HIDDEN IN PLAIN VIEW: BARRIERS TO QUALITY IMPROVEMENT

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**DESPITE A VAST AMOUNT OF KNOWLEDGE** about the technical methods of improving quality and safety in health care, rates of success have been highly variable within and across organizations. 1–7 In our work with many health care leaders and organizations, our observation has been that relational rather than technical issues are the most common barriers to improvement.

This may seem paradoxical in an industry devoted to healing relationships. But we have observed that the complexity and stress so prevalent in health care settings lead to frequent problems in working relationships at all levels of interaction: interpersonal, team, interdepartmental and interorganizational.

Multiple research studies and analyses have suggested that contextual factors (such as quality of relationships, communication, leadership style, organizational culture, team process and behaviors, etc.) are critical facilitators or impediments for change.1–15

In our review of the literature, it is difficult to pin down an estimate of the overall prevalence and impact of contextual issues on quality improvement. One confounding issue is that a wide range of contextual factors have been identified with varying definitions, reporting and measuring.1-7, 9-15 Also, the “richness” of contextual information is not readily amenable to a simple checklist approach to researching and reporting.10

Another barrier to pinning down prevalence of relational issues is that studies tend to be segmented into a variety of topic areas such as team behavior, communication, burnout or conflict. Additional segmentation occurs by type of clinical setting, different problem areas or population base — e.g., inpatient, outpatient, intensive care unit, community hospitals, academic settings, malpractice claims and adverse events.

Clarity about prevalence and impact may also be undermined by the commonality of dysfunctional and even destruc­tive personal and team behaviors in health care that makes them all too often seem like the norm and not amenable to intervention.1, 2

To better define the degree to which relational problems impede health care improvement efforts, we prepared a brief survey that was completed by 420 attendees at 1½ hour work­shops on transformational leadership given at two national quality improvement conferences in 2014.

The return rate of the survey was 50 percent of the total number of participants in the workshop. Those who completed the survey represented a wide range of disciplines including business executives, physicians and nurses. Most of them were in formal leadership positions and most worked in moderate to large sized organizations.

**RESULTS ON PREVALENCE AND REACTIONS FROM LEADERS**

88 percent of the 420 who completed the survey stated that when faced with problems in quality improvement efforts, the predominant cause is relational and not technical in a majority of cases. Relational issues were defined to include quality of communication, motiva­tion and behavior, the way leadership is expressed and meeting structures and processes.

Nearly half of those surveyed reported that relational issues in improvement efforts demand attention four times more frequently than technical issues.

92 percent answered “yes” to the statement “I am currently facing a relational problem which is having a significant impact on my work life.”

58 percent of these relationship problems had been going on for six months or longer.

This survey is, of course, only a rough estimate of the prevalence of relationship problems. The results may be skewed high by a group of people self-selected for their interest in relational issues. But a prevalence even half what we measured would still represent a major barrier to quality.

Also, the high rate we found is consistent with results from studies of adverse events that suggest that a range of 50 percent to 70 percent are due to team and communica­tion problems.15

We have discussed the survey results with many health care providers and leaders and few have been surprised. The data fit their experience. Yet they also expressed substantial difficulty even taking the time to think about, much less address, relational issues.

In the face of the powerful demands of “to do” lists and pressure to achieve results, they find that their attention becomes focused overwhelmingly on technical issues. We frequently find that leaders view relational problems as very difficult, evoking a sense of helplessness and demoralization. Leaders also seem to commonly experience a strong preference for the technical dimension of quality improvement and dismay or even disdain for the relational dimension, which is viewed as a distraction from “the real work.” These perceptions and experiences point to a deeper level of the problem.

**RELATIONAL ISSUES COMMON —** There are at least three major reasons why relational issues are intrinsic to process improvement work. The first is the need to integrate multiple perspectives to develop a full understanding of the work process. No single individual has the capacity to solve problems in complex systems. Each participant’s perspective is partial.

Understanding problems and generating creative solutions requires a group process with wide participation and open, honest dialogue that can manage differences well.16 But conflict easily arises because each person can think his or her personal view is complete and that other perspectives are wrong.

The second issue is that every change in an organization, no matter how well-justified or urgently needed, initially involves some type of loss — loss of role, competence, comfort, identity, relationships or status — especially after the old way is disrupted and before the new way is fully adopted.17, 18 People try to avoid loss when they can, and when they can’t they experience and express their grief in all kinds of ways.

The third intrinsic relationship issue is the need to gain genuine commitment, not just compliance. Compliance actually produces worse outcomes in complex tasks. Commitment is a heartfelt sense of personal ownership; it is created when people can participate directly and authentically in the development and implementation of new directions.9

The technical tools of process improvement do not adequately address these relationship issues of conflict, loss and commitment, but the technical work cannot productively proceed until these issues are resolved. This is the work of the relational dimension. To dismiss it as a distraction is to fail to understand the true nature of the work; it’s arguably a form of denial or neglect.

QUALITY LEADERS ARE WELL­TRAINED IN THE TECHNICAL DIMENSION BUT NOT THE RELATIONAL.

**AVOIDING RELATIONSHIP PROBLEMS —**Given that relational issues are intrinsic to process improvement work, why do we see them as extraneous? One driving force is a traditional bias in Western professional culture that prioritizes rationality, control and agency and devalues emotional and interpersonal dimensions of experience.20

This emphasis on the technical persists despite a large and growing body of evidence from psychological and organizational research showing the impact of relational quality on clinical outcomes, quality, efficiency, patient satisfaction and workforce health and well-being.21-24

This bias shapes the curriculum of process-improvement training programs. Quality leaders generally are well-trained in the technical dimension but not the relational. They may not have readily available opportunities to gain the advanced facilitation skills they need to help groups constructively explore differences, foster engaged participation or empathically support people through the tension and loss of change.

When one is ill-prepared for a task it tends to appear more intractable than it really is. We all prefer to avoid situations that make us feel incompetent. As a result, quality leaders may tend to dismiss the whole realm of relationship issues as extraneous. It’s an understandable form of self-justification but it’s not ultimately helpful to advancing quality. As our survey strongly suggests, too many projects stall because of unaddressed relationship issues.

Another factor that may make relational issues so daunting is the tendency to view relational and behavioral problems as fixed by personality and disposition (i.e., the fundamental attribution error) and therefore intractable.25 From this perspective, there is likely to be a lot of “low-hanging fruit” out there — situations stuck in difficulties that are amenable to intervention with already available relational skills and approaches.8, 25, 26

**WHAT ACTIONS CAN LEADERS TAKE? —**These observations led us to explore some initial interventions — a few simple explanations and recommendations — to help health care leaders take more immediate action to resolve relational problems.

In the leadership workshops in which the surveys were completed, we recommended two steps. The first was to respond to any problem by stepping back to reflect and recognizing the normalcy and sources of seemingly counterproductive behaviors. They often serve legitimate needs. This helps us to avoid making sweeping adverse judgments about others (and ourselves) that have harmful relational consequences and add to the dysfunction. It also diminishes our feeling of helplessness, opening the way for specific, concrete constructive actions.

The second step is to set aside the push to move too quickly to solutions and instead create the opportunity for “dialogue” (defined as eliciting many points of view and ensuring that everyone is heard).16, 26 - 28

Dialogue requires everyone to move beyond win-lose debates, to suspend certainty about their own beliefs and curiously and openly explore disagreements. This can prevent many relationship difficulties that arise from misinterpretations and faulty assumptions about each other that are not checked out.

In the survey, we also asked whether participants felt, based on the brief explanations and tips given in the workshop, that they could take a step toward action on a difficult relational problem in the next week. Ninety-two percent said yes.

**ENHANCING THE TRANSFORMATION —** Reflection on situations and dialogue are not easy to implement. With all the time pressures, even taking time for reflection requires rigorous, intentional practice. Work situations commonly generate strong emotions and convictions that predispose us more toward debate than seeking mutual understanding through dialogue.

The move toward curiosity and openness to differing views requires the capacity for emotional self-regulation and a reasonable tolerance for ambiguity. But it results in deeper understanding, more robust agreement for collective action and, ultimately, better quality.

These challenges notwithstanding, a few workshop participants have contacted us with stories of sudden breakthroughs with relationship problems that had been going on for more than a year. Of course, not all relational difficulties can be solved easily and quickly. Our experience is that the majority of them take time, persistence, determination, and sometimes more advanced skills. Addressing them takes courage and commitment but prevents enormous waste and enables greater success in quality improvement down the road.

Habits of thinking and action are not broken overnight. In health care, we have a long way to go to break our habit of marginalizing relational knowledge, skills and practice. The key ingredients are patience, persistence, courage and compassion for our innately human way of falling into counterproductive behavior under stress.

Paradoxically, by recognizing this less rational side of our humanness and addressing it with compassion, we greatly enhance the chances for transformation.

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