# MINISTRY BEHIND A MASK – A CHAPLAIN REFLECTS UPON SARS

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*Abstract: The outbreak of Severe Acute Respiratory Syndrome (SARS) which occurred in Canada, notably Toronto, in spring 2003 gave rise to two responses which together have profoundly affected the healthcare environment:_ stringent infection control measures, and fear of an unknown enemy. From his perspective as chaplain resident at Toronto General Hospital, the author describes the chaplaincy response to the 'new normal' in hospital life. He identifies the problems created, and stresses the need to adapt to a new healthcare environment 'behind the mask'.*

*Key words:SARS; chaplaincy; healthcare; infection control.*

## Introduction

In attending to a patient, hospital chaplains have only themselves to bring to the encounter. Our training as hospital chaplains focuses on communication as encapsulated in the art of pastoral conversation. This enables us to engage in a dialogue at many levels with a patient. To move this encounter forward appropriately and effectively, we rely on our professional training and intuitive skills.

There are no tools other than the self for the chaplain in such a conversation – no props, no cue cards and no comfort blankets. In addition to the articulated word non-verbal communication is crucial and this is a two way process with patients. Appropriate facial expression, eye contact and speech tone blend with posture, gesture and distance to facilitate patient - chaplain communication. Anything that hinders this interaction can add to the complexity of such conversations.

From the first week of April to the time of writing, chaplaincy practice has changed and has had to be adapted within all Toronto hospitals. Since SARS (Severe Acute Respiratory Syndrome) first appeared, it has created a new framework within which we have to engage in pastoral conversation. It has led to a process of continual adaptation for all healthcare professionals, including chaplains who now must minister always aware of the needs for infection control. In the words of the Ontario Chief Medical Officer of Health, Dr. Colin D'Chunha *we're learning as we're travelling the road*.

Severe Acute Respiratory Syndrome is an infectious disease that was first recognized in south East Asia in late February 2003 (Zambon & Nicholson 2003). It was first identified in Canada in early March 2003. In the first study in Canada the first 10 cases were of patients who ranged from 24 – 78 years (Poutenan 2003). The most common presenting symptoms were fever, and malaise followed by non-productive cough and shortness of breath associated with infiltrates on chest radiography. It was noted that of this group, half required intensive care support including mechanical ventilation. At the time of writing, early May, the current Ontario death total is 23. Most of the fatalities reported occurred in patients with underlying illness.

Current evidence suggests that respiratory droplets are the primary means of transmission and require close contact with a case of SARS. Close contact means having cared for, lived with or had face to face (within one meter) contact with, or direct contact with respiratory secretions and/or body fluids of a person with SARS. In Ontario, the majority of cases can be traced directly to specific transmission settings, such as household, hospital or community exposure.

Fear and recognition of the unknown has contributed to the rapid reaction to SARS. It has an associated morbidity and mortality but its origins are still tentative. The presence of an insidious and non-specific onset incubation period of up to 10 – 11 days has meant that SARS may be transmitted unwittingly in community. It also has a poorly defined pathogenesis, with a current absence of laboratory diagnostic testing and there is the failure of known antimicrobial treatment. Scientists have identified a previously unknown virus in the coronavirus family as the primary cause of SARS. Such viruses often infect animals and formerly only had minimal effect upon humans. The current strain is different. However it has been noted that as many as 40% of Canadian SARS patients did not test positive for coronavirus.

Fear is quite apparent – has the virus mutated sufficiently into multiple strains to avoid detection? As noted by Zambon the optimism of the 1960's and 1970's has given way to a mature realism that the relationship between human beings and microbes is neither completely predictable nor biased in favour of humans (BMJ 2003).

The rapidity of the spread of the disease and the morbidity indicate an agent that is infectious and virulent which requires strict control measures for droplet and contact transmission by healthcare workers, a vigilant healthcare profession and most crucially public education. SARS has challenged the healthcare system and it has crossed traditional healthcare boundaries and the new emperor is infection control. Despite stringent infection control measures hospitals have become places to be feared rather than places of healing. This may apply to staff too.

## How chaplaincy adapted to SARS?

In the early days in many hospitals, chaplaincy services were deemed as non-essential as the various hospitals instigated policies of zero risk. This classification has raised concerns for the perceived role of the chaplain in a crisis situation. Within my own institution, as many of us are chaplaincy residents, we initially followed the governmental directive of the withdrawal of all resident hospital programs.

After two days there was a limited return of chaplaincy but it was into a new world. Hospital services had been drastically reduced with no surgery, minimal staff, no visitors and limited admissions. The normally busy concourse of the hospital was deserted – the few staff present wore facemasks and other protective gear. Chaplaincy developed a phone orientated ministry acting as link people for patients who had become isolated from their families due to an embargo on visitors, unless the patient was a child or terminally ill. The sense of loneliness on the part of patients was palpable. Many patients who were immigrants to Canada experienced the segregation of a language barrier in the absence of their family. The chaplain's role was at times to liase between the gathered family at the hospital entrance, the staff and the isolated in-patient. In these times of uncertainty and fear, this sense of patient isolation was increased as all staff were dressed in complete isolation protective wear. The precautions reached a level where even sitting in the chaplain's office required us to wear facemasks.

As the days passed more staff returned but we were returning to what was called the 'new normal' situation. To minimize possible infection, staff used only one entrance and the few visitors allowed in used another. To date, on reaching the only accessible entrance to the hospital, staff must first show their photo ID badge to hospital staff that are fully gowned with full-face protective helmets and gloves. Hands are outstretched then and liberally covered in antiseptic lotion. A check list must be completed and checked to show where entering staff have been, how they feel and where they will be in the hospital. Next temperature is taken and if it exceeds 38 there is a referral to occupational health. If all these stages are negotiated successful then one can come into the hospital after a further washing of hands.

Though some strict controls have eased a little in the last few days chaplains encountering patients still wear gowns, gloves and facemasks. After each visit the gowns and gloves must be changed. For those chaplains whose practice is to visit all patients in a ward, a new and more infection control approach is mandatory. After every encounter hands must be washed or antiseptic solution applied.

The presence of SARS raises particular challenges for faith traditions liturgically. As no meetings were allowed in the hospital, Easter services were can-

celled and continue to be on hold. In Toronto, radical changes came into worship with both the Anglican and Roman Catholic traditions dispensing with both the common cup at communion and the sharing of the peace. Some patients have needed to explore the challenge that has come to their view that items associated with faith practice somehow had an inherent protection for the faithful.

Frontline healthcare staff have become both physically and emotionally stretched and chaplains have had a major role in staff support. The physical demands of having to gown up repeatedly have taken its toll. Chaplains have also assisted with the many frustrations that such pressures have raised. Staff have also been helped to embrace a new mindset for the caring professions whereby the belief that 'we will to work no matter how ill we are', has now become a more appropriate practice that says the correct response is to stay home.

Concern also was expressed as to where the boundary was between self-care and patient care. Some raised the ethical issues about the expectation placed upon staff and how far care should be proffered in the face of personal risk. The approach of visiting without considering the infection implications has gone forever.

New procedures and practices may well remain within the hospital as the 'new normal' moves to acceptance as the norm. With ongoing reductions in visiting there may be the need to restructure working hours for those services that connect in with families such as social work and chaplaincy. The restriction on visitors has also applied to local clergy, who in Toronto are actively involved in patient visitation. In their absence greater demands have been placed on the chaplains through increased referrals.

## Conclusion

In summary, SARS has, initially at least, unsettled our comfortable thinking and total confidence in the power of antibiotics and that that science has all the answers in this 21st Century. At the same time SARS has demonstrated the calibre of a city and its ability to adapt, comprehensively, swiftly and appropriately, to such a major challenge. As chaplains we need to continue to adapt as we engage in pastoral conversation, often from behind our masks,

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