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CHAPTER 4: RELATIONSHIP-CENTERED CARE AND ADMINISTRATION

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The central concept of this book, Relationship-centered Administration (RCA), has its roots in a clinical approach called Relationship-centered Care (RCC). The original objective of RCA was to support and enhance the practice of RCC, although it's now clear that it can do so much more, as we'll see. In this chapter we explore the origin and meaning of the term "Relationship-centered Care," and consider how this approach (with one key exception) can be transposed from clinical to administrative work.

DOCTOR-CENTERED CARE

The term "Relationship-centered Care" was introduced in 1994 in a report by the Pew-Fetzer Task Force on Psychosocial Health Education.[1] We can appreciate the full significance of this term by tracing the history of the patient-doctor relationship. We begin by going back to the 1950s and 60s when the modern biomedical era was in strong ascendancy. It was the start of a boom time for biomedical research, with massive growth in funding and facilities. All the new knowledge that was emerging led to new medicines, procedures and devices, and also to increasing specialization among health professionals. Thanks to the rapid spread of employer-, union- and government-based programs in the United States (especially Medicare and Medicaid) and national health programs everywhere else in the developed world, a rapidly growing number of people had access to the latest specialty care and the newest technology, so many more specialists were trained.

This era was the age of the expert. It was also the beginning of the age of depersonalization; as the experts had more and more scientific detail on which to focus their attention, they began to lose sight of the life stories and circumstances of their patients. Technological prowess took priority over "bedside" skills in both professional education and fee schedules. Most physicians at this time were white men; white and male hierarchical privilege was not yet being challenged. Trust in and obedience to authority were the norm. For all these reasons, medical decision-making was viewed as an exclusively professional prerogative, with doctors having the greatest authority of any of the health professions. Although the term was never actually used at the time, we could easily characterize the power dynamics of this kind of decision-making as "doctor-centered" care.

PATIENT-CENTERED CARE

The political and social movements of the late 1960s and 1970s challenged hierarchical authority and the privileging of experts' knowledge. Instead, they advocated for more participatory decision-making processes and valued the wisdom of individuals regarding their own local needs and circumstances. These trends affected all social institutions; healthcare was

no exception. A response emerged simultaneously from many quarters against the unilateral authority of the physician and the depersonalization of care.[2]

New integrative disciplines arose – family medicine, general pediatrics and general internal medicine – to reverse the fragmentation of care that resulted from increased specialization. These primary care disciplines would foster continuity of relationships and the coordination of care, and restore a balance of attention between the reductionist perspective of biomedical science and the lifeworld of the patient. (This was not without some irony – the cure for excessive specialization was the creation of new specialties...) George Engel issued his now-famous call for a new integrative medical paradigm, the "biopsychosocial model."[3] But for the purposes of our story, another name for the same movement, championed by Ian McWhinney, helps us recognize the trend more clearly: "Patient-centered Care."[4]

From the late 1970s into the early 1990s, even as biomedicine continued to advance, there was at the same time a growing interest in the patient's experience of illness and care.[5] Part of the clinician's task was to explore and understand the patient's subjective experience of illness. Principles and language from phenomenology found their way into the medical mainstream[6] and the fields of medical anthropology and case-based medical ethics flourished.[7] Patient-centered Care called for care to be organized around the patient's goals and values, with patients as active participants in, if not the ultimate makers of, treatment decisions. Instruction in medical interviewing and relationship skills was becoming more commonplace in both undergraduate and graduate medical education. However, the debate still raged about the basic identity and role of the physician; strong polemics in defense of the biomedical tradition continued to appear.[8]

RELATIONSHIP-CENTERED CARE

In 1994, the Pew Charitable Trusts' Health Professions Commission and the Fetzer Institute convened an interprofessional task force to make recommendations about health professions education.[1] This thoughtful group of clinicians, researchers and educators recognized that while the *purpose* of health care is to respond to the needs of the patient, the *process* of care can be successfully understood from neither a doctor-centered nor a patient-centered perspective alone. Instead, it required an explicit focus on the *relationship* between them, hence their term "relationship-centered." The personhood of the clinician matters as much as the that of the patient with regard to how successfully they can work together, and there are attributes and qualities of the relationship that deserve consideration that are distinct from those of either the patient or the clinician alone. The whole of the patient-clinician system is a different entity than either of its parts.

The Task Force identified four important levels of relationship in healthcare. Beyond the traditional relationship between patient and clinician (and family, which they omitted, curiously), they also called attention to relationships between the various members of the healthcare team, relationships between the healthcare system and the community, and underlying all other levels of relationship, the practitioner's relationship with her- or himself. The term "Relationship-centered Care" calls attention to the communication and relationship dynamics, self-awareness and specific partnership behaviors on which every collaboration depends, even those of a highly technical and scientific nature.[9]

Twelve years after the initial monograph on RCC appeared, Mary Catherine Beach and Tom Inui expanded upon these ideas by articulating four principles of RCC: [10]

1. *"Relationships in healthcare ought to include the personhood of participants."* This principle recognizes the patient's and clinician's unique experiences, values and

perspectives and emphasizes the importance of the clinician's authenticity in interacting with patients.

2. *"Affect and emotion are important components of relationships in health care."* There is always an emotional dimension of the patient's illness experience. The emotional availability of the clinician and the expression of support and empathy for patients are essential to good care.
3. *"All health care relationships occur in the context of reciprocal influence."* While patient's goals take priority, both the clinician and the patient influence each other and benefit from the relationship.
4. *"RCC has a moral foundation."* Personal relationships allow clinicians to develop the interest and investment needed to serve others, and to be morally committed to and renewed by those they serve.

The components and principles of RCC thus include and expand on the patient's perspective from Patient-centered Care by reintegrating the clinician's perspective and adding the perspective of the relationship itself.

More than anything, RCC is about partnership at every level and the compassion, respect, and shared decision-making of which partnership is comprised. It involves the ability to be genuinely present in an interaction and at the same to be aware of what we are experiencing, how the others are responding and what patterns of interaction are unfolding. The domain of RCC includes an extensive body of research on relationship process and a rich set of communication, relationship and self-awareness skills that that we can use to create patterns of partnership moment by moment as we work (*see* Appendix 1).[11]

Relationship-centered care resonates with the theories we've considered previously. Both RCC and the complexity perspective (organizations as conversations) foster an awareness of how people are interacting here and now, what patterns of relating they are enacting together, and what other ways of behaving towards each other might change those patterns (*see* Chapter 2).

The complexity perspective points to diversity and responsiveness as crucial factors for innovation and adaptation. To be willing to reveal our differences and open our minds to being changed by each other we must be experiencing a high quality of relationship, characterized by respectful listening, mutuality and trust.

When we looked at Self-Determination Theory (*see* Chapter 3) we saw that a caring relationship was a critical success factor in fostering behavior change. We also saw how the storytelling of Appreciative Inquiry and the active engagement of Positive Deviance helped to build community, that is, a network of relationships.

RELATIONSHIP-CENTERED ADMINISTRATION

Relationship-centered Administration brings the same quality of partnership and the same attentiveness to relational process to organizational work that Relationship-centered Care brings to clinical work.[12] You'd think it would be obvious: for staff members to treat patients and their family members compassionately and to engage them respectfully as partners in decision-making, they need to be treated the same way in the workplace. You can't beat people into being compassionate; you can't mandate partnership. Yet impersonal, hierarchically controlling workplaces abound in healthcare. Too often we find organizations with toxic cultures trying to help people be healthier – a sad irony. It doesn't work and it results in enormous waste.

The goal of Relationship-centered Administration is to create a workplace environment that engages the staff deeply and calls out their commitment and creativity. A large and growing

literature shows that the relational quality of the healthcare workplace affects virtually every dimension of organizational performance. For example, Gittell and colleagues, studying joint replacement surgery at specialized orthopedic hospitals for patients with severe osteoarthritis, found a strong association between the quality of teamwork and clinical outcomes – patients' pain and functional status six weeks after discharge.[13] Shortell and colleagues found similar associations for coronary artery bypass grafting.[14]

Staff relationships are also associated with quality and safety. Nurse-physician collaboration is the strongest predictor of ICU mortality rates. [15] Aiken and colleagues found that hospital-wide mortality rates were lower in hospitals with collaborative workplace cultures.[16] The findings were similar in studies of staff satisfaction and resilience,[17] staff retention,[18] patient satisfaction and retention,[19] and cost.[20] Even the capacity to master new technology depends on the quality of team relationships.[21]

These data and the case studies in Part 2 of this book show that all kinds of benefits can result when leaders pay attention to the quality of relationships in their organizations. Behavioral patterns spread from the senior leaders to everyone else. Front-line care and the patient experience are affected by everything we do behind the scenes – the way we conduct staff recruitment and development, resource allocation, performance measurement, strategic planning and every other aspect of administrative work. By undertaking these and every other administrative activity in a relational way and inviting greater engagement, we can build high performance organizations. Relationship-centered Administration is not only a moral imperative; it is also a successful business strategy.

What we do in every moment matters. Executives and managers can learn to refine their awareness of themselves and others, enhance their capacity to reflect on group dynamics and strengthen their listening and communication skills (*see* Chapter 5 and Appendix 1). They can use a variety of techniques to make meetings more relational, building an organizational culture of respect and collaboration (*see* Appendix 2). They can be clearer about behavioral expectations and more rigorous about maintaining accountability (*see* Appendix 3).

This is what we mean by Relationship-centered Administration. It all comes down to how we lead in each moment – our mindfulness, skills, knowledge and personal presence – and how we participate in and influence the pattern-making.

Even as we note the important parallels between clinical and administrative work, we should also note an important difference, one that frequently trips up clinicians as they step into administrative roles. The traditional focus of clinical work is on the well-being of individuals; above all else, it is about relieving suffering. Administrative work focuses on the successful function of groups in service of customers, external or internal. There is often a tension between the individual and group perspectives. Sometimes what is needed for the good of the group (and the good of patients) can cause suffering for an individual employee: for example, delivering specific feedback regarding poor performance. Clinician-administrators seem to have particular difficulty with this, tolerating poor performance or making do with cumbersome work-arounds rather than confronting individuals with their need to improve and thereby causing suffering. It may help them to reframe feedback as a service, a form of caring, that helps individuals and organizations fulfill their best potential. It may also help to be mindful of the less-visible but greater suffering of patients and colleagues that results from problem behaviors. And it certainly helps to recognize that problem behaviors can be addressed in a relationship-centered manner (*see* Appendix 3). Chapter 6 includes a story about a relationship-centered approach to removing

someone from a job she could not perform, and in Chapter 13 we read about a relationship-centered layoff.

CONCLUSION

In this chapter, we have reviewed the history and principles of Relationship-centered Care. We have traced the evolution of the patient-clinician relationship from hierarchy to partnership. We have seen how the expertise and power of patients have become recognized and how the subjective experience of both patients and clinicians has come to be valued and integrated into the realm of legitimate clinical work. We have explored the four levels of relationship encompassed by RCC: patient-clinician, healthcare team, healthcare system-community and relationship with self. And finally, we have considered the relevance of this partnership-based approach to the realm of administration.

In part 2 of this book we will many examples of relationship-centered approaches to administration and organizational change. The case studies will show how the dynamics of partnership, emergence and shared decision-making are as powerful in administrative work as in patient care. But first we need to add one more ingredient to our theory mix, the one that brings it all together and makes it work: authentic presence.

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