AMA Journal of Ethics®
November 2024, Volume 26, Number 11: E892-895

VIEWPOINT

Roles of Quiet in Health Care Organizations

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Abstract
This anecdote of one regional academic health network's reputational demise suggests what might be learned about tendencies of undervaluing chaplaincy expertise, peace, and quiet in the everyday operations of professional caregiving.

Pastoral Care

A fine regional academic health center had a long-standing reputation for reliable service to its diverse rural and metropolitan area communities and was well-known for its chaplaincy program. Press Ganey scores (widely regarded in the health sector as measures of patient satisfaction) were high year-over-year in this organization, and nearly everyone attributed this in no small part to bedside care delivered by its chaplains. The chaplaincy program's national renown was a product of its thoroughgoing commitment to spiritual pluralism and its success in connecting with patients, including those who signaled *no religious affiliation* or who, at least upon admission to the hospital, expressed *no interest* in receiving pastoral care services.

Those of us doing clinical ethics consultation in this organization knew the chaplains well and worked closely with them. Nearly everyone in the organization also knew the chaplains as a cadre of clinicians with numerous graduate degrees in a variety of disciplines who didn't complain much about their low pay. They were also known to take a jocular tone about the cultural obsession with "leadership" that plagued the early-mid 2000s: *If you have to talk so much about being a leader, you might not have as many followers as you think.* The chaplains were this organization's proverbial truth-tellers, and they were well respected for their candor, at least for a while.

Organizational Ambition

One summer, the resignation of 2 long-time vice presidents in the organization gave key senior managers long-awaited opportunities to hire for ambition. Nearly overnight—or so it seemed to many of us—this trusted regional health network sought transformation and aggressively sought to become a level I trauma center. A 24-hour on-call neurosurgeon was hired—a necessary but not sufficient condition for level I trauma centerhood—as if an organization could build an egg by erecting a shell. In quick succession, the organization's new strivings toward level I status were heavily promoted; the phrases

capital campaign and *strategic planning* became common, despite the vacuous mysteriousness of their meaning or purpose.

Funds were diverted and redirected. Three new executives were hired. One was particularly Loud and wore gem-studded cuff links that were hard to miss and seemingly worn *because* they were hard to miss. This particular exec walked the halls of various service sites of the organization, their Big Watch clinking against their cuff links. Unsurprisingly, they looked past me as I said my name when we were introduced, and they nearly missed grasping my extended hand during an awkward wine and cheese reception. The organization's traditionally mission-oriented priorities became visibly overwhelmed by its appetite for "limelit" lauds from Becker's and by its desire for a listing as the Top of Something in *US News and World Report*, fed amply by highly produced, brightly lit, shot-from-below power poses of clinicians with their arms crossed.

Extroversion and Exile

Despite some of the organization's new senior managers' displays of kin-keeping in the small ethics unit and the chaplaincy program, the chaplaincy program quickly dimmed from vibrant to a waning, struggling flicker. Many of us saw the proverbial writing on the proverbial wall. If you've ever had the experience of having to leave an organization because you have a sneaking suspicion that your and your immediate colleagues' expertise is at increasing risk for diminished valuation, then you know that one of the things often written on that wall is some variation on the sentiment: *Extroversion is now a job requirement.* Perhaps this happens because, when an organization's attention is directed prominently and purposefully outward, decimation of departments and personnel practicing the internal focus needed to reliably convey sincerity and to forge the kind of connection worth looking people in the eye for can be more easily obfuscated and thus, perhaps, more likely to be missed and less likely to be resisted or problematized.

Dissolution of the ethics unit was no surprise to those of us familiar with these patterns of organizational behavior by which work of restoration and healing that needs peace and quiet is undervalued. More tragic for this organization is that the chaplaincy program was gutted quickly, decisively, and thoroughly. After I left the organization, I learned how the organization changed over the next few years. Reportedly, the organization's Press Ganey scores plummeted quickly, too. The organization hired more risk managers, possibly if not probably because the organization's general counsel could afford, for many years, to blithely take for granted the slow, steady application of anti-litigant balm that was a key practical side effect of so many chaplains' quiet work with patients. It was thought by clinicians I knew, who stayed in the organization for a few years, that patients who needed (and once had) access to a chaplain to talk to about their frustration or painful surprise about outcomes they might not have wanted or anticipated were now expressing their grief by suing.

Having to lawyer up was not the only apparent consequence of the organization's exile of its chaplains. Perhaps a few in the organization finally realized their error when patients in the communities served by the organization also appeared to be migrating to other networks for their health care. But a main ethics upshot here is that this organization's chaplains' labor was invisible and undervalued. Career chaplains, most of whose demeanors exuded the quiet intensity of astute emotional intelligence and whose presence was minimal in decibel but keenly felt by patients who needed their help

reorienting themselves to their illness and injury experiences, were the organization's Peace Agents. And they, too, were gone.

Peace in Professional Caregiving

Unsurprisingly, the organization's level I trauma center ambitions were, reportedly, abandoned after several additional personnel departures. After much public embarrassment and ridicule, an eggshell was acknowledged as hollow, as an exterior that would not hold. The organization continues to this day to grasp at any remnants of its now long-gone reputation as a regional center once defined by chaplains who were key to the work of healing, of peace work in professional caregiving.

Like most questions I ask my students, *What are ethical and clinical roles of quiet in health care?* is more interesting, and perhaps more important, as a question than any of its most common answers. Insightful answers to this question likely suggest that peace or quiet or both should be operational ethical values in the collective strivings of organizations in the health sector, especially among educators and clinicians who have opportunities to endorse spiritual care as fundamental to healing. One thing I learned from working in this organization is that healing is a collective endeavor done with the hands, hearts, and heads of many individuals from many disciplinary backgrounds who probably do their most critical work with patients when it's quiet.

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Citation
AMA J Ethics. 2024;26(11):E892-895.

DOI
10.1001/amajethics.2024.892.

Acknowledgements
The author is grateful to members of the *AMA Journal of Ethics* editorial crew, whose review comments were key to developing this essay.

Conflict of Interest Disclosure
Author disclosed no conflicts of interest.

ISSN 2376-6980