The Influence of Healthcare Organizations on Well-being

Anthony L. Suchman, MD

From the Departments of Medicine and Psychiatry,
University of Rochester, Rochester, NY

Author contact information:
Anthony L. Suchman, MD
42 Audubon St.
Rochester, NY 14610
Phone: 585-271-4233
Email: asuchman@rochester.rr.com

Summary: Healthcare organizations influence the well-being of individuals who work with or within them by patterning their perceptions, thoughts, feelings, expectations and behaviors. These dynamics may enhance or limit the ability of individuals to fulfill their needs to be authentically present, to relate to others and to follow their own trajectory of meaning and growth. Organizational tendencies toward depersonalization, control and pathology-oriented perception adversely effect well-being, but can be modified by careful attention to language and behavior on the part of everyone in the organization, particularly leaders.
“Human beings can be proactive and engaged or, alternatively, passive and alienated, largely as a function of the social conditions in which they develop and function.” [1, p68]

Within healthcare organizations of all sizes—from large academic medical centers to independent solo practices—many people are experiencing distress. Some of this is appropriately attributed to such external factors as payment reductions, regulation, and the business practices of insurers. Less well recognized is the contribution of factors internal to the organizations: styles of leadership and management, administrative policies and procedures, and organizational culture. As compared with external factors, these internal characteristics have more direct, immediate and powerful effects, and are far more amenable to change at a local level. The goal of this paper is to call attention to these internal factors to enable people involved with healthcare organizations to pursue constructive change that will improve their own well-being and that of others.

DEFINITIONS OF ORGANIZATIONS AND WELL-BEING

We usually think of organizations as bricks-and-mortar structures, organizational charts, financial assets, and so forth. But these are tangible manifestations of something deeper. At its most fundamental level, an organization is an ongoing conversation between employees, leaders, customers, suppliers, neighbors, regulators, observers—anyone who comes into contact with an organization in any capacity. The conversation addresses what the organization is, what it does, and how it does it. As the organization’s conversation evolves, there are resulting changes in its more tangible attributes, such as buildings, programs, and budgets.

The language of organizational conversations consists not only of words, but also of symbols and gestures (meanings implicit in behavior); for example:
- the process of conversations (who gets to speak in what way to whom);
- the allocation of time and money;
- the distribution of rewards and perquisites.

Organizational conversations both consist of and shape the thoughts, feelings, and behaviors of their individual participants. The prevalent ideas and values in organizations frequently become assimilated into the minds of individuals—often without their explicit awareness or deliberate choice. To some degree this happens through modeling and reinforcement, but a more subtle powerful dynamic is also at work: organizations selectively direct our attention towards some phenomena and away from others. This determines what we perceive, which then affects our interpretations, expectations, and behavior, which in turn affects how others respond to us, which feeds back into our perceptions, and so on. This self-reinforcing circularity creates much of what we take to be reality.³

Well-being is harder to define, grounded as it is in each individual’s evolving matrix of experience, values, and meaning, but we can get a sense of it from the convergence of three different approaches. Self determination theory identifies 3 basic psychological needs of individuals: competence, autonomy and relatedness.¹ These are similar to the hierarchy of needs—self-actualization, esteem, belongingness, and love—
identified by the psychologist Abraham Maslow. Erickson describes the highest stages of human development as “generativity” and “ego integrity”—a sense that one’s life has been worthwhile by virtue of working productively and contributing to something beyond oneself. Parker Palmer describes the search for authentic selfhood, particularly as expressed in one’s vocation:

“Before I can tell my life what I want to do with it, I must listen to my life telling me who I am. I must listen for the truth and values at the heart of my own identity, not the standards by which I must live – but the standards by which I cannot help but live if I am living my own life.”

Combining these perspectives, we can define well-being as a quality beyond physical and physiologic integrity that reflects the degree to which one is and becomes oneself fully and authentically, experiences connection with others and the world, and finds meaning in one’s life and work. These elements correspond closely to factors associated with physician satisfaction and meaning.

We are now ready to consider how healthcare organizations affect individuals’ well-being. In light of the definitions above, we can state the question as: “How do organizational conversations in healthcare affect the ability of people working within them to express who they are, grow, connect with others, and contribute meaningfully?”

**OBJECTIVITY AND DEPERSONALIZATION**

Organizational conversations in healthcare tend to value objective data and discount subjective, personal experience. This is both reflected in and perpetuated by such things as meeting agendas and protocols, the kinds of data used in organizational decision-making, and the kinds of statements that are made—and not made—in formal organizational activities. Self-disclosure and other personal statements are rare; most speech is limited to statements about external, impersonal phenomena. This is particularly true of the conversation contributed by the two most powerful groups—physicians and administrators.

The lack of consistent attention to personal, subjective experience partitions the experience of individuals—their rational cognitive thinking is brought forward while their feelings and intuitions are marginalized—they preventing them from expressing and developing their whole selves. Depersonalization and objectification create interpersonal distance; with their subjective experience suppressed, it is difficult for individuals to feel truly seen and understood. There is more alienation and less opportunity for meaningful connection.

**THE QUEST FOR CONTROL**

Consistent with broader themes in Western culture, organizational conversations in healthcare accord the highest value to being in control—of disease and clinical outcomes, and of the organization and its members. The most prevalent metaphor for conceptualizing organizations is the machine, with senior managers and physicians in the role of designers and operators and the other people in the organization—including patients and families—in the role of precision parts, expected to perform their functions consistently, efficiently, and in a standardized fashion according to the managers’ design.
The emphasis on control adversely affects the well-being of everyone. For those in power positions (particularly physicians and senior managers) the dynamic of control creates impossible expectations—accepting responsibly for outcomes that are beyond anyone’s control. Individuals who are expected by themselves and others to be in control, but know they are not, are confronted by feelings of inadequacy and the fear of humiliation. Asking for help and emotional support would be to risk appearing weak and incapable, and is thus excluded as an option. Instead, there are 2 common responses.

First, individuals try to maintain the appearance of control, thus constraining themselves from being authentic, increasing interpersonal distance, and exacerbating the fear of being found out—the “imposter syndrome.” Second, they try even harder to exert control over others, thus straining relationships and increasing the level of anxiety throughout the organization. The illusion of control and invulnerability also creates strong social reinforcement for demonstrably unhealthy lifestyles: lack of balance in one’s life, neglect of family, and inadequate attention to rest, diet and exercise.

The control dynamic also creates problems for those in less powerful positions. As people are treated like machine parts—told what to do and expected to fit into standardized roles—they begin to internalize a self-image of helplessness, passivity, and relative incompetence. This has been associated with poor self-esteem, low motivation, depression, substance abuse, and disturbances in family dynamics.

THE PATHOLOGIZING GAZE

A third aspect of organizational conversations in healthcare is their tendency to pathologize—to view the world in terms of problems and deficiencies. In both clinical and administrative activity, little attention is given to that which is working well; the vast majority of attention is directed towards what is wrong, and to the process of judgment itself. The identification of problems provokes a search for causes and the assignment of blame, which then elicits defensiveness and fear. The need for safety is more basic than the needs for belonging, competence, and authenticity, so individuals pull back and become much less than they could be.

ALTERNATIVES FOR HEALTHY ORGANIZATIONS: A PERSONAL NARRATIVE

So far, this article has itself embodied everything that it criticizes: it is impersonal and pathologizing. Instead of discussing how to "take control" over the problems I have outlined, I would like to describe some of my personal experiences in helping to create a medical organization (a department of medicine and residency program) that fostered well-being.

The project began when serendipity provided a seed-crystal for a heartfelt but unfocused intention. For several years, I had been part of a nation-wide group studying patient-clinician communication, trying to characterize at the level of moment-to-moment behavior the differences between the impersonal, hierarchical approach of the biomedical model and the more relational and partnership-oriented approach of the biopsychosocial model, now called "Relationship-Centered Care." At a time when I was beginning to notice parallels between biomedical practice and organizational behaviors in hospitals, a network colleague, Howard, and his family came to visit. It was after returning home
from a performance of African dance, while we were drumming on pots and plastic containers, that an idea suddenly emerged: Howard might apply for the open job of department chief and, with another friend, we would pursue an experiment in relationship-centered administration.

That idea came to pass, and succeeded beyond our expectations. Relevant to this discussion are the changes that took place in the organizational conversation.

First, the conversation became personal. Howard was self-disclosing from the very start, speaking openly about his nervousness holding a formal leadership role for the first time. His personal presence led others to do likewise. He met individually with each faculty member to learn about their lives, to discover what they found meaningful and rewarding, and to work out goals for the year. Faculty meetings began with personal and family news, and a bulletin board prominently featured family pictures of faculty, staff and residents. Programmatic changes in the residency—especially a newly instituted resident support group—further reinforced the invitation to bring one’s whole self to work.16

Second, the organizational conversation was respectful. It viewed people as trustworthy, capable and wise, and invited them to accept power. Howard asked several faculty members to help him recruit a new departmental administrator, and he accepted their recommendation. He convened a departmental retreat to involve the whole department in identifying a mission and setting goals. Initial skepticism gave way to enthusiasm as people discovered that their ideas mattered. The first year’s goals were completed in 7 months. Residents and faculty formulated learning goals together; staff members redesigned administrative processes. Everyone became more comfortable with the process of making things up as we went along, of not requiring a fixed plan—what would now be described as "emergence" in the language of complexity science.17

Third, the organizational conversation celebrated successes, and addressed opportunities for further improvement in the context of building on what was already working.18,19 We celebrated failures, too, valuing the opportunity to learn.20 If fear was not driven entirely out of the organization, it was reduced substantially.

This narrative may create the illusion of a brilliant plan flawlessly executed. In fact, it was an extended trial-and-error project, guided by values of respect, genuineness, and partnership, supported by ongoing reflection and attention to process. And it worked. We all experienced a creative and supportive environment that had positive consequences not only for the individuals but for their families as well.16 Faculty members and residents credit that time with fostering important personal and professional growth. In addition, there were improvements in a number of specific measurable outcomes: improved residency recruitment, residents’ board scores and pass rates; improved faculty satisfaction; and improved academic productivity.

CONCLUSIONS

It is possible to create healthcare organizations that foster well-being if the organizational conversation reflects conducive values. An organizational conversation that honors personal experience as well as objective data, that values relation as much as control, and that fosters change in a spirit of hope, appreciation, and continuous
improvement will be well suited to call forth the creativity, commitment, and capacity—in short, the well-being—of its staff, with favorable implications for its patients.\textsuperscript{18,21,22}

Leaders can influence the conversation, although they cannot control it. The manner of their presence and participation sets an important tone, particularly their relationship skills and their ability to recognize and manage their own anxiety and fear.\textsuperscript{6} Although they have less leverage than leaders, other individuals can also influence the conversation through their own words and behavior. Other specific activities that might foster constructive organizational conversations are shown in the box.

**BOX:** Activities that might foster constructive organizational conversations

- recruitment of leaders based on their self-awareness and relationship skills
- leadership and management development programs to enhance relationship skills; self-awareness; and the capacity to embrace uncertainty, novelty and paradox as sources of creative new possibilities\textsuperscript{23}
- coaching and mentoring for staff members to help them integrate their organizational roles with their personal trajectory of growth and meaning
- introduction of programs to foster reflection, dialog and balance

Leland Kaiser recently offered an inspiring description of the spiritual nature of healthcare organizations and leadership.\textsuperscript{24} The qualities we have used to define well-being—connection, meaning, and authentic presence—are the foundation of personal spiritual experience. Knowing the potential for healthcare organizations to foster such experience, what justification is there for an organization to do anything less?

**References**

Control and relation: two foundational values and their consequences*

ANTHONY L. SUCHMAN

The University of Rochester School of Medicine and Dentistry, New York, USA

Abstract
This paper explores and contrasts personal philosophies based on two different core values, control and relation, with respect to expectations, social relationships, habits of perception and interpretation, and ways of feeling grounded in the world. The paradigm of control is widespread in medicine and certain other health professions, but because it fosters unrealistic expectations, evokes fear and shame, and inhibits effective partnerships, it can actually compromise health outcomes. The paradigm of relation calls attention to interpersonal process and fosters receptivity and adaptability, thus enhancing partnership. A mature clinical approach combines these two perspectives, respecting both the benefits and limitations of reductionistic science and making room for self-organization and emergence.

Keywords: Control, relationships, values and consequences

Introduction
The deepest level determinant of partnership, in health care or anywhere else, is our internal predisposition as would-be partners: our attitudes, values and beliefs. Each of us has a personal philosophy that shapes our perceptions, interpretations and actions. Addressing questions such as why things happen, what is right and what is wrong, and why we are here, our personal philosophies give rise to our own individual ways of being in the world; they also frame our goals and expectations. In adopting a particular personal philosophy, we create the world we inhabit.

Considering its profound importance and implications, the acquisition of our personal philosophy is remarkably uncritical. This process – a gradual assimilation of attitudes and values from our families, culture, education, and life experiences – tends to be so subliminal that we may not recognize our core beliefs as beliefs at all, and instead simply accept them as ‘reality’. We may not recognize that our ‘truths’ are in fact only ‘assumptions’, and that better alternatives might exist.

In this paper, we will examine one of the most fundamental values in Western culture, one that figures prominently in the personal philosophies of most health professionals: the quest for control. As we explore the control paradigm with regard to its core values, goals, patterns of social relationships, approaches to gathering and using knowledge, and sources of existential security (see Table I), we will see the limitations it imposes on the process of partnership. We will then examine an alternative paradigm based on the relation that creates


Correspondence: Anthony L. Suchman, The University of Rochester School of Medicine and Dentistry, New York, USA.
a climate more conducive to creative collaboration and the sharing of responsibility. Although we will use clinicians as exemplars throughout this discussion, the concepts are equally applicable for educators and administrators.

In making an explicit comparison of the control and relation paradigms, we can learn to perceive the values implicit in everyday interactions and to observe their consequences. Then, perhaps for the first time, we can make thoughtful choices about which paradigm to embrace as our own.

The paradigm of control

Core values and goals

The beliefs, thoughts and behaviors of the control paradigm are organized around a single core value: that the ultimate state to which one can aspire is one of perfect willfulness and predictability. What one desires happens, with no surprises; all outcomes are intended. For the clinician, the control paradigm is expressed in the questions, “What do I want to happen here?” and “What’s wrong and how do I fix it?” The ‘will to fix’ extends well beyond the patient’s immediate experience of suffering or dysfunction to encompass intermediate outcomes believed to be associated with future suffering (for example, reduction of blood pressure or glycohemoglobin levels). Thus, the paradigm of control defines the clinician’s role as taking deliberate action towards an improvement in the patient’s current or future experience. Personal success or failure is judged by the clinical outcome, the extent to which one’s intended outcome was realized.

Social relationships

Interpersonal relationships in the control paradigm are hierarchical. At the level of the physician-patient relationship, for example, the physician, by virtue of expertise and responsibility, makes decisions on behalf of the patient, who is expected to comply. This use of power to limit the choices of others poses no ethical problem for the physician, so long as the intended outcome is the patient’s improvement. Relationships on the health care team are hierarchical, as well. Differences in educational and social status, defined areas of responsibility and professional prerogatives create expectations of deference and obedience. In situations of conflict, the control paradigm predisposes the physician to focus on goals and to expect to be dominant, resulting in a win-lose negotiation style (if negotiation takes place at all).

Epistemology

The control paradigm shapes both epistemology—the way we gather and organize knowledge—and clinical reasoning. With control as the principal value, the task of intellectual inquiry is to develop detailed knowledge about causal mechanisms and how to manipulate them. The mode of analysis to produce such knowledge is reductionistic and mechanistic, and tends to move from the particular to the general; that is, it values knowledge of general principles and theories more than knowledge about individual experience (which is dismissed so often as ‘anecdotal’). When applied to clinical work, this approach leads the clinician to encapsulate an episode of a patient’s life experience with a single diagnostic label. Just by this act of classification, the clinician gains a degree of intellectual control and moves from a state of uncertainty towards one of mastery.
Treatment is chosen more on the basis of generalized knowledge about the diagnosed disease than about the particularity of the patient’s experience. So in both making a diagnosis and planning a treatment, what is unique and particular about an individual patient is less valued and therefore gets less attention than the abstracted characteristics of the ‘case’.

Rational thought, in its orderliness and reproducibility, is most consistent with the philosophy of control, and is therefore valued above all other forms of mental experience. Personal meanings, interpretations and emotions, being ‘irrational’, are deemed inferior, hence less worthy of attention. Objective experience, as the substrate of rational thought, is deemed more relevant—even more real—than subjective experience. In focusing on their own objective experience and suppressing their subjectivity, clinicians take the role of detached observer, distanced from the object of observation and affectively neutral.

Existential security

The core of the control paradigm, the source of its compelling power, lies deeper than cognition and behavior, at the level of existential security. Questions at this deepest level include: what is the nature of the world? What stance does one take? Where does one find one’s grounding? At the heart of the quest for control is fear, a perception of the world as lacking any intrinsic order and of danger lurking in the chaos. One’s grounding, or source of security, is in predictability—the order one imposes on the world through collective and individual efforts. Collective efforts include rules of interpersonal engagement and knowledge structures as described above. Individual efforts include staying within prescribed boundaries, obeying rules and resisting the ‘irrational’. Relaxing one’s vigilance and losing control of the details of one’s life opens the doors to chaos and to bad things happening. The worst thing of all is something bad happening that could have been prevented but was not. The clinician’s existential stance in the control paradigm—his basic way of being in the world—is one of mastery: of the instrumental knowledge of medicine and of other people; in metaphorical terms, a stance of holding tight. We may trust others to a point, but we trust nothing and no one as much as we trust ourselves. Therefore, mastery, vigilance and self-sufficiency are the ultimate source of existential security, the best way to keep the fear at bay.

Limitations of the control paradigm

That the control paradigm has channeled human energy towards many remarkable technological accomplishments is undeniable. However, as a philosophy for guiding human interactions and for providing existential grounding, it has serious limitations. These are especially significant in medicine, where technology and human experience intersect with particular drama and salience.

The control paradigm interferes in a variety of ways with the formation of relationships, the medium of partnership. The instrumental, reductionistic approach of the control paradigm and the valuation of the abstract general over the particular leads to an inadvertent depersonalization of others. Patients, students and subordinates become objects to be controlled. The hierarchy of the control paradigm blocks the free flow of communication that is necessary to achieve synergistic interaction. It promotes expectations for those lower down in the hierarchy that the people higher up will be able to control things, leading them to expect little of themselves, thus promoting passivity. There is little opportunity for the
kind of mutual goal setting that enhances motivation and commitment. The full power of the team goes untapped.

At the level of thinking and action, the control paradigm encourages an appealing yet utterly unrealistic fantasy of personal control, focusing on the individual as the primary locus of agency. It interferes with the perception of systems and the recognition of emergent phenomena—synergistic processes which are effectively and spontaneously orchestrated through complex interactions among individuals.

The control paradigm accounts for a number of common problems in clinical practice. For example, consider the way doctors become angry with patients who do not take their medicines. The physicians’ sense of personal success and mastery depends upon the clinical outcome; the patients’ ‘noncompliance’ jeopardizes the outcome and thus threatens the physicians’ well being. Consequently, the physicians become angry, as if it was they and not the patients who had to bear the ultimate consequences. Another common problem is the abandonment of patients with chronic or terminal illness. In these settings, clinicians are predisposed to experience their inability to cure as failure. Not surprisingly, they tend to withdraw, or they may cling to inflated expectations of success and undertake excessive treatment, frequently substituting their own goals for those of their patients.

Ultimately, the control paradigm fails as source of existential security. It is built on two false premises. First, it is not possible to implement perfectly what one wills, and second, even if it were possible to do so, the outcome would remain unpredictable. We know from chaos theory (enshrined in conventional wisdom as the Law of Unintended Consequences) that predictability pertains only within very narrowly defined situations, and is generally a poor construct for modeling natural and social phenomena (Gleick, 1987). Complexity prevails. Expectations of control are created that cannot be fulfilled, resulting in feelings of disillusionment, anger and personal failure (known also as ‘burnout’). The control model ultimately must prove to be an inadequate map; at some point its discrepancies with the real world must cause it to create more problems than it solves.

The paradigm of relation

Core values and goals

An alternative paradigm organized around the core value of relation has the potential to avoid many of the problems of the control paradigm (Toulmin, 1982). In the relation paradigm, the most valued state to which one aspires is one of connection and belonging. In this state, one has a feeling of being part of a larger whole—a team, a learning group, a dance troupe, a community, even the world itself. One’s individual actions seem spontaneously integrated with those of others to a remarkable degree, contributing to the evolution of a higher order process, i.e. one at a higher system level than that of the individuals of which it is comprised. Words like ‘serendipity’, ‘flow’, ‘synchronicity’, ‘self transcendence’ and ‘oneness’ have been used to describe this ineffable state.

The relation paradigm holds that the best outcomes are realized by maximizing the quality of process, which in turn depends on the quality of relationships and on one’s ability to be genuinely present to others and to events as they are unfolding. As often as not, the resulting outcomes will be different from, and better than, those that were originally intended. Being in a state of relation does not imply passivity. Rather, it involves active attentiveness to both inner and outer experience. One asks the question, “What’s trying to happen here?” and,
according to one’s best approximation of an answer, seeks to shape others and the world while also remaining open to being shaped oneself. This balance between control and receptivity puts one in the best possible position to recognize and make use of serendipitous events.

Working within the paradigm of relation, the clinician’s role is to ‘be with’ patients: to acknowledge their suffering and identify opportunities to relieve or prevent it, while also respecting their position as principal makers of values, meanings and decisions in their own lives. Thus, the professional is accountable not so much for the outcome as for the quality of the process: the degree to which one understands what the patient is experiencing; communicates that understanding back to the patient; helps the patient formulate goals and priorities; and applies one’s expertise and commitment to the creation and implementation of a plan for realizing the patient’s goals. These expectations afford the clinician more opportunity to feel successful than do the control paradigm’s expectations of perfect clinical outcomes.

Social relationships

Interpersonal relationships under the relation paradigm are characterized by respect and genuineness. Martin Buber characterized such interactions as ‘I-Thou’, denoting a relationship between two subjects, as contrasted with ‘I-it’, denoting the subject-object relationship of the control paradigm (Buber, 1958). One acknowledges the subjective experience, personal perspectives, values and aspirations of others and one’s own as well. Self-awareness is critically important, as is the ability to act in congruence with one’s feelings. One cannot be in a state of relation without being fully present.

The use of power is another key point of differentiation between the relation and control paradigms. The relation paradigm does not negate power or deny the very real differences in power between patients, doctors, nurses, administrators and others. Rather, it maintains that these differences do not imply differences of worth, dignity or the right to have one’s perspective respected and, to the extent that one has power, one uses it to foster both the power and the accountability of others to the fullest extent possible (within the bounds of the individual’s capacity and the external circumstances). In the realm of negotiations, this is expressed as seeking solutions which maximize mutual gain and strengthen mutual commitment (win-win) rather than maximizing one’s own gain at the expense of the other (win-lose).

The receptivity of the relation paradigm leads one to value diversity. The unique background, perspective and opinion that each participant brings to an interaction or a team can be a resource to the group (provided it is approached respectfully), just as intra species diversity contributes to the adaptability and long-term survival of a species. However, this attitude of receptivity should not be mistaken for a ‘do-your-own-thing’ kind of uncritical tolerance. One cannot avoid making and acting on judgments about quality if there is to be accountability.

Epistemology

The epistemology of the relation paradigm seeks to join the instrumental, abstract knowledge of the control paradigm with a deep appreciation of context and ecology – a science of stories (Stange, Miller, Crabtree, O’Connor, & Zyzanski, 1994). This has two key implications. First, one must recognize the existence of ‘emergent’ phenomena, those which arise at and higher orders of a system and depend on, yet cannot be
explained in terms of, lower order processes. For instance, a cardiology consultation could not take place without normal synaptic function in the brain of the cardiologist, but the one cannot understand or even describe the process of making a diagnosis by analyzing neurotransmitters. ‘Emergentism’ can be seen as a style of analysis that moves across the hierarchy of systems in the opposite direction as reductionism, employing very different tools. Both approaches produce useful, distinct and complementary types of knowledge. Second, one must accept data regarding subjective experience as being equally important and relevant as objective data. Rational thought tends to support instrumentality; emotion, spiritual experience and intuition tend to be the substrate of relation.

When translated to clinical reasoning, this epistemology leads us to discover and value what is unique about each patient and his or her clinical situation, and not to concentrate solely on the abstractable, generalizable features. The accurate understanding of the patient’s experience and communication of that understanding back to the patient is a vital therapeutic process (Suchman, Markakis, Beckman, & Frankel 1997), and an essential part of relationship building (Cohen-Cole, 1991). Likewise, the clinician must be self-aware to be capable of relationship (Novack et al. 1997). So information about the subjective experience of the patient and clinician is important information. Rational analysis and experiential exploration both have their place. The clinician’s role, far from one of detachment, is to participate and to observe both her outer (objective) and inner (subjective) experience (Engel, 1988).

One last aspect of epistemology for us to consider is the relinquishing of answers. Each time one arrives at an answer, one’s desire for mastery may be satisfied, but if answers terminate inquiry, further discovery (and the revision of erroneous answers) is precluded. One needs provisional answers to undertake action; medical care, education and administration constantly demand action in the face of uncertainty. Nevertheless, one must avoid holding too tightly to answers and be willing instead to remain always ‘in the question’ (Goodrich-Dunn, 1991).

Existential security

At the core of the relation paradigm is trust. This philosophy accepts that there are sources of order, goodness and meaning beyond one’s own creation. This source may be at a collective human level (as exemplified by the consistent performance advantage of well-functioning teams over individuals) or on an even higher order: the ‘Tao’, ‘God’, and ‘Great Spirit’ are but a few of the names humans have given in reference to universal sources of order and meaning. Regardless of scale, the basic existential stance in the relation paradigm is one of self-transcendence and receptivity, of letting go of control and remaining open. One’s source of existential security might best be characterized as alignment: recognizing the interdependence of oneself and others in a larger order of things and learning to be part of the flow of that order.

Further implications of the relation paradigm

It is important to recognize that the relation paradigm does not negate the control paradigm; rather, it promotes balance by adding receptivity to mastery, subjective to objective, emergent to reductionist, participation to autonomy. This last pair, participation and autonomy, has been particularly problematic for practitioners in today’s health care
environment. The apparently paradoxical convergence of these two opposites can be accomplished using Arthur Koestler’s conceptualization of the holon (quoted in Wilber, 1996). A holon is an entity which is a complete and autonomous whole unto itself and at the same time a part of a larger whole. A holon thus has properties of both agency (corresponding to autonomy, instrumentality and control) and communion (corresponding to participation, context and relation). Until recently, physicians practiced autonomously, making clinical and business decisions from the perspective of their individual patients and their ‘cottage industry’ practices, respectively. They were conscious only of their agency, their completeness in themselves as loci of decision making. Now in this time of integrated health systems, they must maintain their agency, but at the same time think at higher order system level about the care of a population and about the needs of the integrated network. The relation paradigm encourages awareness of multiple system levels and allows for coexistence, rather than mutual exclusivity, of control and relation.

Looking at personal philosophies from a perspective of adult development, we can observe that aspects of the control and relation paradigms correspond to different stages of personal growth as described in two models. In Erikson’s model, differentiating oneself from the world and coming to know oneself as an independent locus of agency and control is the culmination of childhood development and arrival into adulthood (Acklin, 1986). However, as one progresses through the adult stages of intimacy versus isolation (Stage VI), generativity versus stagnation (Stage VII) and integrity versus despair (Stage VIII), one increasingly transcends the boundaries of one’s self, “[creating] new conditions for, and new avenues of experiencing, enabling a richer empathy, relatedness, and identification with life beyond-the-self” (Acklin, 1986, p. 201). These themes resonate with willfulness versus alignment, mastery versus receptivity, detachment versus participation and holding tight versus letting go.

Perry’s model of adult cognitive and ethical development describes nine stages of growth progressing from Dualism (“Division of meaning into two realms – Good versus Bad, Right versus Wrong, We versus They, All that is not Success is Failure, and the like. Right Answers exist somewhere for every problem, and authorities know them”) to Commitment in Relativism (“Diversity of opinion, values, and judgement derived from coherent sources, evidence, logics, systems, and patterns allowing for analysis and comparison. Some opinions may be found worthless, while there will remain matters about which reasonable people will reasonably disagree. Knowledge is qualitative, dependent on contexts.” “I must be wholehearted while tentative, fight for my values yet respect others, believe my deepest values [to be] right yet be ready to learn”) (Perry, 1981, p. 79). Here we find resonance with the themes of reductionism and emergence, outcomes and process, and living in the question.

Taken together, these two models describe a process of personal evolution in which one’s focus moves from implementing narcissistic willfulness to seeking connectedness, and one’s source of grounding shifts from the existence of Authority and external absolute Truths to the experience of self transcendence and connection.

We have been considering the control and relation paradigms in the context of an individual’s personal philosophy, but these paradigms are manifest in organizational process and behavior, as well (Senge, 1990). Given the considerable influence that organizations have on the perceptions, values and behaviors of the individuals who populate them, we might look to the modification of organizational process as a powerful tool for fostering personal transformation (i.e., changing personal paradigms) (Senge, 1994; Brill & Worth, 1997).
Conclusions

The control paradigm limits partnership. By focusing our attention on the realization of our will, on outcomes and on objective phenomena, it predisposes us towards dominance and distracts us from making observations and taking actions that might help us cultivate relationships. It creates additional problems by setting unrealistic standards for success and cutting us off from our own subjective experience. The relation paradigm avoids these pitfalls and predisposes us towards partnership. It reminds us to attend to process and to personal experience (our own and that of others), not just to objective data. It encourages us to be perpetually skeptical of answers and their false promise of predictability, and instead to live in the question, remaining receptive even as we undertake specific and decisive courses of action. Once we are able to perceive these two philosophies and their consequences, we are then able to reflect on our own experience and to make thoughtful choices about which paradigms help us live in the most meaningful and effective manner and to move forward in our personal growth.

Note

1 Whose arguments about the concept of ‘relation’ as the core of an alternative to the control paradigm inspired my thinking.

References


## Appendix

Table I. A comparison of critical features of the paradigms of control and relation with regard to core values and goals, patterns of social relationships, approaches to gathering and using knowledge, and sources of existential security.

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<td>general = particular</td>
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<tr>
<td>Social structure</td>
<td>hierarchy</td>
<td>partnership</td>
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<td>limit choices of others</td>
<td>increase choices of others</td>
</tr>
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<td>win-lose</td>
<td>win-win</td>
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<td>Implications for clinician’s stance</td>
<td>detached observer; affectively neutral</td>
<td>participant observer; fully present</td>
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<td>fear</td>
<td>trust</td>
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<tr>
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<td>mastery</td>
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<tr>
<td>Source of security</td>
<td>self sufficiency</td>
<td>alignment; interdependence</td>
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<tr>
<td>Existential strategy</td>
<td>holding tight</td>
<td>letting go</td>
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Chapter 9  
Practitioner Well-being

Anthony L. Suchman, MD, FAACH  (Corresponding author)
Senior Consultant, Relationship Centered Health Care
Clinical Professor of Medicine and Psychiatry, University of Rochester School of Medicine and Dentistry
42 Audubon St.
Rochester NY, 14610
585-271-4233 (voice)
775-667-6470 (fax)
asuchman@rochester.rr.com

Gita Ramamurthy, MD
Instructor, Harvard Medical School
Staff Psychiatrist, The Cambridge Hospital
Boston, Massachusetts

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TABLE 9-1
INTRODUCTION

Case Illustration

Don, a 38-year-old primary care physician, sighs as he sees Mrs. D.’s name as a last-minute addition to his patient list. It is midafternoon on Friday, and he had blacked out the last hour of the day to attend his son’s final softball game of the season. “Of all the days for one of her ‘crying headaches,’ ” Don mutters to himself, “why today?”

Don’s skill in handling patients with somatoform problems is respected throughout the health center. Since he assumed responsibility for Mrs. D.’s care, her emergency-department visits have fallen by 90%, and she has even taken a part-time job. Don has almost always been able to help her through these spells by sitting with her, holding her hands, and letting her talk.

When he was growing up, Don was always a leader; he was the pride of his home town, the young man people always thought would “make it out of this place.” Now he is back home, as a founding partner in a successful regional health center—and with a waiting list of residents from the university hoping to rotate through his thriving primary care practice.

“Hey, Don!” The greeting comes from Grace, one of Don’s partners. Briefcase in hand, she is moving toward the door. “What a great afternoon! My last patient just canceled—I’m
going to go home, pour myself a glass of white wine, sit out on the deck, and catch up on some journals. Hope you have a great weekend."

The door opens, the door closes, and frustration, sadness, loneliness, and anger come together as Don watches Grace leave.

Medical practice can be both an enriching source of personal growth and meaning and an unmerciful and depleting taskmaster. It provides us with access to a broad range of human experience—an intimate view of the characters and stories of a thousand novels—and an opportunity to have our very presence matter to others. At the same time, it makes constant demands and surrounds us with perpetual uncertainty; it relentlessly confronts us with our limitations of time, energy, knowledge, and compassion. It is a job that is never done; at best, problems are stabilized until something else goes wrong.

The balance each of us strikes between our own enrichment and depletion is critical to our own physical, emotional, and spiritual health and to our ability to care for others. All too often, however, we lose sight of this balance. We become so outwardly focused, attending to clinical problem solving, that we do not tend to our own renewal. This lack of balance is not surprising; our education has taught us much more about how to care for others than how to care for ourselves. The socialization processes of medical school and residency have cultivated a
variety of unrealistic self-expectations and attitudes, especially concerning control and self-sufficiency.

Over time, this imbalance produces a vague but increasing sense of demoralization. The joy of work is lost; patients seem increasingly annoying and adversarial. Work becomes the means to some other end—skiing trips or a vacation house—rather than meaningful in its own right. When the root causes of this dissatisfaction are invisible to us, we blame external sources such as the government, insurance companies, or lawyers. Although there are many legitimate complaints about restrictions and bureaucracy, the most fundamental determinants of satisfaction and well-being are not external but rather are found within.

This chapter discusses important values, attitudes, skills, and healthy work environments, but it must be remembered that simply reading a chapter is not enough to meet the personal challenges that practitioners face. It can, however, help foster practitioners’ awareness of important underlying issues that affect their satisfaction and well-being.

**BASIC NEEDS OF PRACTITIONERS**

The foundation of our well-being is the acknowledgment that we are human, that we have needs and limits, and that to keep on giving we must know and have reliable access to those things that sustain and revitalize us. Unfortunately, the notion that clinicians have needs has been virtually off-limits. An excessively narrow interpretation of the scientific model that
guides our work has called on us to be detached and objective observers, leaving no room for our own subjective experience. Moreover, we are exposed early and repeatedly to the ideal of the clinician who is selfless, invulnerable, and omnipotent (the “iron man” model). This ideal is at best unrealistic and at worst dangerous to both ourselves and our patients. Each of us has a variety of needs, both universal and neurotic, that will ultimately assert themselves. The more we are aware of these needs and attend to them, consciously and purposefully, the healthier our lives will be.

Among our most fundamental needs are those for human connection, meaning, and self-transcendence—experiencing ourselves as part of something larger than we are. Clinical work is particularly rich with opportunity for human contact and appreciation. Many studies have shown the patient-clinician relationship to be the single most important factor contributing to physician satisfaction (mirroring its central importance to patients). When we are working under excessive pressure or in situations for which we are not adequately prepared, however, clinical work can interfere with the satisfaction of these needs, resulting in depersonalization and alienation from and hostility toward our patients.

Clinical work can also threaten the fulfillment of transpersonal needs through family and community life. Family and career often compete intensely for time and attention, too often
to the detriment of the former. Moreover, we sometimes have difficulty shedding the white coat—leaving our professional caretaking role and expressing the spontaneity and vulnerability necessary for intimacy. As tensions build at home, putting more time into work can provide a short-term escape. In the long term, however, avoidance of difficult relationship problems leads to alienation and potentially to the breakdown of crucial personal support systems.

In addition to our universal needs for connection and meaning, we also have very individual neurotic needs—born of pain and conflict—that are intimately related to our medical work. These needs influence both our motivation to go into medicine in the first place and the way we practice. Out of a need to feel loved or appreciated, we often find ourselves in the role of overfunctioning caretakers, and our difficulty saying no quickly leads to overcommitment. Feelings of impotence engendered by childhood experiences of illness—our own or that of a close friend or relative—may be relieved through our work with patients, but the wishful fantasy of controlling disease is constantly challenged by reality. Voyeuristic desires, fear of death, and the fulfillment of parental expectations are other factors, conscious or unconscious, that can motivate our careers.

These darker, neurotic needs are no less legitimate than those less hidden; they, too, are a normal part of life. When these needs operate outside our awareness, however, they can drive us
to work excessively, assume unrealistic degrees of responsibility, and otherwise distort our work lives, thereby causing us to suffer. If we invest ourselves in unrealistic solutions that must inevitably fail, we risk chronic anxiety, substance abuse, and even suicide. Through various processes of self-exploration (such as psychotherapy, peer support groups, or mindfulness workshops), we can become more aware of these needs that underlie our work and find healthier ways to satisfy them. We ignore them at our own peril.

PERSONAL PHILOSOPHY

Another important but underrecognized determinant of our well-being is our personal philosophy—the deeply held beliefs and values that address the most fundamental questions of our lives: the meaning and purpose of life, death, joy, and suffering; why things happen the way they do; the nature of our relationship to other people and to the world; and the nature of our goals and responsibilities as human beings. Our personal philosophies define our expectations of ourselves and other people. They guide the way we perceive and respond to our world and help us identify our place in it. They define the framework by which we imbue things in our lives with meaning, joy, or pain and by which we determine what seems right and what seems wrong.

Developing a personal philosophy tends to be a subliminal process—a gradual internalization of attitudes and values from family, culture, education, and life experience. This process
makes it possible for us to be entirely unaware of our core beliefs as an ideology; we may take them so completely for granted that they just seem to be part of the way things are. If we do not understand how these beliefs filter our perceptions and shape our behaviors, then we are unable to subject them to critical reflection and to decide which parts work well for us and which parts need to be changed.

The Control Model

An aspect of personal philosophy with special importance to clinical practice is our attitude toward control. Through the influence of Western culture in general and medical culture in particular, we often perceive being in control (of disease, of patients, of the health-care team) to be the ideal state (Table 6-1). We use specific intellectual tools for gathering and applying knowledge: reductionism: “Sickle cell anemia is attributable to the substitution of a single nucleotide”; linear causality: “A causes B”; and moving away from the particular toward the general: “Asthma responds to bronchodilators.” All have a distinctly controlling, outcome-oriented focus, that is, to manipulate A so as to control B. Although this approach has led to important technological advances, it also has important adverse consequences.

The control model creates unrealistic expectations that limit our opportunities to feel successful. Consider, for instance, how our expectations of good control in caring for a diabetic patient
allow us to feel successful only when the blood sugar is tightly regulated. The patient’s blood sugar, however, is influenced by many factors over which we have no control, the patient’s own behavior being foremost among them. We become angry at the patient whose noncompliance stands in the way of our success. If success for us is defined only in terms of controlling disease, we are precluded from feeling successful in many, if not most, situations. Accepting responsibility for outcomes over which we have little or no control is highly stressful and leads us to feel helpless, anxious, and angry.

Our quest for control also creates distance and detachment in the patient-clinician relationship, which, as we have already seen, is an important factor in professional satisfaction. A strong orientation toward control leads to hierarchic relationships. This, coupled with the reductionism and labeling of medical thinking, turns patients into objects, and we find ourselves working more with things—organs, diseases, medications, tests—than with people. We, too, become depersonalized in this process, leaving no room for our subjective experience.

### The Relational Model

An alternative philosophy that avoids many of these problems emphasizes relatedness rather than control. This model does not reject the insights of reductionism, but rather builds on them by adding an appreciation of context and relationship. Therefore, although A may seem to cause B, there are also other mediating
factors and bidirectional interactions (A and B influence each other). For example, the tubercle bacillus causes tuberculosis, but not everyone who is exposed to this bacterium becomes ill; environmental and socioeconomic factors also contribute to the process. The illness, in turn, affects those contextual factors; no portion of the system exists in isolation.

In the relational model, we seek to be with and to understand the patient in a number of dimensions simultaneously—biological, experiential, functional, and spiritual. As we come to understand patients’ experiences, we may or may not identify opportunities to recommend strategies or undertake treatments to ameliorate their suffering. We are mindful that patients are ultimately responsible for their own lives; they may or may not accept our suggestions. In some cases, we may have no suggestions or treatment to offer, but we can still find success in offering, in the words of Arthur Kleinman, “empathic witnessing,” honoring the patient’s need for connection—a healing intervention in its own right.

This relational model helps us avoid unrealistic expectations of ourselves. It offers us the opportunity to feel successful in situations, such as untreatable illness or a patient’s refusal to accept our good advice, that would seem like failures under the control model. The relational model also leads us to more effective action. In contrast to the control model, which attends exclusively to outcomes, this model calls for explicit attention
to process, to the quality of communication, and to the values enacted in the way we work together. Paradoxically, it is by letting go of outcomes and focusing more on making the process as good as possible that we achieve the best outcomes. The relational model also gives us more room to look outside ourselves for guidance and solutions—and to admit our own limitations or powerlessness.

Whereas the control model creates barriers between clinicians and patients, the relational model keeps us closer to the experience of both our patients and ourselves, thereby increasing the opportunities for our work to be meaningful and decreasing the potential for frustration, alienation, and burnout.

**SKILLS**

There are a number of skills that can make the difference between depletion and thriving in practice.

**Time-Management**

These skills are essential both within the office visit and in arranging work schedules. Negotiating an agenda at the start of each visit focuses attention on the issues that are most important to the patient and the clinician, minimizes time spent on unnecessary tasks, and vastly reduces the emergence of last-minute topics (“Oh, by the way, Doc, I’ve got this chest pain. . . .”) that lay waste to office schedules. Informing patients at the outset how long their visits will last and reminding them a few minutes before ending allow them to share responsibility for
using time effectively. On a more global level, time-management skills can help preserve the balance among work, family, community, and recreation that is so important to life satisfaction. Keeping time logs for several days can help us discover whether we are apportioning our time in accordance with our personal goals and priorities. Time logs can also point out time wasters (eg, unnecessary interruptions) in daily work habits and help us devise more efficient office procedures.

**Communication**

Given the important contribution of the patient–clinician relationship as a source of meaning, communication and relationship skills become critical tools for well-being. Learning to be with the patient requires broadening the goal of the interview from making a diagnosis to understanding the story of the patient’s illness as a lived experience. We need to understand the meaning of the illness to the patient—why this disease in this particular patient at this particular time, what its functional effect is, and what role it might be playing in the patient’s life. Thus, we need skills for eliciting deeper levels of patients’ stories and responding to their emotions. As we become more able to do this, it becomes apparent that there are no longer routine or uninteresting cases—each patient is unique. The patient’s personhood enriches our own.

**Coaching & Negotiation**
Sharing responsibility more effectively and more realistically with patients requires both coaching and negotiation skills. Specifically, we must know how to facilitate patients in articulating their own values, goals, and opinions, including their feedback about their medical care. We must be willing to relinquish our traditional—and burdensome—role of unquestioned authority and adopt instead a more flexible stance, trying to combine synergistically our own knowledge of medicine with patients’ knowledge of themselves and the patterns, problems, and balances of their daily lives. We must learn to see patients’ increasing capacity for gathering information and making their own decisions not as a threat but as a sign of our success. Knowing how and when to set firm boundaries without being judgmental and how to discuss communication and relationship problems openly can help to resolve impasses with many seemingly difficult patients, making their care less frustrating and more rewarding.

**Self-Reflection & Self-Care**

We need to be able to reflect on our own feelings and actions, to acknowledge our vulnerabilities and needs, to seek and courageously follow our sense of calling, and to act in support of our own health. Rather than shutting out as “unprofessional” and “unobjective” feelings such as anger, attraction, or insecurity that must inevitably arise in us, we can learn to use them to gain insights about ourselves and our patients. Through
solitary reflection and honest conversation with trusted colleagues (informally or in more organized formats such as Balint groups, workshops, executive coaching, or psychotherapy) we can listen more closely to what our hearts are telling us about the state of our lives. These opportunities to shed the mask of the iron man and disclose our vulnerabilities to each other are also key resources for working amidst uncertainty and coping with mistakes. And finally, we can make choices to limit our work hours, simplifying our material needs to gain more time for whatever it is that truly gives us joy and meaning.

**HEALTHY WORK ENVIRONMENTS**

Our workplaces have an important effect on our well-being. The local culture of the institutions in which we work—be they hospitals, individual practices, or medical communities—subtly reinforces values through both formal educational processes and everyday policies and practices. The local culture can determine whether we feel able to disclose uncertainty and vulnerability to one another or feel constrained always to maintain the iron man facade; whether we can discuss mistakes and ask for help or be forced to work in perpetual isolation; whether we receive encouragement and respect for setting reasonable limits on our workload so we can be present in our families or feel shamed for being “lazy.”
Creating environments that support relationship-centered care is a large topic; a few general principles must suffice for this discussion.

- As clinicians, we tend to treat patients in the same way that we ourselves are treated within our institutions. Core values such as respect, partnership, honesty, and accountability must be explicitly articulated and embodied in institutional policies and procedures. Clinicians and administrators alike may need to learn new communication and relationship skills, and redesign processes for making decisions and maintaining accountability.

- Respecting values and attending to the quality of process must be embraced as the most effective means to high-quality outcomes at the organizational level, just as at the clinical level. This requires a departure from traditional, hierarchic approaches of top-down decision making and control of the work process.

- We can replace the current culture of rugged individualism with a culture of teamwork, accountability, and mutual support. Support groups for all staff, including physicians, may encourage self-awareness, increase sensitivity to patients' concerns, and diminish the isolation and depersonalization that both characterize and accelerate burnout. We can be vigilant to ways in which the
local culture reinforces work addiction and inhibits collaboration and work to improve it.

In this time of concern about health care costs and patient safety, clinicians, administrators, patients, and families need to work together in partnership to redesign our medical institutions, making them more respectful and humane, more collaborative in terms of care, and more responsive to the needs of the people they serve and the people who work within them. Clinical outcomes, financial performance, patient satisfaction, and staff satisfaction have all been associated with factors that create healthy work environments for health care providers; institutions thus have a direct stake in maintaining the well-being of their clinicians and staff.

CONCLUSIONS

Whether the rigors of clinical work become sources of meaning or exhaustion depends on a number of factors. We must be able to know and address deliberately the personal needs that affect our work. The need for connection and meaning is particularly important and when met is sustaining. A more mature perspective of balance, acceptance, and relation must replace the current preoccupation with control. The latter leads only to unrealistic (hence unachievable) expectations and the ongoing specter of inadequacy or failure. We need skills for working with uncertainty, sharing responsibility, and promoting relationship. We must become more attentive to the values expressed
subliminally but powerfully in our work environments and begin to make necessary changes so that our environments call forth the best and healthiest of what we have to offer, both as professionals and as human beings. These approaches can help us to appreciate fully the privilege of caring for patients and to realize our best potential for personal fulfillment and growth.
REFERENCES


Gabbard GO, Menninger RW: The psychology of postponement in the medical marriage. JAMA 1989;261:2378.


Suchman AL. Control and relation: two foundational values and their consequences. J Interprof Care 2006;20:3-11. PMID:16581635


**Table 6-1.** A comparison of control- and relationship-based personal philosophies.

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<thead>
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<th>Attribute</th>
<th>Control</th>
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<td>Thing-in-context</td>
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<td>Subjective and objective data</td>
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<tr>
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<td>Hierarchy</td>
<td>Partnership</td>
</tr>
<tr>
<td>Focus of attention</td>
<td>Outcome-oriented</td>
<td>Process-oriented</td>
</tr>
</tbody>
</table>

\(^a\) Terms are from Martin Buber: *I and Thou*. Scribner, 1970.
Relationship Centered Care


The original presentation of the term “Relationship-centered care,” which was intended to convey “the importance of interaction among people as the foundation of any therapeutic or healing activity.” Available from the Pew Health Professions Commission at the Center for the Health Professions, University fo California, San Francisco, 1388 Sutter St, Suite 805, San Francisco, CA 94109.


Reviews the history and context of the Pew-Fetzer Task Force’s report that first introduced the term “relationship-centered care” and proposes four fundamental principles. Note: this paper is included in a special supplement to J Gen Intern Med devoted entirely to RCC.


A literature review on relationship-centered care describing how the concept has evolved since its introduction in 1994. The most salient developments these authors identify are a more engaged and capable role for patients and increased attention to interdisciplinary collaboration.


Includes an introductory section on theoretical perspectives partnership, followed by sections on partnership in patient-clinician relationships, healthcare teams, partnership between community organizations and educational partnerships


Compares two value sets, one based on control and the other on relations, with regard to clinicians’ goals, the patterns of social relationships, approaches to gathering and using knowledge, and clinicians’ sources of existential security.


Recent literature review on interdisciplinary collaboration.


Describes innovative and exemplary work at the level of health-system community partnership, offering principles and three case studies.

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A multimedia self-directed learning resource to help develop the communication and partnership skills needed for working with patients, family members and colleagues on the healthcare team.


The first book of this pair is an entirely evidence-based textbook on communication and relationship skills. It represents one of the most comprehensive reviews of the research literature in this domain. The second book is on educational methods related to communication and relationship skills.

Relationship Centered Administration


Beginning with a case study of outstanding clinical collaboration in a family medicine practice, the article explores key dimensions of collaboration and how the work environment can facilitate it.


The researchers studied a convenience sample of 45 administrative meetings in healthcare organizations to assess the frequency and types of relationship-centered behaviors. They found a number of parallels between the communication dynamics of administrative meetings and medical encounters.


Describes core principles and practices for establishing effective teamwork and relational work environments.


An excellent review of literature linking organizational culture to a variety of outcomes, including clinical outcomes, length-of-stay and employee morale. It also presents a five-component model of relationship-centered organizations.


Contrasts the implications of viewing organizations as machines versus conversations and proposes a new approach to organizational change that integrates insights from Complex Responsive Processes of Relating, Appreciative Inquiry, Self Determination Theory, Personal Formation and other perspectives.

Healthcare organizations influence the well-being of individuals who work with or within them by patterning their perceptions, thoughts, feelings, expectations and behaviors. Organizational tendencies toward depersonalization, control and pathology-oriented perception adversely effect well-being, but can be modified by careful attention to language and behavior on the part of everyone in the organization, particularly leaders.


This paper describes the key principles of relationship-centered care and their application in the administration of health care organizations.

Describes several methods that can be used at meetings to foster responsiveness and diversity and to promote a relationship-centered work environment.

Describes a relationship-centered approach to consulting and management in healthcare organizations. The values and methodology of this approach mirror those of relationship-centered care, thus creating an opportunity for the organization's leaders and staff to learn about relationship-centered process directly through their own experience.

The effect of relationships on…

…Clinical outcomes

A review of this team’s classic studies showing the positive effect of active patient participation on measurable clinical outcomes including reductions in blood pressure, cholesterol and glycohemoglobin.

A detailed review of primary research demonstrating that patients are more likely to undertake and maintain health-promoting behaviors in a treatment climate that they perceive to be autonomy supportive (as compared to controlling) and caring.

A high degree of “relational coordination” (frequent, timely communication; problem solving; shared goals; shared knowledge and mutual respect among healthcare providers) was associated with improved patient experience of care and reduced length of stay in hip and knee replacement surgery.


Patients’ functional status 6 months after surgery was positively associated with a collaborative team culture. Care was more efficient, as well.


This monograph reviews the rationale for and current practices regarding the teaching of behavioral and social sciences in medical schools. It includes a literature review on the effect of communication and relationship skills on clinical outcomes.


Patients’ commitment to the relationship with their physician was positively associated with adherence and healthy eating behaviors. Also describes the development of a scale measure relationship commitment.


Programs using in-person communication achieved a significant reduction in readmissions and readmission days when compared with routine care patients and programs using telephonic communication. Also, programs using single heart failure experts were less effective in reducing hospital readmissions compared with multidisciplinary teams.

...Quality and safety


This landmark study of 5000 patients cared for in 13 intensive care units found that the quality of the working relationship between physicians and nurses was the most important determinant of patient mortality rates.


Risk adjusted mortality was lower at hospitals with collaborative work environments as compared with matched controls.

This landmark report from the Institute of Medicine identifies poor systems of coordination, communication and decision support as the major source of errors in healthcare.


This survey of 2095 hospital-based healthcare professionals showed that intimidation is a common experience and impedes communication to a point that jeopardizes patient safety. This was not just a matter of “a few bad apples,” not limited to physicians and not primarily a gender issue.


An interdisciplinary care team model that included a structure communication protocol reduced mortality on a cardiovascular surgery unit by 56%. Staff satisfaction was also higher.

…Patient satisfaction and retention


Higher quality of interprofessional communication and relationships in nursing homes were associated with higher levels of resident satisfaction with the quality of their living environment and higher job satisfaction for the staff.


Measures of relationship quality predicted voluntary disenrollment from primary care practices.

Schramm W. Unpublished marketing data from the Henry Ford Health System.

Demonstrates a strong relationship between patients’ ratings of physician relationship behavior and their decisions to re-enroll in the HMO.

…Cost


The active participation of nurses in administrative decision-making contributed to a reduction in costs an improvement in clinical outcomes.


This survey-based study shows that participation in hospital decision-making by clinicians and mid-level managers is associated with improved financial performance.
...Workforce health and satisfaction

An obscure but classic study from 1962, just reprinted recently, showing correlations between rates of illness and absence in student nurses and the quality of the interpersonal environment of the hospitals through which they were rotating.

This excellent review article addresses many contributing and ameliorating factors, with the latter including workplace relationships, mentoring and support groups.

Relationship with patients was the strongest predictor of physician satisfaction with office visits. This relationship has been consistent across many studies of satisfaction with specific visits, career satisfaction and life satisfaction.

Management approach and the work environment are powerful predictors of CNA satisfaction, loyalty, and commitment. The work environment also correlates with how families and state surveyors evaluate quality in a nursing facility.

The resilience of interprofessional orthopedic teams was positively associated with work practices that foster relationship and with the quality of communication and relationships among team members.

...Staff recruitment and retention

Several findings in this survey of how 3500 randomly sampled nurses experienced their work environments address issues of relationship. Overall job satisfaction was associated with the quality of relationships with patients and with the opportunity to influence decisions about the workplace and patient care. The quality of relationship with supervisors and senior administrators was associated with work satisfaction and retention.

Two articles describing a large survey of nurses, physicians and executives that found a high prevalence of disruptive physician behavior and a strong link between that behavior and nurse satisfaction and retention. Various perspectives emerged from the study about responsibility, barriers and solutions.

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An article about an impressive, inexpensive and very successful program to enhance nurse retention by creating a mentoring program for new nurses. It shows how simple and effective culture change can be.

...Malpractice

Depositions in most of the malpractice cases reviewed in this study revealed evidence of patients being seriously dissatisfied with the quality of their interactions with their physicians.

...Capacity for change and innovation

State of the art approaches to changing the culture of healthcare organizations. Trust and partnership must be established before process redesign efforts can begin.

This study of interdisciplinary cardiac surgery teams learning new microinvasive techniques found that teams in which everyone’s voice was valued and respected were able to adopt the new technology faster and with fewer errors than less collaborative teams.

Self-determination theory describes three main factors that predicts internally motivated behavior change: a personal sense of competence, respect for the individual’s autonomy, and a context of supportive relationships. This theory has been validated by research in workplace, educational and medical settings.

Interpersonal and emotional neurobiology

Reviews the neural basis of emotion with particularly emphasis on activities of the amygdala and prefrontal cortex. Also describes the effect of experience on neural circuitry and affective style. Discusses potential favorable health implications of enhanced emotional modulation.


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Synthesizes diverse scientific evidence to describe the influence of social factors on brain development. Describes “the essential experiential ingredients that may facilitate the development of the mind, emotional well-being and psychological resilience…”

Describes the dynamic tension between attachment and stimulation (as reflected in opioid and norepinephrine activity in the brain). Also presents striking results from agent-based computer modeling that demonstrates how this dynamic tension within individuals can account for the self-organization of common social patterns.

Present experimental data supporting the concept of “mirror neurons” which discharge similarly when an action is undertaken and when it is observed. Mirror neurons are proposed to be a biological basis for intersubjectivity.

Organizational Change and Complexity

A fascinating (but dense) description of an important way of understanding organizations. It has a particularly excellent description of the dynamics of attention and expectations.

Plexus Institute: http://www.plexusinstitute.com/
Many resources available from this organization which is interested in applications of complexity science to healthcare. Nearly all their work is based on older complexity models (eg: complex adaptive systems) which were developed in the natural sciences and then applied by way of analogy or metaphor to human interactions.

Stacey begins with an extensive review and critique of traditional management theory (which is based on linearity and control) and then introduces the theory of Complex Responsive Process, the first complexity theory developed specifically for describing human interactions. Destined to be a classic.

Presents further elaboration of the theory of Complex Responsive Process with a particular focus on “knowing.”

Another excellent introduction to Complex Responsive Process, told from the practical perspective of an organizational manager and leaders who is “in charge but not in control,” the paradox referred to in the title.


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An article summarizing the theory of Complex Responsive Process, exploring its relevance to relationship-centered care and its new perspectives on mind, self, communication and organizations. It highlights the theory’s emphasis on moment-to-moment relational process, the value of difference and diversity, and the importance of authentic and responsive participation.


Describes the application of the theory of complex responsive processes and appreciative inquiry in a large scale organizational change initiative.

Suchman AL. Organizations as machines, organizations as conversations: Two core metaphors and their consequences. Medical Care 2010: in press.

Offers a critique of the traditional and widely-held view of organizations as machines, with its problematic emphasis on control. Proposes an alternative perspective that is grounded in the real-world dynamics of self-organizing human interaction and emphasizes mindfulness of relational process.

Organizational Change and Positive Psychology

http://appreciativeinquiry.cwru.edu

A good place to start learning about Appreciative Inquiry. Provides some basic articles and lists many readings and resources.


“…two qualities of appreciative inquiry, a focus on changing how people think instead of what people do, and a focus on supporting self-organizing change processes that flow from new ideas rather than leading implementation of centrally or consensually agreed upon changes…” appear to be most associated with transformational change in organizations. [Quote taken from the authors’ abstract.]


An article providing an overview of the history, philosophy and structure of appreciative inquiry.


An approach to fostering change that identifies individuals with better outcomes than their peers (positive deviance) and enables communities to adopt the behaviors that give rise to the improved outcomes.

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Presents a practical and empirically-verified model of intrinsically-motivated behavior change that highlights 3 determinants: competence, autonomy support and a relational environment.


A detailed case study in the use of Appreciative Inquiry in strategic planning.


Describes use of AI in changing the informal curriculum (the organizational culture) of a large medical school.


Another recent and readable introduction to this methodology. Includes many case studies.

Prepared by:

Anthony L. Suchman, MD, MA
Senior Consultant
Healthcare Consultancy, McArdle Ramerman & Company

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