gave to the chaplain, and how it defined the chaplain's position in the organisation. According to the chaplains, in cases where the chaplain's service was fundamentally limited or completely stopped, the *staff became estranged*, for example, 'Before the pandemic, I established contact with several employees. It was then interrupted by the pandemic' (HC37). The pandemic as such disrupted the coherence between the staff, and the chaplain perceived 'greater isolation of the staff from each other due to measures. In the hospital, there was less communication, more work, more nervousness' (HC27). In these cases, the chaplain was perceived primarily as a potential source of infection and thus a risk that was better to eliminate. A total ban on the chaplain's attendance was easier for hospitals where his position was perceived as marginal. This approach was more frequent during the first wave: 'During the first wave, the nurses explicitly asked me not to go to the sick if I did not have to. (I suppose their motivation was fear and my position as "the outsider" in the team)' (CH22).

One of the hospital chaplains stated that his own illness was also affected by relations with the other staff members. Although there were several employees in the hospital who became ill with covid, he was perceived as the one who had spread the infection across the hospital, even though he was demonstrably infected in the hospital. The specific and unique position of the hospital chaplain thus proved to be a suitable target for gossip. At the same time, it is obvious that the activities of the hospital chaplain are monitored by other employees: 'It was an annoying rumour that I spread covid across the ward. I heard that from many sides in the hospital, so the rumour was quite widespread. No one, though, told me that to my face. (...) If an ambulance driver neglects something, it is just an ambulance driver. There are several hundred of them. But the chaplain is the only one here' (HC7-I).

The questionnaire also shows that in hospitals which, at some stage of the pandemic, tended to support or request the chaplain's service, the topic of *intensified cooperation* with staff appeared in most responses. It was primarily a matter of increasing the frequency of meetings and mutual communication with staff and management. Secondly, it was about a greater need to negotiate one's own role and its importance. According to the respondents, this change had an effect on improving relationships rather than the other way around. In general, chaplains felt that by increasing the intensity of cooperation, teams became more cohesive and individuals more mutually supportive: 'Somehow we stick together more now – there is a wave of solidarity among us. I think it is also due to the fact that I am in the hospital more often helping with the issue of hospitalism, etc.' (HC10).

A subjectively perceived improvement in relations with staff was described by respondents in various terms. Among the subtler nuances was the fact that the staff began to recognise the chaplain (for example, in the hallway they knew that it was the chaplain they had just met, which was not common in the past). The most frequent terms were greater *openness*, *closeness*, and *helpfulness*, which were mostly related to the topic of *sharing* in the comments. Some even felt that they 'can support the staff' (HC13). However, respondents do not state the specific form of this support.

Another answer stated religious support: 'We especially say the Mass and pray for the staff at this time' (HC25). In relation to other answers, we believe that during the pandemic crisis, staff have a greater need to talk about their personal and work problems, complain about fatigue, or – a new element for chaplains – show interest in the chaplain's personal views: 'The staff have become much more communicative. They also started turning to me with personal problems and stories. They cared much more about my observations' (HC12) 'There is a need to talk to someone else, to learn something (for example, my opinion on a specific situation, how I experience it as a believer, whether I am afraid)' (HC6). The need for more frequent interaction with the chaplain allows this type of communication to develop. At the same time, however, it turns out that this is a very careful and random sharing of thoughts. The shift is intuitive and fragile, expressed more by the impressions indicated during the talks at the level of individuals. Caution in evaluating the transformation is evident, for example, in the following selected citations.

'The hospital team somehow subconsciously understands the presence of the chaplain in the workplace and grasps it in their own way' (HC12).

'It seems to me that in the context of pandemic pressure on the psyche and the performance of staff, cooperation has deepened in most cases. Staff now appreciate chaplain interventions as supportive considering patients and the work of health professionals' (HC38).

'And I can observe over a longer period of time even subtle clues here and there that I am being somewhat accepted. That others, even non-Christian paramedics, are beginning to acknowledge that I also belong to the department where they work. Or at least they come to terms with it' (HC23).

Being reconciled with the existence of a chaplain is a relatively strong expression which, however, can authentically reflect on the currently experienced relationship with the staff. Acceptance of the chaplain's position during the pandemic may have intensified to some extent, but it still has its relatively clearly defined limits, related to the difficult tasks of the chaplain's work: 'I still feel that my "just talking" to patients is a completely useless activity for most paramedics and for most nurses ... and if I pray with patients, it "no longer makes sense" to them' (HC31). Several chaplains in our questionnaire shared this experience with the feeling that the spiritual ministry is subordinate to the health service for the staff: 'indirect indications that their work is primarily important and mine is just secondary... I do not take it personally, though, it makes me sad' (HC27). In any case, the pandemic highlighted the role of the chaplain and, figuratively speaking, forced the staff to respond to the chaplain more than in previous periods. In the words of one chaplain: 'it has become more polarised who values my spiritual support and who does not' (HC22).

Some uncertainty in estimating one's own position and its shift during a pandemic is closely related to the topic of *teamwork*. Our questionnaire directly targeted this issue using the phrase 'Your position in the hospital team'. The respondents responded to it abundantly. The fact is – as we indicate above – that the newly experienced increased helpfulness and willingness of the staff does not necessarily mean that the chaplain has become an integral part of the medical team and that he feels that way: 'Every visit begins with checking in. I have to see the senior staff nurse. There is helpfulness, but I still do not feel that I would be considered part of the hospital team' (HC2). 'I am definitely not part of the team' (HC1-I). 'I am not even slightly a member of a multidisciplinary team' (HC23). Being part of a team and an adviser is a certain ideal of hospital chaplaincy. For many respondents, the mere fact that a change has taken place is a significant matter, as it means that they can approach this ideal slightly: 'We are more perceived as part of a team caring for the needs of patients. In the past, we were more perceived as something like better volunteers'

(HC16). It must be emphasised that, again, it is mainly a shift at the level of personal perception than objective changes in the situation (e.g., increase in workload, official inclusion in the team, etc.). Apparently, the hospital chaplain feels a part of the team when he experiences that his role is taken seriously by the medical staff.

But in several cases, the new situation really meant joining the team in a form which the chaplain would probably expect: 'I offered my help and became part of the team for 5 weeks (second wave) – 24-hour service on the phone (...) I was in the team, on the same boat. For many, prejudices against hospital chaplain have subsided' (HC15). For some respondents, the 2020 work year was therefore a crucial stage. They were able to change the opinion of others, starting with the vague suspicion associated with the chaplain and finishing with understanding and appreciation: 'Everyone watched whether my work was worth it at all. Later, there was an evaluation appreciating the importance of the chaplain's work' (HC3). In these cases, the catalyst for change was considered to be mainly the practical involvement of the chaplain in care ('the chaplain must not be afraid to get his hands dirty', HC12-I), such as his presence in a demanding covid unit. This made it possible to present the chaplain's own role in a new, clearer light to the staff. However, the cases of these respondents indicated that the chaplains had already built up a strong position within the hospital before the pandemic, or at least had been supported by the management or staff. Thus, their position was strengthened rather than reshaped by the pandemic. In other words, not all chaplains perceived their position before the pandemic as marginal and precarious, and therefore as requiring gentle actions.

If we were to summarise the difference between the waves, the spring / first wave was perceived as a situation filled with fear of the unknown state and the infection itself. According to chaplains, the staff was perceived as more vigilant and stricter when following the rules. During the autumn / second wave, the chaplains felt that the staff was more exhausted and traumatised from the more frequent deaths of patients, but, at the same time, they were more willing to let the chaplains visit 'covid' cases. In relation to the chaplain's own role, there was generally an assessment describing the second wave that was clearer for the chaplain and, in terms of the relationship with the staff, somewhat pleasant, for example: 'Within the team and the hospital, I was able to establish more intensive cooperation and make many friendships. It took place during the first wave but more significantly during the second wave' (HC15). 'It simply changed in the autumn. I was approached more often by doctors. They needed a consultation about a patient or requested the support for a patient' (HC16). Chaplains frequently noticed that they were actively approached by the staff in the autumn, it was more common.

However, it must be said that some perceived *no change during the period of the pandemic*, and these cases were not exceptional in the questionnaire. Specifically, six respondents commented on the situation in this way, for example, 'I do not feel that my position in the hospital team has changed. I am still a lonely soldier on the battlefield' (HC7). 'There has been no change in my position within the team. Besides technical and organisational differences, there has been no change with patients' (HC19). Sometimes a change was attributed to a different matter: 'The longer the chaplain and the hospital work together, the deeper the collaboration is. I would not say that covid has had such an effect on it' (HC5). 'It is too early to assess the full impact of covid on my role' (HC14-I).

In summary, it seems as if the chaplain perceived himself to a large extent through the eyes of the staff. From the principle of the vocation in the area of pastoral care, the chaplain is, in many ways, dependent on his empathetic recognising of various cues given by other employees. Due

to the context of the ‘hospital at the time of the pandemic’, these verbal and non-verbal cues can be exchanged more or less on the go (‘have a chat’, as expressed by HC36) or, for example, while having a quick coffee in the nurse’s office. In principle, however, the chaplain’s position before the pandemic is crucial for evaluating the development of the relationship with other medical staff. Or in other words: ‘I understand that the situation can happen again at any time if my position is not anchored in an employment relationship’ (HC21).

### **The Chaplain Himself – ‘Work Makes More Sense to Me Now’**

In the final chapter summarising the results of our research, we will focus on the question of how hospital chaplains perceived themselves, their emotions, their level of confidence, and identification with their role during the pandemic.

The answer to the question describing this area shows that the evaluation of oneself and one’s experience during the pandemic was more difficult for most hospital chaplains than the description of the previous three areas. Some of the confessions were rather evasive. The respondents were trying to return to the previous topics – they re-evaluated their position in the institution, their relationship with patients, and their role in the team. Four chaplains from our group explicitly stated that they did not feel any change in themselves: ‘There was almost none, because I like being with people and among people, whether they are healthy or sick or old. I feel for them and I love them. That is all’ (HC6).

Like other health care workers, hospital chaplains do not seem to be very accustomed to formalised mechanisms of self-knowledge and professional growth, such as supervision which has only appeared twice in interviews: once as a used and appreciated option (‘I went to supervision regularly, which also kept me going’ HC36), and once as a need (‘During the second wave, I realised the need for supervision of my work’ HC39). The absence of this topic in the question and the experience of one’s identity, trust, and processing of emotions in stressful situations points to the fact that, in contrast to the proclaimed facts, supervision is still an underused tool, especially in stressful situations in the profession of hospital chaplains.

If the chaplains felt any changes in themselves, they perceived them primarily as *a stronger and more positive identification with their role*. As we have pointed out above, this identification with the role is directly related to the acceptance of the hospital chaplain by the medical staff and his institutional anchoring in the hospital. The self-assessment of hospital chaplains is thus linked to their perception of institutions and staff: ‘On the contrary, I think my identity has strengthened – also because the staff themselves often turn to us’ (HC10). ‘The nurse providing testing, who I did not recognise because of the protective clothing, welcomed me: It is you, our hospital chaplain! This has not happened to me before. It pleased and encouraged me’ (HC1).

Some respondents stated that the pandemic period made them *search more intensively and find their place* in an unknown situation: ‘It went from getting oneself oriented in a new situation, through finding their foundation and role, to coordinated cooperation with medical staff, local churches, and regional press’ (HC34). ‘Gradually, I began to understand that my role was supportive. I must not panic, but I have to bring peace and support. I have to repeat often that we can do it together’ (HC12). Respondents then derived the feeling of *increasing self-confidence* from finding this role and perceiving its meaningfulness and necessity: ‘The covid pandemic forces me to move around the hospital more boldly and with greater self-confidence. The current situation forces me to distinguish more sharply what is really important in my work as a chaplain and what is in second or third place. The difference between the first and second waves can be expressed by

the terms “fears – overcoming fears” (HC26). ‘It helps my self-confidence, I feel that I am needed more than before’ (HC35).

However, the new situation has led some chaplains to the exact opposite – to *doubts* about the meaningfulness of their service or to feelings of their own futility. These occurred mainly in chaplains who were prevented from contacting patients or who felt that their role was perceived as secondary and unnecessary: ‘I had some doubts about my work, its quality, its importance for the sick. I got sick and was out of the hospital for a month and it seemed that they almost did not need me..’ (HC27). ‘In the first wave of the pandemic, I felt somewhat unnecessary when the hospital did not allow me to see patients’ (HC29). There was also a hint of a perceived crisis given the vocation to be in this ministry: ‘It has diminished my confidence. I was not sure about my vocation to be the chaplain’ (HC21).

Several chaplains mentioned the feeling of a certain spiritualisation of their ministry, whether in relation to themselves or to patients: ‘There was a great change, a development which was connected to the growing practice. This increased my self-confidence, and the work could take on a more spiritual dimension’ (HC3). ‘Certainly all this leads to deeper thinking and contemplation on the contexts of the COVID disease, not only at the biological level, but also at the level of relationships and broader socio-cultural and spiritual (especially semantic) contexts’ (HC14). One of the chaplains describes it as ‘a journey into the depths’<sup>21</sup> (HC8).

The most frequently mentioned aspect in the answers to the fourth thematic area was *emotions* and related bodily feelings. The fear of the disease was the most frequently mentioned topic, especially in the first wave which was generally characterised by a large number of unknowns about the degree of infectiousness and methods of disease transmission. The decrease or disappearance of this fear is then one of the most frequently described changes between the spring and autumn period: ‘I basically do not worry about the initial (spring) fears of infection at all ...’ (HC14). Some respondents reacted succinctly: ‘I am not as afraid as I was during the first wave’ (HC32). Fear of infection was not only a worry about one’s own health, but also worry about patients or staff and their possible infection. As we have stated above, this fear, together with the lack of protective equipment, was the cause of the initial reduction in the activities of chaplains in many hospitals: ‘I had a hard time accepting it, ... at the same time I was afraid that I would get infected and infect someone ... Now I am more over it, I am not so scared, I go with the flow ... On the contrary, I say to myself, if I suffered from this illness, I could get to the ward better and I would not be afraid that I would bring it somewhere or that I would get infected’ (HC24).

Several hospital chaplains describe in their responses that they became infected and *suffered from the disease themselves*. However, in accordance with the above-mentioned statement, they perceived the illness as a means of facilitation in the area of their work, because they gained temporary immunity and thus the possibility of action among covid patients. Some even perceived the illness in close connection with strengthening their own chaplain identity: ‘My identification with the role of chaplain was certainly strengthened by the pandemic. Suffering from the illness in the spring allowed me to go to covid patients with a relative sense of security in the autumn’ (HC38). The feeling of fear that was characteristic of the first wave was replaced by a feeling of physical and mental fatigue in the autumn. Everyone was affected by that – chaplains, patients, and health professionals. This fatigue was based primarily on the protracted situation and the indistinct prospect of improvement: ‘It has been a long time, and I feel quite tired’ (HC30). ‘I was

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21 In the Christian discourse, an allusion to the Gospel story of the miraculous catch of fish and Jesus’ call: ‘Put out into the deep..’ (cf. Luke 5:4).



nervous (along with the others) in the spring. In the autumn, I am rather tired of a very long state of emergency' (HC7). As the previous quote shows, it is not just the feelings experienced by hospital chaplains – they reflect the overall atmosphere of the hospital, which is most often described as nervousness, alertness, anxiety in the spring and as exhaustion and fatigue in the autumn: 'Physical fatigue and exhaustion are the main differences between the first and second wave' (HC30).

Some respondents also describe that they are affected by the severity of the disease or a higher incidence of death. However, even these emotions are accompanied by fatigue: 'It is impossible to work on COVID ARO (Department of Anaesthesiology and Resuscitation for covid patients) without any mental and emotional impact. Moreover, the third wave is coming and fatigue is seen everywhere and affect everyone' (HC13). Chaplains who describe the emotions associated with more frequent contact with dying and death also bring up the theme of helplessness and disorientation. This particularly contrasts with the usual perception of the chaplain as someone who can deal with the subject of death in a more qualified way, as we pointed out above: 'I realised that during the autumn, in connection with the number of dying and dead, I began to perceive my inner detachment from my own feelings, fatigue. I often mourned patients. I realised that the whole situation tended to absorb me, and I had to make a greater effort to take care of myself. I often felt survivor's guilt – I felt guilty because I went home after work while some patients died that day. Much more often I became aware of my own helplessness' (HC36). 'I had a strong perception of emotions and a new kind of burden that I did not know before. It was mainly due to contact with covid patients in the ICU. I felt distress and helplessness seeing the overall situation and the staff. Patients in the covid wards die a lot, and that is a fact that everyone has to deal with. As a chaplain, I felt that I should bring hope to the situation. At the same time, though, I needed to establish myself and choose direction considering the way how to actually do my job. All this I had to do quickly, on the go' (HC39).

Some chaplains notice, in relation to themselves and their ministry, a certain *loneliness in the hospital* (unlike medical staff, the chaplain is often alone or only in a small team) and *in the church* which appointed him to be in this service but often has no role in it. They appreciate the collegiality and mutual support of hospital chaplains: 'As chaplains in hospitals, we are in a solitary and, at the same time, in a very responsible role. That is why I am happy for any support, sharing, and encouraging within the regional chaplain community' (HC34). 'I was quite sorry that my church was unable to provide support for chaplains in the front line. I only received a short email that the church was praying for us, but there was no offer of supportive conversations, or a pastoral or common prayer. Paradoxically, such support was given to me by my fellow chaplains, many of whom serve in their own parishes' (HC4). Apart from the mutual collegial support of the chaplain community and possible supervision, we did not identify any currently used sources of support for participants themselves and their service in our research. But that does not mean that the chaplains do not ask for it. However, where they expect it the most, they often do not receive it. One can feel, at a subliminal level, frustration in the statements of some chaplains. It is caused by the lack of acceptance and appreciation in the hospital, the absence of attention and support in their own church, and the feeling of loneliness: 'We depend on medics. They set the limits to our actions. We have to adapt, look for new ways, keep thinking about the way we work, and watch our emotions. Support is minimal. We must defend our motivations and the importance of work (even before ourselves) and rely on our strength. We meet the dying, people completely dependent on the care of others, people who can be helped very little in all respects. It is not easy

work. And it is not universally appreciated' (HC27).

In this context, we cannot neglect the nihilistic answers of the chaplain who answered 'I did not feel it' or 'in no way' to all the questions and finally advised the researchers: 'The conclusions from the evaluation can be awfully misleading. That is worse than nothing. The best would be the Tomáš Baťa's method, although it is more strenuous and less scientific. In this case, it would be a volunteer course and then volunteering for half a year' (HC20). Perhaps the respondent said more about the feelings of the hospital chaplain at the time of the pandemic than he intended.

## Discussion

The year 2020 was not only a stress test for hospitals and a challenge which they faced in various ways during the year. The pandemic brought new concerns, both immediate and aimed at the future.<sup>22</sup> Even the experience of Czech hospital chaplains cannot be summarised in a few simple words. Their reflection on both waves of the pandemic and their own role was diverse and depended on several factors which we will try to summarise here.

We dare to say that one of the most fundamental influences was the setting of the relationship between the chaplain and his institution before the pandemic. This starting position was then largely decisive in the reorganisation of the hospital and the scope of work. The crisis has revealed the real relationship between the hospital and the chaplain and the extent to which the institution is willing to meet the needs of chaplains. A significant variable in this equation was also the type of work, the length of the chaplain's employment in the hospital, integration into other structures (palliative team, crisis intervention, senior hospital management, etc.), and undoubtedly also the location of the hospital considering the region.

It turned out that some form of employment relationship with the hospital was an important factor for the chaplain's involvement in the care of isolated covid patients, where, in addition to their own spiritual care, the chaplains played an important role in contact with the outside world. It was precisely the need for access to closed wards, including infectious wards, that Tretera used as an argument when favouring institutionalised spiritual care in inpatient facilities even before the pandemic.<sup>23</sup> However, the pandemic situation suddenly and for an unprecedented period of time turned the entire hospital into a closed ward. Thus chaplains who did not have an employment relationship with the hospital were limited when visiting patients, or the visiting was completely forbidden.

However, it was not just an employment-legal relationship, because some chaplains with part-time employment or contracts for work taking place outside their main employment relationship were allowed to contact patients during the pandemic. Rather, it was a question of the previous position of the chaplain in the hospital. If he was already a rather marginal player<sup>24</sup> before the pandemic, there was often a partial or complete ban on visiting the hospital. Those chaplains in our research who expressed the feelings of frustration of the past year also seemed to feel that their role was not sufficiently recognised. While they perceived themselves as support and strength that could be used in times of similar crisis, the hospital not only did not appreciate their usefulness, but did not even recognise it as important. Thus, a pandemic could also deepen the feeling of loneliness in one's own role, especially in the cases where chaplains also felt a lack of support from their

22 Cf. CONNELL, 'COVID-19/Sociology...'; p. 749; WARD, 'A sociology...'; p. 729; MATTHEWMAN and HUPPATZ, 'A sociology...'; p. 676.

23 Cf. TRETERA, 'Vážná potřeba...'; p. 17.

24 In this case, it is not exclusively the Czech experience. Similarly, it is reported by the already cited studies from Spain (MARTÍNEZ-ARIÑO and GRIERA, 'Catholic...'; pp. 144–145, or the United States (NORWOOD, 'The Ambivalent...'; p. 15).

church. Behind some of the answers was an unspoken question: who will support the chaplain so that he can support others? We have also repeatedly encountered expressions of an increased need for supervision which, in some cases, was insufficient or non-existent. However, the vast majority of our respondents did not mention the topic of supervision at all, and that is very surprising in a situation which the chaplains themselves describe as demanding and exhausting. Our findings thus contrast sharply with the conclusions presented by Zuzana Vačkářová in her master's thesis. Her respondents from the ranks of hospital chaplains experienced regular (mostly group) supervision and appreciated its contribution.<sup>25</sup> In our research questions, we did not target the issues of supervision. However, given the crisis year that the hospital chaplains reflected on in the questionnaire and in the interviews, we would consider a more frequent comment on supervision to be appropriate.<sup>26</sup>

On the contrary, in hospitals where the chaplain was already considered more or less part of the team, cooperation intensified and the chaplains felt that their service was better understood. They shared the impression that, thanks to the pandemic crisis, the staff better understood who the chaplains were and how they could contribute within day-to-day operations. In this context, there was also the idea that during the past year it was possible to break down some prejudices against chaplains. However, it must be said that, in the case of the staff, it was still a matter of careful communication. It consisted of reading various hints between the lines – most chaplains perceived possible shifts subliminally rather than being able to explicitly name them. At the same time, it is the staff and their behaviour that is the main confirmation of the chaplain's self-concept and a source for evaluating his role. It turns out that despite a significant shift in the institutionalisation of hospital chaplaincy in the Czech Republic, the professional definition of the chaplain's job position, and the related competencies and content of his work are still lacking. This ambiguity is not only a source of uncertainty and misunderstanding, but also affects the entire multidisciplinary team of which the chaplain should be a part.<sup>27</sup>

Chaplains in our research also felt that their abilities and capacities could be used in a better or more efficient way. They would be able to overcome their fears and adapt if they received a signal from others that there was interest in their service. They perceived that they were able to help, above all, with the loneliness and fears of a number of patients in the crisis. It is worth noting that the results of the above-mentioned ERICH questionnaire lead to a similar conclusion.<sup>28</sup> It is interesting that chaplains formulated the benefits of one's own work less as religious (need for reconciliation, forgiveness) and more at a psychological level (calming the patient, expressing emotions), which is a repeated finding in foreign literature.<sup>29</sup> During the pandemic, chaplains often had to adapt their work to the situation and current demand, and they were the ones who could and had to be flexible. In this sense, in many cases, the chaplain proved to be a functional replacement for visits that were banned in hospitals for most of the year. Chaplains often substituted the patient's family and filled his time with meaningful conversation and human closeness. This approach, for example, according to Riggs, is possible thanks to the chaplain's unique posi-

25 Zuzana VAČKÁŘOVÁ, *Specifika supervize nemocničních kaplanů v České republice*. Praha, 2020. Master's thesis, Charles University, Faculty of Humanities, Department of Management and Supervision in Social and Health Organisations, thesis supervisor Zuzana Havrdová, pp. 47–48.

26 Cf., for example, Miranda THRELFALL-MOLMES and Mark NEWITT, *Being a Chaplain*, London: SPCK Publishing, 2017, p. 137.

27 Cf. VAČKÁŘOVÁ, *Specifika supervize...*, p. 33.

28 © European Research Institute for Chaplains in Healthcare, 'International Survey...'

29 Cf., for example, Martínez-Ariño and Grier state that chaplains legitimise their activity in terms of the effect their presence may have on the wellbeing of the patient. MARTÍNEZ-ARIÑO, GRIERA, *Catholic...*, p. 151.

tion in the hospital system.<sup>30</sup>

The pandemic crisis also highlighted the stereotypical connection between the chaplain's role and death.<sup>31</sup> The reality of more frequent deaths in hospitals during the pandemic reinforced the idea that for the chaplain the presence of the dying is somehow natural. The staff and patients' families thought that thanks to the ritual equipment (here mainly the Catholic Anointing of the Sick), they can deal with it better. At the same time, however, this stereotyping can be an obstacle for some patients who want to ask for the service of a hospital chaplain and for staff who want to offer such service, because, as Tretera notes (in this context), 'to see a priest is like to see death.'<sup>32</sup> In some hospitals, according to our judgement, especially in more religious traditional areas, the presence of Catholic priests in seriously ill and dying patients was taken for granted, while the activities of hospital chaplains (non-Catholics and Catholics who were not priests) were suspended and perceived as unnecessary.

Last but not least, the chaplains in our sample reflected upon the difference between the spring and autumn waves of the pandemic. They perceived both the differences in the institution's approach (the shift from chaos to organisation) and in the mood of the staff (the shift from fear to fatigue) and adapted to them. In general, they felt more like a part of the team in the second wave and had more access to patients, including those with covid-19.

## Conclusion

The pandemic of the viral disease covid-19 caught the Czech hospital chaplain in the phase of ongoing institutionalisation. Although hospital chaplains in the Czech Republic have been, in theory, included in hospital operations and since 2019 the Tripartite Agreement has established a binding framework and structure for the provision of spiritual care in health care facilities by the churches, the reality in individual Czech hospitals is very diverse. The situation of the crisis, which the current pandemic undoubtedly is, also threw light on the real position of hospital chaplains in the system and on the problems that their real involvement in multidisciplinary patient care encounters.

Last year, Czech hospital chaplains had the opportunity to prove that they belong to the world of hospitals and have something to offer. Especially in times of crisis, such as the current pandemic, their uniqueness could become more important. If chaplains have any specific competence, it is the knowledge of the most intimate human problems and existential situations which are not in short supply in medical facilities and to which adequate attention is not paid at the same time. They could therefore, in accordance with Bard's wishes, be pillars and become 'central in efforts to support all of us suffering from the intensities of this uncertainty and the threat of illness and death.'<sup>33</sup> They often do really well. At the same time, however, in the context of the current situation, it became clear how precarious their position is, as it is based on an unstable labour law situation, and it is subject to the hierarchy of the institution.

We believe that in order to establish hospital chaplains in the institution, in addition to their clear employment relationship with the medical facility, it is necessary to clearly define their role and work activities, so that their irreplaceable role in a multidisciplinary team is not only a declared but a practically realised element.

30 RIGGS, 'The COVID-19...', p. 263.

31 Similarly, cf. MARTÍNEZ-ARIÑO and GRIERA, 'Catholic ...', p. 151; cf. also DE GROOT, 'The Institutional...', p. 25.

32 TRETERA, 'Vážná potřeba...', p. 16.

33 BARD, 'COVID-19...', p. 81.

Equally important for chaplains is the support of the churches that have entrusted them with the ministry. The pandemic has shown that in crisis situations, the support of their church communities could be a source of reinforcement for chaplains. In our view, churches should retrace what the ministry of hospital chaplains means to them and how they can support it beyond simply delegating those persons to be their representatives in the ministry of hospital chaplains. Professional supervision is still an underused supporting tool for hospital chaplains. In addition to chaplain associations, the churches that appoint chaplains to be the representatives in the ministry should take responsibility for them.

The research presented here needs to be understood as a pilot probe into a completely new situation. The main limits of this study could be considered a relatively small sample of respondents and also the time interval which is too short as the issue of the pandemic is still evolving. We would recommend more in-depth ethnographic research for future studies of this kind, as well as highly desirable reflections on other actors involved, such as healthcare professionals and patients.

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