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CHAPTER 4: AN INTRODUCTION TO RELATIONSHIP-CENTERED CARE

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THE ORIGINS OF RCC

The central concept in this book, relationship-centered administration, derives from a more general clinical philosophy called Relationship-centered Care (RCC). We thought it appropriate to begin with an exploration of this clinical philosophy for several reasons. First, it's important for healthcare managers and leaders to understand this dimension of excellent front-line care. Second, healthcare administrators and clinicians must be mindful of that front-line care is affected by everything they do behind the scenes – staff recruitment and development, resource allocation, measuring organizational performance and every other aspect of their administrative work. Behavioral patterns tend to cascade from the senior leadership level throughout the organization (a point we will return to at length in the next chapter). Clinical staff members are more likely to treat patients and families as partners if they are experiencing that same kind of respectful, collaborative and participatory treatment backstage. Third, the core concepts of relationship-centered administration were first developed in the clinical realm and only later extended into the domain of organizations.[1] So the structure of our exploration recapitulates the history of the concepts themselves.

The term "Relationship-centered Care" was introduced in 1994 in a report by the Pew Fetzer Task Force on Health Professions Education.[2] Its significance can be appreciated most readily by tracing the history of power in the patient-doctor relationship.

The modern biomedical era was in strong ascendancy by the late 1940s and in full bloom by the late 1960s and '70s. It was a boom time for biomedical research, with massive growth in research and medical facilities and increasing specialization of medical knowledge. The rapid spread of employer-based private health insurance, introduction of major federal programs to insure the elderly and the poor and rapidly growing federal support for research provided unprecedented levels of funding to finance this expansion.

This era was the age of the expert. As medicine developed a stronger scientific and reductionist foundation, the clinician's attention was increasingly directed towards

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events at the cellular and molecular levels and away from the lived experience of patients; care become impersonal. The rapid growth of diagnostic and therapeutic technologies led to specialization; care became more fragmented. Treatment decisions were increasingly based on principles derived from scientific study, knowledge that was the exclusive province of professionals. Thus, medical decision-making was viewed as an exclusively professional prerogative. 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.

The political and social movements of the late 1960s and 1970s criticized hierarchical authority and the "absolute" knowledge of experts, advocating instead for more participatory process and an appreciation for context-dependent knowledge. 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. New integrative disciplines arose – family medicine, general pediatrics and general internal medicine – to foster continuity of relationships and the coordination of care, and to 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 more specialization...) George Engel issued his now-famous call for a new integrative medical paradigm, expressed even in the etymology of its name: the "biopsychosocial model."[3] But for the purposes of our story, another name for the same movement helps us recognize the trend more clearly, the term "Patient-centered Care" championed by Ian McWhinney.[4]

From the late 1970s into the early 1990s, even as the advance of biomedicine continued, there was at the same time a growing recognition and acceptance of the need to be mindful of the patient's experience of illness and care. 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[5] and the fields of medical anthropology and case-based medical ethics flourished.[6] Patient-centered Care called for patients to be active participants in treatment decisions and was organized around their goals and values. Instruction in medical interviewing and relationship skills was becoming more commonplace in both undergraduate and graduate medical education, but a debate was still raging about the basic identity and role of the physician; strong polemics in defense of the biomedical tradition continued to appear.[7]

This was the context in which the Pew-Fetzer Task Force gathered to make recommendations about health professions education in the 21st century. This thoughtful group of clinicians, researchers and educators recognized that while the *purpose* of health care was to respond to the needs of the patient, the *process* of care could be successfully understood from neither a doctor-centered nor a patient-centered perspective alone, but rather required an explicit focus on their relationship, hence the term "relationship-centered." The personhood of the clinician mattered as much as the personhood of the patient with regard to how successfully they could work together, and there were aspects of the relationship that deserved consideration that were distinct from attributes of either the patient or the clinician alone.

The Task Force identified four important levels of relationship in healthcare. Beyond the traditional level of the patient-clinician relationship, they also called attention to relationships between the various members of the healthcare team, relationships

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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" thus refers to clinical approach based on partnership and shared decision-making at every level. It calls attention to the communication and relationship dynamics and the specific partnership behaviors on which the success of every collaborative endeavor depends, even those of a highly technical and scientific nature.[8]

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: [9]

1. *"Relationships in healthcare ought to include the personhood of participants."* This principle recognizes the clinician's and patient'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."* The emotional presence 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 those of Patient-centered Care by reintegrating the perspective of the clinician and adding the perspective of the relationship itself.

IMPLEMENTING RCC: A 4-STEP MODEL

With this background on the origin and meaning of RCC, we can now turn our attention to its implementation in clinical practice, which we can characterize as an approach based on partnership and shared decision-making. We'll consider a 4-step model of relationship-centered process. Following the description of each step, we offer examples of communications exercises or illustrative teaching tools. Simply imagining these exercises can bring the abstract principles to life; actually trying them is even better. And, of course, these exercises are available to anyone attempting to teach these skills in the course of their work as an educator or organizational-development consultant.

Step 1: Being Personally Present and Inviting Others to Do Likewise.

The first step of relationship-centered process is to be fully present and to invite others to do likewise, or more simply, to "show up." We can only be present in a relationship to the extent that we make ourselves available to the other person and welcome and acknowledge his or her presence. This is not simply a matter of physical presence, although that is certainly a factor – not being physically present can constrain the potential of a relationship, as in not keeping an appointment or interacting only in cyberspace. But even when we are physically present, it is necessary to bring ourselves

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fully into the moment. Are we offering our genuine thoughts and feelings as they arise or are we holding parts of ourselves back behind a screen of stereotyped conversation? Are we authentic and do we invite the authenticity of the other? Do we behold with full attention the person before us, or are we distracted, with significant portions of our attention focused elsewhere? And if we do behold this person, how do we let that person know and feel that he or she is truly being seen, heard, and respected?

Reflective Listening Exercise: In a group of any size, ask participants to divide up into pairs. Invite partners to take turns describing to each other what it feel like to be in that moment, right there and then. The first speaker has an opportunity to reflect for a moment on the content of her consciousness – the physical sensations, anticipations, distractions, delights, fears, whatever. As she notices these, and to the degree that she is willing (always having the right to choose what she wishes to disclose), she describes them. A typical comment might be, "I'm aware of a slight tension in my stomach, like butterflies. This exercise is new to me, so it makes me a little nervous. But I'm also hopeful about working in this group and I think I will learn a lot." The role of the listener is to attend to the speaker, and to limit his responses to simply reflecting back what he understands his partner to be communicating. "So you're feeling a mix of things: eagerness about learning, but also a little apprehension, like being in slightly unfamiliar territory." It might be a mirroring back of the partner's actual words, or a summary or paraphrasing, and it might include a reflection of on-verbal cues, as well (e.g.: "you smiled broadly as you were saying that.") After just a minute or two, the partners trade roles.

This very brief and simple exercise often provokes profound insights. Participants often discover how seldom they notice what's going on in the here-and-now of their own experience. Their attention is often off in the future or back in the past. For some people, even this limited self-disclosure may feel new and uncomfortable. But they also describe the joy at having the time to reflect, and to speak knowing that they will not be interrupted – they do not have to actively hold the floor – and they appreciate being heard. The experience of listening elicits strong responses, too. Many people are surprised how hard it is to restrain themselves from offering stories or reactions of their own, to simply be with and acknowledge the other person. But they also feel that their patience and restraint is rewarded: resisting the urge to ask directive or leading questions gives space to the speaker to introduce poignant themes that the listener could never have known to ask about; there can be a surprising efficiency in this strategy of restraint. Both speaker and listener are struck by the profound sense of contact or connection that can emerge in a very short time. Following this exercise, people often resolve to give more undivided attention to others and to be better listeners.

Reflective listening is one of the most powerful and efficient of all communication skills. It simultaneously accomplishes three tasks. First, it verifies the accuracy of what's being understood, preventing subsequent misunderstandings, errors and even conflicts and all the associated extra effort and potential harm. Second, it demonstrates to the interviewee that the interviewer not only understands but also cares enough to want to understand correctly. Third, it often encourages the interviewer to say more. Three tasks accomplished with one simple statement: it doesn't get more efficient that that.

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Step 2: Speaking Your Truth and Listening to Understand the Truths of Others

This step builds upon the first one by calling attention to the interdependent disciplines of advocacy and inquiry. Skilled advocacy involves articulating our point of view and the reasoning behind it. When our opinions aren't fully formed, explaining our thinking to others gives us a chance to explore and better understand it ourselves.

Advocacy is greatly facilitated by inquiry, the offering of time, attention, and curious open questions to help someone develop and articulate his or her thinking. Inquiry begins with curiosity and a genuine wish to understand someone else's thinking. It involves temporarily putting aside our own ideas and agenda, letting the other person talk without interruption and without having to fight to keep the floor. It requires a discipline of silencing the inner voice in us that is already formulating a response (regardless of whether our intent is to agree or disagree) and thus distracts our attention from the other person. Inquiry also involves refraining from asking questions intended to lead the other person towards a particular point of view and instead asking straightforward, non-leading questions that invite the other person to reflect and piece together the elements of his own thinking. And there is a continuing role for reflective listening to ensure that we have an accurate understanding and that the other person feels heard and understood.

Skillful Inquiry and Advocacy Exercise: Invite participants to form pairs or triads. Each person takes about 10 minutes to respond to a thought-provoking question, explaining the basis for her response (skilled advocacy). Her partner(s) ask open, honest questions to explore her thoughts and feelings in greater depth and reflect back what they are understanding (skilled inquiry). They specifically refrain from commenting on the views being expressed or offering views or their own. Examples of open, honest questions include: "Tell me more about that," "What does ___ mean to you?" and "How did you come to hold this value?" but not "How could you possibly believe that?" or "Have you thought that [some other point of view] might be true?" Questions may widen the scope of the conversation, whether they are abstract and general (e.g., "What core values inform your work as a leader?") or highly specific (e.g., "What do you think of the new performance-based incentive plan?" or "What are you telling yourself about why the patient is acting this way?").

Skilled inquiry is epitomized in the image of a good newspaper reporter conducting an interview. The reporter's views are irrelevant in the conversation – the content of the interview is filled with thoughts of interviewee, and the reporter's role is to help the interviewee bring those thoughts forward.

In debriefing this exercise, participants report that just as in the first exercise, it takes discipline to hold back their own opinions when interviewing. They describe both the difficulty and value of quieting their "inner voice," but they find themselves able to listen better and to understand more deeply. As listeners, they appreciate the unusual and delightful experience of being able to thoughtfully explore and elaborate on their thinking without having to fight to keep the floor. And having felt fully heard and understood, they feel better able to hear the views of others.

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At a typical hospital committee meeting, the usual pattern is conversation is one of escalating exchanges of interrupted advocacy as people attempt to prevail over one another in a contest of ideas, a battle over who's right and who's wrong. A more functional pattern would consist of successive rounds of advocacy supported by inquiry, with new understandings emerging from the interplay of diverse ideas. But this depends upon how well people manage the differences that are surfaced by effective inquiry and advocacy. This leads us directly to the third step of relationship-centered process.

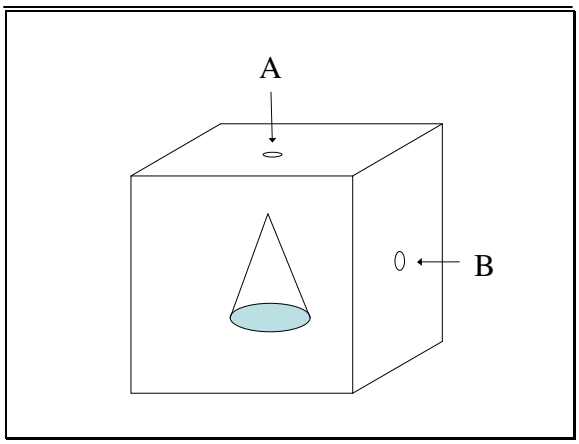
Step 3: Valuing and Harnessing Difference and Diversity

If the participants in a relationship are practicing effective inquiry and advocacy, it will not take long for major differences to emerge. The way people perceive and respond to their differences may be the single most important factor that determines the quality of partnership. It is without doubt the greatest source of difficulty, frustration and wasted energy in relationships. So we can describe this third and arguably most critical step as valuing difference and diversity.

A group's differences and diversity are its most important natural resource. If there was no diversity – if everyone's thinking was exactly alike – there would be no source of novelty from which new ideas could emerge. There could be no creativity, learning, growth or adaptation. We can find a useful parallel in population biology: the less the variability within a population, the less capable it is of adapting to environmental changes and the closer it is to extinction.

To value difference and diversity as a resource, we must first overcome our habitual "either-or" and "right-wrong" ways of thinking and instead allow ourselves to recognize that multiple divergent perspectives can be true simultaneously. Most situations are so complex that no one can see every facet; each person holds some unique piece of the truth. If any person's perspective is excluded, everyone loses.

<u>The Cone in the Box Exercise</u>: A simple drawing of a cone inside a box is a profound tool for demonstrating the need to value and explore diverse perspectives.[10]



Participants are asked to imagine that there is a cone (for example, one of the pylons used on highways to divert traffic or mark hazards) inside a dimly lit box and to describe

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what they would see looking through the peepholes first at point A (where they would likely see a circle or a point) and then at B (where they would perceive a triangle). We then let the participants "listen in" on a conversation between people at points A and B:

"What do you see in there?"

"Well, it's some kind of circle."

"What? That's no circle. It has three points. It's a triangle."

"A triangle? Are you crazy? It's smooth and round. It's obviously a circle. I can see it clearly."

"You need your eyes examined. It's a triangle, plain as the nose on my face."

And on it goes from there.

After acknowledging the familiarity of this kind of conversation, we explore why A and B get into an argument, and quickly identify two major causes: the assumption that there is one right answer (an "either-or" perspective) and the intense desire to not be wrong - to avoid shame and maintain the integrity one's identity. But as the figure shows so clearly, reality is more complex than either perspective alone. The A's and B's need each others' perspectives to gain a more accurate understanding. The A's may be supervisors and the B's front-line workers. Or the A's may be women and the B's men; or clinicians and administrators. The A might be you and B's might be everyone else. The point still holds: ***if either side can successfully suppress the other's point of view, everyone loses.***

When explorations of difference are framed in terms of right and wrong, or winning and losing, they are destined to fail. Everyone is left with an incomplete and inadequate understanding. The Cone in the Box reminds us to take a "both-and" perspective, to recognize that seemingly contradictory perspectives can be simultaneously true, and to explore these perspectives with openness and curiosity. That brings us right back to Skilled Inquiry and Advocacy as essential skills for exploring and harnessing difference. To them we add two additional skills.

Skilled Self Monitoring – the capacity to notice what we are feeling – is a helpful precursor to Skilled Inquiry. It is this capacity to notice that we are starting to feel threatened by someone else's different perspective that gives us the chance to break out of the either-or habit, to remember that we are not necessarily wrong just because someone sees something differently, and to turn away from argument and towards wonder. ("I wonder why I'm feeling this way?" "I wonder what led him or her to that stance?") The discipline of shifting from needing to be right to curiosity allows us to move to inquiry.

The other skill that helps us have constructive conversations about difference is the use of relationship-building statements, summarized by the acronym PEARLS (see Table).[11] Relationship-building statements are explicit affirmations of the other person and expressions of personal commitment to our relationship. They help to counter the potential of differences to disrupt relationships. When we express a point of view that differs from that of another person, that person may accept the difference at face value, or might begin to make inferences about the state of our relationship, perhaps interpreting the expression of difference as competition, disrespect or distrust. By using PEARLS to explicitly communicate our positive regard for that person our commitment to

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maintaining a good relationship, it leaves less room for the more negative inferences to form.

Table: Types of relationship-building statements, summarized by the acronym 'PEARLS' with illustrative examples.

Partnership	We'll see this through together I really want to work on this with you.
Empathy	It sounds like that was frightening for you. I can feel your sadness as you talk.
Acknowledgment	You put a lot of work into that project. You researched this proposal very thoroughly.
Respect	I so respect your commitment. I've always appreciated your creativity.
Legitimation	This would be hard for anyone. Who wouldn't be worried about something like this?
Support	I'd like to help you with this. I want to see you succeed.

PEARLS and Inquiry Exercise: To provide participants with first hand experience of an alternative to the usual pattern when differences are encountered, namely advocacy meeting advocacy, we use an exercise that involves the exploration of an actual subject of an controversy within the group. Each person has a chance to make a simple statement. The adjacent person in the circle offers a PEARL followed by an inquiry. The first person then responds to the inquiry with an elaboration of her initial opinion. Turn taking proceeds around the circle until each person has had a chance to practice offering a PEARL and an inquiry.

While it's not necessary (or even helpful) to adhere to such a rigid formula (PEARL followed by Inquiry) in real-life conversations, this is such a powerful and underutilized combination that it bears rehearsing, making it easier to incorporate this method into actual conversations. Participants typically report gaining comfort and confidence during the course of this exercise.

Relationship statements help to weave a container that is capable of holding the difference; it holds us together so we can explore the difference and learn together. That container can also be strengthened by stepping outside of the disagreement for a moment

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to remind everyone involved of our shared vision and purpose or sources of other common ground.

Step IV: Letting Go of Control and Trusting the Process

We have now arrived at the fourth and last step of relationship-centered process, letting go of control and trusting the process. Rather than approaching a conversation with a predetermined outcome in mind and pushing towards that outcome at every opportunity, we can approach it with a sense of curiosity and hopeful expectancy. We can trust that if we have helped to establish an excellent process – if people are being genuinely present to each other, practicing skilled listening, inquiry and advocacy, and welcoming of difference as a stimulus to creativity – then the conversation can scarcely fail to yield a constructive outcome, one that will be more creative, robust and well-supported than anything we could have designed on our own or attempted to impose on the group. In a field with as much control-oriented as healthcare, letting go of control is not easy, but it is important because, paradoxically, the effort to control only diminishes the result.

Dialogue Exercise: We know of no better way to illustrate the creative and emergent potential of skilled conversation than to hold a dialogue. It's important that the topic be interesting and important to the participants. Just before beginning, it's helpful to invite them to make intentional use of the skills described above and to notice how others are using them. Twenty to thirty minutes into the dialogue, we call a "time out" and go around the circle inviting the participant to share their observations of how the conversation is going, what they are experiencing and what skills they've tried to use (always explicitly offering them the opportunity to pass). People often recognize the self-organizing nature of the conversation (see Chapter 3) and give and receive positive feedback for facilitative remarks. The time-out often intensifies everyone's sense of being present, thus deepening the subsequent conversation. In experiencing the method of taking a time-out to talk about the conversation, the participants are also experiencing first hand a powerful method that they can use to help groups free themselves when conversations become stuck.

Taken together, these four core steps of relationship-centered process allow people to work together more effectively across all levels of healthcare, whether they are patients, families and clinicians; professional colleagues; or clinicians, administrators and community members. They establish more trust, greater willingness to share diverse perspectives, greater ability to hear and be affected by each others' views, more resourceful ideas and plans, and more buy-in for whatever plans are ultimately chosen. And the experience of working together is likely to be more meaningful and satisfying to everyone.

CONCLUSION

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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 hierarchical to collaborative. We have seen how the expertise and power of patients have become recognized and how the subjective experience of both patients and clinicians have come to be valued and integrated into the realm of legitimate clinical work. We have explored the 4 levels of relationship encompassed by RCC: patient-clinician, healthcare team, healthcare system-community and relationship with self. And finally, we have considered in depth four specific steps for fostering the kind of partnership and shared decision-making that are the hallmarks of Relationship-centered Care at every level.

In the rest of this book we will focus specifically on relationship-centered approaches to administration and organizational change. The case studies presented later in this book 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 will gather some additional theoretical perspectives on organizations and organizational change that will help us better appreciate and apply the insights that these stories offer.

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