

In Their Own Words



TRANSFORMING CHAPLAINCY

**STORIES OF CHAPLAINS' COURAGE, CREATIVITY,
AND COMPASSION DURING THE EARLY PANDEMIC**

*In Their Own Words:
Stories of Chaplains'
Courage, Creativity, and Compassion
During the Early Pandemic*

**Cate Michelle Desjardins & Nina Redl
Editors**

Transforming Chaplaincy
Chicago, Illinois
2022



Table of Contents

Acknowledgments	4
Foreword Katherine Piderman, PhD, BCC	5
Introduction Cate Michelle Desjardins, MDiv, MPH, BCC	7
Chaplain Journals	
Brenda Wall's Journal	11
Adam Ruiz's Journal	21
Nina Redl's Journal	57
Alyssa Foll's Journal	79
Amy Karriker's Journal	98
A Physician's Response to the Chaplain Journals Steven Clark Cunningham, MD, FACS	112

Acknowledgments

We thank the five chaplains who chose to open their journals and share vulnerably and powerfully with all of us.

Special thanks to all of the chaplains who shared their journals with us for the wider research project on chaplains' experiences of COVID-19 and the early pandemic.

Thank you to our respondents, Steven Clark Cunningham, MD, FACS, and Katherine Piderman, PhD, BCC, for thoughtfully reading the journals and exploring their implications for chaplaincy and medicine. A special thanks to Katherine Piderman for her superb editing of the journals for the plenary presentation at the 2021 Association of Professional Chaplains annual conference.

The research team for this project included the following individuals.

- Cate Michelle Desjardins, MDiv, MPH, BCC
- Beth Muehlhausen, PhD, MDiv, LCSW, BCC
- Paul Galchutt, MDiv, MPH, BCC
- Beba Tata, MDiv, MPH, BCC
- George Fitchett, DMin, PhD

Funding and support for this project were provided by Transforming Chaplaincy and Ascension.

Thank you to Steve Dahl for cover design and eBook design and to Kristen Schenk, MDiv, MA, BCC, for copyediting and formatting.

Foreword

Katherine Piderman, PhD, BCC

Several years ago, a physician asked me if my ministry as a chaplain had become easier or harder with time. It was a question that I hadn't considered before, and I paused briefly to reflect. Then I said, "It's easier because, after over 20 years of chaplaincy, I have been in a multitude of challenging experiences, and I am rarely surprised by what I see or hear. I feel calmer and more solid when confronted with suffering and usually feel able to respond in ways that seem helpful. It's harder, though, because my heart is softer. Somehow, I feel the depth of the pain before me at a deeper level."

I was not on the front lines of patient care during the early days of the pandemic, and I wondered how I would fare if I were. What I heard from colleagues and saw on the media not only surprised me but also horrified me. No one really knew much about COVID-19, except that it spread easily and was deadly. There was fear, confusion, and danger. Many chaplains were sidelined, at least for a time, but their desire and commitment to serve prevailed. They were able to find within themselves the faith, resolve, and creativity to respond to the needs around them with the utmost compassion. I was truly inspired.

When I was asked to read chaplains' journals about these early months, I was not sure I wanted to be immersed in that time again, but, recalling chaplains' remarkable courage and dedication, I was led to say yes. What I found within the journals was a graphic depiction of the tumult five chaplains experienced as the pandemic took root in the United States. Things they had taken so much for granted—being present in the hospital, entering and leaving through a certain door at a predictable time, being with patients, supporting families, working with teams, easy conversations over coffee, visible smiles, hugs, feeling safe, opportunities for self-care—had all been stripped away. They paused and, perhaps, even shook in their boots, but they did not crumble.

These chaplains stood their ground and faced head-on the unrelenting siege of the pandemic and its brutal wake of challenge, suffering, and death. They sought and found remarkable ways to bring the best of spiritual care to patients, their loved ones, and staff. They became aware of the reality of their own vulnerability but also their own resilience. They witnessed the amazing goodness and generosity of so many, and at the same time, the injustice of health disparities and disparities among staff, and the bitter divisions and racial tension in their cities and country. They trembled and they wept, but they also persevered and contributed the good they could amid the unimaginable nightmare in which they found themselves.

These chaplains trembled and they wept, but they also persevered and contributed the good they could amid the unimaginable nightmare in which they found themselves.

I invite you to read this book with hearts open to respectfully receive the candid honesty of these five chaplains. Their words give voice to their raw experiences, and there is much we can all learn from them. My reading invited me to examine my own practices of spiritual care and ponder new possibilities. It urged me to

develop an even softer heart with deeper sensitivity and more responsiveness to the suffering in our world. I hope that your reading will be a catalyst for your own reflection and lead you to personal healing and growth, hope and resolve.

Katherine Piderman, BCC, PhD, is a chaplain, researcher, and associate professor of psychiatry at Mayo Clinic in Rochester, Minnesota. She is also a senior research fellow with Transforming Chaplaincy and a certified spiritual director.

Introduction

Cate Michelle Desjardins, MDiv, MPH, BCC

Like many health care chaplains, I remember the first murmurs of something called a “Coronavirus” on the ward of the children’s hospital where I worked in February of 2020. It felt like only a few days passed before I was on a Zoom call with my colleagues and leadership, where the decision was made to speak with families only over the phone or via video call for the foreseeable future.

That first Zoom call with the other chaplains turned into daily Zoom check-ins, staff support groups, and sometimes long phone calls with patients and families. Only one chaplain at a time remained in the hospital to provide support in dire situations. In so many ways, my daily work was fundamentally the same: supporting the spiritual and religious values and health of patients, families, and staff at the hospital. Yet it felt so different, like my professional life had been turned upside down, and I had to keep going, walking on my hands if necessary.

At the same time, yet another aspect of my work and calling as a chaplain was suddenly shifting. For more than six months, along with my colleagues at Transforming Chaplaincy, led by Dr. George Fitchett, I had been working on a research project to understand the variety of chaplaincy services offered throughout the United States. We had completed the design, received IRB approval, and were on the cusp of launching the telephone survey where we would speak to managers about their *usual* deployment of chaplains throughout a given hospital.

Yet there was nothing at all usual about what was happening in chaplaincy. Should we give up the project? Or, instead, should we turn our energies and some of our groundwork toward understanding not what *usual* chaplaincy practice looked like, but how various chaplaincy departments, managers, and chaplains themselves were responding to and experiencing the now-global COVID-19 pandemic? Did they feel like I did—swimming upstream, doing handstands, all the while wondering if they were really making a difference?

We choose the latter plan, first organizing to interview chaplaincy managers every few months to understand their decisions, struggles, and personal experiences. In speaking to the managers, we realized that we wanted the written perspective of chaplains working on what became known as the “front lines” of healthcare—and so we decided to ask chaplains from across the country if they would be willing to contribute a journal of their time serving during the early pandemic for research purposes. George Fitchett invited chaplains into the project with this request: “How do you find words to describe the times we are living through? I am writing to ask if you would help us find them.” In total, 21 chaplains agreed to share their words with us.

Those chaplains most certainly found words to describe these times. We received over 150,000 words, around 600 pages, of intimate, carefully narrated journals. As a research team, we anticipated a profoundly important project and contribution to the field of chaplaincy.

We could not have anticipated just how movingly, heartbreakingly, and lovingly each chaplain who journaled for this project would write their stories. While we forged ahead with analysis, utilizing hermeneutic phenomenology as our interpretive method (led by Beth Muehlhausen, PhD, Ascension Health), it quickly became apparent that the stories of devastation, tempered by deep hope and unbelievable resilience, that had been shared with us were worthy of wider sharing than the academic paper we had planned.

It quickly became apparent that the stories of devastation, tempered by deep hope and unbelievable resilience, were worthy of wider sharing than the academic paper we had planned.

We reached back out to five of those journalers and asked if they would be willing to remove the confidentiality they had initially agreed to as a part of being research subjects in order to share their remarkable journals more broadly. All five, although what they had written was deeply personal, enthusiastically agreed.

Many of you heard a beautiful reading of those five journals at APC's 2021 National Conference, prepared by Katherine Piderman. Even at the Plenary, the journals were excerpted, and as much had to be left out as was left in. So again, those journalers graciously agreed to not only share excerpts from their journals but to share the entirety of their writing from the early pandemic. This is the result.

On that phone call with the research team in March of 2020, I could never have anticipated that this project would become a two-year-long endeavor, one that has not only shaped me immensely as a researcher but has deeply shaped me as a person. Immersing myself in these incredible stories of chaplains, both at their professional and personal edges, and reading about them finding extraordinary resilience, creativity, and courage in that place, has been a privilege I will never quite find words to describe.

This project has re-emphasized for me some of the core of what I believe research can do for us in the profession of chaplaincy.

RESEARCH IS STORYTELLING, AND STORYTELLING IS RESEARCH

Chaplains are natural storytellers. We are immersed in the stories of our religious, spiritual, or philosophical traditions long before we enter the world of chaplaincy. We essentially write stories throughout residency as we share our verbatims. We listen to the stories of our patients and their families, and we help draw out those stories, aiding those we care for in shaping their stories into a meaningful, whole, and healing narrative.

While the word “research” may seem foreign to many chaplains, and certainly not immediately correlate with storytelling, the best research in any field is that which tells a powerful story about whatever question is being investigated. Whether that story is told in numbers and statistics or in narrative words like the stories in these journals, like any good story, research can move us, inspire us, and change us and our practice for the better. As storytellers and story-workers, chaplains innately possess many skills for high-quality, effective research.

This has been only one incredible project that engaged these chaplaincy skills for wider impact and outcomes, and it is our hope as a research team that others will be inspired by this work to find ways to investigate and share their own stories through innovative research projects that build the evidence base in chaplaincy and bolster the visibility of our profession.

RESEARCH ILLUMINATES CHAPLAIN CONTRIBUTIONS AND CREATIVITY

When we initially conceived this project during the whiplash of early pandemic changes and shifts, we knew the journals would capture immense fear, stress, confusion, and exhaustion. This was inevitable. The work that chaplains do on *any* given day, let alone a pandemic day, is hard.

We also knew that somehow, amid their fear and confusion, chaplains were making important contributions: caring for staff, being a bridge between families and hospitalized loved ones, and, perhaps more invisibly but no less importantly, serving as beacons of faith and hope in times and spaces that were devastating. To make those contributions, chaplains were drawing on their creativity to find safe and effective ways of making the greatest contributions possible amidst a world of restrictions.

The journals did not disappoint in their clear illumination of this profound creativity and the immense, often unnoticed and under-appreciated, contributions that chaplains were making in their places of work and wider communities. This is one of the most important functions of chaplaincy research: to shed light on the great variety and impact of the contributions chaplains make daily. Our American healthcare system is simply not set up to appreciate the contributions of chaplains. As such, it is our role and privilege to conduct high-quality research to help stakeholders *and* us as chaplains ourselves fully see and appreciate the depth, variety, and impact of chaplaincy contributions.

RESEARCH FOSTERS OUR RESILIENCE

There is evidence that reflective journaling can be a resiliency intervention during times of struggle. While initially selflessly agreeing to journal for the sake of research and not their own processing, many of the chaplains who journaled for this project shared in their journals, or later with the research team, that writing these journals became, in and of itself, a source of their resiliency during the early pandemic.

Many of the chaplains who journaled for this project shared that writing these journals became, in and of itself, a source of their resiliency during the early pandemic.

While we as researchers have long believed that research fosters resiliency in our profession by illuminating our contributions and helping to describe chaplaincy at its best, it is a particular privilege to see the research project itself be a tool to foster resiliency, hope, and creativity in the participants. Perhaps not every project can rise to this; for this research team, it was not an anticipated result but a welcome one. However, it remains true that research participation, which we often think of as a “burden,” can, when designed and implemented rightly, prove instead to be a balm and benefit to those who participate.

RESEARCH BRINGS US TOGETHER

While the image of the researcher alone in her lab late into the night is a common one, research is far more often a collaborative and community endeavor. While solo research in chaplaincy is certainly possible, the strength of this project was built on its excellent and collegial research team and the community of chaplains all writing together—whether they knew each other or not.

The chaplains who wrote for this project, as you will read in their journals, are not all the same. Many would not have met if it weren't for this project. They come from different traditions, backgrounds, and countries of origin and live thousands of miles apart. By coming together to journal their experiences of the early pandemic, they formed a community, together with us as the research team. The significance of this project, I believe, is, in these times of division, a sign of the power of coming together even amidst differences in beliefs and experiences.

Perhaps one reason we, as a research team, could not have anticipated the power and ripple effects of this project is simply that we couldn't have anticipated how these individual journal entries, writings, and writers would speak to each other, forming a kind of dialogue across time and space, enriching the broader picture. Indeed, the whole is far greater than the sum of its parts.

By reading these journals as gifts of the writers to each of us and the profession of chaplaincy as a whole, you are entering our community and coming together with us. We welcome you.

Cate Desjardins, MDiv, MPH, BCC, serves as Executive Director of Mennonite Healthcare Fellowship and conducts research with Transforming Chaplaincy and Ascension. Cate was a Templeton Fellow with Transforming Chaplaincy.

Brenda Walls' Journal

My name is Reverend Brenda Walls. I was born in Concord, North Carolina, to the late Reverend Arthur and Carrie Walls. I received a BA in music from Livingstone College, an MA in music from Butler University, an MA in urban ministry and pastoral counseling from Martin University, and an MDiv from Indiana Wesleyan Seminary.

I am a Board-Certified Chaplain with the Association of Professional Chaplains and an Ordained Minister in the A.M.E. Zion Church. Currently, I am employed as the full-time Night Chaplain at Ascension St. Vincent Hospital in Indianapolis, Indiana. Our hospital is a full-service hospital with 24/7 emergency care and a Level I Trauma Center.

I learned about the journal project through Dr. Beth Muehlhausen, the Ascension Mission Integration Researcher. She approached me about participating in this project because I have a reputation for bringing a diverse perspective that is often missed in research and in general.

I have a reputation for bringing a diverse perspective that is often missed in research and in general.

Writing these journal entries was interesting and intimidating. I did not have a problem writing my thoughts in the journal, but I did have some concerns with sharing those thoughts with others. When writing for myself, I could be open and honest, and I knew that I would not be judged by what I might have thought about a situation or patient. Sometimes I would write down my thoughts and then go back and rewrite them after I said them out loud, as I thought that whoever read my thoughts would not understand what I was saying, and, without having the complete history and facts regarding the conversation, may take what I was saying negatively or out of context.

I discovered while writing this journal that COVID negatively impacted “people of color.” I witnessed it at the hospital. I shared with my supervisor that almost every COVID patient was a person of color. I wondered why this was a reality.

During this journaling project, I learned that people of color were more likely to be affected by this disease because of their underlying health conditions. I also learned that where a person lives and works affects their risk of COVID. Many people of color work in service jobs and are considered “essential workers.” They could not work at home to avoid contact with others.

Painfully, I also learned that people of color in ancillary jobs at my hospital felt discriminated against because they were not, at first, offered the same level of PPE as the medical personnel when they entered the COVID rooms. They shared with me that they felt like their lives “did not matter as much as others.”

Since writing these journal entries, I have enjoyed being part of two related research studies, and I subsequently enrolled in and completed the Research Literacy 101 course through Transforming Chaplaincy. Another bonus of these studies is that I had the opportunity to present about both research studies at the Association of Professional Chaplains' National Conference, including in a Plenary Session. I even have in mind some research studies I would like to conduct in the future.

JOURNAL ENTRY: EARLY APRIL 2020 - ENTRY 1

Tonight was a very challenging night for me, to say the least. I responded to a “Protected Code,” which is a patient who coded and is COVID-19 positive. I was informed by staff that the patient was not doing well. The patient had respiratory issues and a faint pulse. Hence, the medical staff decided that further CPR would be futile.

When I arrived, the doctor was talking on the phone to the spouse. I could hear the spouse pleading in the background for the doctor “not to give up on her husband.” The doctor repeatedly informed her that “they did not give up on the patient, but the patient’s body had given up on the patient because the patient’s heart had given out.” The medical staff decided not to provide any further interventions, including ventilator support. I believe that they felt that further support would not be beneficial to the patient.

I felt God speaking to my spirit and leading me to speak with the spouse to creatively provide to her and the patient emotional and spiritual support. I offered to talk to the spouse and suggested that she use this time to provide a final gift to her loved one by “sharing with him on the phone how much she loved him so that her voice could be the last voice the patient hears as he is transitioning from ‘death to life.’”

I informed her that her loved one would be able to detect the anxiety in her voice and that this would probably cause anxiety and worry for the patient. Thus, I suggested that she present a calming spirit, focusing on the love that the two of them had shared for those many years. She agreed to do that, and the doctor gave his phone to the nurses inside the room, and she talked to her husband.

I suggested that she present a calming spirit, focusing on the love that the two of them had shared for those many years.

Eventually, the patient passed away. The wife informed her son that his father had died. He did not take it very well. He was very upset and did not understand why he could not come to the hospital to see his loved one and why the doctor would not continue the CPR attempts even though the doctor informed the family several times that it would “hurt, not help.” The doctor also explained to the son, as he did the rest of the family, the restrictions of visitors because of the COVID-19 virus and the hospital’s attempts to try to prevent the spread.

Unfortunately, anger and grief overtook the son, and he lashed out in anger. He said some things to the nurse and the doctor and accused the doctor of “trying to kill Black people.” Understandably the doctor did not take this very well, and he angrily left the floor.

I tried to see both sides. I understood the doctor’s anger because he and the rest of the medical staff were putting themselves at risk of the virus to save their patients’ lives; however, I also saw the patient’s son’s side. The son should not have accused the doctor and the medical staff of “trying to kill Black people” when they are risking their lives to save the patients, who unfortunately are mostly African American. On the other hand, I know that African Americans’ distrust of the medical community is based on a history of the medical abuse they have suffered throughout the years. When we think about the “Tuskegee Study of Untreated Syphilis in Negro Males,”



the “Gynecological Experimental Surgeries” on “negro slaves” who were used as medical guinea pigs without their consent and without the benefit of anesthesia, and countless other medical monstrosities that were inflicted on African Americans, it becomes clear why some may feel as he felt.

I was convinced that a scenario like this would occur again. Hence, I shared it with the chaplain staff so that they could be prepared. We are learning that African Americans are disproportionately dying from the virus, which may cause some to wonder, as Marvin Gay says, “What's Going On?” I have researched this dilemma that is affecting the African American community so that I can be informed and provide a level of insight and understanding (for my colleagues and the medical team).

The available data and census demographics show that counties with an African American majority have three times the rate of infections and almost six times the rate of deaths compared to counties with a majority of white residents.

Research says that this is attributed to the health care disparities for African Americans. African Americans' higher rates of diabetes, heart disease, obesity, and lung disease are well-documented. These health problems make them more vulnerable to this new respiratory disease. They also have limited access to health care mainly because there are limited opportunities to access quality health insurance.

I believe that Chaplains need to be aware of this dilemma and understand why some people of color may be angry and frustrated and distrust the medical community. We need to be ready when we are confronted by these situations and be ready to support both the medical staff and the patients when such a situation arises again.

JOURNAL ENTRY: APRIL 17 - ENTRY 2

I received a call from the nurse informing me that a COVID-19 patient had passed away, and she requested that I call the family to get funeral information. She informed me that the patient's family had been notified of the passing of the patient. I called the daughter, Cathy (alias), and introduced myself to her as a chaplain from St. Vincent. I also expressed my condolences to her.

Cathy informed me that she was on her way to see her father to inform him of the patient's death. I asked her if there was going to be someone with her out of concern for her safety, and she said her husband would be going with her. I again offered my condolences and asked about the funeral home.

I did inform Cathy that we did not have to have the information at this time, but when the family got together, if they could get in touch with us, it would be appreciated. The husband got on the phone and said, “Now is not a good time to talk about this; we just found out about the passing of Cookie (alias), and not all of the family members have been contacted.” I felt badly because I was not aware of the fact that the doctor had just called Cathy, and she had not yet had the time to contact other family members.

I apologized and told her to take the time she needed, and we would check in with her the next day just to see how she was doing. The family agreed that the next day would be better, gave their thanks, and hung up. I contacted the nurses' station and informed them about the call.

Later that day, I was paged by the Case Manager on duty in the ER. She informed me that one of the associates from the EVS wanted to speak with the chaplain. The patient was primarily Spanish-speaking but also spoke English. She appeared at first to be hesitant to talk. I assured her that it was o.k. to talk with me and that I would keep what she had to tell me confidential. I assured her that I would not judge her on anything that she may want to share with me.

Tearfully she admitted to me that she was scared. With all the COVID-19 sickness going on and people dying, she was afraid. She said that she believed in God and knew that she should not be afraid, but she couldn't help it. Upon hearing this, I just wanted to hug her but remembered that we were practicing social distancing.

I said to her, "It is okay to be scared. I am an ordained minister, chaplain, and preacher's kid, and I'm scared too. In fact, I think that everyone is scared. This virus is new to all of us. We are charting new grounds, and none of us knows all the answers." She replied, "I just need a word." I said to her, "I have a 'word.'" I pointed her to the 23rd Psalm, where it says, "Yea, though I walk into the valley of the shadow of death, I will fear no evil."

I told her, "God is not just talking about physical death. He is talking about spiritual and mental deaths and physical deaths from plagues and diseases." I asked her what the next sentence said, and she said, "For thou art with me."

"Bingo," I said, "God does not promise that we are not going to go through storms; all of God's people are going to have to experience storms. God, in fact, tells us that in His Word, but here's the best part: He promises that He will be with us every step of the way: He promises never to leave us or forsake us. Just as our hearts are breaking, His heart is breaking too." I continued, "Some say that God sent the plague. I do not believe that He sent it, but I believe that He is allowing it for a purpose."

She then asked me to name one positive thing that has come out of this pandemic.

I then shared with her a conversation my sister and I had recently. We were talking about the sickness and deaths that we have had to endure because of the pandemic. She then asked me to name one positive thing that has come out of this pandemic. I thought about it for a while and came up with several things. Parents are now taking care of their children and not letting the school and social media parent them. Churches are coming out of the four walls and ministering to people outside of the walls. Families are growing closer and appreciate each other more since they don't know who will be affected by the virus next.

The associate then added that people she works with are helping other people in the community. It gave her a different perspective. She asked me to pray for her, and I prayed for her and asked God to remind us that, even in the midst of the storm, like the song says, "He's got the whole world in His Hands."

What I learned from this encounter was that *everyone* is impacted. We tend to focus on the doctors and nurses first. And that is okay, but what about all of the ancillary staff people who are also risking their lives going into rooms where people are infected and not even having the proper PPE (personal protective equipment) at first, as if their lives were not as important?

JOURNAL ENTRY: MAY 6 - ENTRY 3

The RN called me to assist with the terminal wean of a COVID-19 patient from the ventilator. When I arrived at the nurse's station, the nurse informed me that the doctor was talking to the spouse of the patient over the phone and informing him of the patient's condition. The patient was brought in from a nursing home unresponsive due to a possible cardiac arrest. The patient was placed on a vent, and a CT scan was done. The doctor was informing the spouse that doing further CPR/shock would be of no benefit. He explained that further aggressive measures would not be taken.

Hearing the comments from the doctor, I could imagine how the spouse was feeling; not only would the spouse have to deal with the inevitable fact that he was losing his loved one, but he also had to deal with the fact that there was a strong possibility that the next time that he would see his loved one would be at the funeral home. The spouse asked the doctor about the visitor restrictions for COVID. This was during the early stages of the COVID virus, and we had strict guidelines regarding visits to COVID-positive patients to prevent the spread of the virus to the family members. I informed the doctor that I would follow up with the spouse after I consulted with the Director of Nursing regarding end-of-life, COVID-positive patient visits.

While the doctor was finishing up talking to the spouse, I had a chance to sit down and talk to a couple of the nurses and check in with them about their feelings. They admitted that they were concerned about their health. "Sometimes," they said, "it gets to be really depressing, dealing with all the deaths, but we also know that this is part of our job." There were other associates at the desk, and they also admitted that they were feeling the same way.

We talked about the fact that there were more African Americans on this wing with the virus. They all felt that the reason that so many African American patients were affected by the COVID-19 virus was due to inconsistent access to health care, lack of insurance or being underinsured, and not being able to afford doctor visits, medications, and equipment.

While I was encouraging staff members, they were also encouraging me.

While I was encouraging staff members, they were also encouraging me, especially when they discovered that I was in the high-risk category. I had chronic health conditions: I am prediabetic, have high blood pressure, am over 65, and am African American myself.

In the end, I provided a prayer for the staff and returned to my office, waiting to hear back from the medical staff regarding the patient's spouse's admittance to see the patient. Before I returned, I suggested to the medical staff that if the patient's spouse was not allowed to come, the chaplain could arrange for an iPad visit between the patient and the spouse. When I followed up on this request, I was informed that, for the safety of patients, associates, and family members, when there is an end-of-life situation, only two members of the family are allowed to visit COVID patients; they must be screened to ensure that they do not have the virus or any symptoms of the virus. Thus, the spouse was able to visit before his loved one died.

JOURNAL ENTRY: MAY 15 - ENTRY 4

The Evening Chaplain was attending to a family when I arrived. The patient was actively dying, and family members were escorted in to see him. The family was Christian and mostly Spanish-speaking, but some of the children spoke English. The mother and oldest daughter were with the patient when I arrived at the bedside. I provided a requested prayer, which included playing the Lord's Prayer in Spanish on my cell phone.

They also asked if one other daughter could come to see the father. I talked it over with the staff because the family had already spent well over their allotted time at bedside, and I knew that this was a decision that we would make together. We agreed, under the circumstances, to let the family member come. However, as the family members were leaving, our understanding was that the family member was not coming up because her father had already passed away at this time. They did not have funeral information, so I gave them the information for Security.

When I escorted the mother and daughter to the ER, two daughters were waiting to come up to the room after all. I asked whether they had been given permission to come up, and they said that the doctor permitted them. The screeners told me that they had been properly screened according to the COVID-19 visitor protocol, which included asking them questions about their exposure to the virus, their temperature, and if they had any of the symptoms of the virus. They responded no to all of the questions, so I escorted them up.

When they arrived at the room, it was obvious that they did not know beforehand that their father had died. It was also obvious that the staff was not aware that they were coming up, but they agreed to let them see their father. Once they entered the room, they became very emotional; they were screaming and crying. I knew that I had to calm them down because I did not want the doctor and nurse in the room to have to deal with their emotional outbreak alone.

I was not, however, prepared to go into the room without the proper PPE, and I knew that it would take some time to get me into the proper equipment. I was also thinking about the fact that I was high risk and advised not to go into the COVID rooms. Hence, I stayed at the door and tried calming the daughters at the entrance of the room. The doctor and the nurse in the room also did a good job of helping them to calm down. Between all of us, we were able to ease them out of the room. I provided words of comfort and prayed with them.

As I escorted them back to their car, I thought about how I would feel if I was told that my father had passed away by an unknown "killer" that had no regard for who you were. I imagined what it would be like to hear the medical team tell me, "He was doing okay, but then the virus took a turn for the worst, and now he is gone." It was so heartbreaking to even think about this.

I stayed with the daughters as they were getting into the car and made sure that they were okay to drive. The son ended up switching places with the oldest daughter because she was too emotional to drive. I went home that night thinking about my father, and I was sad but grateful that I had been able to spend time with him when he had been very sick and died of a heart attack. A brain tumor and other anomalies triggered the heart attack. I felt grateful that I got the time to say goodbye to him when he could hear me; he got the time to tell me that, if he "left this world today, you [his children] gave me more happiness than I could ever imagine or deserve."

I was thinking about how I would feel if this were my loved one. Sometimes this week, it was difficult for me to walk alongside others in their grief while I was dealing with the memories of my own losses. I would feel the same anger, pain, and sense of helplessness that these family members were feeling. When my father died at 63 years old, I was angry at God. I could not understand how a God who said He loved me could take my Daddy away from me, a man who was so loving and giving, while leaving other daddies here who were just the opposite: unloving, uncaring, selfish.

I believe that God allowed me to feel all those emotions and go through those stages of grief so that I could help others. When I had patients who lashed out at God and me, I understood. I knew what it was like to be angry at God, so I was not judgmental. I provided a safe place for them to grieve however they needed to grieve. Sometimes it meant closing the door while they fell to the floor screaming. Sometimes it meant being an advocate, and other times, it was helping the staff know that some cultures grieve differently than others because they express their feelings differently.

I believe that God allowed me to feel all those emotions and go through those stages of grief so that I could help others.

It was important for me to walk along with these patients, associates, and families. Sharing in their “soul secrets” made me want to do all I could to advocate for them and give voice to their feelings of unequal treatment. We are all created in God’s image, and no one is more important than another because of their race, beliefs, sexual orientation, or social status.

Our mission statement at this hospital talks about “being advocates for a compassionate and just society through our actions and our words.” I believe that how we respond to the poor and those most in need and how we demonstrate compassion for the dignity and diversity of life during this pandemic reflects and reveals how we are living out our mission on a daily basis.

JOURNAL ENTRY: JUNE 5 - ENTRY 5

Last week a young African American patient named Billy was brought into the hospital because he jumped out of a two-story bedroom window. He was admitted to the ER. I was so puzzled as to why someone that young would risk ending his life by jumping out of a two-story window that I knew I would try to visit him before my shift was over.

When I entered the room, I introduced myself to him and said to him, “I just could not leave here today without talking to you about what brought you here to this hospital last night.” Unbeknownst to me, when I entered the room, he was talking on the phone, and the person on the phone said, “I want to know the same thing.”

Billy told me that he was at a party at a close friend’s home and admitted to drinking and taking some mushrooms. He later went upstairs to sleep and dreamed that the police were after him and were trying to kill

him. That did not surprise me because I have also had nightmares about the police stopping me. He woke up in such a panic that he knew that he had to escape to save his life. He jumped out the window because he felt that he had a greater chance of surviving the jump than he had of being caught by the police.

Miraculously he survived and did not have any broken bones. But I just wondered how many young African American young men don't survive. He was so scared, and it was so real to him that he jumped out of a window to save his own life from those who were supposed to safeguard his life. My heart was broken for that young man. I just wanted to hug him and tell him that it was just a dream, and everything would be alright, but I knew that this would not be true. Everything has not been alright, and unless this world drastically changes in its treatment of Black and Brown people, nothing will ever be alright.

Everything has not been alright, and unless this world drastically changes in its treatment of Black and Brown people, nothing will ever be alright.

I have been talking to associates who have come to me considering what is going on to address two crises: the crisis involving Black and Brown people dying disproportionately from the COVID-19 virus, and the crisis of Black and Brown people dying at the hands of those who have sworn to protect us, the police. Each can be considered a pandemic crisis.

A couple of weeks ago, I even talked to several EVS workers who were Black and Brown and who were voicing their concerns about the fact that they were not given PPE when they were going into the rooms of COVID patients. Long before this happened with George Floyd, they were voicing their feelings that their lives did not matter to the establishment. They were not good enough to receive protection, and no one cared if they lived or died. They felt that “only the privileged doctors, nurses and other associates in the medical field had earned the privilege to be protected against the virus, not them...not us...”

I was asked by a White associate colleague of mine whether I am scared? My response: “I have been scared for a long time. Every time a police car pulls behind me in traffic, I am scared. My heart starts racing because I think: What if he stops me? What if I say or do the wrong thing and lose my life because of it? I have stories of racism at the hands of police that I have experienced that I won’t go into at this time, but they are real, and I worry about my three nephews and my brother, my pastor, and my friends.”

I shared with her a comment that a White friend of mine had shared. He said he also has to have conversations with his children about how they should handle themselves when stopped by the police out of respect for law enforcement. I informed him that his children do it out of respect, but children of people of color have the conversation out of survival.

Having said all of this, I believe that I am not the only one with righteous anger. Maybe the spiritual care department should take the lead in sponsoring a forum or prayer vigil of some sort. There are many hurting and angry people of all races, genders, faiths, etc., who are disturbed about what is happening and those who are

seeking an understanding of what is happening. We should take the lead in providing support and encouragement for hurting associates, families, and patients.

JOURNAL ENTRY: JUNE 15 - ENTRY 6

We have what is called a “Blessings Cart” that is supplied by the Care Team. One of our CPE Supervisors is a member of the organizing group. This cart is equipped with snacks, including drinks, candy, chips, cookies, bars, etc. It also has prayer cards that we can pass out to patients and associates. It helps create a relaxing atmosphere for associates who may be stressed out or overwhelmed due to the pressures and hazards of working through this pandemic.

I must admit that most of the time, the snacks are provided for the medical staff on each of the floors where the chaplains are assigned. However, I try to include those associates who are on the front lines but not medical staff so they can get the same recognition and appreciation.

Tonight, I took snacks to the transporters. My mission was two-fold. I wanted to provide snacks to show our appreciation to them, and I also wanted to talk with them and dialogue about their experiences working during a pandemic crisis. They were eager to share their feelings. They shared with me how they felt about having to work on the frontlines, sacrificing their physical and mental health just like the medical staff, but not being compensated with hazard pay or even meals, desserts, or snacks.

They also mentioned the fact that when it was shared with the world that PPE should be utilized when entering patients’ rooms, they were not given the protective equipment; only the medical staff were given protective equipment at first, even though they too had to enter the rooms. They shared it made them feel “as if our lives are not as valuable as those of the medical staff.”

I have heard this same sentiment from my conversations with the EVS staff. They were cleaning the rooms of COVID patients with just gloves and masks. The medical staff members were using N-95 masks while the EVS crews were not given gowns, N-95 masks, or face shields.

Most of the people I talk to are Black and Brown people: African American and Hispanic, groups where we see suffering from the highest numbers of COVID infections. Some of them are convinced that this is another example of how they are treated as if their lives do not matter. When I first had this conversation with some of the people in Environmental Services, I encouraged them to speak up for themselves and let their supervisors know that they don’t want to jeopardize their health or the health of their families and others with whom they come in contact by exposing themselves to the disease without all of the right PPE. Some of them did go to their supervisors, and now everyone is wearing the proper PPE.

It bothers me that there are disparities even in the way we dole out equipment and in how we value who is worthy of extra pay for putting their lives on the line and who is not.

Adam Ruiz's Journal

AT THE TIME OF PUBLISHING AND JOURNALING...

JOB TITLE: Mother-Baby Chaplain

LOCATION: Louisville, KY

COMPANY: Norton Healthcare

I first learned about the journal project from a former chaplain colleague who works closely with Transforming Chaplaincy (TC). On April, 2020, she sent me an email saying, in part, "I gave your name to some TC folks about a journaling project we are going to invite chaplains to participate in."

The next day, I received an email with an attachment from TC: "Participants must be actively involved in providing spiritual care to patients, families and/or staff, in person or virtually. It does not (necessarily) have to be spiritual care for persons with COVID-19. How do you find words to describe the times we are living through? To create that account, we are asking a group of chaplains to keep a journal of important activities, interactions, events, and we are inviting you to be a part of that group."

I was already keeping a journal, so the invitation to officially maintain a journal wasn't something I needed to "create [my] account." Nor did I need to ponder on too long. I just simply continued the writing I had been doing.

I am a person who likes to write, and from experience, I know that writing and keeping notes on current events and/or my current emotional/spiritual state helps me to enter more fully into the experience. So, the journal project kept me focused on remembering, recording, and reflecting on the daily encounters I was intimately involved in.

I captured a lot of what I was doing, and, in looking over the day's journaling, I realized I was doing a lot.

I began to realize that I was having a positive impact on others through my ministry. Without the daily journaling, I would have lost a lot of the voices and conversations that took place.

In looking at my journal, I began to see more clearly how God was using me. I was able to celebrate my ministry, even though some journal entries left me feeling very sad.

I'm sure I would have remembered big picture events without journaling, but I would not have remembered the specifics of an encounter. In looking at my journal, I began to see more clearly how God was using me. I was able to celebrate my ministry, even though some journal entries left me feeling very sad. (Of note, three of my own family members died of COVID or COVID-related illnesses.)

Knowing that we would read our journals out loud for one of the plenary sessions at the Association of Professional Chaplains annual conference made me a bit anxious. What would it be like to read the journal via Zoom? How would participants receive the journal from their homes? What would it have been like to have had this opportunity in person as opposed to doing it remotely?

One good thing about doing this from our computers or mobile devices was that people had the opportunity to immediately send an email to those of us on the panel. I received a few direct messages from people who affirmed my work, my journal entries, and my participation on the panel. Additionally, a couple of people affirmed and acknowledged the importance of ministering to Spanish-speaking patients/families. All in all, it was a good experience, and I am glad to have been invited to participate.

At the height of the COVID surge in my individual hospital, we averaged between 60-70 COVID patients. Collectively, counting all five hospitals in our system, our combined census averaged between 200-230 patients. Today, in November 2021, we have 16 confirmed cases. Collectively, we have around 70 patients.

In the first year of COVID, there was a mixture of anxiety around the virus, the deaths, and the unknowns associated with it. Added to that anxiety was all the social unrest sparked by the death of George Floyd. Further added was the political division that took place between those who felt that COVID was a national emergency and those who opted to see efforts to mitigate the impact of the virus as an infringement of individual rights being perpetrated by certain sectors of society.

Today, the new division is between those who believe that the COVID vaccine is safe, effective, and necessary and those who view the COVID vaccine as not only another infringement on individual rights and freedoms but also something that can, does, and will cause great harm.

As I write these words on November 1, 2021, mask mandates are being loosened, more public gatherings are happening, and the anxiety around COVID continues to decrease even as the overwhelming number of COVID deaths are among folks who were not vaccinated.

I continue to be vigilant; I continue to limit my social gatherings; and I continue to journal.

I continue to have faith that there will come a day that our default stance as a people will be to believe in the best of each other.

Finally, I continue to have faith that there will come a day that our default stance as a people will be to believe in the best of each other.

JOURNAL ENTRY: MARCH 5 - ENTRY 1

Today saw the first communication from the hospital regarding COVID-19.

JOURNAL ENTRY: MARCH 8 - ENTRY 2

We had the first confirmed case of COVID in our hospital.

JOURNAL ENTRY: MARCH 10 - ENTRY 3

The hospital created a process for patients under investigation (PUIs) for COVID.

An email from our leadership went out to chaplains: "If we get a [COVID] patient in our facility, the staff will need a lot of our care, as anxiety is high."

JOURNAL ENTRY: MARCH 15 - ENTRY 4

Today we have 10 PUIs (patients under investigation for COVID). We received confirmation that two new patients have tested positive for COVID.

I'm sending emails to as many different employees as possible to check on them. Many have responded with thanks and gratitude. I sent notes to folks I did not even know, and I just sent some to different locations, not just our hospital.

* * *

We have not had any babies die in a little while. But today, we had our first two babies in our morgue during this time of COVID.

JOURNAL ENTRY: MARCH 16 - ENTRY 5

Starting tomorrow, we are having weekly chaplain conference calls via Zoom. It will be interesting to see how this works. I don't think I have ever done anything with Zoom.

* * *

In an effort to curb the spread of COVID-19, we have decided to suspend "routine" non-COVID patient visits starting Tuesday, March 17, at all facilities. Many of us chaplains were not sure what this would look like in real-

time. The decision to suspend non-COVID visits made some of us feel anxious in that the concern regarding the virus was becoming more and more real.

* * *

Today is the first time the hospital CEO has done a YouTube video for staff. The video was meant to share information regarding the virus: what our medical team was learning about it; how it affected patients; how it spread or might be spread; what our hospital was doing in terms of PPE; how we were going to treat patients; and how we would manage visitors, etc. It was good to hear directly from him.

JOURNAL ENTRY: MARCH 17 - ENTRY 6

11 PUI patients.

A prayer request was sent to me by an employee: “Please pray for my mom, who works at the hospital and is scared. She is 72 and is worried every single day. I have emptied my bank account to stock up on food because my mom is scared and telling me to do so, and I have no money to pay my bills. I am scared as well; I was pulled to the ICU yesterday and had to give patient care to two people who are being tested for this virus.”

“Be intentional and active in creating a less anxious environment.”

This list of pastoral care priorities was sent to us by our director:

- a. Remain effective: take care of ourselves, wash our hands, avoid groups, etc.
- b. Be intentional and active in creating a less anxious environment.
- c. Patient care: focus more on consults (verbal and through our electronic health record system) and pages, less on rounding.
- d. Put more time into staff care.

* * *

Today I looked at our House Supervisor Report and noticed that we have:

- A mom who is COVID+ and 28 weeks pregnant.
- A mom who is COVID+ and 29 weeks pregnant.
- A mom who is COVID+ and 32 weeks pregnant.
- A mom who is COVID+ and 34 weeks pregnant.

Even though I am the mother-baby chaplain, we are not visiting these patients in person. We are just not sure how COVID affects patients, and we are trying really hard to limit the number of people entering COVID-positive rooms. We need to keep mothers safe, and we don’t want to cause harm inadvertently. I tried calling a mom via phone today, but she was tired and asked if I could call another time.

JOURNAL ENTRY: MARCH 18 - ENTRY 7

13 PUI. A mom is COVID+ and 29 weeks pregnant, and another mom is COVID+ and 34 weeks pregnant.

I checked and found new guidelines for communion distribution and for Eucharistic ministers from the Archdiocese.

1. Archdiocesan ministers will comply with hospital and facility guidelines. Many are not letting even clergy in.
2. Assuming ministers are allowed into a hospital, the Archdiocese prioritizes urgent cases (viaticum) and urges all others to make an act of spiritual communion. Some of the priests themselves are in the at-risk category, so the Archdiocese wants to protect them, too.

* * *

Today, a family asked me to visit a patient. When I went down to check on the patient, I happened to see the unit manager and nurse director at the nurses' station. They asked me to speak with the patient via telephone. I noticed the fire door to the rest of the unit was closed and that a large sign hung on the door prohibiting entry into the unit except for essential staff.

I felt conflicted about this. Once again, I felt some relief because I didn't have to risk getting COVID myself by visiting these patients. And yet, isn't part of my job to enter into scary and dangerous places and provide care for those who themselves are ill or caring for those who are ill? Why should I be safe while they risk exposure (or are ill)?

It felt a bit unnerving to be barred from entering. A part of me felt like, wait—I'm an essential staff person, too! Do you really think my work is incidental (nonessential) to patient and staff care? I felt a bit disrespected and not fully appreciated. So I struggled with that a bit. Am I considered a fringe bit player in all this? Or are they doing this to protect me? To protect staff? To protect patients? Maybe to protect us all?

Further, I was told, if a phone call to a patient wasn't satisfactory for the patient and/or family, they (managers) would brainstorm other options. They assured me that this policy is to severely limit all visits to keep our staff and patients safe from someone inadvertently causing harm.

As a follow up, I just spoke with the patient on the phone and prayed with her. She understood why we were limiting visits, and she was very grateful for the support over the phone; it worked out really well. She was getting tired and wanted to sleep, so I told her we would call her again. She said, "Please do."

* * *

I received this prayer request from an employee: "I would like prayers that my mom will have her needs met in the facility where she lives now and that when we see each other again, she will know who I am. Prayers too for

my father; the separation is all-consuming for him, and he misses her dearly (54 years married). Prayers for the health and wellbeing of the caretakers there and that they will love my mom in our absence.”

* * *

Me to our PR/Media department: “Is it possible for us to collaborate with Spanish-language newspaper to give vital information to the Spanish-speaking population in our area?” The information I was thinking about was how the virus impacts the community; how they could keep safe; what symptoms to look for if they become ill; where to go in case someone gets severely ill; whom to call with COVID-related questions, etc.

The answer was yes. I spoke with the editor of the Spanish-language newspaper, we sent materials to them to print, and they did (and have continued). The publisher of the local Spanish-language newspaper expressed gratitude that the hospital was taking the Hispanic community into account and providing valuable information in the appropriate language.

* * *

The manager of the Labor & Delivery unit requested a written prayer for the unit. I wrote this to share.

O God of Light, You comfort us in our smallness because your love is so great. We know that you want to help us step out of our story and enter into Your story. Therefore, filled with a little bit of faith, we come before you asking that your story become ours, that your peace becomes ours, that your compassion become ours. Help us to know that your hand is in our hand and that you walk before us, giving light to what is now so dark and scary. The mystery and sorrow of this current time are difficult to manage, and yet we know we must walk through it. You want to walk with us. Help us to say Yes to you: Yes to your love; Yes to this journey; Yes to using the gifts you have given us to help others. This pandemic is so much bigger than we are. And we want to believe that Your Love is bigger still. Help us. This is our prayer today. We thank you that we matter, that our sorrow matters to you, and that you will see us through this difficult time. May it be as we have prayed.

“We thank you that we matter, that our sorrow matters to you, and that you will see us through this difficult time.”

JOURNAL ENTRY: MARCH 19 - ENTRY 8

The staff has asked for more support at night. I’ve changed my work schedule to 11-9 p.m., Monday-Friday, as a result.

Someone from leadership grabbed me to talk about supporting other staff, but then he started crying and said he was scared and asked me to go to the ED to support ED staff who were in tears as well. The ED staff had been experiencing a significant number of COVID-positive patients. They were feeling overwhelmed and anxious, as

they were the ones most vulnerable to COVID exposure and had to keep doing their jobs despite all the unknowns and the rising number of infections and deaths in our hospital system, in the country, and in the world. There was no road map for them to follow; there was no light at the end of the tunnel. Were we at the beginning? Or at the end of the beginning? Was this pandemic soon to end, or would the virus continue its current onslaught and trajectory?

Leadership to me: “Round on staff. Focus on staff more than anything else.”

* * *

A question posed in today’s ethics committee meeting: What happens if we have too many patients and too few ventilators? Our response was to create a list of significant people in the community with whom we would consult prior to any decisions being made. In fact, we wanted to form a committee with them NOW before there was a need to make decisions. In this way, we would be anticipating, planning, consulting, and ready should the need arise.

* * *

I helped to create a break area for relaxation and eating meals for staff care. We call it the Zen Den. This area would be available for use 24/7 for at least the next week. We could potentially have soft music playing in there or any other ideas we can think of. The room is set up conforming to social distancing, so we will be able to keep all staff safe during this time.

JOURNAL ENTRY: MARCH 20 - ENTRY 9

14 PUIs.

From the chaplaincy director: “Chaplains, see below. If a funeral home asks you if the patient had COVID or any other medical information, we DO NOT give that information. There has been no change to the privacy law.” (This, however, was later changed: Funeral homes have the right to know if the deceased was COVID-positive in order for the funeral home to do their jobs safely.)

* * *

There is a new process for completing living wills for all isolation patients, as we want to avoid going into the room as much as possible. So, if the need is for information, have staff take in a brochure when they are going in next to see the patient. Chaplains can speak to the patient on the phone to answer questions. In this way, we can have questions answered, facilitate options chosen by the patient, and have the living will signed and witnessed by the RN the next time he/she is in the room.

JOURNAL ENTRY: MARCH 21 - ENTRY 10

I went to Labor & Delivery due to a conflict between a doctor and a manager. I supported both because they needed support: the manager struggled with the MD, who wore a surgical mask and an N95 on top of it, even though it is against the policy.

I spoke privately and quietly with the MD as well, as this was his first PUI C-Section delivery. He said he was anxious and was trying to do what he felt was best to keep himself safe. I don't know why the policy is not to wear two masks. I didn't question it or ask why because I probably would not understand it fully. What I do know is that each of them was anxious about COVID; each had a sense of how to keep him/herself safe and others safe during the C-section procedure. No one was a bad person. They were simply trying to do the best they could in the circumstances, given that there are many unknowns with COVID.

* * *

As a proactive measure, we're putting up a tent outside the emergency department at the hospital. The tent will allow staff to triage patients and better isolate them before entering the facility. This plan was met with relief and gratitude. We had a plan to help support and protect staff, patients, etc. It was necessary to continue to innovate and strategize and attempt to get ahead of the virus as much as possible.

* * *

An email from an employee to me: "Thank you; you have no idea how blessed I just felt when I read your email. I am doing fine right now, nervous, anxious, but doing okay. Thank you so much for asking."

JOURNAL ENTRY: MARCH 22 - ENTRY 11

I spoke with a director who asked for support: "We don't have sufficient PPE. My staff is stressed and scared. We're told one thing one minute, and then it changes the next minute. This makes staff more anxious. Plus, no one knows when we should use N95 masks."

"Infection prevention tells us that we need to do x, y, and z. But to do what they say we need to do to be compliant means we have to have certain ventilation in each ED room. And we can't do that. We would have to tear out all the walls to put them in, and we don't have time or money for this major renovation that they want us to do to be compliant."

"It's stressful, no doubt. But we need the tents to protect the staff. This way, we can have visitors screened before they enter the hospital. We can then send them to a hot side or cold side. We have to protect ourselves. Now."

Since everything about COVID is “learning as you go,” there will be bumps, mistakes, and continued changes as more information and research become available.

As a chaplain, I don’t have any of the responsibilities that this manager (and others like her) have, but I can appreciate her concern. Everyone continues to do what they think is best or what the guidelines say is best. And since everything about COVID is “learning as you go,” there will be bumps, mistakes, and continued changes as more information and research become available.

* * *

An employee asked me to please check on her mom, who works in the hospital. The employee shared, “We’re running out of money. Help.” I did check with her mom. She has a lot of anxiety: she is over 60 years old and works here—but doesn’t want to work here anymore in the midst of this virus. If she leaves work, though, how will they survive financially?

* * *

A manager asked me to check on an RN from Labor & Delivery. I did. She was in tears. She was afraid of working with COVID-19 patients undergoing labor. She was concerned for her health and her family. She felt it was unfair since she had already worked on the antepartum unit the week prior but was not counted as having done so, and now she had to rotate to care for pregnant patients who had tested or were presumed COVID-19-positive.

JOURNAL ENTRY: MARCH 23 - ENTRY 12

Leadership to me: “I really appreciate you reaching out. I will certainly call when it’s time. I also appreciate all you are doing to help with the wellbeing of visitors and staff...this is huge.”

I received this note from a Respiratory Therapy (RT) manager: “It probably wouldn’t be a bad idea to see if someone could round through Respiratory Therapy staff if they have time. Thanks for all you do.”

After I sent an email to an MD, she replied: “I really appreciate that! It has been a struggle trying to work and homeschool as a single mom, but I am getting some help from friends and family. I’m trying to focus on how fortunate I am to have all that I have right now!”

I received this prayer request from an employee: “I ask that we all pray for our country and others. That we will be healed of the virus that has taken over. In the mighty name of Jesus, Amen.”

I sent an email to a person in leadership who replied: “Hi. Thank you so much for reaching out. I am doing okay. I am not on the front lines of patient care but instead, have the usual concerns for exposure by working in a

hospital. I truly feel for those providers, nurses, and other staff that are at a much greater risk. I always appreciate prayer for God to watch over and protect my family and me, physically, emotionally, and spiritually.”

* * *

I found out today that an 8-week old baby has COVID.

* * *

A director asked me to provide support for the night shift; she asked me to be at the bed huddle and praise and affirm staff for their care of patients.

* * *

A director asked me to support an RN caring for a COVID patient. I went up and casually spoke with the nurse. She admitted that she was scared and was not happy that she was the one being asked to care for the patient, given all the unknowns. She said she spoke with her mom earlier for emotional support. She then told me that she is better now: “What can I do? There is nothing I can do but leave it in God’s hands.” I asked if I could quietly pray with her. She agreed. We prayed at the nurses’ station. She cried softly and said she felt better.

An RN told me: “I think we should have erred on the side of extreme caution rather than try to catch up afterward. To me, we should all be wearing masks already. But we don’t because the CDC says the data doesn’t support it. But to me, the data is so new and not sufficiently collected in terms of numbers that we don’t know what is appropriate or not. Err on the side of caution. You can always pull back later once the data confirms that masks are not called for.”

An RN told me in passing in the hallway: “I love all the different things that chaplains are doing for staff.”

An RN told me in passing in the hallway: “I love all the different things that chaplains are doing for staff.”

I spoke to an RN in Labor & Delivery because I was told she volunteered to work with antepartum patients who are positive for COVID. She says that she did not volunteer but had to do it because no one else was willing to do it. She is not happy with the constant changing of policies and procedures and the lack of protective gear.

JOURNAL ENTRY: MARCH 24 - ENTRY 13

Many RNs have moved out of their homes, renting hotel rooms or rooms in other RN homes. If they’re young RNs and live with their parents, they don’t want to expose them. If they’re partnered, and their partner is immunosuppressed, they don’t want to expose them. So, for these RNs, there is no home away from work right now. The greatest concern I have heard expressed is that their exposure will compromise the health of their children, grandchildren, siblings, parents, and partners.

* * *

There is significant anxiety that pediatric RNs will be asked to cover adult COVID-19 patient care, get exposed, and therefore be unable to care for their own pediatric patients.

* * *

An employee sent me an email: “Thank you. It's a tough time for my family, but we are a family of strong faith, and we know that we will get through this. I appreciate the prayers.”

* * *

I sent an email to a staff member who sent a response in return: “Hi. How nice of you to ask—well, dad isn't doing too well and finally agreed to have hospice get involved. I was going to fly out there, but my family is concerned about me possibly spreading the virus, so I am staying here. I've listened in on the visits, spoken with nurses, helped with the logistics of many things. I'm doing all I can do to help from afar.”

* * *

An RN tells me that we need to watch for Post-Traumatic Stress Disorder in staff after all this is over.

* * *

I provide support to a family whose loved one died in the ED. The funeral home would not allow family visitation or a prayer service due to family members having traveled and possibly having COVID-19. I prayed and provided an abbreviated funeral service in a room where the patient was taken after her death.

Only later did I realize that none of us in the room wore masks. I didn't wear PPE. The only person who actually wore a mask was a younger member of the family. She wore a mask because she has asthma and didn't want to cough without a mask on. I noticed how the nurses at the nursing station looked at her with what seemed like suspicion. They later asked me if the young girl was ill. I told them, “No. She has asthma; that's why she was wearing a mask.” This greatly relieved them.

JOURNAL ENTRY: MARCH 25 - ENTRY 14

Today, 17 are PUIs for COVID.

Code Blue. The first one with a possibly COVID-positive patient. We were all scared, anxious. Some of us who were outside of the room probably felt relief that we were not the ones having to do chest compressions and/or intubate anyone, etc. I felt some guilt around that as well. Others were possibly risking their lives but, as a non-clinical person, I didn't have to expose myself to that risk.

There were a lot of questions around how to gown up, how to transport the patient from the unit to the ICU, how to clean items and surfaces, how to dis-garb and place soiled garments in the soiled bin, etc. I realized at that

moment how important Infection Prevention is in all this. They are the ones who have been tasked with educating the rest of us on best practices. I also came to appreciate how courageous our staff must be to do their jobs.

Correction: It does not appear that COVID-19 deaths need to be reported to the coroner. (This will get changed later. Another example of things evolving and policies changing as new information and/or new conversations with stakeholders are had.)

JOURNAL ENTRY: MARCH 26 - ENTRY 15

21 PUIs, one confirmed.

* * *

Email I sent to a chaplain colleague:

- Stay in the present.
- The fear of a million deaths is a reality that does not exist.
- Focusing on what isn't yet the reality is debilitating.
- Doing something is empowering.
- Anxiety is real. Fear is real.
- 30,000 people in Italy have or had the virus. 40 million don't.
- COVID is big. We're bigger.
- Lots of people are working around the clock. We're not alone.
- You work in a hospital, so you know more than most people about this.
- We have been given stubborn hope.
- We bless the virus and the opportunities it presents.
- We send love towards the virus and accept its gift to us: community, sharpening us on the essential, a realization of how much good in the world there is, a shift of focus and priority, building bridges, bringing people together, deepening our faith.
- We are together, my hand in yours, and we live this moment together.
- Stay together with me. We will be okay.

The fear of a million deaths is a reality that does not exist. Focusing on what isn't yet the reality is debilitating. Doing something is empowering.

* * *

Today a colleague recognized my work: "I appreciate your help with the family visiting their loved one for the last time, for you escorting them in and out, having the service in the room after the first declined chaplain support, and getting the administrative portion completed. I appreciate all you do!!!"

* * *

The Governor announced plans to have one police officer and one National Guard soldier stationed outside each state hospital Emergency Department.

* * *

I have been rounding on Medical-Surgical units and COVID-19 units. Today, an RN told me some of her staff were anxious about caring for the PUI patients. And a doctor was wearing an N-95 mask on top of a regular mask. The anxiety was real.

I decided to get some brisket for the three nurses and the Patient Care Assistant (PCA) taking care of the COVID-19 patients. A dad in our NICU has a catering business. I went to his place and picked up some food. I was trying to help morale in little ways. This seemed like something that I could do, and that would be appreciated.

* * *

As we continue to address the ongoing impact of the COVID-19 pandemic, we are doing everything we can to take care of our employees best while continuing to deliver great care to those who need us. Early on, we eliminated elective procedures to reduce nonessential visits to our hospitals.

As a department, we are close to printing and distributing little laminated cards with pastoral care services we can provide staff on one side and motivational quotes on the other side. Today, I had a five conversations with employees about COVID-19.

JOURNAL ENTRY: MARCH 27 - ENTRY 16

25 PUIs and three confirmed.

* * *

The nurse manager of one ICU publicly affirmed a colleague and me for our work yesterday, stating we helped staff feel reassured, rounded on them, and are available for the unit in general.

* * *

Our hospital established a partnership with the YMCA with several locations offering childcare.

* * *

I was called to think of how to have a family (with a very young daughter) connect with her mom (PUI, intubated, and near-death). The girl and her older brother were on day 12 of self-quarantine, since their mother was a PUI.

The son wanted the hospital to write a letter to get permission for the grandfather from Mexico to visit the patient, who is divorced.

The goal of my involvement was two-fold. First, I speak Spanish, so could I find a way to get the grandfather permission to visit his daughter (the patient) legally? Second, how could we creatively find a way for the girl to be able to say goodbye to her mother given that the mother was a PUI and the daughter was on day 12 of the quarantine? (Underlying all this was the hope that, after the mother died, the young girl would be able to go back to Mexico with the grandfather).

I shared with the RN and Care Management that I have worked with situations like this before. The hospital would have to write a letter stating the condition of the patient. The Mexican Consulate would most likely have to get involved in petitioning the State Department or Customs & Border Patrol for expedited permission for the grandfather to come.

The Mexican government would have to review the petition and give authorization for this to happen. The Mexican Consulate would have to provide the funds to help the grandfather make haste to the US. However, with COVID-19 precautions, the grandfather would likely have to be quarantined for 14 days. Also, the staff did not think the patient would live for another two days. Furthermore, the family's expectations that after the patient's death, the girl could simply leave the US without any authorizing agency endorsing it was unrealistic.

In the end, the patient died. Photos of the patient were taken by a nurse using the phone camera of the son. Child Life gave the daughter a teddy bear to keep as a reminder of her mom; a similar teddy bear was given to the patient, which eventually was buried with her. These teddy bears are the kind where you can write notes, color, or draw something and then place the notes into a pouch on the back of the bear. So, while the little girl couldn't see her mom, she at least was able to express her love for her mom and, through the teddy bear, know that her love/words would be buried with her mom.

While the little girl couldn't see her mom, she at least was able to express her love for her mom and, through the teddy bear, know that her love/words would be buried with her mom.

With COVID ravaging the world and so many unknowns associated with it, an RN mopped the patient's room so that Employee Services staff didn't have to enter and risk infection.

* * *

Today, I had a conversation with a nurse manager regarding COVID-19 patients. She says staff struggle with all the frequent changes to the protocols for caring for patients.

JOURNAL ENTRY: MARCH 28 - ENTRY 17

26 PUIs and four confirmed COVID patients.

JOURNAL ENTRY: MARCH 29 - ENTRY 18

29 PUIs and two confirmed COVID patients.

JOURNAL ENTRY: MARCH 30 - ENTRY 19

Checked in with Infection Prevention employees. They were grateful. They say they feel very much at the forefront of all that is happening.

* * *

I buy box lunches for 30 employees. The owner of the restaurant is a patient of ours.

* * *

An RN in the emergency department asked me to visit a patient who was very agitated because she could not have any visitors. COVID-19 protocols no longer allow patients to have visitors. Indeed, when I arrived in her room, she was incredibly anxious. The patient couldn't understand why she is in the hospital and wanted to leave. Her daughter must stay in her car while her mom is being treated.

When the nurse introduced me as the chaplain, the patient exclaimed, "Oh, Father. I'm so glad you are here." The patient calmed down upon interpreting my presence and title (chaplain) as meaning I am a priest. I let her believe that. I shared that I am Roman Catholic. We prayed some Catholic prayers, and I gave her a rosary that I had with me. I decided not to talk about COVID or protocols. I simply asked her to rest in the peace of God who is with her. She calmed down and allowed the staff to continue to treat her.

I decided not to talk about COVID or protocols. I simply asked her to rest in the peace of God who is with her.

JOURNAL ENTRY: MARCH 31 - ENTRY 20

Leadership tells me in the hallway: "Keep doing what you are doing."

* * *

Today, I provide Pastoral Care to a mom who had an IUFD (fetal demise). Her husband is in lockdown in another state. The patient has a mother in town, but her mother has serious comorbidities, so she stays away. The patient has two other children at home. She is confused by everything that is happening. She is having a hard time making decisions regarding the disposition of the baby. She doesn't know what to tell her other children. She asks me to help her decide what to do with the baby. "You decide for me," she says. "I can't think."

Then she says, "Can you pray? Like a funeral-type prayer?" So I pray in the room, with only her nurse present.

This entry is from my personal journal:

The Angel Gabriel had announced the good news of glad tidings only a few months before. And now a birth has come, and the Angel of Death is also present. Alone and scared with nothing and no one familiar to lean into or lean on, a mom asks the nurse and me to be her proxy family, to help her bless her baby to Heaven.

And so we pray and celebrate a baby once here but now gone. We pray a hello and a goodbye in the same sentence. We pray as Scripture foretold: there is a time for everything, a time to be born and a time to die, laugh, and mourn. Today, there are tears. And sadly, a father cannot be here to see his new baby. Grandma can't be here either. Two siblings at home will not be able to see their baby sister.

Such is COVID; such is death; such is this time of infinite sorrow.

The mom cries and tells me, "Thank you." I can see she is very grateful and very sad. And very alone.

Later, I reflect that we prayed, I left, and I know I didn't do much to comfort this mother. I write this not out of guilt or feeling of failure. I write it because it is the reality. I didn't know what to do, just as she didn't know what she needed. The prayer was incomplete; my spiritual care was limited, uncertain, discombobulated. I walked into the room, not at all prepared. The nurse had called me and said, "Mom has questions about disposition."

I went in blindly because I had just come from a code. (For context: I work in mother-baby units, but now I have switched my ministry to focus almost primarily on COVID-19 units, supporting staff mainly). I went in with certain assumptions: her significant other was in there; she had been thinking about this already; she simply wanted clarification. The nurse had not indicated anything other than this would be a routine "mom has disposition questions" visit.

It was not a good visit. But I only realized it was not a good visit long after I had left and forgotten her and then remembered her later that night. I provided very little. The solace I do have is that she cried as I prayed over the baby and thanked me afterward. The nurse remained in the room for the "service." That was wonderful. And Child Life was able to get a footprint from the 13-week baby—a miracle in itself.

JOURNAL ENTRY: APRIL 1 - ENTRY 21

HIPAA permits a hospital to disclose PHI about a decedent to funeral directors as necessary to carry out their duties with respect to the decedent.

We had a request come through for a chaplain to check in daily with Employee Health. A colleague begins to make this a regular part of her pastoral care.

There's a new initiative. The Emotional Support Team now involves chaplains to provide 24/7 coverage.

I rounded today on the COVID unit. The staff was grateful. When I asked what they needed, one PCA said, "chocolate." So, I got chocolate for employees. I spoke with around 20 employees on the unit and seven elsewhere about their feelings related to COVID-19.

JOURNAL ENTRY: APRIL 2 - ENTRY 22

I rounded on all units.

I received this prayer request from an employee: "Praying for everyone being impacted by the COVID outbreak. Praying for our healthcare providers and all essential employees during this time."

JOURNAL ENTRY: APRIL 3 - ENTRY 23

A mom of twins called me to ask for support for herself and the twins. She used to be at our hospital but is now at another hospital. We spent several minutes on the phone.

JOURNAL ENTRY: APRIL 4 - ENTRY 24

35 PUIs with nine confirmed COVID-19 cases.

JOURNAL ENTRY: APRIL 6 - ENTRY 25

40 PUIs with 16 confirmed cases. The numbers are going up.

I called into the COVID-19 line...I had to trust that the person on the other side of the line was seasoned and experienced enough to give me the best counsel possible based on what I communicated.

I was ill on April 2 and did not work on April 3. I called into the COVID-19 line. They said I was free to work unless I developed other symptoms. I was glad we had a hotline to call. Even though I wasn't sure how to describe my symptoms—were they from allergies or a cold or stress or maybe even COVID? Am I really not feeling well? Am I being hypersensitive or overreacting?—I had to trust that the person on the other side of the line was seasoned and experienced enough to give me the best counsel possible based on what I communicated.

JOURNAL ENTRY: APRIL 7 - ENTRY 26

47 PUIs with 16 COVID-positive patients.

I checked in with a mother in the antepartum unit who is COVID-19 positive. No visitors are allowed. She has a child at home who does not understand why she can't visit her mother and another child who is struggling with what FaceTime is.

* * *

Later today, I received a call from a person in Washington wanting me to check in with her godmother, who is 90 years old. No visitors are allowed. I talk with the patient via phone. Fortunately, her voice is strong, and her mind is sharp. I had wondered what it would have been like to speak with someone at that age with pneumonia and COPD. Would her voice be strong enough for me to hear well? Would I be able to provide good spiritual care from a distance? But it worked out. We prayed over the phone. She was appreciative.

* * *

We had a Code Blue for a COVID-19 suspected patient. There is fear and anxiety among staff. Lots of gearing up to do. The MD and ER tech must wear respiratory-type support. The staff is working fast and the patient is intubated, but now there is fear of the virus is in the air.

Staff are asking: what's the protocol for transport to ICU? Who wears what? Who is gowned up, and who is clean? How do we do this? The Nurse Educator is there, and she is giving the instructions for proper transport.

JOURNAL ENTRY: APRIL 8 - ENTRY 27

I spoke with the director of the second floor, where the majority of patients with COVID-19 are housed. She shared...

- The regular nurses who work that floor are tired (they rotate off every two weeks).
- The nurses from the Med-Surg units are upset that they are being pulled to work the second floor with COVID-positive patients. They are scared and anxious.
- Plus, around nine regular second floor nurses are out (maternity leave, pregnancy, underlying health issues, or family concerns around COVID-19).
- One RN quit with no notice.

I probably spend more time with leadership/directors than other chaplains. I think I am getting a bigger view of things.

* * *

I've been calling more and more patients on the phone (COVID-19 patients, antepartum patients, Labor & Delivery moms with COVID-19). Yesterday, I called maybe 10 or more and prayed with most of them over the phone. I was able to help facilitate conversations around how this is for them. They have been very appreciative, so I will keep doing this.

* * *

I happened to be in Labor & Delivery last night when two fetal demises were in process. It was good that I was there and could support staff and patients. I visited these patients today. The spouse was in the first room.

The other mom had no visitors. Her husband left her 10 days ago. She has four other children at home. Her family is in another state. While I was speaking with her, she began to deliver her baby. I began a quick prayer but had to end the prayer as two nurses rushed in to attend to the patient. RNs cry because of this mother's situation.

* * *

I spoke with an RN in the NICU. She said her nine-year-old daughter cried because she thought that, if her mom went to work, she would never come back because she would have died from the virus. The RN said kids are hurting—no friend visits, no visits with classmates, no visits with grandparents—and they are absorbing the anxiety around them as they hear the news of healthcare workers dying.

* * *

I spoke with a Labor & Delivery nurse who is taking care of two COVID-19 patients today. She said doctors could be tested for the virus, but nurses could not. She doesn't think nurses are really valued, evidenced by how they are being told to suck it up and do their job without adequate PPE. When this is over, she thinks there will be a mass exodus of nurses who won't want to work as frontline nurses since they are being treated so heartlessly, as commodities rather than as real people with real-life stories apart from their work as nurses. She thinks many nurses will have PTSD afterward.

[One nurse shared that she feels nurses] are being treated so heartlessly, as commodities rather than as real people with real-life stories apart from their work. She thinks many nurses will have PTSD afterward.

JOURNAL ENTRY: APRIL 9 - ENTRY 28

From the birth certification office to me: “Hi, due to circumstances with COVID-19, we are anticipating needing your help in our birth certificate office with notarizing legal paternities.” I think the reason why they wanted our help was because we were all trying to limit the number of people and the number of times staff were entering into the rooms of COVID-positive patients. They were also anticipating some of their staff becoming ill with the virus.

JOURNAL ENTRY: APRIL 11 - ENTRY 29

30 PUIs with 14 confirmed COVID positive cases—one in Labor & Delivery, one in pediatrics, two in OB, and one in NICU.

JOURNAL ENTRY: APRIL 12 - ENTRY 30

A patient died in the ED after being rushed from home. She had collapsed. She had no prior health conditions. She was young, in her early 30s. Her two children (maybe seven and eight years old) were brought in by dad to see their mom after she had died. The coroner came. It was really sad.

The ED nurse said the staff may have been exposed to “who knows what” since they began coding her immediately upon her entry to the ED.

JOURNAL ENTRY: APRIL 13 - ENTRY 31

From an email from an RN to me: “Just received word that a nursing home facility is sending my mom to a local hospital because of a slightly elevated temperature and little interest in eating or drinking. Anxious. Worried. Concerned. Hope for the best. I haven't seen either parent in over a month.”

* * *

A mom is COVID-positive. She delivered a baby at 24 weeks gestation who is in the NICU. She is not concerned about her COVID status—at least, that is what she says. I am not sure if she is in denial. She seems a little too upbeat, considering she is alone, the baby is only 24 weeks, she is COVID-positive, the baby's father is not involved, and she has a seven-year-old who is being cared for by a neighbor. Plus, her extended family is from another country.

* * *

I am using music therapy every Monday in the newly created Employee Respite Room.

JOURNAL ENTRY: APRIL 14 - ENTRY 32

30 PUIs with 13 COVID-positive patients.

JOURNAL ENTRY: APRIL 16 - ENTRY 33

We are conducting a Zoom prayer meeting for our hospital staff. The staff prayed for my family member who has COVID. The surgery for a collapsed lung did not work as intended. He received plasma this morning. Maybe his final hope? Well, the plasma intervention did not work, according to my niece. There is no other possible treatment available. There is no therapy to be tried. It was heartbreaking because he is three years younger than me, and he has five grandchildren under five years old who all love and adore him. COVID is such a bear.

JOURNAL ENTRY: APRIL 17 - ENTRY 34

I made calls to two family members of two different COVID-19 patients today. A wife told me, “Pray for my husband. He is all I have.”

A wife told me, “Pray for my husband. He is all I have.”

I went to the ICU to speak with this patient’s RN. She said these two patients’ families are “always calling.” I was disappointed in her response. I was disappointed because it seemed harsh and judgmental, and not very compassionate.

However, as I stayed in the ICU for a while, I began to understand what she meant. Families called a lot because they couldn’t be physically present in the room/hospital. Their anxiety was lessened a bit with the gathering of information through the phone call. However, I saw that patients were often remaining in the same condition hour after hour. So, most phone conversations were simply a repetition of prior information that was being shared.

In addition, every time the phone rang, it meant a staff person had to pause what they were doing to answer the phone temporarily. And, with 16 COVID patients and two or three family members per patient calling in, some RNs or PCAs (Patient Care Assistants) had to run to the phone and then run back to the patient room and then run back again to the desk to answer another call in case it was a physician.

Since most staff work 12-hour shifts, the amount of effort was exponentially increasing because of the complexity, intensity, and interventions required to care for COVID patients—not to mention caring for the emotional and informational needs of family members and the staff person’s own internal processing of what they are experiencing. It was starting to feel unsustainable.

JOURNAL ENTRY: APRIL 18 - ENTRY 35

Today I spoke with a Labor & Delivery RN who was the first one to volunteer to care for moms with COVID. “I’ve always been a helper. I’ve been taught to care. And I’m a nurse. That’s what we do. We do our jobs. Maybe if I had children, I would have felt differently about it. But honestly, I don’t see this much differently than anything else I do. Maybe I’m just different that way, but I didn’t feel any extra anxiety.”

A COVID patient was actively dying. Her family was on Zoom call. Her husband has renal failure. He had been admitted before his wife contracted COVID.

JOURNAL ENTRY: APRIL 19 - ENTRY 36

The first COVID-19 patient died today in the ICU. His spouse never got to see him until this moment.

Their rabbi asked me to read the prayers for the dying. I did.

“There was no anticipatory grieving, no preparation possible that allowed her to ease into this. It was as though her husband had suddenly died...before the wife could get there in time. It’s sudden and incomplete.”

As one RN said afterward: “There was no anticipatory grieving, no preparation possible that allowed her to ease into this. It was as though her husband had suddenly died in the ED before the wife could get there in time. I’ve seen this when I worked in the ED. Only now, she can’t touch her husband; she can’t have family in here with her. It’s sudden and incomplete.”

The wife wanted to go into the room to touch him to make it “real.” The assistant nurse manager said she would allow it, but the rabbi talked the wife out of it due to the risk.

Another nurse said, “We are not doing a good job of helping families of COVID patients. We have RNs screening downstairs when we should have them at the desk to make calls, field calls, and/or to be the ones to help facilitate Zoom meetings. Or we have furloughed RNs at home getting paid instead of being here to help us. We’re winging everything. Families are calling six times a day. They’re hardly processing anything we are saying. We’re missing something. The phone is a way to communicate, but without a visual to go with it and without physical presence, it doesn’t seem to really work. The lack of touch and maybe talking. That’s missing. If it’s missing for them, what must it be like for the patient? It’s horrible.”

JOURNAL ENTRY: APRIL 20 - ENTRY 37

29 PUIs with eight confirmed COVID patients. Three moms positive for COVID-19 are in antepartum.

I was called this morning (on my day off) by another chaplain at another hospital to help with a COVID patient who was Spanish-speaking. There had been attempts to speak with the significant other and the patient's mother (in Mexico) via conference call, but apparently, it was confusing.

I got the significant other's number and spoke with her. We clarified some issues (the patient's mother is in Mexico and not in the US, as the hospital staff thought). The patient was on disability, and the significant other had stopped working a few months prior (reason unclear). I asked how they were surviving. She said he paid the rent right before he became ill.

There was going to be a phone call that included the staff, the significant other, and the patient's mother tomorrow. I asked her if she wanted me present. She said yes. I decided to buy the family groceries, since I was certain they had little to eat. I took the food to their apartment. When I came to her door, she opened the patio door and stepped way back inside. I had been told she had tested positive for the virus. It was awkward to leave the food by the door and then have to back out before she approached to pick up the grocery bags. But that was what we did; both of us respected each other's need for safety. I left then, and she thanked me.

JOURNAL ENTRY: APRIL 21 - ENTRY 38

A group in town is bringing the chaplains of Norton Healthcare lunch on Friday.

* * *

Follow-up from the 4/20 encounter written about above: I was driving to work when I received a call from the same chaplain who had called me the day before about this same family. She said there had been a problem trying to speak with the significant other and the patient's mother again. The same issues came up again as in other phone conference calls: misinterpretation of information; interpreter not fully competent in interpreting (e.g., saying that a machine in the room was blowing air into the patient's nose; the significant other and mother becoming upset with each other; one or the other crying and not being able to continue with parts of the conversation).

The chaplain who called asked me to come in. I arrived at their hospital (in our system but not the hospital I am assigned to). I was told that the patient would not survive much longer, even with intubation and treatment, and that if the significant other wanted to see the patient alive, she needed to come in now.

I ignored the rest of the conversation to call her immediately. I appraised her of the situation and asked what she wanted to do. She was in distress and didn't know what to do. I was confused a bit because she said she wanted to see him but didn't know how to do it. I recalled that she had told me yesterday that they had a car. I asked about the car. She said they had a car but that she didn't know how to drive. I asked, "If I come to pick you up, would you come with me to the hospital?" She said she would absolutely come.

The Infection Prevention nurse happened to be present. We asked her if I could pick up the significant other. She said, “No way in hell am I okay with this.” She said if the significant other had tested positive for COVID-19, then she was putting everyone at risk by being present and that we would be irresponsible in transporting her to the hospital knowing her health history.

We decided to use Zoom or FaceTime to have her and her daughter view the sacrament of the sick that our priest was going to celebrate, as requested by the family. With time being of the essence, I was a little upset that no one had helped her download the app on her phone. I had suggested this the day before but was told that they could do it today. Well, it was much harder to do this than what the other chaplain had thought. I told the chaplain, “She can barely use the cell phone. She doesn’t know how to search for or run an app, download it, and set up the features needed.” Luckily, the daughter was there, and somehow, we got things working.

The audio on their app was not working, so I held the other chaplain’s camera/video and spoke with the significant other and her daughter on my phone, providing a play-by-play of what was happening, who was who, etc.

Finally, we were given the green light to enter the patient’s room. The priest had been prepped and instructed on what he could do in the room. He was helped with his gown, gloves, and goggles. I was told I could enter the room without any PPE so long as I stayed behind the red line in the room and didn’t stay there longer than 10 minutes. So we went.

The priest did his anointing. I filmed it in real-time and narrated what was going on. After the anointing ended, I stepped back out. The priest had agreed to stay in the room until the patient passed.

The significant other asked me to stay on the phone and continue telling her what was happening. It was during the next 20 minutes that she told me his story. He had traveled to visit his family; he returned at the end of March and immediately became ill. He was taken by ambulance to a hospital. She didn’t know which one. He called her the first two days to tell her he was in an ICU, but then he stopped calling. She called for a week, but he never answered. Then his phone died, so it stopped ringing.

One morning, she opened her door and found a note stating that he was at our hospital. She had been given a phone number. She called. And now here we were.

After 20 minutes, the patient died, and I relayed that to her. She cried on the phone for five minutes.

Then she asked me to tell her what she should do next. I asked her about disposition. She said he had wanted to be buried in Mexico. There would be no funeral, of course, and transport now was probably out of the question. Cremation would cost \$750. She said she didn’t have the money. We spoke off and on for the next few hours. She was trying to get in touch with his mother to see what she wanted to do. But no resolution could be reached because the patient’s mother would cry and could not continue the conversation.

No resolution could be reached because the patient’s mother...could not continue the conversation.

Meanwhile, a Labor & Delivery nurse had asked me if I knew anyone who could use help during this time. I called the patient's significant other and told her of the offer. She said she was too embarrassed to ask for help. I encouraged her. She needed fruits and veggies and cleaning supplies. I asked her if she was COVID-positive. She said no; however, she and her daughter wanted to get tested but didn't know how.

This was among the misunderstandings between the staff, interpreter services, and her: she had been identified as positive. She may well be, but at this point, she was not certain. Her daughter, she thought, had the flu right after he became ill, but she was sure it wasn't the virus.

An RN took food, cleaning supplies, and several gift cards.

JOURNAL ENTRY: APRIL 22 - ENTRY 39

Sr. Cathy calls and says she is in contact with Catholic Charities for funds for the family, maybe even enough to cover cremation. I speak with the deceased patient's significant other. She says she is very grateful for all the support, for the camera viewing of her husband, and for the nurses who bought groceries and supplies and gave them gift cards.

JOURNAL ENTRY: APRIL 28 - ENTRY 40

I worked with a church and Catholic Charities to secure money for cremation for a gentleman with whom we worked.

* * *

A mom tested positive for COVID-19. She had a fetal demise. But she did not want to see a chaplain.

* * *

I spoke with a pregnant mom who is in addiction recovery. We talked about COVID-19. Her response was: "If I get it and it is my time to die, so be it." I paused a bit. I wanted to ask, "What if COVID causes injury to your unborn baby?" But I didn't ask her the question because I knew from experience that moms like her in our treatment program often do all they can to get into our program.

Admitting you have an addiction problem, being willing to share that with your OB, and then being willing to allow a hospital team to help you...well, to me, that was such a huge victory that I didn't have a need to burden her with something very heavy. She was simply trying to survive this day. And that to me was enough.

* * *

I met with a mom of twins. One died; one lived. The mother said it was hard and strange to have no contact with family/friends due to COVID. She also said it was sad and strange to celebrate and also grieve at the same time.

She didn't know if she should be happy for her baby who lived or sad for the baby who died and was feeling guilty either way.

JOURNAL ENTRY: APRIL 30 - ENTRY 41

Yesterday I received a text from the significant other from the earlier described encounters informing me that her family wanted me to be at the funeral today. This morning I received a text directly from the family inviting me. I was there with them this a.m.

How very different to see a photo of the gentleman in a healthy state instead of at the end when his body was so broken and vulnerable.

The funeral was very moving and very sad. How very different to see a photo of the gentleman in a healthy state instead of at the end when his body was so broken and vulnerable. His ashes will be shipped to his mother in Mexico tomorrow.

* * *

I helped place 700 brown bags with inspirational quotes at every screening station for employees.

JOURNAL ENTRY: MAY 1 - ENTRY 42

We have 7 PUIs with one confirmed COVID-19 case.

JOURNAL ENTRY: MAY 4 - ENTRY 43

Wednesday, May 6 will be the start of reopening for elective surgeries. Overall, this is a good sign. Maybe we're getting back to "normal." For example, staff who work in endoscopy feel both relieved to get back to work again and some anxiety about being exposed to COVID.

JOURNAL ENTRY: MAY 6 - ENTRY 44

A teenager had an IUFD (fetal demise). She was in a car accident a few weeks prior, and no one is sure if it contributed to the baby's demise. I visited with her and her boyfriend. She was still in shock and could not really connect with the reality that her baby had died. She had not delivered.

JOURNAL ENTRY: MAY 7 - ENTRY 45

I spoke with the manager in Labor & Delivery. She said that:

- a. Nine nurses tested positive for COVID-19.
- b. They have had nine COVID-positive mothers on the unit.
- c. One IUFD (Fetal Demise) mom was COVID-positive.
- d. They are now testing every mom who is coming in.
- e. Initially, staff was stressed due to COVID: fear of exposure and taking it home to family.
- f. But now, with masks being given to everyone, testing being done, etc., staff feels better about what they are doing and that they are safe.

The first RN to volunteer to care for a COVID mom became ill soon after. She was diagnosed with COVID and was out 30 days. I went and spoke with this nurse. She said that she is a nurse and that this is what she signed up to do. She was very matter of fact about it; she was not emotional, nor did it seem to her that her volunteering was of great significance.

* * *

A baby died in the NICU. That chaplain asked me to help the family since they were Spanish-speaking. I spoke with the father of the baby. He was grateful to have someone speak with him in Spanish. I spoke to a funeral home in town and helped make the arrangements for the baby's cremation to occur tomorrow. The funeral home picked up the baby, and I dropped off memory-making gifts to the father of the baby the next evening.

JOURNAL ENTRY: MAY 8 - ENTRY 46

I spoke with a patient who is Hispanic and positive for COVID-19. In the next room over is her daughter, who is also COVID-19-positive. Fortunately, I speak Spanish, so I was able to talk with the mother. She sounded like she was crying, and she is concerned that her daughter is not getting better. She was concerned also concerned about the family at home (husband, grandchildren). One of the other children is being taken to the ED because he is ill. I told the mother that I would speak with her husband and provide support.

JOURNAL ENTRY: MAY 11 - ENTRY 47

I checked on a Spanish-speaking mother and daughter w/ COVID-19. The mother is worried about her husband, who is not well and who checked in to get tested.

JOURNAL ENTRY: MAY 13 - ENTRY 48

The Spanish-speaking mother and daughter are now in the ICU. The daughter is very ill. I speak with the mother. She has a hard time breathing when talking. The daughter had to be bagged. I am worried she may not survive.

JOURNAL ENTRY: MAY 14 - ENTRY 49

I saw a patient who was told he was going to another hospital for a liver transplant in a few minutes. We didn't get to complete the conversation. But he was grateful that I came by. I prayed quickly since time was of the essence to get him ready for immediate transport.

* * *

The following is a story from our internal employee newsletter that I wrote. The patient's daughter gave permission for the story to be told publicly.

Chaplain and patient care associate support patient and daughter for emotional farewell

Thursday, May 14, 2020

End-of-life situations are among the many aspects of care that have been affected by COVID-19. Our employees have often been called upon to act as a surrogate family for patients when they pass with few or no loved ones by their bedside. A Norton Women's & Children's Hospital chaplain recently teamed up with "Mary," a patient care associate at the facility, to demonstrate that our employees remain empowered to provide compassionate care in these delicate moments. The chaplain recaps this powerful experience in his moving account shared below.

Yesterday, a chaplain colleague asked me to check on a patient who was very ill. I was only able to visit the patient at the evening shift change.

As I walked down the hall, Ashley, the day shift nurse who was taking care of the patient, whispered to me that she didn't think the patient would last much longer.

Mary, a patient care associate, was standing outside the patient's door giving a shift report when I approached. She told me the name of the patient as well as the name of her daughter. We entered the room together, and I introduced myself. I knew the patient was Baptist, so I asked the daughter if she would like me to pray. She said yes.

Mary stayed in the room. She moved next to the patient's bed, placed one hand on the daughter's back, and joined us in prayer.

Afterward, I asked the daughter if I could stay with her. She nodded yes.

Mary now stood by the bed and lovingly touched the patient's forehead and hair.

Just then, Ashley walked back in to say good night to the daughter. It seemed to me that Ashley had taken care of the patient a few times and had come back in to say her own goodbye. She looked down at the patient, touched her shoulder and said something quietly, and left.

Afterward, I asked if anyone in the room sang.

The daughter said she did, and in fact, had just finished singing a song a little earlier. However, she didn't think she could sing a song now.

Mary then took out her cell phone and started searching for something. She finally found a YouTube version of "What a Friend We Have in Jesus." She hit the start button and began to sing along with the singer.

I wasn't sure of the words, but I knew the melody and hummed along. The daughter sang and cried softly as the song was being played. As we sang, I noticed that the patient's eyes were open but "unseeing." Her breathing continued to be shallow and labored.

After the song finished, there was some small conversation among us. I kept my eyes on the patient. Her breathing remained the same: very shallow.

Mary went back to her phone and found Judy Collins' rendition of "Amazing Grace." We all sang quietly in unison. The daughter occasionally wiped tears from her eyes, as did Mary. Sitting next to her, I alternated between singing and praying.

When the song finished, Mary found another song called "Lead Me Home." The song was slow and rhythmic, meditative and soulful. I had never heard of it before.

Mary laid her phone on the patient's pillow. I could see the lyrics on her phone from where I sat. The song started with a steel guitar that was soon joined by a piano. Soon, the instrumental transitioned into lyrics.

I intuitively knew the patient would die before it ended. Soon the singer found his voice: "I have seen my last tomorrow."

When I looked at the phone and read the first line of the song, I intuitively knew the patient would die before it ended. Soon the singer found his voice: "I have seen my last tomorrow."

With those words, the room became quiet and gentle. Outside, the sun began to fade a little. There was a hush on the streets as cars seemed to have stopped. The shadows were lengthening, and the sunlight drifted into the room, giving the atmosphere a sense of silence and reverence.

The patient's breathing now started to really slow down and not be as labored. I noticed there was a pause between each sung lyric of the song. But then music would quickly follow. It was almost startling each time the singer made his voice known again: "I am holding my last breath."

Mary's hand stayed on the patient's face and forehead.

The daughter's quivering voice could barely be discerned underneath the music, but it was there as she began to say her final goodbye to her mom. Her shoulders trembled as her tears gushed forth.

Mary kept her left hand on her back: comforting, soothing, consoling. “Goodbye, sweet world of sorrow.” The patient's breathing continued to relax, and every exhale and inhale seemed to match the song's gentle pace. “My new life begins with death.”

A singular tear left the patient's eye. Mary noticed the tear and mentioned it to the daughter. “Look. She knows you are here.” The daughter saw it too, and her own tears joined her mother's tear. Mary then wiped the tear from the patient's face.

The patient's breathing slowed even more.

The singer again: “I am standing on the mountain...” Her breathing slowed even more. “...Take my hand, Lord, lead me home.” The song now moved deep into the background as we watched the patient. And then, three gentle breaths later, she departed this world. She was home now.

The daughter stood up from her chair and draped herself over her mother. “I love you, Mom. I love you. I love you so much.”

She told us, “I couldn't have done this alone. Thank you for staying with me...I'm glad you were here with me and that mom and I were not alone.”

Mary quietly cried next to the bed, and I stood as well in awe and wonder at what I had seen. When the daughter straightened out again, she told us, “I couldn't have done this alone. Thank you for staying with me. With the virus and everything, it will be so hard not to have a funeral like Mom would have wanted. But I'm glad you were here with me and that mom and I were not alone.”

JOURNAL ENTRY: MAY 15 - ENTRY 50

19 PUIs with nine confirmed COVID-19-positive.

Today I am with the Spanish-speaking family of a man dying of COVID-19. His three kids under 16 years old are present.

Doctor: “He is dying.”

Significant other: “Please don't tell me that.”

Doctor (to the children): “The three of you have to help your mother now. And you [gesturing to the oldest at 15]—you have to be the man of the house now.”

This kid goes over and touches his seven-year-old sister's head in a loving, protective manner.

The significant other had COVID herself and was in the hospital for three days. I tell her that I can get a priest to visit tomorrow to do the anointing. She asks me to tell her when he will do it so that they can be there as well. She is bleeding from the nose. I feel a little concerned, not knowing why she is bleeding. She doesn't know either.

JOURNAL ENTRY: MAY 17 - ENTRY 51

The mother and daughter who had been in the ICU with COVID are both back in a step-down unit.

JOURNAL ENTRY: MAY 20 - ENTRY 52

Today, I had a conversation with a NICU mom and grandmother about having a baby during a pandemic. Visitors are now allowed, but only one visitor apart from parents.

Mom said, "The NICU is already hard, but with few visitors allowed, there is less support. You feel more isolated—no celebration with hugs and no support with hugs. Our NICU baby is overshadowed by COVID. And so, there is no empathy for me as everything is focused on the virus. And even worse, because of the political divide and anger over everything, there is even less support."

JOURNAL ENTRY: MAY 21 - ENTRY 53

A Spanish-speaking woman (mentioned above) has gone home, but her daughter is still in the hospital. I speak with her. She sounds much better. Her voice is stronger than I have ever heard—even compared to the first time I spoke with her several weeks ago. (She eventually goes home. This is a miracle, really.)

JOURNAL ENTRY: MAY 25 - ENTRY 54

George Floyd dies in Minnesota. People are upset.

JOURNAL ENTRY: MAY 26 - ENTRY 55

Thinking of possible future ramifications from the pandemic:

1. PTSD from this period.
2. The anxiety of a second wave of COVID.
3. Anger and division between those staff who see this as a crisis that we needed to address and those who believe this was an overreach and overreaction.

4. Skepticism about what the proper use of PPE is. Guidelines before the pandemic were of a certain standard (one use, etc.), and suddenly, those standards were relaxed or adjusted due to lack of PPE. How many staff were potentially exposed?
5. Some resentment towards those employees who took leave to get out of caring for COVID-19 patients (as some other staff interpreted their actions).

[From some staff, there is] resentment towards those employees who took leave to get out of caring for COVID-19 patients.

6. “Hometown Heroes”: the term could be positive, or it could be something where people take on the persona (e.g., work too much, sacrifice self-care, etc.) needlessly in order to meet the societal definition of what a “hero” is or does.
7. Meetings by Zoom.
8. Use of technology to connect with others (including departments, colleagues, and patients with doctors). Patients seem okay with the use of a phone to talk with chaplains.

Notes of significance:

- I worked with the Catholic Church and Catholic Charities to get money for the cremation of a COVID patient.
- I was asked by the family to attend the funeral.
- I prayed the rosary over the phone with a Catholic patient.
- A Rabbi asked me to pray from the Jewish prayer book as a COVID patient died.

JOURNAL ENTRY: MAY 27 - ENTRY 56

There was COVID testing at a Catholic Church. I was a volunteer. Four hundred and three people got tested. I was tested as well and later received negative test results.

JOURNAL ENTRY: MAY 29 - ENTRY 57

I was able to request that Catholic Charities help with rent/food assistance for a Hispanic COVID-positive patient’s family. I got the family to sign documents for food/rent assistance.

I also received a call from the social worker at our other hospital to help with a Hispanic COVID patient and their family. I called the family to get their impression of how a conference call with the medical team went yesterday. I asked them if they wanted to visit their dad. They said yes.

I had to tell them, based on information from the RN, that their father's ventilator had to be turned off to help protect them. The two daughters agreed on the phone and understood the implication. They understood that to enter the room and have the ventilator turned off meant their dad would die. They were ready: they knew he would not recover. COVID had effectively destroyed all of his lung tissue. There was no longer any need to keep him suffering on a machine that was delaying the inevitable.

The RN was clear that they had to be careful in entering the room, had to wear PPE, and had to limit their time in the room. Also, to enter the room meant they could be exposed to COVID. They said they understood. They will come today at 5. I will meet them there.

They came at 5 p.m. I prayed in the room. As their baby had died a few years prior and I had been with the family, I knew them.

The youngest daughter asked the RN, "Can you please save my father?"

The son shared that his father worked at a processing plant; he was first furloughed but then went back and contracted COVID.

The nurse practitioner told the family that it was not correct that the patient would be taken off the ventilator in order for the family to visit. The RN was behind her. I think she was the one who gave that inaccurate info to my colleague, who passed it on to me and had me pass it on to the family. The NP gave the family this "new" information regarding the ventilator. They were somewhat relieved, but it felt to me that they were having a difficult time processing the information.

We all entered the room together. The RN and NP stepped out after some more explanation was given. They asked me to pray a prayer, which I did in Spanish. I then excused myself, and they stayed. I could hear them talking to their dad, asking him not to die. They were all crying and grieving greatly. After about thirty minutes, the RN went back into the room and asked them if they were ready to leave.

As we were walking out, I asked the oldest daughter to let me know the outcome. She said she would. She called me that evening at about 9 p.m. to say that her dad had died. It was a Friday.

There are national protests over George Floyd's death. Protests happen locally over a similar killing. There is protesting happening around City Hall. Hospital employees become emotionally involved in the social unrest. Protests become violent. Some staff have spouses/families who are in law enforcement.

JOURNAL ENTRY: MAY 30 - ENTRY 58

29 PUIs with 13 confirmed COVID-19 patients.

JOURNAL ENTRY: JUNE 1 - ENTRY 59

The family whose dad died Friday evening called me the next day to tell me that the funeral is set for June 5. I will attend. They are happy that I will be present.

JOURNAL ENTRY: JUNE 3 - ENTRY 60

I continue to work with Spanish-speaking COVID-19 patients who are in our hospital.

JOURNAL ENTRY: JUNE 4 - ENTRY 61

I was asked to round on staff due to all the social unrest resulting from the death of Mr. Floyd. I rounded on each of my units and initially waited to see if anyone was talking about it. Staff on some units were already engaging in conversation about it.

I knew right away this was going to be a very delicate issue for everyone. Some staff were not happy with Mr. Floyd receiving so much media coverage. Some folks were upset that he died the way he died. Some folks were upset that some people were now anti-police. It was an issue that brought out a lot of very strong and definite feelings, opinions, and thoughts.

There is a lot of pain here. There are stories and histories and hurts that I am not privy to and that are outside of my universe, in some cases.

Given how unpredictable and visceral the feelings provoked by this incident are, I have decided not to write down any (or not many) of my thoughts or experiences surrounding this. There is a lot of pain here. There are stories and histories and hurts that I am not privy to and that are outside of my universe, in some cases. I am listening; I am thanking folks for their candor; I am suggesting that there are some counseling resources available if folks need further support. It's a scary time since our city has also experienced violence since Breonna Taylor's death here in March.

JOURNAL ENTRY: JUNE 5 - ENTRY 62

I attended the funeral of a COVID-19 patient. The family and friends are glad I am there.

Later that day, there is a tribute to a local woman killed by law enforcement. Many staff members participate. Others are upset the hospital has taken a stance in support of this.

JOURNAL ENTRY: JUNE 6 - ENTRY 63

One of the families I previously helped wants to know where the ashes of her significant other are. Tracking from USPS says it was processed in Chicago and is on the way to the destination. That's all I know.

Another family wants help with rent assistance. I believe a nonprofit helped them with \$964 rent for May. Now they want money for the next month. They will come by tomorrow to give me rent info so I can turn it to Catholic Charities.

JOURNAL ENTRY: JUNE 8 - ENTRY 64

I was interviewed by Louisville Magazine about my work with patients with COVID who died.

JOURNAL ENTRY: JUNE 9 - ENTRY 65

I rounded with Behavioral Medicine to support staff who are struggling with the recent unrest over George Floyd's death.

JOURNAL ENTRY: JUNE 10 - ENTRY 66

I attended a funeral for a patient.

Later, an RN called to ask if a family could ship the body of a deceased COVID-19 patient to Mexico. I called the Mexican consulate and the funeral home about shipping regulations for the body of a COVID-19 patient to Mexico. Is it allowed? How much is the cost?

The cost is around \$5,000 (\$3,000-\$4000 for airplane transport and \$2000 for funeral expenses). The consulate said it is allowed, and the family has to work with the consulate to make that happen. I gave the consulate the contacts for both the family and the hospital.

JOURNAL ENTRY: JUNE 16 - ENTRY 67

We have 10 COVID-19 patients in the hospital.

JOURNAL ENTRY: JUNE 18 - ENTRY 68

The families of two Spanish-speaking patients still call, asking, respectively, if I can help with rent, food, etc., and where the (shipped) ashes of their loved ones are.

JOURNAL ENTRY: JUNE 19 - ENTRY 69

There is more division in certain units of the hospital regarding the social unrest happening nationally.

JOURNAL ENTRY: JUNE 20 - ENTRY 70

I got tested to see if I have COVID-19 antibodies. The result was negative.

Nina Redl's Journal

Looking back at what I wrote almost a year and a half ago, I am stunned by how similar and yet different it is to where we are now. We had no idea how much more there was to come and how long we would have to be in this pandemic.

Early March through late June 2020 formed the first COVID-19 surge. We thought it was big—little did we know. But it was big for us at the time with the experience that we had: the initial fear and trepidation; the constant updates on the virus; scrambling to find the right way of dealing with it not just as a hospital team but as a community; the lockdowns, curfews, and the constantly changing policies and insights that made our heads spin.

I remember so well the feeling of nervousness mixed with a strange sensation of excitement and pride when I put on a reusable type of personal protective gear, a PAPR, in the COVID lockdown unit for the first time, walking into the first COVID room, having the first family meeting via iPad...all the kind of firsts you never want to experience because you know how “wrong” it is to have to adjust this way. Still, you do it anyhow since it is the only way.

In healthcare, we adjust to the unforeseen tragic and the impossible every day. It is amazing to see just how much we have been able to adjust in such a short period of time. Back then, during the first wave, we were still glued to the national news, holding emergency ethics and pandemic meetings to see what we would do if we ran out of resources. Today, I can say that so far, almost two years into a pandemic that we thought would be over in a few months, we have adjusted to a new normal...living in a frozen conflict state of a plateaued pandemic. It moves more slowly, but it is always there.

Almost two years into a pandemic that we thought would be over in a few months, we have adjusted to a new normal...living in a frozen conflict state of a plateaued pandemic. It moves more slowly, but it is always there.

Sometimes there is a break, with just a few COVID patients, and then we are back again with having a quarter or more of the hospital being COVID units. And we are not sure when it will end. Is this the third or fourth wave? Does it matter? Thankfully, we have not run out of resources, at least not on the material side. The much higher toll the pandemic has taken on us comes in the form of the realization and resignation that we are in it for the long haul...and some of us have lost hope that it will ever end. COVID is here to stay—that's what we hear all around us. But what does that mean? Is it ok to have gotten used to most people not making it out of the COVID ICU alive?

Vaccines are available, at least here in the US, but vaccine hesitancy and refusal have taken the top place on the list of comorbidities. We now live in a world where a 101-year-old vaccinated gentleman has good chances to survive a rather rare COVID breakthrough case. He is likely to go back home, while a 25-year-old relatively

healthy but unvaccinated pregnant woman might have to endure an emergency C-section prior to intubation. We will have to fight for both her and her micro-preemie's lives, and we know the chances of losing the fight are high.

The Delta variant of the virus is more contagious and even less discriminatory than the original one: the length of morbidity, especially on younger and middle-aged people, is high; spending a month on a ventilator maxed out on everything is nothing unusual (in fact, the chance of surviving with a reasonable life quality is next to nothing for many). At the same time, for many in the anti-vax community, the so-called "healthcare heroes" have turned into their number one enemy: "I decide what I put into my body," "you can't make me," and "I decide how you treat me" are just some of the main comments we hear every day while trying to still fight for their lives and health.

It is not about winning or losing; it is about being able to continue.

Some of us have even had our careers and wellbeing verbally threatened by enraged patients and family members who are still convinced that COVID is a hospital conspiracy for the sake of profit. Is it a lost fight we are in? Physically? Emotionally? Theologically? Legally? I don't think so. However, it is not about winning or losing; it is about being able to continue. I am more than ever reminded of a quote that I once heard and have often used: "Courage is the little voice at the end of the day that says, 'I will try again tomorrow.'"

In the midst of this storm, we have become more tired but also more resilient. Many have left the healthcare world. The ones who are staying are defying the odds every single day. While our COVID patients dance on the edge of intubation, we dance on the edge of resignation, burnout, and compassion fatigue again and again.

Still, I could not be prouder of my medical team and all the healthcare professionals out there who do this job every day, no matter what the odds are. In a way, we had to give up the question of "when is this over?" because we don't know. Staying in the moment is what counts for now, one day, one patient at a time. Is it survival mode? What will the future look like when COVID is over? We will figure it out.

The biggest resource we have is one another and the endurance to make it through one day at a time, with humor, leaning on each other, sarcasm, continued courage, survival mode, faith, and the simple, yet at times irrational conviction that we can, no matter what. It doesn't make sense; it is messy, exhausting, enraging, frustrating, crazy.

And we will do it together.



JOURNAL ENTRY: APRIL 5, 2020 - ENTRY 1

This past week has been intense again. The hospital is now completely shut down and allows no visitors (other than one for pediatric patients, neonatal babies, and delivering mothers, unless they are COVID-positive—and I am incredibly grateful for that).

I struggled on Monday when I was unsure how and whether I would be able to be with my ICU staff and patients, now that this area is a full-fledged COVID-19 lockdown unit. It felt so wrong not to be there after I spent almost seven years helping to build this unit, creating long-lasting relationships, and always being there for my staff in every crisis. I felt like I would abandon them in the worst crisis they have faced so far if I could not be there. I always emphasize that we are work-family to each other; how could I not be with my work family now? And at the same time, I realize that it is exactly this that we demand of the patients' families in this unit.

Plus, I would never take PPE equipment away from the nurses that need it. However, as of Tuesday, it was clear that I have to wear PPE anyhow at all times, no matter where (at least a mask and goggles). So now all I have to do is change my uniform, and I can at least be partially present on the unit in what are called the cool and warm zones (lobby and hallways), just not in patients' rooms. But since the rooms have glass doors, the patients can still see me, and I can talk to them via phone.

I have an iPad now that allows me to Skype, Zoom, and FaceTime with patients and families while being anywhere in the hospital. I'm able to help connect anyone with their loved ones in the hospital. On Wednesday, I held my first virtual family meeting for an intubated and dying patient in the COVID unit.

It is hard to put in words how heavy this iPad felt once I had all family members present on the screen. I found myself semi-consciously cradling the iPad in my arms, like in a hug, exactly the hug and holding I cannot give in person right now. I am acutely aware that the family can only see my eyes, and for the first time in a while, I hope they can see that I have tears in my eyes too, and that those tears are not a weakness but the last sign of deepest care I can give them and their loved one in a visible way.

Due to the COVID restrictions, so much of our care that goes beyond words through gestures has become limited: the gentle touch, the hug, walking next to someone, a friendly smile. All those are gone, replaced by the hope that through the screen, you can still see me just a little behind a pair of glasses and a pair of goggles and know that I try to send you care with everything I have. Hoping that, if there is a God, he/she/it can be the caring force that still connects through the glass of the door and the glass of the screen.

Also, how wonderfully paradoxical that the moment I can step into the lockdown unit and see the familiar faces of the staff I am closest to, it is the first moment I feel happy and non-anxious, like coming home. My presence feels *right*, right there in the midst of the thunderstorm. I see this relief reflected in the smiles of my staff under their PAPR hoods—now, the world is okay again, even though nothing is normal or right.

In my personal Jewish belief, God has always been faceless. For the first time, I reflect more deeply on this. How does he manage to be so present? Now that my chaplaincy has become faceless, how do I stay present? I have to chuckle as I quietly ask God to help me figure out to be a little more like his facelessness: ever-present and so close that a face is not needed (how I image God in my best moments) and not just some weird alien-like cold

distance or non-presence (like I feel in other moments). My prayer of the day: God, help me be less alien-like if you get the chance.

My prayer of the day: God, help me be less alien-like if you get the chance.

Nevertheless, even if I do not always believe in God, I believe in the power of human connection, in the invisible string between our hearts, sometimes forged over many years, simply appearing in the moment to keep us connected.

One young mother I have worked with for over a week after her complicated fetal demise was reluctant to leave the hospital; she said she felt safe here and was not sure about the outside, even though her two living children and her husband wait for her on the outside.

The hospital has become like a cocoon of safety for some of my patients, and having to leave it, having to leave the world where everyone is so careful, is scary. How do I help take away this fear? How do I help her see that there is an outside world, one that is good and kind and one that will heal, just as she is healing, when she faces so many more fears than just having to enter the outside world without her baby daughter?

The outside world looks cold and hostile to her. The place where she suffered the loss of her baby girl has become almost home-like. How can she leave her baby girl behind and step into a world that has become so much more dangerous than she ever thought possible? We talk for hours, we FaceTime with her two little boys, and we slowly rebuild the invisible string of connection that is there between her and her family, acknowledging both the missing link in this string to her baby daughter and the possibility of holding on to this string as a guide through the unknown.

JOURNAL ENTRY: APRIL 8, 2020 - ENTRY 2

I had a hard time not breaking completely into tears today. In my COVID ICU, we admitted an 80-year-old woman; her husband died of COVID last week. As I am standing there only 20 feet away from her, separated through the glass door and the negative pressure in her room, I hold the iPad that connects me visibly to her. She starts telling me how she felt she died already since she could not be present when her husband died last week.

She couldn't care less whether she has COVID or not. She tells me that if she has it, she wants it to take her fast because she does not know how to live without her husband after having been with him for more than 60 years. The only day they were ever separated was the day he died; the hospice did not allow her in. I hear my nurses cry around me, and it is impossible not to cry with her. I ask her to simply let all her tears out, all the anger, all the hurt, and that even though I am on the other side of the glass, I will catch all her tears. We talk about the one force that is bigger even than death: love. We talk about how we both believe that not even death can take away love. And we cry.

In the end, she asks me to come back and see her again tomorrow so that she feels less lonely, and of course, I will. I ask her for permission to bless her and her husband since I believe – as I tell her – that he is a part of her, a part that no one, not even death, can take away from her. She smiles and permits me, and with my staff standing behind me, I bless both her and her husband and ask God to make sure that even if physically separated, he keeps them together through love, tears, and smiles. Whenever she needs to feel her husband. I pray that God may help her reach deep inside of her and find him right there in her heart.

I heard another chaplain say that her job has turned into hell, and I understand what she means. However, I feel my world has turned into a broken heart that can help hold and mend, one tear at a time, and maybe as I once heard, even if it hurts, there is more room in a broken heart.

JOURNAL ENTRY: APRIL 10, 2020 - ENTRY 3

I had two wonderful visits via iPad today. For the past four weeks, I have visited a young mother who hemorrhaged after a 14-week gestation miscarriage, then went into septic shock and eventually had to undergo amputation of both legs below the knee. Her fiancé left her two weeks into this ordeal, and we have tried to find the rest of her family ever since then. All we know is that she has six young children, but it took until today to find her sister and her cousin.

Today was her birthday, and she was finally extubated and seemed to regain consciousness. I helped her sister and her cousin make a video call to her. And despite the disbelief of the doctors, the moment she heard their voices, she started reacting. Her cousin sang her a song from her childhood, and it was almost like a miracle when she moved her hands for the first time in weeks by herself and tried to mimic the motions of the children's song she grew up with. After a week filled with anxiety and death, this was the most life-affirming moment that my medical team and I were honored to witness.

For another patient, somewhat alert and oriented on the vent, I FaceTimed with her dog (her daughter held the dog to the camera at home), and the difference in this patient's demeanor was breathtaking. There was life in her eyes again; no matter how jaundiced, there was a spark of hope.

It took almost 50 hours this week of exhausting and life-defeating experiences to finally reach this moment. It helped me heal a little bit inside, too. This experience made it possible for me to get through the last five hours of my shift. Five hours don't sound like much, but recently when every hour feels like a week, when even walking to my car at the end of the day is more exhausting than a marathon, it is those hopeful moments that make sure I can continue to bring life into this darkness without breaking.

When every hour feels like a week, it is those hopeful moments that make sure I can continue to bring life into this darkness without breaking.

JOURNAL ENTRY: APRIL 13, 2020 - ENTRY 4

Tonight, I gave our iPad to a woman whose husband was dying in the non-COVID ICU. Her son, on self-isolation at home in Seattle due to COVID, could not be with them, and our iPad was the only way he could be with his father during the last hours. The wife asked me to stay with them, so while holding the iPad in the right position, the nurse and I explained everything in the room to the son in Seattle and tried to have him see exactly what we saw. After he felt more connected to the room, we put his dad's favorite music on the regular computer, and we all sat in a circle around his dad's bed, listening, holding hands, at times singing.

I encouraged the wife and the son to talk to the patient (who was unresponsive at that time) and share stories with him. I got to listen and, now and then, I would add something that struck me as particularly beautiful in their stories and memories. It was a strange feeling, almost like a campout but in an ICU and with one person present yet so far away. The son got himself comfortable on his couch, we got snacks and warm tea for the wife, and staff came in and out and joined our little circle every now and then. The most wonderful comment I remember was the son saying at one point: I really feel I am with you.

JOURNAL ENTRY: APRIL 16, 2020 - ENTRY 5

Today, we had a direct admission from the ED with a young woman suffering from end-stage tongue and throat cancer. Recognizing that she would die within a few hours, we allowed her husband and two children to be with her. She could not speak anymore; the most that was possible were some sounds. Hearing their loved one gurgle was incredibly hard for the family, but the woman insisted on trying to speak to them.

I gave her a writing board, and with a little help, we could decipher that she wanted them to sing her the same songs she sang to her children when they were little. We ended up sitting around her bed, her husband and her children holding her hands and singing children's songs. When I prayed with them, we decided to sing a prayer, even though I had jokingly warned them that my voice is not a singing voice. I tried nevertheless, and we all ended up laughing. I asked the daughter, who had a beautiful voice, to hum a melody while I spoke a prayer, and that worked beautifully.

The most precious moment came when I stepped into the room of an elderly lady next door who had tears in her eyes. Even if she could have had visitors, she had no one left, she was the last one standing, but she had heard the singing next door, and it reminded her of her time when she was little and her mother sang to her some of the same songs. I saw her smile for the first time in days.

When sharing (with her permission) that little fact with the family next door, the husband and the children got up and stood outside the door of this lady and sang her a song. My oncology unit had never felt that peaceful in the midst of this pandemic. It was beautiful. I was able to sit on the bed with her, hold her and cry and laugh with her and her family, and in the end, lead us all in prayer—what a beautiful moment.

JOURNAL ENTRY: APRIL 19, 2020 - ENTRY 6

On my day off, the hardest part is finding ways to relax. Rationally, I know that nothing the new week will throw at me will be too much to handle, whether COVID or non-COVID. But every week feels like a year, and by the end of it, I am so tired. Sometimes the day or two I have off are just not enough to recharge my batteries, process everything, and get from wartime mode to calm mode. They are not enough to take care of my family and get the rest I need.

I am thankful for the calmness of anything outside the hospital; the lockdown outside feels more welcome and calmer than it feels eerie to me.

It is a constant dance. I am thankful for the calmness of anything outside the hospital; the lockdown outside feels more welcome and calmer than it feels eerie to me. It is like the quiet is welcoming me after the long hours of the noise and the despair. But it takes time to let it sink in and get back to myself in a more composed way. I know I will be fine the moment I am at work, but Sundays haven't felt so heavy in a long time.

JOURNAL ENTRY: APRIL 20, 2020 - ENTRY 7

The best part of my day was to help an elderly woman on the COVID unit to FaceTime all her family shortly after her test came back negative. It was incredible to be able to see the relief and joy in their faces, the happy tears knowing that their mother and grandmother will survive and, most likely, will be able to discharge home in a few days. Being able to be part of the very moment they realize this wonderful truth—it goes beyond words. It makes it worth all the moments of exhaustion and despair, simply knowing that there are still good things happening.

JOURNAL ENTRY: APRIL 21, 2020 - ENTRY 8

I had an encounter today that made me laugh and cry at the same time. A young woman who had suffered an 18-week gestational fetal demise and, after severe hemorrhaging, had almost bled out on the table, had finally recovered enough that she felt strong enough that we could do a baby blessing. Her little boy was beautiful. Her only wish was to do the blessing outside; she had been in dark and sterile hospital rooms too long.

With the help of the incident command center, I got permission to take her and her husband outside to the little green area next to the parking lot. The rest of her family, including her four young kids, were not allowed to participate because of the policy that limited all visitors except the husband. However, they parked outside the hospital ground and were there about 30 feet away on the other side of the street. One of my nurses and I rolled the young woman out in a wheelchair, all in masks with her baby boy wrapped in her arms.

As we blessed the beautiful boy, her other children stood on the other side of the street, laughing, crying, blowing kisses, and sending air hugs. With the help of smartphones, we video-conferenced and recorded the blessing. It

took all I had not to call those children across the street. It felt so good that they were there, and so wrong that they had to stay on public grounds 20-30 feet away.

The joy of seeing them, the pain of not having them closer, was tangible in the air. They were so close and yet not close enough... their mother held the beautiful baby boy, the sibling they will never see grow up, in her arms. She was crying and laughing at with all of her children. It was simultaneously one of the most beautiful and one of the hardest things I have ever been part of. We were connected despite the distance with a street between us that felt as wide as an ocean.

All I could do in the end was call across the street and promise them that I would help bring their mother back to them as quickly as I could. Even though I normally never make promises, I knew I would do everything I could to bring this family back into each other's arms.

JOURNAL ENTRY: APRIL 22, 2020 - ENTRY 9

I am spending a lot of time every day taking care of my staff. The highlight of my day is still seeing my staff on the COVID ICU. This ICU has been my work family for seven years, and I could not even imagine not being with them. Seeing them every day and finishing my workday with them is perfect for me. Nothing could make me happier than smile, a joke, a prayer, a few minutes sitting down and just talking, crying together, and making sure they always know that I am there for them.

A nurse from my oncology unit had her first day after a long maternity leave today. Her baby is at home on oxygen, so she is not going back to her normal unit but will only work the COVID telephone hotline. I sat with her and held her as she cried. She misses the work-family of her unit (and feels guilty to not be there, but also relieved. She felt torn but knows her baby must come first). She is overwhelmed by the influx of panicked calls that keep coming from the community to our hotline. I think she is battling more COVID over the phone than anyone of us on the COVID units.

All I can do for now is sit with her, let her talk, hold her, let the silence between us be one of understanding and togetherness. I try to help her go back to her desk after lunch, while making a mental note to drop off later a bag of her favorite tea and a card where I will put in words once more how much her work means to all of us and how much I care about her, so she can not only hear it but read those words.

JOURNAL ENTRY: APRIL 23, 2020 - ENTRY 10

A young mother coded today. She was admitted with complications from a miscarriage before the pandemic started and has not yet left the ICU. She had bleeding in her lungs, multiorgan failure, and eventually needed a bilateral amputation and a feeding tube. Today she was supposed to be trached, but she coded first. I had only known her family (husband, sister, and six young children) via the iPad since shortly before the pandemic; they did not have the money to get to us.

As we code her tortured body, all I can think about are the happy faces of her kids that I saw yesterday in our last iPad meeting, along with the patient's smile and the words she carefully mouthed to them, "I love you, I will try." And I so want her to try. But I also see her body convulsing under all we do to her. Torture and hope, wanting her pain to end and wanting her to pull through...

The only person close by was her father-in-law. We got permission to let him in for 10 minutes as we finished the second code on her. As I walk into the room with him, catching him as he nearly collapses, I see her looking barely alive and not much more than a pain-filled shadow of the young woman he saw last. All I can do is help him stand. We stand there for minutes or hours, and I just hold his hand. We pray for God to be there. There is nothing more I could put into the prayer, just "God, please be there, hold her."

There is nothing more I could put into the prayer, just "God, please be there, hold her."

When I walk him out to the front entrance, he looks at me and mouths "thank you" with so much heart and despair in his voice. I hold his hands and ask him to go home, call the rest of the family and have them hold her children tonight; I do not want the last night that their mother may be alive to be a night that they do not feel loved. It is all I can do right now.

JOURNAL ENTRY: APRIL 25, 2020 - ENTRY 11

We got the announcement today that the governor declared that within the next 10 days, he wants to carefully reopen the economy, including religious services, tattoo parlors, and restaurants. As much as I want people to have a paycheck, this is so scary and dumb. Yesterday was the first day in over four weeks that I did not tend to a death. I had almost forgotten how it feels to work a shift with no one dying. My COVID ICU had one open bed, and it remained open for the whole shift. We almost felt like dancing!

Still, this hopeful lack of deaths is not enough to endanger everyone by reopening everything. Most of my staff have barely had enough time to breathe, let alone start tackling all the stress, and we all know this is not the end of the pandemic but just a break. We have several cities nearby that are getting more cases by the hour, and we already got notice that, if we have open beds, we will have to absorb some of their patients.

Reopening the state feels like playing with the lives of our patients, our lives, and our families' lives and health, not even to speak about everyone's sanity. There must be other ways to help people have paychecks without throwing us right back into worse circumstances.

JOURNAL ENTRY: APRIL 26, 2020 - ENTRY 12

Today, the big shopping outlet mall in our area announced that it would reopen in a few days to the public. Yes, they will have "security measures," but only recommended ones, not mandated ones. Given everything I have seen, very few people will adhere to security measures. It scares me: for myself, my patients, my colleagues in all

the hospitals here, and for all our families and friends. I want people to have paychecks, but I primarily want all of us to be healthy and alive and not be in danger due to widespread greed and entitlement. My hospital is tired; it holds up every day with so much courage and force, but we do not need another wave. We need rest. And if, writing this, I feel like I want to cry in despair, I cannot even begin to imagine what my medical staff must feel seeing the same announcement. Sometimes I just want to run away. But even more, I want to go back to work tomorrow and be strong enough to continue carrying us and supporting however I can.

JOURNAL ENTRY: APRIL 30, 2020 - ENTRY 13

A large part of my day was spent in the NICU, taking care of a 19-year-old mother and her 26-week preemie baby. The little one had taken a turn for the worst, and we spent the day knowing we were preparing for the inevitable turn to comfort cares. This young woman has no support from the baby's daddy or her parents, and her only friend must self-isolate at home due to being positive for COVID.

I spent long hours of the day just sitting with her, listening to her life story and her fears and struggles with feeling connected and disconnected to her baby, accompanying her through waves of grief, hope, and numbness over and over again. She needed a friend, and for today I could be that friend who is just there. I did not talk a lot. I just listened, and the longer our conversation went, the more comfortable the young mother felt until I could carefully suggest that reaching into the incubator and holding her baby's hand was okay (nursing approved this as well).

It was a magical moment when the little one grabbed her finger. I think it was right then that she fully became a mother and right then that the worst anticipatory grief hit. We sat in silence for almost an hour, marveling at the little miracle, feeling the impending passing, being somewhat okay in the in-between. Some support cannot be put in words.

In the end, before I left for home (knowing I would go back in the middle of the night if death occurred), I left her with our iPad so that she could also FaceTime with her only friend at home. With one hand, she held her baby's hand when I left, and with the other, she connected with her friend. What a beautiful and sad embrace.

JOURNAL ENTRY: MAY 3, 2020 - ENTRY 14

I have become more and more creative regarding taking care of my staff. Obviously, from the beginning of COVID (well, even before the pandemic) until now (as we get close to our peak), people are anxious and stressed. The first two weeks, it was primarily anxiety and fear of the unknown until we saw our first couple of patients. In these weeks, I took a lot of time to listen, come alongside, affirm that it is normal and okay to be anxious, and help them think through what helps each one individually (meditating, spending time with family, talking it out, taking extra "me" time, making emergency plans).

As a notary, I have notarized many more last wills of staff members and paperwork that deals with who will become the guardian of their children if something were to happen to them. I take those times not just to notarize but listen to people's stories and fears. Most times, we have been able to strengthen people's coping and allow

them to feel heard. It is impossible not to be anxious and stressed, but I can show that that anxiety is not in control of them; they can still control it with whatever they have as old or new coping skills.

We are not able to hold services in the chapel, so my department has live-streamed Good Friday and Easter Sunday services. I have recorded a blessing for healing and protection for the whole hospital, and I am thinking about live-streaming a healing service this coming week, as we have so much sickness and death due to COVID and are expecting the peak in the next ten days or so. All our services after the live stream have been put up on the hospital's Facebook page and the intranet platform so that people can watch them whenever they have time available.

Ramadan set up for the chapel had to be adjusted: no prayer rug can be used, so instead we laid out an easy-to-clean yoga mat. We could not leave open dried fruits and nuts, but single wrapped halal granola bars and single-serving nut pouches are allowed. Next to the yoga mat, we placed not just the Qur'an but also bleach wipes that are fixed to the wall so that no one walks away with them and instructions on how to clean the prayer station after every usage. Despite those additional challenges, we have received many happy comments from Muslim staff that this is still available. The sense of really feeling safe during prayer times is even more appreciated.

Twice a week, I send relaxing music, funny or inspirational quotes, blessings, and other quick reads (no more than 2 minutes) as "relax and take a break" material to all my staff via email. I find some of it online, and I write specifically for a certain unit and its specific circumstances.

Whenever a COVID-19 patient dies, after the room has been cleaned thoroughly, I will perform a blessing for the room to open it up again for the chance of healing.

Before we closed three units to become COVID-19-only units, I performed unit blessings and hand blessings for the staff on these units. Now, whenever a COVID-19 patient dies in one of the rooms after it has been cleaned thoroughly, I will perform a blessing for the room to open it up again for the chance of healing.

Tea for the Soul has become portable. I designed and printed cards with calming images, with a blessing on the inside and a quotation about tea's healing, reinvigorating, and calming nature. I write personal messages in the card for each staff member that gets one, and a tea bag goes into the card. That way, the Tea for the Soul can travel.

Every day before our COVID drive-through clinic opens, one of our chaplains will bless the staff at the beginning of their prep meeting.

Together with employee wellness, I partnered in getting small bags of dried lavender bag for all frontline staff. Being stuck in PAPRs and masks all day long does not smell good... these mini bags fit into people's pockets, smell strong enough even through a mask, or can be a fresh breath once the PAPR comes off. Each bag has a little motivational quote about finding peace and calm.

JOURNAL ENTRY: MAY 5, 2020 - ENTRY 15

Today was one of the rawest days so far.

The number of severely ill COVID patients is rising by the hour, and we know that many of them will not make it through the next few days. We had one man in his 50s arrive from a rural area. Even though we thought he would arrive within an hour, it took over five, which was not good for him medically. Upon asking what had taken so long, we were informed by the ambulance that he violently refused to be taken away from his wife. In the end, the police had to step in and, for the man's best interest, almost force him into the ambulance to try to save his life.

This gentleman has been with us for two days, and the amount of time that I have spent on the phone and FaceTime with his wife is extraordinarily high. She seems in constant, extreme despair and spirals more and more. The police did another wellness check on her, trying to convince the son to stay with her, but she refused all help.

About two hours ago, she placed a desperate phone call to the nurse manager of the COVID ICU where her husband is now intubated (he is severely ill but may have a good chance of surviving after all), threatening the nurse manager to come to the hospital with a gun and “shoot her way into the hospital” so that she can be with her husband. When I called her, I listened to her desperate cries for almost half an hour before she was able to speak. She shared with me that when she finally was able to close her eyes, she had the feeling that without her presence, her husband would give up and die.

Given that we have had a connection for the last few days, she did not threaten me with a gun. In the next two hours, we explored her feelings of fear and loneliness and her perceived inability to function in any way without her husband. I tried to affirm that her husband is part of her, that she is a part of him, that the bond they share is stronger than any physical separation, and that I admire her strength to go on under these circumstances.

I helped her FaceTime with her intubated husband, holding the iPad up to his face and trying to strengthen her coping skills while explaining that God has put him in the best place for help under the care of amazing professionals who will do everything for him. It took almost two hours of repetition of this before she was able to calm down. I was exhausted and sad about what this world has come to.

JOURNAL ENTRY: MAY 10, 2020 - ENTRY 16

One of the most interesting ways my self-care has changed is that I have incorporated time for just *being* on a very regular basis. Normally, I am someone who enjoys doing a lot. Many of my coping skills and practices have to do with activity: running, martial arts, cooking, walking, talking to friends, and reading are all things that are fun, calming, and life-affirming to me.

But recently, I have felt myself on my days off drained and less interested in these things because they still require some energy. So, I have experimented with simply being: sitting on the porch or on the couch, actively just letting thoughts come and go without holding on to them, breathing exercises, and listening to music. It is not that I have

never done those things before, but now I see how crucial they have become for me and that they need to be scheduled reliably so that I can recharge.

Joining support or Zoom groups for chaplains or rabbis is something I have avoided. I have never been a big group person in my free time, and even just the thought of one more Zoom meeting makes me feel more drained than almost anything else.

Also, right now, I have in my friends, colleagues, and family all the support I need; I do not want to connect to more people just for support, where inevitably, in those support groups, I must give again or listen. I have no energy for that.

JOURNAL ENTRY: MAY 11, 2020 - ENTRY 17

I spent some lovely time today singing with some of my pediatric patients. Many of the younger ones realize that things are so different and feed off the energy and anxiety of their parents. I learned a wonderful song from a dear friend of mine for children, “Bye-Bye Yuckies” and today, I got to teach and sing it with two of my pediatric patients.

As always, I am amazed at how simple but profound some things are for my little patients and how much we can all learn from them.

First, we sang the song and danced to it and then when they felt better from the happy music and the dancing, we started looking at what is yucky in their lives now and then we sang the song again, naming the yuckies and “sending them off to space to not return.” I feel better, too, and as always, I am amazed at how simple but profound some things are for my little patients and how much we can all learn from them.

JOURNAL ENTRY: MAY 12, 2020 - ENTRY 18

Today was an exhausting day. The COVID ICU numbers are constantly rising, many patients are incredibly sick, and we know there will most likely be hardly anything we can do. We have had COVID deaths, just not quite so many within one day.

I am still dealing with the wife of one COVID ICU patient. He has not improved (but also not declined) in over 10 days. It is a waiting game, and it is hard on everybody. We want him to get better, and the medical team is working tirelessly to help him.

His wife at home is COVID-positive as well and calls 30-40 times a day. She is extremely aggressive due to her anxiety and almost complete lack of coping. She turns from crying and despair to threatening in a heartbeat, and not one of the nurses I work with has not yet been threatened by her. I FaceTime with her (to let her see her

husband) about two or three times a day. I seem to be the only one she does not directly threaten, and sometimes, I manage to help her remain calm.

I cannot even begin to imagine how hard this is for her without any support from her family and friends while being worried about her health as well. Still, it is hard to stay compassionate when after almost every threatening phone call, I must take care of the damage to mental wellbeing that she causes the medical staff.

There is no reasoning with her; she is so deep in her anxiety and grief that I worry greatly about what would happen if her husband died. All she knows is grief – pure, raw emotion – and she lashes out in complete survival mode. Balancing care for her and for my staff is extremely exhausting. Still, I am glad I can do at least a little bit of it, trying to keep everyone going, hoping the patient will improve soon.

And what exhausts me even more is feeling her raging pain twice a day, trying to take it in and hold it for her just for a moment so that the tears she cries can bring relief for a heartbeat...wondering whether in my deepest, darkest moments of despair, if this was my husband, I might at times present like her, disconnected from reality, since reality is too unbearable.

JOURNAL ENTRY: MAY 15, 2020 - ENTRY 19

One of my challenges is that, at times, it is hard for me to feel that I have enough support. I feel blessed and happy to see COVID patients via telehealth and, if need be, with PAPR and PPE (we have enough of it), but it also often makes me feel lonely. Thankfully, I have my medical team and many friends there.

If it wasn't for the amazing medical team I work with that *is* my team and for my wonderful friends around here, I would not stay. I often feel like I will never be able to grow in my department. Professional development and chances to grow and move up in the career ladder are not a part of my department or institution. I have so many dreams about growing the department and the hospital as a whole, and I know I can, but will I ever have a chance to? Putting that together with not knowing whether my salary will ever give me the financial security that I would like, not just for the moment but for the future, is challenging—especially when dealing with an unsettling pandemic.

What made the day good was my last interaction with the wife of one of the intubated COVID patients (see above): after two weeks of talking with her twice every day, I finally had the feeling that we built a careful connection. After I FaceTimed her to her husband and then let her cry and helped her calm down, she looked at me and whispered, “Thank you.” There was so much despair but also hope and heart in these words and her eyes. I knew I had been able to reach her just for a moment and hopefully helped her for just a heartbeat to feel less lonely.

JOURNAL ENTRY: MAY 19, 2020 - ENTRY 20

I realized one thing about self-care and work-life balance. Even though my job has become a lot more stressful and intense due to COVID, my downtimes are also more complicated. While I am working and going, I feel rather good and normal; I do one thing after another, and the days fly by. When the weekend or my day off finally arrives, I am just so tired, and, with little more to do than just being home, I often feel unmotivated to do a lot.

While that is ok for a certain time, it also means that my head starts spinning and all the worry and emotional pieces from the week come rushing in. Even with good self-care, my days off seem to be hard work dealing with all of this and preparing to go back to work. It is not easy. My head does not stop spinning and going through the nervousness and emotions that I don't feel as acutely when busy at work; it is tiring and not relaxing. I have to work hard on finding relaxation.

JOURNAL ENTRY: MAY 21, 2020 - ENTRY 21

The nicest compliment I got today was from one of my nurses in the COVID ICU. She simply said: thank you for being right here with us every day. And she continued to explain: "everyone else seems to avoid us like we have the plague, even some of the doctors just rush in and out, but you are here as if this was just a normal day."

I have come to realize that being in the COVID ICU is just a normal day. If I treat it in any other way, then it gets to be too much.

I have come to realize that being in the COVID ICU is just a normal day. If I treat it in any other way, then it gets to be too much. The patients and families still need care, maybe more care in different ways, but I can find a new normal for that and make it into a routine that feels good to me. And my staff is still the same—more tired, more stressed, more worried, but the same people that I have known—so unless we are together like normal and I take care of them in normal ways, everything is just so much heavier. We can create a normal even in a COVID ICU; it is simply a different normal, but it can be normal and safe for now.

JOURNAL ENTRY: MAY 21, 2020 - ENTRY 22

I had to help in probably one of the hardest scenarios since the beginning of COVID. The wife of the patient who is currently intubated on the COVID ICU came to the hospital and tried to physically fight her way into the hospital to be with her husband. She was upset, shaking, enraged beyond measure, and simply desperate.

Together with security and the critical care director, we could keep ourselves and her safe from her attempts with only minimal touch needed. The scary part was that the wife herself is COVID positive. Standing in full PPE outside the hospital trying to protect ourselves and protect her was nothing I ever wanted and made me very grateful for our very kind and determined security people.

She was emotionally and mentally in a state of such despair, rage, fear, and existential angst that there was no way anymore to talk to her. All I wanted to be able to do was to offer this shaking bundle of a woman the hug that I felt she somehow needed more than anything else. Her anger was fired through the worst fear she could imagine and probably beyond what she ever thought she would have to imagine. But a hug was the one thing I could not give her due to inadequate PPE (we only had masks and googles but not PAPRs available).

Her state was one of oozing pain, beyond what I have seen outside of a war zone.

We managed to contain her and then hand her over to another family member rather than the police. All I could do was advocate on her behalf, seeing that this was not driven by maliciousness but by despair beyond measure. And as much as it hurt me being part of this, I am glad we could contain it and, in the long run, hopefully, help her and control the damage.

I was reminded of a line in a song that I like: “There is nothing more important than you and I being together,” and I know that is what she was fighting for with utmost despair and all the energy she had. And I want to say, “Yes, there is nothing more important than being with the one that means the world to you, other than saving his life, and this is what we are trying to do.” We have to try under the most challenging social, emotional, and medical circumstances imaginable.

I worry about the damage, though, that the COVID regulations put on people like her. What if we cannot save her husband after all? Then she has lost everything. Even if we can save him, will she be able to be whole again one day after this trauma?

JOURNAL ENTRY: MAY 22, 2020 - ENTRY 23

An update on the angry/desperate wife scenario: obviously, we could not follow her wish to transfer her husband (intubated, paralyzed, and sedated) to a rural hospital where no ICU treatment is available. I woke up with a sinking feeling in my stomach that this would be another round of trying to help her through gut-wrenching despair while trying to help my staff decompress from her verbal attacks.

All I could say is that my heart breaks for her, and even though I felt that her course of action was not ideal, I can empathize with her and wish for her situation to be different.

When I got to work, however, I saw a missed call from her. I called her back and got to meet a quiet and subdued woman who asked me whether I was angry at her for her behavior yesterday. All I could say is that my heart breaks for her, and even though I felt that her course of action was not ideal, I can empathize with her and wish for her situation to be different. I told her that it was okay not to be okay and that I would not expect her to be okay under the stress she was experiencing. I told her that I care about her and her husband and that the same is true for all the medical staff. She finally then allowed herself to break down and cry for a long time.

At least I could help her feel relieved and forgiven and lower her emotional burden just a little bit. We will continue to talk/FaceTime twice a day, hoping and praying that there is a way for her and her husband, even though we may not know the way, allowing her and the medical team to take one step, one breath at a time.

JOURNAL ENTRY: MAY 28, 2020 - ENTRY 24

For the wife of the COVID ICU patient, today marks four weeks of her husband on a ventilator. Even though he is slowly getting better, the last four weeks have not just weakened him physically but have drained this woman of everything she had. When I FaceTimed with her today—still with no news, neither good nor bad, holding in the never-ending waiting game—I could see that she could barely breathe. So, I asked her whether we could do a breathing exercise together. She agreed.

Quickly with her breath, her tears came back, and all I asked her to do was “let everything out; I am here for you.” For the next 30 minutes, she sobbed inconsolably, wave after wave of sobs. I held the iPad with her on the screen, but I felt that I was holding her. Her sobs could be heard all over the unit until my nurses started coming over. When this woman finally opened her eyes again, all the nurses were standing behind me, smiling at her through the PAPRs, and we all prayed together with her, reassuring her that even on the day that seems darkest so far, we will take care of her and her husband. It was an incredibly powerful moment.

I held the iPad with her on the screen, but I felt that I was holding her.

Coincidentally today was my birthday.

I had not even remembered until Facebook reminded me via lots of messages from friends. I felt blessed to spend the day with my work family, being able to do what I love and knowing that even on those really hard days at work, I am not alone. I have a wonderful work family right beside me that cares about me just as much as I care about them.

I took the evening off; it was the first evening sunshine came through the clouds after almost two weeks of rain. As I was sitting on the porch with one of my cats on my lap, breathing in fresh air after over 12 hours of mask-wearing, I felt calm and thankful.

JOURNAL ENTRY: MAY 29, 2020 - ENTRY 25

I did something today that I hadn't done in a long while. I took a few hours of paid time bank (PTB) time to leave work early. All my travel plans for the last two months had been canceled due to COVID, so my PTB time was piling up. I am normally not the person who just takes a few hours off unless I have a purpose for it. Coming home a little early, doing some garden work, and then enjoying some sunshine in my hammock helped me relax. Relaxing has become both a necessary discipline and an achievement when I get to it.

JOURNAL ENTRY: JUNE 2, 2020 - ENTRY 26

We have been under curfew for two nights in a row, and we have had violent riots now for four nights. I have spent a lot of additional time on staff and patient care in the last few days. Some of my staff members are related to police officers, and they are very worried. On top of the nervousness about COVID, the fear of the nightly happenings in the streets has come. Normally, Lincoln, Nebraska is a rather quiet community, but the racial disparities, people's ignorance, and people's already tired nerves and emotions have heightened the anxiety all over town and, of course, in the hospital. I have patients and staff fearing for the safety of their families.

My department now does little debriefings every evening—and every morning for the ED as well—and then for selected staff members who are particularly worried. We also did a debriefing two days after we had to treat two particularly heavily injured police officers and several severely injured protestors. It makes for long days. Patient care has switched a bit from emotional and spiritual support due to COVID to additional support due to all the different experiences and opinions related to the racial disparities and the riots.

The biggest need seems to be an outlet for people to talk about their opinions and feelings, especially for their burning wish “for everything to be over and okay again.” The stress around the riots has brought out people's already over-extendedness and complete exhaustion. We just got the first break in COVID cases yesterday (no new admissions with COVID), and now we have new admissions of police officers and protestors due to the riots. It is like we cannot catch a break.

People's anger is quite clear: anger that there is more to deal with, anger that on top of COVID there are riots, anger upon the discovery that Lincoln is not as nice and safe as they thought, anger at the disparities in the system that have already been shown by COVID and now are even more evident. There is anger at racial injustice and anger that now is the time we must deal with it. And above all, there is fear: fear about loved ones on either side of the riots, and fear about not being able to handle one more challenge.

I have heard people being glad that there is something that they may be able to change since COVID is not under our control. Still, human interactions are what we can control, yet people fear that their anger and exhaustion will now consume them beyond control. They had barely anything left to give and to care for due to being overworked by the COVID situation.

Many of my conversations have become just an outlet for anything going on for people, and I find myself going back to the basics of being a safe, non-judgmental presence, confidential, and with an open ear and a shoulder to lean on when things get too much. After acknowledging everything they feel, joining them, and coming alongside their worries, fears, and anger, I then gently help them refocus on what is good in their lives despite all the hardship—glimmers of good things (a hug from their daughter, the new puppy, the sunshine) to help them find a breath of refreshment in all of the stress.

When someone asks for a prayer or a good way of helping them to cope, I will often focus my response on God being the one who listens and understands, who comforts and helps us take one more step even when we thought we could not take one, because in him there is consolation and rest, as well as strength. At least, I hope...

JOURNAL ENTRY: JUNE 3, 2020 - ENTRY 27

Today I had my most complicated support conversation with a staff member so far.

Her husband is part of the local SWAT team and has been deployed during the last four nights of riots. She is at the end of her emotional strength, being tired from being a frontline COVID healthcare worker and now having to fear for the wellbeing of her husband every night and deal with the fear of her teenage children. She confided in me that all she prays for anymore is for God to finally put an end to this world because it is just too dark and too much to take. She worries about her husband not having enough protective gear both for his physical safety in the riots as well as for COVID safety. She was hurting so much.

We sat for a long time, and I just listened to her voicing her fears. The loss of trust in her environment, both due to COVID here in the hospital and outside in our normally relatively calm small-town community, was felt to her core. When there was a moment, I commented, “There is nothing for you to hold onto at the moment”; that is when she finally started crying. She confirmed that that was exactly how she felt, with no ground under her feet, just fear and overwhelming worry.

We will just take it a breath at a time.

Little by little, we started looking at what may give her back some ground under her feet—just one piece of it to stand on, one little element of security in her life while acknowledging that her fears are true and real. We decided to meet for at least 20 minutes for her next couple of shifts to give her a place to let down, cry, and recharge. We will just take it a breath at a time. Depending on how she is doing in the next few days, I will also consider seeing whether she may be open to receiving additional stress relief help from our Employee Assistance Program colleagues.

JOURNAL ENTRY: JUNE 4, 2020 - ENTRY 28

Another setback for my longest-term COVID patient: For the second time, he had just been taken to a different unit after two negative COVID tests in a row and was finally “trached” (had a tracheostomy placed). His wife was able to visit him for the first time in five weeks.

Within a few hours in the afternoon, he developed a new high fever, and infection control mandated that he needed to move back to the lockdown COVID ICU. The fear and disappointment in his eyes were grave. His wife reacted with an equal amount of fear and resistance of being separated yet again from him and with a lot of anger towards the medical team since, in her mind, the COVID ICU was not safe (“He will catch it again and die”).

Her viewpoint was very understandable; nothing in the past five weeks on the COVID ICU had been soothing or trust-invoking for her in this crazy time. The COVID ICU was the place that separated them and the place in which he almost died three times.

At that point, I decided that the best help to give him and her would be to have a large meeting with all of the team members involved—providers, nurses, care management, and myself—so that many things could happen: the patient and his wife sharing their concerns, feeling heard, and having the opportunity to ask all the questions they had about this new move and what it meant medically, as well as seeking reassurance that the team would continue to care for the patient safely and with everything necessary.

We were able to get a different room for the patient so that at least he did not have to go back into the room on that unit that was so filled with terrible memories. I offered to bless his new room first before the transfer to ensure that all that awaits him are gentle care, safety, and healing. They were very happy about that. The wife also got permission to stay longer today and be present for the transport up until the doors to the isolation room. Upon saying goodbye, I blessed both of them and the medical team.

JOURNAL ENTRY: JUNE 9, 2020 - ENTRY 29

We are running out of regular ICU beds. Due to our COVID numbers coming down slowly, there are talks that we may be able to have only half of our COVID ICU remain as such and open the other half as a regular med-surg ICU.

In a way, I am relieved for some normal; at the same time, I share the worry I heard from staff during our morning huddle. Is this going to be safe for the patients and the staff? We are all excited to have half of this unit be a place where 24/7 PAPR is not required any longer, but we have also gotten used to the perceived safety of this gear.

What I plan on doing today is spending time with staff, and when we clean half of the unit and then reopen it as a “normal” ICU, perform a unit blessing or a blessing room by room for safety and healing as well as offer hand blessings for staff. If things go well, I am thinking about a portable Tea for the Soul (via cart) later in the week for this unit to allow for some additional downtime and sharing of feelings, experiences, and stories.

JOURNAL ENTRY: JUNE 10, 2020 - ENTRY 30

It looks like we will have a permanent COVID unit. The hospital is also working on a protocol to possibly allow one or two family members for one visit during the end of life of a COVID patient. Given that the main COVID floor has been under my pastoral responsibility for over seven years and that I have been dealing with most of the COVID patients and families, I was offered to be the chaplain who will be on call for COVID deaths and support of the designated family member, and I accepted.

Even though I feel some burden with these responsibilities, I also feel relief that those patients will no longer die alone and that I will be able to be in the hot zone with their families to help make a terrible situation maybe just a little more endurable. I hope that this will help not just the patients and families but also the staff members who have been distressed due to the deaths of COVID patients that had to occur in such emptiness and loneliness. Despite the help of technology like video conferencing, there is nothing that can replace physical presence next to a loved one and human touch.

JOURNAL ENTRY: JUNE 20, 2020 - ENTRY 31

Today I got to be part of discharging a young mother, barely 35, who had been diagnosed with aggressive AML about two months ago. She spent the past six weeks with us due to extended induction chemo and severe wounds that needed wound vacs and debridement, which of course slowed the course of chemo down and created a combination that, upon admission, only a few thought she would survive.

She spent six weeks in complete isolation since infection control did not deem it safe enough, even after opening the hospital for one visitor, to allow anyone but the medical team into her room. Hence, she spent six weeks in a small room filled with equipment, only being able to connect to her husband and her 10-year-old son via FaceTime. Both her mother and her grandmother had died of cancer, and her father was undergoing radiation for cancer at the same time she was admitted. Her son was convinced that his mother would never return home after saying goodbye to her in front of the hospital doors.

I spent time with her every day I was working. COVID restrictions and fears combined with cancer isolation are probably the worst I have seen in my career regarding emotional isolation; it is devastating beyond words. For this young woman, the world had turned into her enemy, full of invisible death traps, as she expressed in total shock to me when we first met.

The world had turned into her enemy, full of invisible death traps.

In her initial fear, there was only enough will left to start a treatment that she had no idea whether she would survive. Due to her wounds, staying home had become impossible, and the feelings of shame, embarrassment, and horror of what her body looked like were the only motivation to enter the hospital “so that no one ever has to see me like that.” She told me how she thought, “My body is already dying; it does not matter if cancer takes it.” At the same time, she had one wish left: to “be okay and see my son one more time to tell him that he will be fine.”

We spent weeks sitting together and talking, allowing her to voice her fears and doubts, her thoughts of dying, and her barely existent hope that there may be some life left for her. Sometimes we just sat in silence, and sometimes we just watched a little TV together. Slowly, ever so slowly, she would smile, and we would start to laugh together over some bad sarcastic joke. The whole medical team was emotional about this case; it was everyone's worst fear, two potentially lethal conditions simultaneously, while in total isolation with little hope to ever see her family again in person. Each visit with her was followed by a visit with one or several staff members.

But now, six weeks later, she has reached the first stage of improved blood counts, and her wounds have healed to a level where she can be home if she comes to the specialty clinic three to four times a week for dressing changes.

Discharging her was one of the happiest and most emotional days that our whole oncology team has gone through in a long while. It was a mixture of wonder and disbelief that, with a combination of her own will, teamwork and medical interventions, and a whole lot of luck, faith, or fate, she had come that far. It was fear of releasing her from the safety of a perfectly safe hospital room into a world of COVID. It was the unbelievable joy of seeing her

son run towards her and holding on in such a way that we knew he would never let go of her again. And it was hope that the impossible sometimes, totally silently, whispers, “I’m possible.”

JOURNAL ENTRY: JUNE 30, 2020 - ENTRY 32

Our COVID visitation policy is now complete.

Two visitors are allowed, one time, for one hour, per COVID patient under the circumstances of end of life or end of life decision-making.

Since we have enough reusable PPE and PAPRs, this is now possible, at least for the first phase, to see how everything works. If we get too many cases, we may have to limit to one visitor. We even developed a policy around it, complete with waiver forms, additional nursing support, and general pastoral/emotional support that will cover the briefing, the supervision during the visit, and the debriefing afterward.

Given that I worked with most of our COVID patients, I have begun training some additional support staff. The briefing of the visitors includes describing what they will see when they go in, what they are allowed to do, and what cannot happen in the room and developing a roadmap with them of what they would like to get done during the visit (pictures, memory making, careful touch with appropriate protection). We will then carefully supervise the visit, give support during the time, and, after removing the PPE, do a debriefing depending on what the visitors need technically, emotionally, and spiritually.

We also finally got one designated Catholic priest from the diocese whom we PAPER-trained, who is now our COVID priest—but only for sacramental needs in emergencies.

The first few visitations have happened, and they were emotional, exhausting, beautiful, and hard at the same time. But they were worth it. This is not a “back to normal.” This is a new normal for “in-between” and constant adjusting. But it is one more step towards what I have fought so hard to have my staff hold on to: we can do this somehow, even if sometimes we don’t know how.

We can do this somehow, even if sometimes we don't know how.

Alyssa Foll's Journal

AT THE TIME OF PUBLISHING...

JOB TITLE: Manager, Ministry Formation

LOCATION: Chicago, IL

COMPANY: Ascension

AT THE TIME OF JOURNALING...

GENDER: Female

RACE: White / Caucasian

AGE: 33

YEARS AS CHAPLAIN: 7 (2013-present)

SPECIALTIES: Mental health, oncology, geriatrics, research

LOCATION: La Grange, Illinois

I saw her while standing in line for my flu shot from employee health. It was Caroline, one of the surgical nurses I had worked with last year before I transitioned from chaplaincy to a mission integration role. I managed to catch her eye, and we both moved to the same line so we could talk.

“Chaplain, it’s so good to see you! I wish you could see under my mask — I have such a huge smile on my face.” “I do, too!” I say happily before continuing, “I think the last time I saw you, Caroline, was during the early days of the pandemic. I remember we had paused all nonemergent surgical cases and you volunteered to serve as a nurse on the COVID floors.” My voice catches for a moment, and I look her directly in the eye. “I’ll never forget your courage and your selflessness, that you were willing to care for COVID patients during those early weeks and months.”

She meets my gaze and then looks down before meeting my eyes again. “Thank you for saying that, Chaplain. Not many people say thank you anymore.” I reach out and give her arm a quick squeeze. “And look at where we are today,” she says. “Vaccinated, still masked, and getting our flu shots! Look how far we’ve come! And we’ve still got a way to go. Who would have known in those early days that we would still be in the midst of a pandemic, 18 months later?”

Who would have known, indeed.

It’s November 2021 now, and as I reread my journal entries from back then, I marked my naiveté. In January or February of 2020, one friend thought she might need to be prepared for a two-week quarantine. I read that now and think, “if only that’s how long this virus lasted.” I re-read my words, written in May 2020, about the pandemic becoming a slog, and I groan as I try to count how many waves or surges we’ve had since the initial breach.



There are signs of hope, too, as I reread. I remember counting “up”—one day closer until we found effective medical treatment, one day closer until a vaccine would be available. I type this today, having had two shots against COVID-19 and soon to receive a third—a booster shot. Thank God.

Those early days of COVID felt like the world was holding its collective breath. I think we hoped that, if we held still and froze in our tracks for a time, death, sorrow, and grief would pass us by. These past two years have shown that this virus has touched us all in some way or another; time keeps on moving, life still unfolds. I couldn't tell you the date when the realization reached me, but there was certainly a day and a time when I realized that life wasn't stopping, even amid a global pandemic. The Book of Common Prayer says, “In the midst of life, we are in death.” I think the prayer might need to be written the other way around for COVID-time: COVID-19 showed me that even in the midst of death, there is still life.

Even in the midst of death, there is still life.

In the last eighteen months, I achieved board certification as a chaplain (and was part of the first cohort to achieve certification via a virtual committee meeting), and I accepted a new leadership role within mission integration in my health system. I attended a friend's wedding with pandemic protocols and masked guests. I've presented at several virtual conferences and have even run a virtual event for 600 leaders on a web platform—something I would have never imagined I would do before COVID-19. (I think I can safely list Zoom/Microsoft Teams/Google Meet under the “special skills” section of my CV!) I worshipped online with my church community for over a year and invented ways to play board games with my friends over Zoom. Life has continued on. Even in the midst of death, there is still life.

I'm grateful for this record that allows me to look back in detail at life in the spring of 2020. There are things that have already escaped my memory from those early days of the pandemic that I wouldn't have remembered had I not written them down. It seems to me that memory-keeping is an essential part of the meaning-making process: if I can remember, I can ascribe meaning.

The meaning that I see today, in November 2021, may be different than what you, the reader, will see. I imagine it will be different in five years or ten, or if historians should see this journal in one hundred years. I don't think I have all the meaning worked out from these pages, but I don't have to in order to have profound gratitude: gratitude for my colleagues, for my profession, for my patients and their loved ones. And gratitude for you, the reader, and however these words will intersect with your own life and stories.

This is all grace, and I am so grateful.



JOURNAL ENTRY: MARCH 20, 2020 - ENTRY 1

The whole world has changed, and I've watched it unfold like it was happening in slow motion.

I first heard the term “coronavirus” in January. I attend daily safety huddles in my hospital, and there were some conversations about some coronavirus from China. It came up in our huddle because our materials management representative said that our disinfectant wipes were capable of protecting against the virus. Then I heard about the coronavirus from our clinical informatics lead, who told nursing leaders where they could find charting information for coronavirus. There was already a coronavirus protocol in the system, she said.

My friend from graduate school, a PhD in Theology, called me in mid-February and asked how the coronavirus was being talked about in the hospital. “It's not,” was my reply, with a bit of a snort. “It’s nothing to worry about,” I told my friend. She replied that her husband had been following news of the virus in China and had taken their family to Costco to stock up on water, toilet paper, and other essentials. “He thinks we need to be ready to be quarantined for two weeks,” she told me. I laughed again.

At work, I ask our infection prevention director what she is hearing from the CDC and from WHO about the coronavirus. She tells me that it’s nothing to worry about, that she, too, has been fielding calls from worried family members and friends. “It’s no worse than the flu,” says the employee health nurse. “People are freaking out over nothing.”

The mass hysteria for toilet paper (so strange!) began, and for masks and gloves, by early March. We had family members of patients in the hospital who were stealing N95 respirators and gloves. We had community members calling into our materials management department and asking to buy supplies from the hospital.

I still thought this was overblown, another trend that would soon dissipate, maybe like the Tide Pod challenge (and if you don’t remember what that was, that’s exactly the point). But then came the restrictions. First, a ban on Europeans entering the country; then, a ban on persons from the United Kingdom entering the country. Then schools closed, and all students switched to e-learning. Then came the declaration of a national emergency. And then the day that I saw Yahoo news announce that the coronavirus had reached the scale of a global pandemic.

At that moment, everything changed. The mall closed, the restaurants closed, the theater closed. I was supposed to travel to Ohio State to present at a conference in late March, and that event was canceled. I was supposed to meet my committee for board certification on March 17, and that was canceled. All the career milestones that were supposed to occur in the spring were suddenly gone.

The way everything changed was like preparing for a tornado. The sky turns greenish-black, the wind kicks up, and everyone hunkers down. No one is out and about or moving around; tornadoes mean, “seek shelter now.” This is what coronavirus feels like. I’ve had countless people tell me to “stay safe,” and the look in their eyes is the same as someone who is preparing for a natural disaster.

I tried to think about how I should prepare. I live alone, so I tried to think of what items I might need if I couldn’t leave my home. I stocked up on groceries, bottled water, and any extra cleaning supplies I could find. Once the essentials were in hand, I turned to the essentials of the mind—books, games, puzzles.



I love my home, and I don't mind living alone, but I did cry for several nights as the world slowly shut down. Will I ever see my parents or sister again? (They live in Kansas City.) What if state borders are shut, and I can't fly or drive to get to them? What if they get sick? What if I get sick and they can't get to me? When will I ever see my friends again? If I get sick, will they come and drop off medicine and supplies for me?

The world changed in an instant, and yet, I saw it all in slow motion.

JOURNAL ENTRY: MARCH 27, 2020 - ENTRY 2

Happy pandemic birthday to me! I turned 33 this week, and never in my 33 years did I think that I would celebrate a birthday in the middle of a global pandemic. This birthday is a reminder of the many losses that COVID has quickly introduced to my life: a state-wide shelter-in-place order meaning that my best friends can't come over to my house to celebrate with me. I can't go out to dinner or even to a bookstore to browse. The whole world has come to a screeching halt.

My spiritual care department has gone through a very difficult season where we had significant cutbacks and turnover. In light of these changes, none of our systems or processes are working correctly. I look around the room at our department meeting and think of all my friends and colleagues who left the organization just before the pandemic began. I know that I am being called upon to set aside my personal grief over the changes in my department to serve my hospital—the associates and the patients. I need to turn my attention to COVID-19.

My constant prayer is to have the grace and strength to face what I'm called to face at the hospital.

My constant prayer is to have the grace and strength to face what I'm called to face at the hospital. I know there is no way to truly "shelve" or compartmentalize my personal grief, but I also know that I don't have the emotional space to process everything that is unfolding around me. I know that my disenfranchised grief is something that the entire world is experiencing as well.

There are so many losses: planned-for vacations canceled, academic conferences unattended, senior proms gone, graduations scrapped, weddings postponed. I think everyone understands on an instinctive level that containing the virus to save lives is essential, but that doesn't make the losses any less real. All loss is loss, I tell my patients frequently. There is no need to compare grief or loss or to qualify your loss by saying, "It's not as bad as someone else's." Every loss is real, valid, and worthy of having space to be grieved.

It's just that those spaces, both physically and emotionally, are not readily available to us at the moment.

JOURNAL ENTRY: APRIL 3, 2020 - ENTRY 3

I am a part of a Christian denomination that emphasizes the imminent return of Christ. The tricky part of that belief is that if you want the return of Christ, then you also have to go through "the end of the world." I have always wondered what the end of the world will look like—after all, hasn't the human race survived plagues and

climate change and natural disasters and famines and wars? I mean, didn't people think in World War I, the Great War, that the world was ending? Or what about World War II? Didn't people recognize that it was the end of life as they knew it?

As a chaplain, I also know this: the world is always ending somewhere, for someone.

As a chaplain, I also know this: the world is always ending somewhere, for someone.

The end of the world comes every day in my Emergency Department for one of my care receivers.

Somewhere, an eight-month-old has died of SIDS. Somewhere, a healthy, 36-year-old mother of two has died of a heart attack. Somewhere a 17-year-old has died in a car crash. I care for those individuals and for their loved ones on a regular basis as a hospital chaplain. For those families, it is the end of the world. It is the end of life as they know it. All of their hopes and plans and the futures they have imagined are gone.

All of this is to say, I never really thought I would see the end of the world in the way that my tradition has often described it. But for a brief time, at the beginning of this pandemic, I started to have a sickening feeling: "Maybe this really is the end of the world. Maybe this is the start to the end of the world."

The hospital does feel like a scene from a dystopian or post-apocalyptic movie. Before COVID-19 descended, there were volunteers and vendors and family visitors bustling in and out of the hospital all day long. Fresh flowers were being delivered, departments were ordering pizza to celebrate birthdays, meetings and continuing education seminars were being conducted. I could go across the lobby from my office to the coffee shop and have a delicious cup of coffee if I wanted to.

Now there are three entrances into the hospital: the employee entrance, the emergency entrance, and the main entrance. When I come into the hospital in the morning, I have my temperature checked and must report if I've developed any respiratory symptoms. The hospital is eerily quiet. I used to walk the halls and have many people call out "hello" to me or I to them, and now we nod at each other from behind our masks. People are pushing the elevator buttons with their elbows.

Yesterday, I took care of a family in the Emergency Department after a sudden cardiac arrest. We always keep the family comfort room stocked with tissue boxes, and the deceased patient's daughter, through her tears, asked, "Can we get a new box of tissues? I don't want to touch that!" (She gestured to the opened tissue box sitting on the end table.) Her mother kept sobbing and then reaching up to wipe her tears away and rub her eyes. "Stop touching your face, Mom!" was her daughter's insistent reaction.

And of course, the question for me is, how do I minister in a time of great sorrow when words usually fail, and a gentle touch can be soothing? I can't hug my care receivers; I can't place a hand on their shoulder and give it a gentle squeeze; I can't put a hand of support on their mid-back. I truly think the worst part of the pandemic is the fear and isolation. So many people look at each other as a threat, a potential carrier.



My ministry has dramatically shifted. Where I once primarily ministered to patients on a referral basis or perhaps through rounding on my units, I now spend the majority of my time with staff. I make a point to connect with every single nurse and patient care technician on my medical floors, including the floor that's now being called the "COVID floor."

There is a visible look of relief when I walk onto the units. With no volunteers, no administrative staff, no social workers, no visitors coming to the unit, I'm one of the few people who can still move about the hospital. One of the charge nurses on the COVID floor said to me, "I can't believe you come on this floor. What are you doing here?" (I wasn't seeing patients on the unit.) I replied, "I'm here to be with you. This unit is the Ground Zero of COVID. I want to be here; I want to be with you and with your team. And I'll be here until we are on the other side of this."

As I round on the staff, I make a point to ask how they chose the profession of nursing or healthcare. When I would thank nurses for being present and for responding to the crisis, many would reply, "Well, I knew what I was signing up for," or "I chose this profession." I wanted to hear the stories — how did you know you were meant to be a nurse? What is your calling? By asking these questions, I hoped that staff would hear their own responses and find their inner resources to have more strength for their work.

Our work has become a bit more disembodied through the use of technology, but it's also been more public than ever before.

My ministry has also shifted in terms of public worship and leadership. My hospital has a weekly chapel service that my colleagues and I oversee, but frankly, it's never been well attended. Now in place of the service, there are daily overhead prayers (encouraged by our administration as we are a faith-based hospital) and daily devotional emails being sent to staff. Our work has become a bit more disembodied through the use of technology, but it's also been more public than ever before.

JOURNAL ENTRY: APRIL 10, 2020 - ENTRY 4

Today I rediscovered the gift of laughter at work. It started when one of my colleagues texted the other female chaplains and me on our team a meme that showed several elderly ladies all in pastel-colored nightgowns saying, "Easter dresses for online church this year." One of my quick-witted colleagues replied, "Oh darn, I've already ordered the yellow mumu. I hate when that happens." Between the meme and the flurry of texts that ensued, I spent the next several hours chuckling.

I can hardly fathom Easter without a church service. I know that church, the *ekklesia*, is not a building; it's a community of people, but what happens when that community cannot gather and participate in shared rituals? How does this experience shape and form us? How will it form us spiritually?

The sacramental ministry that is so essential in the hospital has also shifted dramatically. Our hospital demographics consistently show that 50-60% of all our inpatients are listed as Roman Catholic. Thus, we typically had Ministers of Care from local parishes who would offer daily Communion to our Catholic patients, but since volunteers are prohibited from entering the hospital campus, we haven't been able to offer that sacrament.

We also have a large population of elderly Catholic adults in our community who usually request (or their families request) to have the Anointing of the Sick (the Sacrament of the Sick) performed prior to their death. Currently, our local Roman Catholic priests are not able to come to the hospital to perform the Sacrament of the Sick, either. My colleagues and I have gotten creative: over-the-phone anointings by local priests, masses being said for dying patients, and offering more general end-of-life blessings.

It also helps that Pope Francis gave a blessing to all those affected by COVID-19 who could not be anointed prior to death. I took his prayer and created simple prayer cards that my colleagues and I have been sharing with patients and their families where appropriate. Even when the family cannot be physically present with their loved one, we've held the phone up to their loved one's ear and all said the same prayers together.

My friend's meme for Easter reminds me, though, that the church, the *ekklesia*, has endured plagues and pandemics before. It has also weathered violent regimes, dictators, worshipping underground, and other natural disasters and crises. As Julian of Norwich, a fourteenth-century mystic, once wrote, "Nevertheless, it pleases him (God) that we should laugh to cheer ourselves and rejoice in God because the Fiend has been conquered."

I print several humorous memes I can find about COVID and mount them on cardstock, which I then carry in my lab coat pockets. When it's appropriate, I pull out the meme to show a nurse or two. Our laughter eases some of the distress of this nonsensical pandemic. The laughter comes because life is sacred and fragile, but also because human beings are resilient. We will get through this... with a little laughter.

*The laughter comes because life is sacred and fragile,
but also because human beings are resilient.*

JOURNAL ENTRY: APRIL 17, 2020 - ENTRY 5

I am astounded by the generosity of our community at the time of this pandemic. Within a week or so of placing our hospital campus on lockdown (no visitors or extraneous staff), daily food deliveries started finding their way to our lobby. At first, local car dealerships, restaurants, and Rotary clubs sent food. This food would be dropped off and then taken up to the COVID floor or to the ICU, where the staff caring for the most critical patients could enjoy a hot meal.

After a few weeks, though, the food kept pouring in, but it was from neighborhoods. "This meal is provided by the 300 block of Oak Street." Neighbors were actually pooling their money to provide meals for our hospital staff. As I drive to the hospital, I pass by countless houses that have signs in their front yards: "Thank you, Healthcare Workers!" "Thank you, Healthcare Heroes!"

I've also been stunned by the amount of media coverage chaplains are receiving because of COVID. I honestly never thought I would see profiles about chaplains and the profession of chaplaincy in The New York Times or The New Yorker or The Atlantic. It seems like every day, there is a new article, video, or interview featuring the work of healthcare chaplains.

Is it wrong to be delighted about the amount of media coverage for my profession? I hope it makes a difference when it comes to job opportunities and staffing. Many hospitals have a sense that chaplains are important but don't really grasp what we do. Or we are thought to be "nice people who pray with patients." There has been little recognition of how chaplains are master's level-prepared, with four units of Clinical Pastoral Education (CPE) and a residency and formation process in the hospital that is as grueling as many of the other healthcare professions.

But COVID has brought about a deeper understanding—chaplaincy is about the human spirit and finding meaning to go on when living through the unimaginable. I am really proud to be a chaplain.

JOURNAL ENTRY: APRIL 24, 2020 - ENTRY 6

The COVID-19 pandemic has turned into a slog. At first, anxiety and fear were so high. Nurses were crying at work; some were balking at going into COVID rooms or onto the floors. Others were barely sleeping because of the anxiety, stress, and exhaustion.

And here we are—six weeks in—and things do not seem to be improving. The pandemic has become a slog. How do you deal with a disaster that is a slog? All the disaster training I've ever received was how to deal with a sentinel event. One school shooting. One train derailed. One tornado. What do you do when every day feels like facing another sentinel event?

I've kept my spirits up by saying, "One day closer." I'm a big countdown person; when I'm going on a vacation or a trip, I set the date into a countdown app on my phone and then check the app frequently. There is no way to "count down" with COVID. Even counting down until we are released from sheltering-in-place does not signal the end of the pandemic.

So instead, I count "up." One day closer to finding medicines and treatments; one day closer to understanding more about the virus and how it functions. One day closer to having a vaccine. One day closer to the "other side" of whatever life will be in the post-COVID-19 world.

I've been telling the staff on my units this, and they like the saying. Some say, "This too shall pass" or "There's light at the end of the tunnel." One day I joked, "It will pass, but it will pass like a kidney stone," which got lots of uproarious laughter. Dark humor and humor, in general, are partly what's keeping us sane right now. My ministry has changed quite a bit, too. In the first few weeks of the virus, my main ministry and attention was to the staff. I increased rounding, offered myself for debriefings, and went to shift change for prayer. Now, the attention has shifted a bit to the COVID patients who are lonely, isolated, and scared. If they can talk, I will try a tele-visit. If they are intubated, my colleague and I reach out to their families.

I don't mind the tele-visits. For a brief time in my chaplaincy career, I actually worked in tele-chaplaincy, or as some call it, "on-demand spiritual care." I found those conversations to be very meaningful; many people used anonymity to be vulnerable. I'm finding a similar effect in speaking with COVID patients. But it is a new thing to grapple with a virtual ministry of presence.

So much of chaplaincy is incarnational—you want to be right there with someone, be present, sit down, take time. You're meant to be in the room.

So much of chaplaincy is incarnational—you want to be right there with someone, be present, sit down, take time. You're meant to be in the room. So, what should we do when there isn't enough PPE to go around? Do chaplains suit up and go in, all in the name of incarnational ministry? Do chaplains stay out of the rooms to conserve PPE for those who must go into the rooms and therefore are vulnerable? Do chaplains go in because our faith calls us to do so and to minister even at risk to ourselves? Or do we think about sustainability, since this crisis will be with us for a long while to come? How do we minister in a way that will enable us to serve for however long this crisis lasts? These are some of the tough conversations that COVID demands.

JOURNAL ENTRY: MAY 1, 2020 - ENTRY 7

May 4th is coming, and I'm already looking forward to greeting my colleagues like this: "May the fourth be with you." "And also with your spirit."

I'm looking for levity where I can find it. Right now, the levity is to distract me from the fact that bodies of deceased COVID patients are being transferred from a sister hospital to our facility because we have a mobile morgue or "refrigerator truck" on our property. Other facilities' morgues simply could not keep up with the number of deceased patients.

What kind of world am I living in?

COVID fatigue is real. I've been anticipating a rise in moral distress from nurses and healthcare workers and have been trying to prepare myself for it. I bought a new book about trauma and resilience and read two chapters of it last week. The next morning, I awoke to the breaking story from the *New York Times* about an ER physician who had taken her own life after treating so many patients with COVID in NYC.

That same morning, I got to work and received a call from the COVID floor nurse manager, A. She told me that a nurse had lost a COVID patient that morning and needed some extra support and care. I went up to the floor to find her, and she was in the break room, pacing, crying, sitting down and putting her hands on her head, and sobbing.

I spent the next hour and a half with her, companioning her, agreeing with her about the horrible things she was seeing and witnessing, and trying to gently brainstorm how she could care for herself. "I didn't sign up for this,"

she wailed over and over. For nine years, she had been a nurse and had not experienced anything like COVID-19.

“I keep feeling like I’m breaking a piece of my soul every time I come to work,” she told me. “How much further do they [administration, staffing, etc.] want me to break?” We talked about the COVID commercials on TV, selling cars or phones or some technology product, but how disturbing it is to those of us who work at the hospital every day.

“I watch TV to escape,” I tell her. “I don’t want to be reminded of COVID.”

“Yes,” she agrees, “I don’t need a commercial to tell me I’m a hero. I know what I am and what I’m about. But telling me I’m a hero doesn’t fix the shit that I’m seeing and dealing with every day.”

“Yeah, heroes are human,” I reply. “We’re not invincible.”

I’ve spent this past week reading up on moral distress. How else can I support my nurses? How else can I support our healthcare team? How am I going to support our security team, who must unload all of those bodies and place them in the refrigerator truck? What kind of psychological damage is this inflicting on our healthcare workers?

As for me, I can barely sleep at night; I’m so restless. I wake countless times in the night or toss and turn repeatedly. This is such a difficult thing for me because I’ve always counted sleep as one of my “spiritual gifts”—I’m a great sleeper. But I’ve joined the countless others—friends, family, and colleagues—who are also telling me that they aren’t sleeping well. We’ve all joined the restless sleeper club.

JOURNAL ENTRY: MAY 8, 2020 - ENTRY 8

There are some days when the reality of COVID hits harder than other times. COVID has become a grueling slog, and in many ways, I’ve become accustomed to the awfulness of this virus. But there are times when something lands in a different way when something breaks through; that just reminds me all over again of the reality of this pandemic.

One of those breakthrough points came a while ago when bodies of deceased COVID patients moved to our campus’ mobile morgue, also known as a “refrigerator truck.” Something about running out of space in the morgue weighed so heavily on me.

This was compounded today when I was rounding in the ICU. One of the case managers pulled me aside and whispered in a hushed tone, “Do we have a—umm, you know—a refrigerator truck on our campus?” I had a split-second decision to make: do I confirm, or do I say that I can neither “confirm nor deny?” It’s not exactly confidential information, and yet, I know we’ve not been sharing this information widely with staff. The only reason I know this is because I work closely with the head of campus security, and he told me we had run out of room in our morgue.

“Yes, we do have a mobile morgue, or a refrigerator truck, on campus,” I confirm. Her eyes grow wide and then fill with tears. I gently ask a follow-up question, “Did you see the truck?” “Yes, I accidentally almost bumped into it. I was on my usual route from the parking lot to the employee entrance, and I looked up to see a giant truck in my path. I couldn’t figure out what it was doing here, and then I realized...it’s a morgue.”

Working in the hospital means that I see death regularly. Working in the ICU as a case manager means that my colleague sees death regularly. But never in our personal or professional lives have we ever witnessed a time when we had so many people dying at our facility that we could not house them all in our morgue. What would it be like to be walking into work and realize that there is a mobile morgue in your usual path? How does that affect you mentally, emotionally, spiritually?

Interestingly enough, just a few minutes after she and I ended our conversation, I was talking with a palliative care nurse practitioner about a case in the ICU. She spoke about the unpredictability of the virus, about how things had gotten bad in Chicago, but at least they weren’t as bad as things had been in New York City.

“At least we don’t have refrigerator trucks driving down our streets,” she said, referencing an image that had emerged from the crisis in New York City.

I was faced with another choice. Say nothing or gently tell her that we do have a mobile morgue on campus? I suppose it was my own need to share such heavy information that I looked at her and said, “Actually, we do have a mobile morgue on campus.”

Her head jerks up, and her eyes widen. “Really?”

“Really,” I confirm.

When healthcare workers have never seen so much death before, even seasoned and hardened professionals, you know things are reaching a breaking point.

COVID has ushered in a “brave new world.” When healthcare workers have never seen so much death before, even seasoned and hardened professionals, you know things are reaching a breaking point. I sometimes wonder what more I can do or say in the face of such massive suffering.

JOURNAL ENTRY: MAY 15, 2020 - ENTRY 9

COVID-19 feels a bit like playing Russian roulette. Where one person may experience fatigue and fever, another person develops viral pneumonia-like symptoms and requires ventilation support. Sometimes you can predict what will happen along the lines of gender, health condition, and age. But sometimes not.

Today, I spoke with two young adults who had just lost their mother, age 62, to COVID. They both shared with me that they had been positive for COVID a few weeks before but had quickly recovered. The son remarked, “It’s an insidious disease. It killed her, but I only lost my sense of taste.”

How do you make heads or tails of that? And how do I live with the fact that my mother is 63 years old, healthy, and alive? I could be the one sitting in the place of the young adults in front of me, speaking about my mother in the past tense. How does that happen?

COVID does reveal the beauty and complexity of humanity, though. The same two young adults who sat and wept in front of me asked me where they could donate their plasma.

“We both had COVID,” the daughter shares, “and we want to donate our plasma to help other COVID patients.”

“Yes,” her son replies, “the plasma treatment really helped my mom. Even though it didn’t save her life, it did make a difference and give us one more day with her. I want that for someone else.”

I don’t have the information about where they can donate plasma, so I leave them in the ICU waiting room while I go to find out. I am stunned. Who loses their 62-year-old mother and then, in the next breath, asks about donating plasma? Who thinks about someone else’s mother receiving plasma treatment when they have every right to be focused on the loss of their mother?

This virus is awful, insidious, and sometimes deadly. But the resiliency of the human spirit is also alive and well.

JOURNAL ENTRY: MAY 22, 2020 - ENTRY 10

I was asked to give a devotional for my regional spiritual care staff meeting. This is the first time that we are meeting in person after months of calls and Zoom meetings. We are meeting in a large room, spaced with two people at a table, and we are all wearing our masks. It feels good to be in the same physical space with each other.

I’ve chosen the story of Elijah, from 1 Kings 19, to tell and reimagine. It’s the story where Elijah receives a death threat from Queen Jezebel, and he flees to the desert and eventually to a mountain cave. When God speaks to Elijah in the mountain cave, God asks, “What are you doing here, Elijah?” Elijah responds, “Israel’s leaders have killed all the prophets and faithful people. I’m the only one left, and now they are trying to kill me, too.”

I read these words to my colleagues once, then I pause and read them a second time. “Do you hear the trauma response in what Elijah is saying?” I ask. “Elijah is fearful for his life; he has received a credible death threat, and his body reacted with fight, freeze, or, in his case, flight. Elijah is in the middle of a very traumatic experience.”

“Now, did you also notice,” I continue, “that Elijah says, ‘I’m the only one left’? I’d always chalked that up to whininess from the prophet, but now I see that as a trauma response, too.”

Elijah is convinced that he is the only one suffering in this way, the only one who has suffered in this way, the only one left in these maddening times. And because Elijah believes he's the only one left who is still faithful to the God of Israel, he isolates himself further and hides out by himself. He is deeply traumatized by recent events and is convinced that his own death is imminent.

God responds to Elijah's trauma by instructing him to go and stand at the mouth of the cave while God passes by. I give my colleagues slips of paper that have a responsive reading on them. As God sends an earthquake, fire, and wind, we all stomp our feet, make thundering noises, crackling sounds, and wind noises before all saying together: "But the Lord was not in the earthquake." We repeated this three times before coming to the twist: then there was the sound of sheer silence.

Sheer silence.

The passage says that Elijah covered his face with his mantle. Could that be like our masks? The masks that keep our breath so close to our own faces? Has the world gone so quiet that all we can hear is the sound of our own breath in the midst of sheer silence?

I gently instruct my colleagues that we will take five minutes of silence together. We all breathe heavy sighs into our masks. Some close their eyes; others lean back in their chairs; still, others hide their faces in their hands. When you're faced with unspeakable tragedy, maybe silence is truly the best response.

It feels healing to be in the same physical space with each other again and to engage in collective silence. It's what my own soul has been longing for.

It feels healing to be in the same physical space with each other again and to engage in collective silence.

After the silence, I offer a few concluding remarks and then invite responses. One chaplain said, "I just felt like crying. The silence gave me space to let out my tears." Another chaplain spoke up and said, "I just so needed this breathing space."

In the last two months, I've been living in a world that's gone quiet. My social calendar cleared. My professional calendar cleared. I live alone, and my friends can't visit right now. No church or church responsibilities. Quiet can be enforced, but silence must be chosen.

And my chaplain colleagues and I need some silence right now to grapple with our callings and our souls.

JOURNAL ENTRY: MAY 29, 2020 - ENTRY 11

I've never given much thought to breath before. I've taken yoga classes, and I'm also a singer, so I'm vaguely aware of the idea of breath and different ways of breathing. But I've never thought about the way breath connects and separates.

Over Memorial Day weekend, our country has exploded, sparking another global pandemic — an outcry over systemic racism. The brutal execution of George Floyd under the knee of a police officer has gotten me thinking about breath.

“I can’t breathe, I can’t breathe,” were some of his last words.

My COVID patients can’t breathe, either. They’re struggling to get enough air into their lungs, and some require ventilation support. Supposedly, a way to “test” for COVID is to hold your breath for five seconds and then let it go. Can you get a deep breath? How does that feel?

Why is that billions and trillions of dollars are being spent to beat back the horrors of COVID, to save patients who can’t breathe, but we have invested so little time, energy, or education in defeating systemic racism, which also chokes out the lives of thousands, if not millions, every year?

Breath separates the living from the dead.

We have a lot of people who are struggling to breathe but only seem to want to save some of them.

We have a lot of people who are struggling to breathe but only seem to want to save some of them.

JOURNAL ENTRY: JUNE 5, 2020 - ENTRY 12

“If the virus doesn’t kill us, we will kill each other.” – A chaplain colleague, commenting on the riots and looting in the city of Chicago and the suburbs

I walked into work this past Monday morning, and the energy had shifted considerably. Everyone seemed to be on edge, almost as if we had gone back to the early days of COVID, except with even more fear and danger.

There is a screener at the front entrance of my hospital to take my temperature, offer me a new mask for the day, and ask any other questions relevant to my health and work that day. We also have a security officer sitting at the front to offer additional assistance when needed. I saw Officer E when I walked in, and he called, “Oh good, Chaplain! You’re here! I need to talk to you.”

Once through the entrance and issued my new mask for the day, I stepped off to a quiet part of the lobby to talk with him. He explained that he lives with his girlfriend on the southside of Chicago and that he commutes to our suburban hospital.

“I’m afraid,” he confided in me. “I’m afraid that I can’t get back and forth between home and work. I’m afraid...” His voice trails. He doesn’t need to say what he’s afraid of: he’s afraid of being shot, of being in the wrong place at the wrong time. Whether a stray bullet from gang activity or at the hands of the police, as an African American man, he could easily be in the path of a bullet.

Tears spring to my eyes as he asks for prayer. I offer an extemporaneous prayer and then tell him I'll meet up with him later in the morning; I want to get something for him. I return to my office and make a copy of Psalm 91, and then write a hand-written note to E on it. I offer it to him later in the morning, and tears come to his eyes when he reads the ancient words. He carefully folds the paper and places it in the cargo pocket of his pants. "This is going to keep me safe," he tells me.

I make a point to visit as many departments and staff members throughout the day to talk with them about the riots and looting. One woman, a native of Chicago, recalled the last time that the riots and looting had been so severe was when Reverend Doctor Martin Luther King, Jr. was assassinated.

"Not the Rodney King riots?" I question. "No," she replies. "It was this bad in 1968." (My age is not lost on me as I talk with staff in the hospital. I was not alive in 1968, and I don't remember the LA riots—only from my history textbooks. But I also can't deny that it feels as though we are on the brink of a true social revolution, much like the late 1960s.)

She goes on to tell me about her daughter, who lives in a high-rise building in Chicago. "The rioting is right outside her building," she says. "The whole building is on lockdown. No one can come in or go out. They have security guards at the entrances, but if the rioters breach security, then...I just don't know." The pain, worry, and anger all register across her face.

Another staff member, a patient care technician, spoke to me about growing up in downtown Chicago and her experience with crime and gang-related activity. The riots and looting had triggered childhood memories from over fifty years ago. She then went on to say, "I'm just so scared that all these riots are going to cause a spike in COVID cases. And we've been working so hard to contain the virus." The exhaustion and helplessness in her eyes resonate inside my heart.

What am I to do as a chaplain? I've long believed that to be a chaplain is to be both pastoral and prophetic.

A question comes to me: what am I to do as a chaplain? I've long believed that to be a chaplain is to be both pastoral and prophetic. How do I advocate for the dignity of all persons? How do I gently, prophetically challenge staff and associates when they say that the riots "delegitimize" the cause of the protest? How do I confront the idea that Black people rioting are "hurting their own people"? How do I offer both pastoral care and education about systemic racism?

I feel inadequate to this task, though I've spent the last five years or so reading and educating myself about racism and anti-racist efforts. Is it my role to address racism as a chaplain? I'd say yes. But the tension is this: how do I use my "prophetic" voice with staff, but do it in such a way that they can also come to me or feel comfortable receiving pastoral care from me?

I wish I had more guidance and support around the prophetic and pastoral aspects of my calling as a chaplain. COVID and the social unrest have highlighted the need for both.

JOURNAL ENTRY: JUNE 12, 2020 - ENTRY 13

Things have eased enough with COVID cases that I'm able to take about 10 days off from work. I plan to spend my time at my parents' home in Kansas City, mostly eating good meals, napping every day, reading, and going for long drives in the countryside.

I've always been good about taking all my vacation time. Early in my ministry career, I had someone tell me that I should try to take a vacation every quarter—whether that was only a three-day weekend or a longer break. I've followed that advice, more or less, but with COVID, I've not taken any vacation time since the beginning of the year.

The intensity and volume of our COVID cases have settled to a manageable place so that my colleague and I agree that I should take a vacation, and he will take some vacation after I return. But my thinking about this vacation is very different from other breaks I've taken before.

I typically schedule my vacation times to follow large work events (Week of Spiritual Emphasis, holy days, etc.) or once a project is completed (training spiritual care volunteers). The rhythm of this is that I push myself at work, and once the sprint is over, I take a break. It's a good rhythm that has worked for me in my first decade of work and ministry.

But COVID is not over. It's not even close to being over. I will leave my work unfinished when I go on vacation and return to the pandemic when my vacation is over. The question then becomes, how do I take a break in the midst of struggle? In the midst of ongoing sorrow and challenge?

It reminds me of a question that a CPE educator once posed to me, half-musing and half expecting me to answer: "How do we live with pain that just doesn't go away? How do we teach people what to do with the pain that doesn't fully get better?"

His words are the new reality of COVID. What do we do with a virus that is not just going to evaporate one day? This virus will take years before it truly "goes away"—and that will come through massive public health efforts and mass vaccinations. So how do we live and rest in the midst of a pandemic?

I was reminded of Jesus' words in the Gospel of Matthew: "Come unto me, all ye who labor and are heavily burdened, and I will give you rest." What I had forgotten about was the context of those words. Earlier in that chapter, John the Baptist's disciples came to Jesus and asked if He was really the Messiah. The underlying accusation was that if Jesus really was the Messiah, then why was their rabbi in prison? Couldn't Jesus do something about that?

Jesus invites these disciples to follow Him and to witness His work: the blind can see, the lame can walk, hungry people are fed. And then Jesus says to His disciples—and presumably to John the Baptist's disciples, too—"Come unto me...I will give you rest."

I find myself pondering these words in a new light. There was still so much work to be done. There were still so many more people to feed, to heal, to liberate. John was still in prison. But Jesus says, “Let’s get away and take a break.” This is the lesson of my vacation.

It reminds me of a Talmudic saying: “Do not be daunted by the enormity of the world’s grief. Do justly now, love mercy now, walk humbly now. You are not obligated to complete the work, but neither are you free to abandon it.”

I am not obligated to complete the work, but neither am I free to abandon it. My work and my ministry will be right here waiting for me when I return from vacation.

I am not obligated to complete the work without rest or break until the virus is eradicated. I should get away; I should take a break while things are a bit more settled. I am not obligated to complete the work, but neither am I free to abandon it. My work and my ministry will be right here waiting for me when I return from vacation.

JOURNAL ENTRY: JUNE 19, 2020 - ENTRY 14

I’ve written before about the things that seem to “break through” in this pandemic: commercials while watching TV, the mobile morgue. Today, a husband and wife were both removed from ventilation support, and they both died of COVID. In an effort to honor their relationship and their humanity, the care team arranged for the two patients to be in the same room. This couple literally lived together for fifty-some years and then died together in the same room on the same day.

Nurses, physicians, the ICU social worker, and other patient care technicians came to witness these two patients as their lives were ending. They seemed to be consoled by the care that we had offered them and that they were both present in the same room at the very end, though neither was alert enough to really know that the other was there (or so we think).

But I came away from that experience shaking my head. Angry. Distraught.

I’ve had families lose more than one family member to COVID. I’ve had families lose both parents to COVID, but not on the same day. But somehow, witnessing this couple be removed from ventilator support in the same room was too much.

There is something so fundamentally wrong with a virus that can make someone an orphan in one day. There is something evil about a virus that causes a family to lose a mother and a father.

While our cases are becoming less in volume and in acuity, it doesn’t get easier to face this pandemic every day. Some things break through in a way that I know I’ll be haunted by for a long time.

One of the things that has helped a little has been the use of the healing arts. There is a program at my hospital, led by an incredible artist. She made journals out of handcrafted, hand-marbled paper for our healthcare workers (chaplains, too). She included prompts for reflection and prayer and encouraged everyone to write down their feelings, prayers, and hopes. Those journals will serve as a sort of time capsule, she said.

That's what this journaling project has meant to me. It's been a space to express my fears, hopes, the absurdity of battling a pandemic (at times), and the reflections on my calling. I hope the reflections here will make a difference to my profession and the world.

This journaling project has...been a space to express my fears, hopes, the absurdity of battling a pandemic (at times), and the reflections on my calling.

JOURNAL ENTRY: JUNE 26, 2020 - ENTRY 15

This is my last entry for my pandemic journal. We seem to be on the “other side” of being a COVID hotspot in Chicago. There is a bit of breathing room—outdoor dining and retail stores being opened. I can feel that things have picked up in the hospital; elective surgeries have been going on for close to a month, and we are now allowing one visitor per patient per day.

I found myself becoming angry with a friend who isn't in healthcare. They talked about being ready to go back to “normal,” and I thought, “I'm not.” I'll take the quieter pace for a while longer. I could use some breathing room. I'm not ready for things in my department to go back to “normal” in terms of patient visitation, metrics, and other responsibilities.

I recognized this in myself as a sign of grief: everyone is returning to “normal,” and you look at them and think, “What the heck is wrong with you?” because, in your world, everything is still broken and chaotic. That's sort of how I feel about this lull. I'm so grateful, but I'm also not ready to go back to normal.

There's been talk about the “second wave” of COVID, which has two different meanings, depending on who you are talking to. Of course, there are the scientific experts who believe that there will be another outbreak of COVID in addition to flu season or just rolling hotspots, rolling waves of the virus. But there are also mental health experts who warn about rising rates of PTSD, moral distress, depression, and alcohol and drug use.

I know that I need to prepare for this second wave. I often think of chaplains as being trained in mental health first aid, not as mental health professionals, but what else can I do to care for my staff? How do I care for myself as I continue to care for others?

A part of my brain is thinking about preparation for the next wave of COVID. What resources will we need? What kind of staffing? Can we build up our department before the next big wave hits? The other part of my brain

is saying, “Oh, please stop. I just need a break. I don’t want to think about COVID.” It’s the tension of preparation versus fatigue. It’s hard to live in a state of hypervigilance.

One thing that I know will help is the arts. I’ve written before about the healing-arts program in my hospital, but I miss the arts as a whole — concerts, theater, ballet, art museums. One of my best friends is a pediatric chaplain in Texas. We had a long conversation about COVID; she sounded very depressed. I asked a lot of questions and listened closely. She finally asked, “What kind of world are we living in where there are no arts?” I quickly remembered my dear friend is a dancer as well as a chaplain. She has studied ballet since she was three years old and has taught ballet for over ten years. All of her classes have either been canceled or taught online.

Her words made me think of a novel I read four or five years ago called *Station Eleven*. It’s set in a post-apocalyptic world where 90% of the world’s population dies because of a global pandemic, the Georgian flu. (The novel feels frighteningly relevant now.) Most of the novel is set 20 years after the pandemic. It follows a young woman, Kiersten, who was just a child when the pandemic began. She and several friends travel around the Midwest in a Shakespearean troupe, performing plays in town after town. The motto of their company is “Because survival is insufficient.” (And yes, that’s also a reference to *Star Trek*.)

It strikes me that the arts and humanities are needed now more than ever before. We can survive this pandemic, but what my friend was really getting at was, how long will it be until we flourish? Until we can dance, watch plays, browse bookstores, go to the theater, or teach a ballet class in person? How long until we move beyond survival?

We are hoping and praying that our work as chaplains, as soul artists, is making a difference in the remaking of the world.

I don’t know the answer to that. My friend doesn’t either. But we are hoping and praying that our work as chaplains, as soul artists, is making a difference in the remaking of the world. There is much that needs to be remade, reworked. Much was broken before the pandemic, and COVID has laid those things bare.

We have a chance to set some things right. We have the chance to work for human survival, and after that, human flourishing. May it be so.

Amy Karriker's Journal

AT THE TIME OF PUBLISHING...

JOB TITLE: Director of Spiritual Care

HOSPITAL: Stony Brook Medicine

AT THE TIME OF JOURNALING...

At the time of my journaling, I wrote in the present tense, in a timeline format, as it was happening. My thoughts and feelings were substantial and scattered. During the reviews and editing of my entries, it all felt like a lifetime ago while also feeling like it was just yesterday. As a result, I edited it into past tense and with some hindsight and perspective.

COVID-19 numbers for New York State to date as of October 29, 2021

Positive Cases: 2,533,557

Fatalities: 57,913

Cohen Children's Medical Center of Northwell Health (CCMC) is a 202-bed, Level 1 Trauma Center that opened in 1983 as the New York metropolitan area's only hospital designed exclusively for children. Today we are the largest provider of pediatric health services in New York State, serving 1.8 million children in Brooklyn, Queens, Nassau, and Suffolk counties.

Our services include from a 64-bed neonatal intensive care unit, 27-bed pediatric intensive care unit (PICU), 12-bed ICU step-down, 3 medical/surgical floors, a hematology/oncology unit, a Bone Marrow Transplant unit, a Palliative Care Program, and kidney transplant services and certified ECMO services.

The Chaplaincy department began in 2011 with my hiring, and it now consists of myself as the director and two staff chaplains. Before COVID-19, we worked Monday to Friday, 9 am to 5 pm, with no on-call duties.

I first heard some low-frequency rumbles of a new coronavirus in China in January 2020, not because it was huge national news but because I live in New York and the JFK Airport was one of three US airports starting to screen for it among passengers arriving from China. Shortly after that, I remember hearing the first case in the US was now in Washington State. I didn't think much of it because, in the pediatric arena, we always have a "coronavirus" season.

By the end of January, this virus had begun to spread rampantly. Global air travel was restricted by early February, and the US declared a national public health emergency.



JOURNAL ENTRY: MARCH 1, 2020 - ENTRY 1

The first COVID-19 case was confirmed in New York, a 39-year-old woman who lives in Manhattan and had recently traveled from Iran. Robust testing began in the state in an attempt to gain knowledge of the spread and to contain it.

JOURNAL ENTRY: MARCH 12, 2020 - ENTRY 2

The first COVID-positive case came into our Emergency Department but was discharged home. We heard it was affecting the older population more, but not really children. We were a bit surprised that it was now in our hospital.

Later that day, I received a text message from my director giving me a heads-up that many departments were being furloughed home to preserve the PPE supply for nurses and doctors, to cut down on potential exposures, and for better staff tracing if there was an exposure. I was asked to prepare my department for this possibility. All volunteers had been put on hold, including our Jewish Chai Lifeline group, the Eucharistic ministers, and CPE interns.

We didn't want to just sit at home and do nothing, so we came up with a plan that would allow us to still be present.

That same day, my team and I began brainstorming a telechaplancy plan. We didn't want to just sit at home and do nothing, so we came up with a plan that would allow us to still be present, albeit in a minimal format.

JOURNAL ENTRY: MARCH 13, 2020 - ENTRY 3

At noon, I participated in an emergent, department-head meeting that was strangely being run by our Chief of Surgery and our brand-new Chief Nursing Officer, not our Executive Director. Apparently, all our administrative suite was home quarantining, having been exposed. Chaplaincy was mentioned as one of the teams to be sent home. I raised my hand and presented our new telechaplancy plan. They loved it and asked that we put it in place that day to be implemented on Monday. The rest of our Friday was spent printing copies of our flyer, handing them out on all of the units, and educating the staff on this new plan.

JOURNAL ENTRY: MARCH 14, 2020 - ENTRY 4

Over the weekend, Cohen Children's Medical Center (CCMC) began seeing a sharp decline in admissions due to school closures. Elective surgeries were canceled, and there were fewer traumas. No one was venturing out, and fortunately, so far, we weren't seeing the virus in children as much as in adults.

JOURNAL ENTRY: MARCH 15, 2020 - ENTRY 5

Our first COVID-positive pediatric patient was admitted to CCMC.

JOURNAL ENTRY: MARCH 16, 2020 - ENTRY 6

During the first week implementing our telechaplancy plan...

- We rotated one chaplain in-house each day while the other two worked from home.
- We made flyers with our names and our respective office numbers, which were forwarded to our cell phones. We distributed the flyers on all units, in the chapel, in the administrative suite, and to the concierge desk.
- We educated the nursing staff on when and how to reach out to us and to give the flyer to families who request a chaplain.
- The in-house chaplain rounded on all units for staff care, referrals, codes, deaths, and traumas. However, we were not allowed to enter the rooms of ANY isolation patients because of the possibility of exposure and PPE preservation.
- The other two chaplains remained home. They were to call their respective units twice a day and speak to the charge nurse to determine how everyone was doing on the unit, particularly the staff, and then to forward us to any staff member who may need to talk. We were to ask about any patient/family needs, attend to any patient/family/staff calls that came to us, attend regularly scheduled conference calls/Zoom/Microsoft Team meetings, and work on continuing education (reading, webinars, etc.).
- Each chaplain received approximately 8-12 calls a day from patients/families/staff.
- At the end of the week, we had weekly team meetings to discuss what worked, what didn't work, any adjustments we needed to make, and how we were coping (or not). Some were ok with this new arrangement; it gave them a much-needed break before this all got started. Others felt that we weren't doing enough and made themselves available to their staff more than the team had agreed upon, i.e., 24/7, which was not our schedule, which resulted in conversations around self-care and team preservation. I constantly reminded my team that this was a marathon, not a sprint!

There were some common themes among our team in response to this new telechaplancy plan:

- Exhaustion: Being the in-house chaplain was exhausting. You needed roller skates to be everywhere and do everything that was asked of you. Our days had become 85% staff care and 15% patient/family care.



- Frustration: This was the theme for those stuck at home and not in-house when we are needed most. It was very frustrating not being able to provide spiritual care in the traditional sense, especially when human touch and comfort come with a threat of contracting the virus. Caring over the phone was not something I wanted to get used to.
- Guilt: There was a lot of guilt that we weren't doing all that we could do and wanted to do.
- Shame: Other chaplains across the country were not furloughed and still working in-house full time; the term "essential worker" was coined. As one of those at home, I felt we were not seen as essential; I felt I was not essential.
- Disconnect: We experienced a huge disconnect. We had worked so hard to build connections, to be seen, to be a part of the multidisciplinary team. Now we were physically disconnected, trying our hardest to stay connected, to feel like we were a part of it all, that we were there in the midst doing our part.
- Scared: Like everyone else in the world, and especially in healthcare, we were scared of personal exposure on the days we were in-house or while we were out running an errand and worried about bringing the virus home to our families or back to the hospital children and staff. The horrors that were seen, experienced, and spoken about were enough to drive anyone indoors.
- Worried: We were worried about the staff's wellbeing—their physical, psychological, and spiritual health. We were worried about our personal out-of-state families, wondering if they were being as careful as they should be when it wasn't as bad there as it was in New York. We worried about those in our church families: how were they faring, did they have folks running errands for them, were they staying safe?

We were eager to get back into the hospital when it was our scheduled day, but anxious about what lay ahead.

- Eager/Anxious: We were eager to get back into the hospital when it was our scheduled day, but anxious about what lay ahead. What we would see, and what will we have to deal with?
- Anger: We were angry that we were made to go home and not allowed to stay and help, angry at what felt like a competition about who was more essential. While the discipline of chaplaincy benefitted (for what feels like the first time) from a large amount of press and media coverage to those of us at home, it began to feel like a competition; who was doing what, how many hours were they staying at work, how many deaths did they work in a day, how many prayers were spoken, how many were overextending or sacrificing themselves in this process?



JOURNAL ENTRY: MARCH 20, 2020 - ENTRY 7

New York governor Andrew Cuomo requested that all New York state hospitals increase their capacity by 50%. Long Island Jewish Medical Center (LIJ) is an adult hospital physically connected to CCMC. Within hours, CCMC made rapid discharges, and moved patients from two units into others, and flipped those units into adult non-COVID units, one ICU and one Med/Surg.

JOURNAL ENTRY: MARCH 23-27, 2020 - ENTRY 8

It's the second week of telechaplancy, and the "Messiah Complex" is strong. Although we were making this new schedule and way of chaplaincy work, it wore out its welcome within one week. The intensity of all our emotions from the first week was now doubled. Our frustration of having to be home was wearing on our sense of self, our sense of calling, our usefulness, and our belonging.

JOURNAL ENTRY: MARCH 30, 2020 - ENTRY 9

Doctor's Day ...Everything that had been planned was canceled. That is usually a big and busy day for chaplaincy because we do a Blessing of the Hands for our physicians, and that too was canceled. A distanced Blessing did not feel meaningful, and they were too busy to stop for one.

JOURNAL ENTRY: MARCH 31, 2020 - ENTRY 10

I received a call from my director that they needed us to come back!! It was now all-hands-on-deck. Not only did they want all of us to come back in-person to the hospital, but now I needed to create a new schedule to include weekends so that we didn't have the same days off. We were also to cover seven days a week (which we had never done before). Finally! We were so relieved to be going back. We were going to be where we were needed most with the people who needed us most! But I learned a very valuable lesson: to be careful what I ask for. Seven days a week for three chaplains is tough!

The adrenaline kicked in as we now prepared physically, emotionally, spiritually, and mentally to be back every day. I reminded my colleagues, once again, that this was a marathon and not a sprint.

JOURNAL ENTRY: APRIL 1, 2020 - ENTRY 11

We were all back in the hospital. The numbers for New York were staggering; 47,439 COVID cases in NYC. 83,712 in New York state. 1,941 deaths in New York state. PPE and ventilators were in critical need.

We were reminded that we were not allowed to enter ANY isolation rooms to avoid potential exposure and use of PPE and to lessen exposure tracking.

Not only were we all back at work and now covering weekends, but we were also asked to go to other hospitals in our system that either didn't have a chaplain or only had one chaplain to help with staff support. We went from zero to one hundred in a minute.

Our PICU intensivists and fellows were now taking rotations in the adult ICUs. Many PICU RNs and NPs were also taking rotations in the adult ICUs, and our med/surg nurses had been deployed to help where needed. This was especially difficult on this particular group of nurses. The majority of these nurses were young and new. They had no idea what they were about to step into when they started.

Our first week back was utterly exhausting. Because CCMC is a children's hospital, our census declined rapidly due to school closures, elective surgeries being canceled, and *literally* no traumas. CCMC is connected to one of our adult hospitals, Long Island Jewish Medical Center (LIJ). As a result of NY governor Andrew Cuomo asking all hospitals to increase capacity by 50-100%, LIJ had converted every possible space into COVID units, most into ICUs...adult and pediatric post-anesthesia care units (PACUs), interventional radiology, the infusion center, half of their main lobby, conference rooms, emergency department tent, etc.

CCMC flipped three of our inpatient units into two "clean" med/surg units for LIJ and a "clean" ICU. Half of our emergency department was now an adult COVID ICU, and the other half of our ED was asked to see patients up to 30 years of age. My department met with LIJ's chaplaincy department, and we offered to cover their patients in our hospital to take some of the load from them and free them up to provide more support to their staff. Since the adult patients in our hospital were "clean" patients, we could help. The "clean" designation and our ability to see their patients were short-lived because, by April 6, all units became COVID units except one, which became their maternal/child unit.

JOURNAL ENTRY: APRIL 7, 2020 - ENTRY 12

With all of the fear and stress and loss and active grieving happening within the walls of our hospitals, I felt the need to place a protective bubble around our campus, something that would provide some comfort and peace on a large scale.

It was moving to see the solidarity and hope shine through the fear and grief, if for just a moment.

I created a blessing for our campus. I invited the LIJ chaplains and staff from both hospitals to join together outside, surrounding our buildings, to offer the blessing at noon. Word spread, and anyone who could step outside for 15 minutes showed up and spread out to surround our campus. Camera crews and a drone team were also brought in to capture the event. The plan was to use this footage in a documentary our system was making throughout this crisis. It was very meaningful and appreciated by all. It was moving to see the solidarity and hope shine through the fear and grief, if for just a moment.

JOURNAL ENTRY: APRIL 8, 2020 - ENTRY 13

Passover.

We have always worked with our local Jewish volunteers to bring in kosher and Passover food for our Jewish patients and to help keep the Bikur Cholim room stocked. This is usually done by volunteers that enter the hospital and stock the room and visit patients on a daily basis. However, given that volunteers were unable to come into the hospital, my team made scheduled arrangements to meet them outside, receive the meals and supplies, deliver them ourselves, and keep the hospitality room neat and stocked. Despite the pandemic and all of its roadblocks, Passover was observed with dignity and respect.

JOURNAL ENTRY: APRIL 10, 2020 - ENTRY 14

CCMC has gone from 13 pediatric COVID-positive patients to 23, with 1 pediatric death overnight. No, children have not been affected by this to the volume and degree that the adult population was, but they were definitely not immune to it. Children were getting sick, some very sick, and some did die from it! I continued to worry about my family back home, especially my 98-year-old grandfather, my mother, and my young nieces.

JOURNAL ENTRY: APRIL 12, 2020 - ENTRY 15

Easter.

This is usually a time of celebration and joy, a time for Christians to proclaim Christ has risen from the dead and that death has no sting. But it is really hard this year. There were no gatherings at churches, no Hallelujah chorus being sung, and it certainly did not feel like a time to celebrate.

New York's numbers seemed to have plateaued but at a high rate. Total deaths in NY state were at 9,385 to date. A field tent hospital had been set up in Central Park. How do we as chaplains bring the good news of Easter to those so in need of some good news? A Christ risen from the dead when so many deaths were happening all around us?

Working closely with our Infection Control and Quality teams, one of our chaplains was given permission to offer an Easter prayer service for day and night shift staff in our chapel, offering communion with special protocols and social distancing in place. It was very well attended; everyone was starved for being together around something other than COVID and grief.

All of the staff that floated to the adult side, when asked, called it a "war zone." Many were in shock with what they were seeing and the volume of what they were seeing, and the hopelessness and helplessness they were feeling. Their fear of exposure was heightened. Many were self-quarantining when they got home, staying in their garages, in hotel rooms, or in their basements...not really seeing or interacting with their families. And yet, they continued to return every day and serve.

The med/surg staff were really struggling. Many of them were young, new nurses and had never seen much death, if any—definitely not this much. They were the ones being asked to take the bodies down to the morgue, a place they had never seen. In the meantime, the PICU staff were operating on adrenaline. While they said it was the most terrible thing they had ever seen, they felt very helpful and that working on the PICU had prepared them for this work.

Working with the staff and these opposing emotions, I felt like the ball in a ping-pong match! I rounded with nursing leadership several times a week to the adult side to check in with those working over there. They were so grateful to see us, get support from us, and know that we hadn't forgotten about them or abandoned them. It was so difficult to see them struggling and feeling overwhelmed, and yet there was a sense of pride among them and within myself, seeing them step up and do whatever was needed, without complaint, even on the days when they felt they weren't making a difference.

By this time, the chaplaincy department's focus of care had become 90% staff care, primarily one-on-one. We were not holding any Code Lavender events where we would take time to debrief with staff after difficult events, at the dismay of leadership, because it really wasn't appropriate at this time. We were still in the middle of this crisis, and no one had time to leave the unit and sit down and talk about it. Although it was suggested we attempt some Code Lavender debriefings remotely through Zoom, I feared no one would participate after hours once they were home (they didn't want to talk about it in the presence of their families and they wanted to leave it at the hospital, if they could), and the efficacy of these sessions would be diminished. So, we continued our one-on-one care, rounding on our units all day in order to find that one nurse or doctor or respiratory therapist that wasn't in a patient's room.

Food donations from community businesses and individuals were coming in faster than our hospital could disperse them. There were so many donations every day and night that each meal and all snacks were covered. Hardly anyone went off their units to go to the cafeteria: there was no need, and it saved time.

I am so proud of how our staff has stepped up and supported the adult side and one another. And I am so proud of my department stepping up to support the adult staff, our staff, and the staff at other hospitals.

I am so proud of how our staff has stepped up and supported the adult side and one another. And I am so proud of my department stepping up to support the adult staff, our staff, and the staff at other hospitals.

JOURNAL ENTRY: APRIL 13-17, 2020 - ENTRY 16

Northwell Health System's Chaplaincy Services, working with our system's Employee Assistance Program (EAP) and the system's mental health program, put together several initiatives to support the staff at all 23 hospitals.

- "Heart-To-Heart": A 24/7 Chaplaincy hotline for staff across the system. This provided more opportunities for private, one-on-one support, especially for the staff at those hospitals in our system that did not have a chaplain on staff. This hotline was staffed by our system's per diem chaplains. If a staff member wanted to speak to a particular staff chaplain of a particular faith, then those calls were routed to that chaplain.
- Employee Health and Wellbeing Resource Tents were being set up at each hospital near their employee entrances, staffed by either a chaplain, an EAP person, or a Behavioral Health staff member at shift changes. This was for staff to stop by before or after their shift for support and wellbeing resources like prayer, aromatherapy lotions, scripted guided meditations, simple stretching and breathing exercises, finger labyrinths, refreshments, etc.
- Staff resiliency visits to different departments are being facilitated by chaplains. Our team visited Respiratory Services, Communications/Operators, the Morgue staff, Security, Pharmacy, Environmental Services, Concierge, Case Management, Social Work, etc. to provide support, a listening ear and to remind them of the incredible work they are doing for our patients/families/staff. This was a complete team effort.

It was especially meaningful to show our appreciation for our Environmental Services Team. By this time, our system was providing free antibody testing for all employees. Our rate of those with antibodies was very low, which meant that not many of our staff had contracted COVID through all of this! That was great news! To be able to tell our Environmental folks that they had done an amazing job at keeping our hospital clean and infection-free and keeping our staff safe helped them feel such a great sense of pride in their role in stopping the spread. Knowing they were protecting their colleagues was so rewarding.

Personally, I was feeling it all by this time. My emotions were raw like everyone else's. Yet, I felt the need to be the strong one, the leader of my department, and the supporter of our staff.

Still, some of the emotional stress I was experiencing included the following.

- Fatigue...I felt I was sleeping ok, but I was always tired. Another chaplain in the department was feeling and saying the same thing. When I heard or saw them showing signs of being over-stressed, I sent them home early (if possible). I could not afford either of them to be out because of exhaustion, burnout, or getting sick.
- Short-fused...EVERYTHING that was not in the category of caring for folks on the floors and in their departments seemed so petty. This pettiness frustrated me. It didn't take long for it to turn to anger, and I was struggling to hold my tongue. By the end of the week, I spent only a few hours on the floor, mostly in the office, trying to avoid anyone and anything that felt petty and purposely not placing myself into a situation in which I could get in trouble.
- Old recordings...Unhealthy, learned messages of self-sacrifice for the sake of others were rearing their ugly heads. "Be all things, to all, at all times." "A true and faithful representative of God would never turn down an opportunity to care for another." I tried to hold onto the truth and my own words that this was "a

marathon and not a sprint”; therefore, I needed to pace myself. But pacing myself seemed to bring up the old guilt and shame from the old recordings. “If others are giving above and beyond, then I should too.”

A barrage of demands and expectations was being launched at me as the director—from others, but mostly from myself. I felt that during a crisis of this magnitude, there needed to be a balance between new initiatives and boots-on-the-ground work. I felt that there were those in the white towers making up numerous initiatives for those who are just trying to keep their heads above water.

- Psychosomatic symptoms...I experienced headaches, backaches, achy feet, gastrointestinal issues, and sinus problems. With all of these, I worried, like everyone else in the hospital, that some of these could be COVID symptoms. Was I exhibiting signs? Was it just in my mind?

I was also trying to keep some normalcy within our department. We held our regularly scheduled staff meetings, had our morning coffee together, and worked on our continuing education opportunities by watching webinars and reading articles. I hoped that some normalcy would help, but there were times when it felt like forced normalcy. Is forced normalcy *normal*?

I hoped that some normalcy would help, but there were times when it felt like forced normalcy. Is forced normalcy normal?

JOURNAL ENTRY: APRIL 16, 2020 - ENTRY 17

To date, CCMC has had 63 COVID-positive pediatric inpatients, 51 discharged, 2 deaths. The families of the two children who died did not want their death certificates to read that they died of COVID. They did not want their children to be a statistic. It was so hard to see them and hear them arguing with the medical team over this and begging them not to write that. I don't know why there seemed to be such a stigma around this virus for these families, whether it was from the shock that this had happened to them or disbelief that kids could die from this. Whatever it was, their pain, anger, and fear were real and palpable!

JOURNAL ENTRY: APRIL 19, 2020 - ENTRY 18

CCMC discharged a COVID-positive ECMO patient that recovered!!! We had a huge celebration! We lined the unit hallway as they exited, held up banners and balloons, and had a photoshoot in the lobby, all the while playing “Don’t Stop Believing” on the overhead system. News crews were present too.

This was a true miracle, and many staff came in from home to be there and see the patient out. There wasn’t a dry eye in the building. The patient’s mom stayed in the room with the patient for the entire three weeks, away from her other children, husband, and family. She never panicked nor stopped believing that her child would get better. She had full confidence in our team and our plan. They were both very sweet-spirited and gently-spoken people

and very grateful for the love and care given to them. The celebration felt good. Do we dare believe and hope that the tide is turning?

JOURNAL ENTRY: APRIL 20-25, 2020 - ENTRY 19

We were now seeing a lessening in the New York COVID numbers. There was some relief and a decline in adult patients needing hospitalization and ICU care. As a result, LIJ began taking back some of their patients from our hospital. By the end of the week, they only needed two of our inpatient units for maternal/child care.

It seemed to decline almost as quickly as it peaked.

Our nurses didn't seem to be needed as often now due to travel/contract nurses arriving from other states. The contract nurses were now taking some of the shifts and some of the burden from us.

A decision was made by CCMC administration and LIJ administration to convert our new (under construction) PACU to a 60-bed adult ICU COVID unit. An emergent order was put in place to have it done in 10 days. I was asked to join our administrative team to thank the construction crew, give them a pep talk, and offer a blessing for them, their work, and the space. This decision was made to move the patients in our current pediatric and adult PACUs out so that the space could be terminally cleaned and so that our operating rooms could re-open as the surgery schedule was readied in the coming weeks.

JOURNAL ENTRY: APRIL 24, 2020 - ENTRY 20

I decided it was imperative that I hold one of my usual staff support sessions ("What's Popping") for the PICU staff, which are usually done every other month. The theme was "coastal": "If you can't go to the beach, I'll bring the beach to you."

I wrote a quote on the giant whiteboard in the conference room where I held the session, "Life, like the tide, is a balance of holding on and letting go." I displayed two fishbowls filled with rocks, beach glass, and water in the middle of the table and placed small pieces of dissolvable paper between them. We talked about the quote and our experiences over the past two months.

"What are some of the things we want to hold onto: the lessons learned, experiences that have made us better nurses, doctors, chaplains, RTs, humans, etc.?" "What do we want to let go of?" The things we wanted to let go of were to be written on the pieces of paper and placed into the bowls to watch them disappear in front of our eyes.

Some shared what they wanted to let go of, and some didn't. One of the staff in attendance struggled to come up with something he would let go of because, despite how horrible it had been, he learned things from it...all of the deaths, all of the loss, pain, grief, and helplessness. He didn't want to let go of it and lose what he learned from it. He finally came up with the intensity of it; the amount of it was what he'd like to let go of. It was just too much of everything.

During this session, I also learned something about the nursing staff. A few PICU nurses are larger-than-life on a normal day, but in the midst of a pandemic, this is multiplied by 1000!! While they are still top-notch nurses, their personalities were becoming massively exaggerated, which, for me, made it a bit difficult to communicate, reason with, work with, etc. What made matters worse was that my fuse gets way too short when I am exhausted, frustrated, and feeling less than (incompetent). So, put those two things together, and communication is poor at best.

This week also include four emergency Code Lavender training sessions. Toward the end of 2019, we recruited new Team Lavender members. Before COVID, I was able to train only those on the night shift but didn't get a chance to train the day and evening shift folks. Now that we seemed to be on the downward slope of the COVID curve, we would be expected to start holding Code Lavender debriefings; therefore, we would need everyone on board and ready to go. This week, I trained four of 13 new members. I also went to another hospital to offer staff support and a Blessing of Hands on each of their units.

JOURNAL ENTRY: APRIL 27-MAY 1, 2020 - ENTRY 21

This week started with two more Code Lavender training sessions and a departmental meeting. Given that no one is traveling and planning vacations or attending conferences, our calendars are void of scheduled days off. Our system announced that they were graciously rewarding our efforts by giving employees a \$2500 bonus and an extra week of vacation!! While this was amazing and greatly appreciated, the vacation time was piling up because no one was scheduling vacations.

I suggested to my team that we each take a few days around a weekend and take a long, relaxing, renewing weekend now that things seem to be slowing down and before the pace starts picking back up with "normal" patient loads. While one chaplain was willing to take me up on the offer, the other declined self-care. They said they would be in a worse place staying home and doing nothing than if they just continued to work.

It has become difficult to get them to take care of themselves throughout this whole crisis. Granted, I don't know what life at home is like, but I know that every time I suggest self-care, they decline. Looking at my impending schedule for the rest of the week, I took time off not only for self-care but also to attempt to model for them how to care for yourself during difficult times.

Self-care, as mentioned earlier, can be a two-edged sword.

Self-care, as mentioned earlier, can be a two-edged sword. While it is totally needed and vital, for me, it brings feelings of guilt. But the ways that I chose to care for myself included taking this brief time off, painting, working puzzles, binge-watching *Schitt's Creek*, sitting in the sun on my back porch, doing a five senses centering exercise, Zooming my church family during fellowship time, trying to go to bed early in order to catch up on my sleep, continuing my personal therapy through FaceTime, and FaceTiming with friends and family.

It was a good, restful week off, except for forgetting that I needed to put together a PowerPoint presentation about our Community Outreach team for kids and parents on dealing with all of the emotions that we all are experiencing during this pandemic. Irony, huh?

JOURNAL ENTRY: MAY 5, 2020 - ENTRY 22

One of my chaplains tested positive today and is now out for 14 days. Everyone in our office, including myself, has been exposed and needs to be tested.

THIS JUST GOT VERY PERSONAL.

JOURNAL ENTRY: MAY 8, 2020 - ENTRY 23

My other chaplain tested positive and is now out for 14 days also. The supervisor for the concierge team and I tested negative. Our office was terminally cleaned following each positive test. Now my staff is forced to take time off. Irony again, huh?

JOURNAL ENTRY: MAY 11-19, 2020 - ENTRY 24

I worked alone during this time. The week was busy with many Code Lavender education sessions until all 13 new team members were trained. Now that COVID seemed to be waning, a new pediatric syndrome had developed and was becoming prominent at my hospital. PMIS or MIS-C, Multi-organ Inflammatory Syndrome in Children, had developed due to having had COVID four to six weeks prior. The numbers we were seeing rivaled the amount of COVID positive kids we saw, if not more.

I was able to have “normal” face-to-face conversations. This felt good. I felt useful again.

Some were extremely critical, affecting their blood pressure and heart function, needing a ventilator for a week or more, while others were turning around quickly within two days or so. A common theme I heard from the parents was that of guilt. They assumed they had exposed their kids to the virus and, thus, this result. They assumed that either their child never had it, or if they knew they had it, it was very mild, and everything was okay. Because these kids were not COVID positive anymore, their parents were allowed to leave their child's room, and therefore, I was able to have “normal” face-to-face conversations. This felt good. I felt useful again.

I received our first request for several Code Lavenders for those young, new Med/Surg nurses. Their manager worked on determining some dates and times of their availability and was able to get the sessions arranged. I was also working with the Chief of Critical Care to arrange some Code Lavenders for the attendings and fellows that

served on the adult units. There were four sessions scheduled for the nurses. Only two nurses showed up for one of the sessions...no one else. I guess they really weren't quite ready to talk about it after all.

Both staff chaplains remained symptom-free during their quarantine. My plan was to get tested a second time when they returned, but since I remained symptom-free during their time out, I did not get tested again.

One chaplain returned on May 19, and the other returned on May 22.

JOURNAL ENTRY: MEMORIAL DAY WEEKEND, 2020 - ENTRY 25

I, for one, am very happy about a three-day weekend.

For the first time since early March, New York state finally dropped below 100 deaths per day! Most beaches and boardwalks have been opened, with “social distancing police” keeping things under control as much as possible. The general public was ready for everything to get back to normal, with many defying all of the pandemic safety protocols, so I chose not to venture out. Church was still virtual, I had all my groceries and drug store orders delivered, and I literally only traversed between work and home.

There were many personal and professional lessons learned during recent weeks. I learned to pivot on a dime and that I could be quite creative and flexible when needs and demands changed from moment to moment. I learned that although I am an extrovert and need to be around people, I am also perfectly comfortable being alone, sequestered in my home. I believe the long, cold winters of my time living in Montana prepared me for this. I learned I am more resilient than I could have ever imagined needing to be. I learned new self-care rituals, realizing that my normal routine was not going to be enough.

While I remained sequestered in my home, I watched the nightly news and remained fearful of the potential duration of the pandemic and the condition of the soul of our world. Many beautiful things were happening around the world—and equally horrible things as well. During the last two months, I saw and heard and joined in on imagining what our world would be like on the other side of this.

I pray for a coming together, a united humanity, a healthier planet, and an end to this tragedy.

Will we be nicer to one another? Will we take better care of our planet that seems to have been able to finally take a breath because of all of this? Will we realize we are more alike than different? Will we come out of this better and not just settle for what was “the norm” before it all started? I pray for a coming together, a united humanity, a healthier planet, and an end to this tragedy.

A Physician's Response to the Chaplain Journals

Steven Clark Cunningham, MD, FACS

This remarkable collection of personal journal entries from the early days of the COVID-19 pandemic in the United States contains the poignant and revealing reflections of five chaplains—four women and one man—from five different states.

As a physician caring for similar patients in similar situations, I found it remarkably easy to identify with the entries of these chaplain colleagues, as they documented their experiences over a combined period of four months, from March 1 through June 30, 2020. Like the pastoral and spiritual care that they and countless other chaplains around the country provided, the medical and surgical care that my colleagues and I provided during those early days of this still-alive-and-strong pandemic afforded us a remarkably similar experience, albeit different in some salient ways.

And somewhat ironically, I am writing this response while in isolation at home in my basement, having tested positive for COVID-19 myself while covering Christmas weekend 2021, which, again ironically, I was covering because the surgeon originally on-call was home, also with a COVID-19 infection. Thankfully, we both were vaccinated and, therefore, had mildly symptomatic cases, unlike the many profoundly ill or succumbed patients described in these journals.

Reading these moving entries revealed to me at least seven themes: 1) identity issues, in which providers identify with their fellow humans for whom they are caring; 2) racial issues, which were all the more prominent during this period due to the murder of George Floyd by police officer Derek Chauvin in Minneapolis, Minnesota, on May 25, 2020, and the subsequent, widespread social unrest that followed; 3) issues of guilt, ethical dilemmas, and fear; 4) exhaustion, both of providers and patients' loved ones, to say nothing of patient exhaustion; 5) confusion and disorientation regarding the rapidly changing situation, the elusively evolving policies, and the general uncertainty unsurprisingly associated with a new, worldwide pandemic; 6) a shift in the focus of chaplain care from patients to providers; and 7) small glimmers of hope and optimism.

If I was left with one salient message for these (and all) chaplains in response to reading their journal entries, it would be, "Thank you!"

If I was left with one salient message for these (and all) chaplains in response to reading their journal entries, it would be, "Thank you!" Although chaplaincy as a profession is increasingly availing itself of research and metrics—in no small part due to the laudable efforts of the thinktank Transforming Chaplaincy,¹ which strives to promote evidence-based care and to integrate research into practice and education by fostering a culture of inquiry—still, it strikes me that the value provided by chaplains to patients and their medical providers is one of those thankless intangibles that all too often go unacknowledged.

So, before looking at these themes in more detail, let me begin my response by expressing my gratitude to these and all chaplains for doing such important work. As I am completing my master's degree in religion, focusing on religious literacy among healthcare providers, it has become increasingly clear to me that, although the religiosity/spirituality of people in the United States continues to be very diverse and widely prevalent, there is a lack of religious literacy in the United States^{2,3} that does not spare healthcare providers.⁴⁻⁷ So, for helping to fill this important gap, I salute and thank you, chaplains!

All seven aforementioned themes were clearly present among the majority of the five chaplains' journals. However, that the first theme, identification with patients, families, and providers, was, on my reading, the most uniformly present theme among the journals, is perhaps unsurprising, since empathy, sympathy, and—the greatest of these interpersonal feelings/abilities—compassion all abound in people drawn to chaplaincy.

All five chaplains recorded seeing themselves or their loved ones in the COVID-19 beds of their patients. And the responses of the chaplains to COVID-19's spilling inevitably over to the care teams and *their* loved ones, and the chaplains *literally seeing* their colleagues and loved ones become positive for, sick with, or even dead of, COVID-19, was perhaps most accurately captured for all by Amy Karriker's May 5, all-caps entry: "THIS JUST GOT VERY PERSONAL."

Segueing to the second theme – of racial disparities – the entries of Brenda Walls similarly record her reflections on both being herself at risk for severe COVID-19 disease due to medical issues and also being African American and therefore a member of a group further at risk for COVID-19. As if to add insult to injury concerning race, the murder of George Floyd occurred not only upon a background of systemic racism and widespread police brutality, but also just as the first COVID-19 peak was occurring, at which time, as Alyssa Foll notes, makeshift morgues were already being required to accommodate accumulating COVID-19 corpses.

The intersection of COVID-19 death and the injustice of George Floyd's death was present in many entries, but particularly painfully in Foll's May 29 entry: "'I can't breathe, I can't breathe,' were some of his last words. My COVID patients can't breathe, either." And further complicating the tangle of race and COVID-19 is the irony that George Floyd himself had not only just lost his job at a restaurant, as did many restaurant workers due to COVID-19, but also had COVID-19 himself.⁸

Indeed, the anger and widespread social unrest surrounding racial issues was present in many journal entries, as in some late entries in June by Adam Ruiz about the existence even within the hospital of social unrest, and as in earlier entries, even prior to George Floyd's death. One of Brenda Walls' first entries, in fact, in early April, relates the terrible scene in which a COVID-19-orphaned son was overcome with grief upon the death of this father and "lashed out in anger ... and accused the doctor of 'trying to kill Black people.'"

The third theme—issues of guilt, ethical dilemmas, and fear, all so often wrapped up together in complex ways—is present in protean manifestations throughout these writings. Feelings of guilt pervade the described scenes, including both in the patients described by the chaplains and in the chaplains themselves. Adam Ruiz, for example, describes on April 28 the palpably painful guilt of a mother of twins: "One died. One lived... [and] she didn't know if she should be happy for her baby who lived or sad for the baby who died, and was feeling guilty either way," while Amy Karriker, working at a level-1 trauma children's hospital caring for critically ill children

with COVID-19, notes on May 11 that “a common theme I heard from the parents was that of guilt [as they] assumed they had exposed their kids to the virus.”

In the chaplains themselves, feelings of guilt were also infectious, as when Amy Karriker reflects on April 27 about her own “self-care...a two-edged sword[, which] is totally needed and vital, [but] brings feelings of guilt,” or when Ruiz describes a March 25 code blue in which he had feelings of guilt from not being among the ones in the room so directly exposed to COVID-19.

Such ethical dilemmas extended beyond guilt, however, to include other issues born of an emergency situation like that first peak of the COVID-19 pandemic, such as the issue of privacy. For example, Ruiz describes on March 20 the conflicting rights of patients and families to privacy regarding their protected health information on one hand, and the rights of funeral homes to protect themselves from COVID-19 on the other. And finally, inextricably bound up with the guilt and related ethical dilemmas, is fear, as in the revealing voice of a patient care technician, shared by Alyssa Foll on June 5: “I am just so scared.”

Nobody who was on the front lines during this time will be surprised to read in these entries the sheer exhaustion that that so many experienced during this time. The presence of this fourth theme in the journals, like actual exhaustion itself, sneaks up on and catches you unawares. For example, in one of Adam Ruiz’s earliest entries, on March 15 (just as the first patient tests positive in his hospital), although there is in his tone then a bluster of positive energy and enthusiasm, this was, as we now know, the energy and enthusiasm of the yet-to-be-exhausted: just a month later, as Ruiz insightfully reflects, “It was starting to feel unsustainable.”

Nobody who was on the front lines during this time will be surprised to read in these entries the sheer exhaustion that that so many experienced during this time.

Similarly, there is an early energy with which Amy Karriker describes her team’s eagerness to return to work *in person*, which is how, of course, they do their best work, and an excitement that she relates when the call finally came on March 31 “that they needed us to come back!! It was now all-hands-on-deck.” However, as she soon thereafter describes, “our first week back was *utterly exhausting*” (my emphasis).

Meanwhile, around the same time in another hospital, Nina Redl, in April, accurately and pithily personifies, “my hospital is tired.” And, of course, COVID-19 gave us no warning that it was coming; life with all of its ordinary exhaustions was already happening, as noted by Alyssa Foll on March 27: “I was already feeling burned out ... and now I need to turn my attention to COVID-19.”

The fifth theme, the confusion and disorientation that necessarily accompanied such a rapidly changing situation of elusively evolving policies and of general uncertainty about this new and poorly characterized virus, underlies many of the other themes. For example, Adam Ruiz relates many such instances, as on March 20, when he describes the confusion surrounding the dilemma about privacy issues above; and in early June, when he described the sense of disorientation that accompanied social unrest among hospital staff who disagreed about

what, if any, stance the hospital should take; and on March 23 about the “constant changing of policies and procedures” regarding PPE and staffing. At one point, on April 19, he simply recognizes, “We’re winging everything.”

Apropos of expertly “winging it,” of doing that which is most urgently called for by the emergency, the sixth theme, a shift in pastoral care to those whose exhausting efforts to provide medical care demanded it, was very commonly expressed by these chaplains. Alyssa Foll, for example, notes on April 3 that “I now spend the majority of my time with staff”; Amy Karriker on March 16, that “our days had become 85% staff care and 15% patient/family care”; and Adam Ruiz on March 19, “Leadership to me: ‘Round on staff. Focus on staff more than anything else.’”

This was one area where I noted a difference between chaplains and my medical colleagues, since we probably do not do as good a job as we should—certainly not as good as the chaplains do—of caring for each other on the medical staff. There is indeed much we can learn from these journals and from our chaplain colleagues. And, as Brenda Walls notes on April 17, chaplain concern extended not only to us on the clinical staff, but also to “all of the ancillary staff people who are also risking their lives” to keep the rooms turned over, the hospitals clean, and all the humans therein fed and protected.

Despite all the difficult issues with identity and race, with guilt, ethical dilemmas, and fear, and with exhaustion, confusion, and disorientation, there were glimmers of hope and optimism.

Finally, despite all the difficult issues with identity and race, with guilt, ethical dilemmas, and fear, and with exhaustion, confusion, and disorientation, there were glimmers of hope and optimism. Even the smallest of gestures, such as that recorded by Nina Redl—“she looked at me and whispered, ‘thank you’”—coming as it did after the extremely difficult, persistent, and emotionally taxing patient/family situation that she describes regarding “the wife of one COVID ICU patient,” can make all the difference for those chaplains (and all people) who refuse to give up on their fellow humans.

Alyssa Foll’s April 17 reflection, for example, that “COVID has brought about a deeper understanding — chaplaincy is about the human spirit and finding meaning to go on when living through the unimaginable ... I’m really proud to be a chaplain,” clearly reveals the tenacity of the human spirit both in those afflicted and in those who minister to them. Her words show how the roles are fluid, sometimes reversing, in a care relationship. Even though, as she notes on May 15, “this virus is awful, insidious, and sometimes deadly[, still] the resiliency of the human spirit is also alive and well.”

Even when that spirit begins to break, as Redl notes on April 8, there is hope: “I heard another chaplain say that her job has turned into hell... and I understand what she means. However, I feel my world has turned into a broken heart that can help hold and mend, one tear at a time, and maybe as I once heard... even if it hurts, there is more room in a broken heart.”

Referring to the Carly Simon song “Coming Around Again,” her mention of “more room in a broken heart” reminds us that this kind of mulishly optimistic view of human healing is indeed just what is needed. It is also expressed by Adam Ruiz on March 26, when he observes that we humans “have been given stubborn hope.” And in what is perhaps one of the journals’ most profound statements of charity, hope, and love, he writes that same day:

We send love towards the virus and accept its gift to us: community, sharpening us on the essential, realizing how much good in the world there is, a shift of focus and priority, building bridges, bringing people together. (My emphasis.)

Although it may sound perverse at first to speak of loving this oppressive virus, Ruiz is speaking here, I believe, of the highest kind of love: the love that the ancient Greeks called agape (ἀγάπη in Greek, *ahavah* in Hebrew⁹): a universal, charitable, “brotherly,” Godly love; the love that Jesus showed to *his* oppressors and that many Christians emulate; the love that many Muslims believe is an attribute of God that He recreated as an instinct in us humans¹⁰; the selfless, elevated, pure love of Hindu *prema*⁹; the selfless love of the Buddhist Brahnavihara or the Four Immeasurables (which, reminiscent of Ruiz’s phrase, is called by some a radical love¹¹); and yes, even the Lily Potter love that rescues us from Voldemort-level evils. It is an utterly powerful love that overcomes.

As the evil that has been the COVID-19 pandemic challenges and tests our love, it prompts us to consider, as Amy Karriker wonders at the end of her journal,

what our world would be like on the other side of this. Will we be nicer to one another? Will we take better care of our planet that seems to have been able to finally take a breath because of all of this? Will we realize we are more alike than different? Will we come out of this better...?

Indeed, taken all together, the most important questions these journals prompt us to ask ourselves are, Will we love ourselves? Will we love each other? Will we “love the virus”?

Dr. Steven Clark Cunningham was born in Denver, Colorado. After graduating from Creighton University with majors in chemistry and Spanish, he attended medical school at George Washington University and completed residency in general surgery at the University of Maryland and fellowships in oncology research and surgery of the liver and pancreas at Johns Hopkins University. He now serves as the Director of Pancreatic and Hepatobiliary Surgery and Director of Research at Ascension Saint Agnes in Baltimore, Maryland. In addition, he is currently finishing a master's degree in religion at the Harvard Extension School, where he has served as teaching assistant for HarvardX's MOOC (massive open online course) “Religion, Conflict and Peace.” He has published two children's books of poetry and prose, one about dinosaurs and one about the human body. His third book, for middle- and high-school students, parents, and teachers, It's Considerate to be Literate (About Religion, Conflict, and Peace), is written for middle- and high-school students, parents, and teachers and is about religious literacy; it is forthcoming in 2022 from Orange Hat Press.

References

1. Fitchett, G., & Andresco, A. (2021, December 27). *Mission and Vision*. Transforming Chaplaincy. <https://www.transformchaplaincy.org/about/mission-and-vision>
2. Moore, D. L. (2007). *Overcoming Religious Illiteracy: A Cultural Studies Approach to the Study of Religion in Secondary Education*. Palgrave.
3. Prothero, S. (2007). *Religious literacy: What every American needs to know—and doesn't*. Harper San Francisco.
4. Chan, W. Y. A., & Sitek, J. (2021). Religious Literacy in Healthcare. *Religion and Education*, 48(1), 102-120. <https://doi.org/10.1080/15507394.2021.1889453>
5. Dinham, A. (2018). Religion and belief in health and social care: the case for religious literacy. *International Journal of Human Rights in Healthcare*, 11(2), 83-90. <https://doi.org/10.1108/IJHRH-09-2017-0052>
6. Palmer Kelly, E., Hyer, M., Tsilimigras, D., & Pawlik, T. M. (2021). Healthcare provider self-reported observations and behaviors regarding their role in the spiritual care of cancer patients. *Supportive Care in Cancer*, 29(8), 4405–4412. <https://doi.org/10.1007/s00520-020-05957-1>
7. Vasconcelos, A., Lucchetti, A., Cavalcanti, A., da Silva Conde, S., Gonçalves, L. M., do Nascimento, F. R., Chazan, A., Tavares, R., da Silva Ezequiel, O., & Lucchetti, G. (2020). Religiosity and Spirituality of Resident Physicians and Implications for Clinical Practice-the SBRAMER Multicenter Study. *Journal of General Internal Medicine*, 35(12), 3613–3619. <https://doi.org/10.1007/s11606-020-06145-x>
8. Hill, E., Tiefenthäler, A., Triebert, C., Jordan, D., Willis, H., & Stein, R. (2020, May 31). *How George Floyd Was Killed in Police Custody* [Video]. The New York Times. <https://www.nytimes.com/video/us/100000007159353/george-floyd-arrest-death-video.html>
9. Eck, D. L. (2007). Forward. In Y. Kornberg Greeberg (Ed.), *Encyclopedia of Love in World Religions* (p. xxiv). ABC-CLIO. Kornberg Greenberg, Y., Ed. ABC-CLIO: Santa Barbara, CA, 2007; p xxiv.
10. Abdin, A. S. (2004). Love in Islam. *European Judaism*, 37(1), 92-102. <http://www.jstor.org/stable/41444586>
11. Robinson-Morris, D. W. (2019). Radical Love, (R)evolutionary Becoming: Creating an Ethic of Love in the Realm of Education Through Buddhism and Ubuntu. *The Urban Review*, 51, 26–45. <https://doi.org/10.1007/s11256-018-0479-4>