

Organizational Dimensions of Relationship-centered Care

Theory, Evidence, and Practice

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Four domains of relationship have been highlighted as the cornerstones of relationship-centered health care. Of these, clinician-patient relationships have been most thoroughly studied, with a rich empirical literature illuminating significant linkages between clinician-patient relationship quality and a wide range of outcomes. This paper explores the realm of clinician-colleague relationships, which we define to include the full array of relationships among clinicians, staff, and administrators in health care organizations. Building on a stream of relevant theories and empirical literature that have emerged over the past decade, we synthesize available evidence on the role of organizational culture and relationships in shaping outcomes, and posit a model of relationship-centered organizations. We conclude that turning attention to relationship-centered theory and practice in health care holds promise for advancing care to a new level, with breakthroughs in quality of care, quality of life for those who provide it, and organizational performance.

KEY WORDS: Organizational culture; health care teams; quality of care.

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Four domains of relationship have been highlighted as the cornerstones of relationship-centered health care.¹ These are: clinician-patient relationships; clinician-colleague relationships; clinician-community relationships; and clinicians' relationships to self. Relationship-centered health care denotes an approach that recognizes the importance and uniqueness of each health care participant's relationship with every other, and considers these relationships to be central in supporting high-quality care, a high-quality work environment, and superior organizational performance.

Of the 4 relationship domains that comprise the model, clinician-patient relationships have been most thoroughly studied, with several decades of attention to both the development of detailed, reliable measures, and the application of these measures to identify organizational and individual characteristics that contribute to clinician-patient relationship quality, and evaluating the influence of relationship quality on outcomes. A rich empirical literature illuminates significant linkages between clinician-patient relationship quality and a wide range of outcomes. These include health outcomes—such

as patients' adherence to clinical advice,^{2–6} symptom relief, and improvement of both clinical and functional status^{6–11}—as well as “business” outcomes such as patient retention and loyalty,¹² and malpractice risk.^{13–15}

By contrast, the other 3 domains of relationships posited by the model¹ have been relatively unstudied. This paper explores the realm of clinician-colleague relationships—which we define to include the full array of relationships among clinicians, staff, and administrators in health care organizations. Building on a stream of relevant theories and empirical literature that has emerged over the past decade, we synthesize available evidence on the role of organizational culture and relationships in shaping organizational outcomes, and posit a model of relationship-centered organizations. Our goals in this paper are to: illuminate the principles of relationship-centered health care organizations; synthesize available evidence concerning outcomes associated with the quality of clinician-colleague relationships; and motivate attention to this realm of relationship in both research and practice. We begin by positing 2 scenarios in health care organizations: one illuminating the principles of relationship-centered organizations at work; and the other highlighting the absence of those principles.

RELATIONSHIP-CENTERED ORGANIZATIONS AT WORK—OR NOT: 2 SCENARIOS

Scenario 1

It is Wednesday morning, and Dr. Larry Pantrof is seeing the seventh of 13 patients in his busy primary care practice. As part of his practice group's decision to be more patient-centered, the practice leader, Dr. Mary Slade, has implemented routine patient surveys with quarterly reports to each clinician on his or her performance. Between patients, Dr. Pantrof glances at this quarter's report and sees that his results are still below the group average in several areas, including patient communication and trust. What is more, despite the financial incentives to improve, his results have steadily slipped over the past 18 months. Commitment and motivation to deliver the best possible care are not the problem. Dr. Pantrof is a sincere, dedicated physician who wants to do the best possible job for his patients. He sighs and thinks about the invitation he recently received to join the staff of a large pharmaceutical company, making 3 times his current salary.

At noontime, Dr. Pantrof settles into a chair in Dr. Slade's office for their quarterly meeting to go over the most recent performance data, including the patient survey results. In a now-familiar discouraged tone, Dr. Slade points out the downward slide in Dr. Pantrof's results and reminds him of the organization's commitment to providing patient-centered care and the pressing need to grow the practice. “You know,” she

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says, “the organization is continually subsidizing our practice’s losses, and I’m not sure how long they can do it!” He hands Dr. Pantrof a brochure prepared by their outside consultant and he spots a bulleted list of practical recommendations like opening each visit with a personal greeting and making good eye contact with patients. He returns to his office to prepare for his afternoon clinic. There are 16 patients scheduled and the first 2 are waiting. Feeling quite alone and almost hopeless, Dr. Pantrof’s eyes drift across the office landscape as he wonders if there is any help in sight.

Scenario 2

Clinton Heights Individual Practice Association (IPA) is a communitywide physician organization. Its largest contract is with Stanton Health Plan (SHP), 1 of 3 large insurers serving the area’s major employers. This year, the employers have formed a coalition and are demanding that SHP and each of the area health plans develop and implement a “pay-for-performance” program under which physician payment will be based partially on measures of quality and cost. Stanton Health Plan recognizes that it needs to consider carefully how to meet the employers’ demands without antagonizing its clinicians. The plan’s leadership is aware of litigation in which a nearby IPA has filed for an injunction against a leading health plan to prevent implementation of a similar pay-for-performance program. The SHP leadership decides that the only way to avoid this fate—and to honor the plan’s mission of ensuring the highest quality medical care at an affordable price—is to work collaboratively with the Clinton Heights IPA in developing its pay-for-performance program.

Stanton Health Plan establishes a working panel comprised of plan leadership and 7 clinicians selected by the Clinton Heights IPA to represent the network. The panel has a 5-month timeframe to develop the pay-for-performance program. At the first meeting, Dr. Lois Murray, the SHP chief medical officer and chair of the panel, tells the assembled leaders their charge. She adds that nationally, the trend toward pay-for-performance is increasing and that refusing to participate will result in the loss of business from the entire employer coalition. She invites the leaders to work with her to create the most meaningful, fair, and forward-looking pay-for-performance program possible. The leaders spend some time expressing their anger and frustration about the unraveling of medicine. They voice their resentment about society’s failure to appreciate the complexity of clinical medicine, and the failure of the public to recognize that professionalism has always been a sufficient safeguard for ensuring high-quality care. They recount a long list of methodological problems with comparing quality across clinicians and groups whose patient mix, they say, are too different to be compared, and for which, they hold, available data are highly inaccurate.

Dr. Murray listens carefully to their concerns and lists them on a flip chart. She asks, “Given these concerns, what should we do?” The group discusses the issues for a time and recommends that a subgroup explore what is being done elsewhere and report back. Over the next 5 months, the panel sketches out a program that incorporates findings from other communities. On the basis of the evidence gathered, they set realistic expectations for clinician performance, develop a communication plan, and begin to inform the practitioner community, allowing time for discussion and the expression

of the natural emotions to surface as part of the process of introducing significant change. Listening, responding to the expression of feelings, respecting the turbulence engendered in change, and engaging partners as respected equals result in a program that is viewed by most clinicians throughout the IPA as acceptable. The program is implemented later that year.

EMPIRICAL EVIDENCE LINKING OUTCOMES TO ORGANIZATIONAL CULTURE AND RELATIONSHIPS

What will happen when Drs. Pantrof and Slade, or Clinton IPA clinicians return to their practices and begin working to change processes and behaviors? Is there a theory of relationship-centered organizations and administration that can help guide their next steps? What does the research literature suggest about relationship-centered health care organizations and the extent to which clinician-colleague relationship quality contributes to organizational outcomes?

Compared with the rich literature on clinician-patient relationship quality and its impact on outcomes, the quality of clinician-colleague relationships remains relatively unstudied. The relative paucity of measures for evaluating clinician-colleague relationships and organizational culture signifies the fact that this area has largely been a blind spot in the health care quality field until recently. Attention to reducing medical errors and improving patient safety—spurred by the Institute of Medicine (IOM) report “To Err is Human”—has begun to increase attention to this area.¹⁶ The IOM report underscored that medical errors are almost never a result of individual clinicians or clinical incompetence—but rather, are due largely to bad systems. This assertion was widely interpreted to mean that improved technology and enhanced information infrastructures would be the solution to medical errors and the path to improving safety in health care. However, early evidence with technology-based solutions has underscored the fact that systems alone cannot solve the problem of medical errors or dramatically improve patient safety.^{17,18} The role of human factors and of well-integrated, highly functioning clinical teams has emerged as essential to accomplishing the intended improvements. Recent work and commentaries highlight the fact that medical errors are largely a result of failed communication among clinical teams.^{19–24} Here, the parallel to the commercial airline industry has been underscored several times—but bears mention.

Aviation was ahead of health care in its recognition of the central role of human factors in producing safety—and more specifically, the importance of highly functioning teams with explicitly defined and shared goals and ongoing effective communication. In 1977, a large-scale study of the commercial airline industry found that 70% of accidents could be traced to failures of communication among crew members.²⁵ A year later, a sentinel event involving the crash of United Airlines flight 173 proved to be a tragic case in point in which communication failures among flight crew members led to a disaster that could have been averted.²⁴ What followed was the formalization of requirements for human factors’ training in aviation and a revolution in aviation culture and work environments. Interestingly, the Joint Commission on Accreditation of Healthcare Organizations recently reported that 60% of sentinel events in health care are because of communication failures.²⁶

Concerns about patient safety and medical errors are 1 important set of factors motivating attention to organizational

culture, relationships, and teamwork. In addition, a small but compelling empirical literature highlights other important advantages of highly functioning teams. To date, most research on health care teams has focused on environments characterized by high risk, and tasks that involve extreme time sensitivity and high interdependence, e.g., anesthesia and surgery. It is in these environments that the importance of teams and the potential benefits of improved team functioning have been most obvious—the “low hanging fruit” for intervention and for study. The outcomes associated with high-quality teams include the following:

Reduced Mortality

Several hospital-based studies have found that highly functioning care teams are associated with significantly reduced patient mortality. For example, Aiken et al.²⁷ found 5% lower risk-adjusted mortality rates among Medicare beneficiaries cared for at 39 hospitals characterized by highly collaborative work environments compared with 195 hospitals chosen as matched controls. Similarly, a prospective study of intensive care unit (ICU) patients at 13 tertiary care hospitals found that the level of interaction and coordination among the ICU staff was significantly associated with favorable risk-adjusted mortality outcomes.²⁸ Likewise, a study of collaboration between nursing staff and residents on a medical ICU (MICU) found that the risk of negative outcomes to patients was significantly associated with nurses' assessments of collaboration ($P=.02$)—with 16% risk when nurses reported “no collaboration” and 5% when “full collaboration” was reported.¹⁹

Among the largest reported effects of teamwork on mortality risk is an observed 56% reduction in risk-adjusted mortality among cardiac surgery patients after introduction of a new “interdisciplinary care team” model. The interdisciplinary care model included a structured collaborative communication protocol and included daily rounds conducted at each patient's bedside and attended by every member of the care team, the patient, and available family members.²⁹ Finally, in a review of emergency department malpractice cases, Risser et al.²¹ concluded that more than half of the patient deaths and permanent disabilities could have been avoided if more highly integrated, high-functioning teams had been in place.

Improved Functional Health Outcomes

Better functional health outcomes for patients have also been associated with highly integrated care teams. Gittel et al.³⁰ studied the outcomes of patients undergoing total hip and knee arthroplasty at 9 hospitals in Boston, MA; New York, NY; and Dallas, TX, and found that better “relational coordination” among the care teams was significantly associated with reduced postoperative pain ($P=.04$) and increased postoperative functioning ($P=.04$) reported by patients. “Relational coordination” was defined as: frequent, timely, accurate communication along with shared goals, shared knowledge, mutual respect, and problemsolving. Likewise, in a study of 3,045 patients undergoing coronary artery bypass graft surgery at 16 hospitals, Shortell et al. found that a team culture was significantly associated with both processes and outcomes of care. With respect to process, a supportive culture was associated with shorter postoperative intubation times ($P=.01$) and longer operating room times ($P=.004$). In terms of outcomes, a supportive cul-

ture was associated with a higher patient functional health status (physical and mental) 6 months after surgery ($P<.01$).³¹

Shorter Length of Stay (LOS)

Several studies have found improved team functioning to be associated with increased efficiencies of care—particularly reduced LOS, but also shorter on-site waiting times. Gittel et al.³⁰ found relational coordination to be a highly significant correlate of LOS—with a 1-point improvement in relational coordination (5-point scale) associated with a more than 50% decrease in LOS. Moreover, relational coordination accounted for 81% of between-hospital variation in LOS, while only one-quarter of the variance was accounted for in statistical models excluding relational coordination. Similarly, in a large study of ICU patients at 42 hospitals, Shortell et al.³² found that the quality of caregiver interactions—including culture, leadership, coordination, communication, and conflict management—was significantly associated with shorter risk-adjusted LOS. Argote³³ showed that coordination among emergency department staff at 30 hospitals significantly reduced waiting times for patients attending the emergency care units.

Workforce Morale and Turnover

The links between workplace quality—particularly the presence of a positive, collaborative culture—and staffing outcomes (including burnout, turnover, and staff satisfaction) have been more widely studied than other organizational outcomes. Outcomes among nursing staff have been particularly widely documented, with numerous studies demonstrating a significant association between a collaborative culture and rates of nursing burnout and turnover.^{27,32,34,35} An effect of improved workforce satisfaction that generalized across disciplines was found by Uhlig et al.²⁹ with the shift from a traditional rounding model to the interdisciplinary care model described above.

Importantly, several studies have revealed that perspectives on the degree of collaboration and the quality of teamwork differ markedly across disciplines—at least in the absence of structured efforts to design highly integrated and collaborative team structures and processes. For example, in the study of nurse-resident collaboration by Baggs et al.¹⁹ nurses and residents had highly discordant views about the degree of collaboration between them ($r=.10$), and while nurses' assessments of collaboration were significantly associated with patient outcomes, residents' assessments were not. Likewise, Sexton et al.²² found highly discordant views about the degree of interdisciplinary teamwork among members of surgical and ICU teams at 12 urban hospitals in the United States and 4 other industrialized nations. Among surgical teams, high levels of teamwork were reported by 64% of surgeons and 74% of surgical residents, but only 10% of anesthesiologists, and about one-quarter of nurses shared their views. Similarly, among ICU teams, physicians were nearly twice as likely as nurses to report high teamwork (77% vs 40%). Moreover, one-quarter of the surgeons and one-fifth of the surgical residents reported that junior team members should not question the decisions made by senior team members. By contrast, 84% of anesthesiologists disagreed with this perspective. The field of anesthesia has been held out as the “bright light” of hope for culture change in health care as it has gone through a cultural revolution similar to that described in aviation, and has assumed vastly dif-

ferent attitudes, rules, and protocols concerning hierarchy, communication, and teamwork.²⁴

FROM EVIDENCE TOWARD A MODEL OF RELATIONSHIP-CENTERED ORGANIZATIONS

The empirical evidence summarized above demonstrates a significant role for organizational culture and relationship quality in organizations' financial, clinical, and operational performance. The core features of a high-functioning organizational culture, as reflected in the literature include: facilitative leadership, shared goals and expectations among clinicians, staff and administrators, a context of mutual respect, shared knowledge as the foundation for interactions, and effective conflict management and problem-solving strategies.

While there is not yet a similar body of outcome-based evidence from ambulatory care settings, there is a growing observational literature on primary care practices that seeks to understand and characterize the nature of clinician-colleague interactions, organizational structures, processes and culture, and learn how these contribute to organizational performance. We summarize the key findings from this literature, and then draw upon the combined observational and outcome evidence, together with recent advances in organizational theory, to propose a model of relationship-centered organizations.

Observations About Organizational Functioning from Primary Care Research

One of us (W.L.M) is part of a multidisciplinary research team that has conducted several mixed methods, in-depth descriptive, and intervention studies of primary care practices over the past 11 years. The studies yield a mix of qualitative and quantitative data that inform our model of relationship-centered organizations. Qualitative data include: participant observation; key informant interviews in all areas of a practice; and direct observation of clinical encounters. Quantitative data include results from surveys of staff, patients, and clinicians, chart audits, and other varied measures.³⁶

In the late 1990s, the Direct Observation of Primary Care study highlighted the importance of competing demands in primary care and introduced the notion of practices as self-organizing complex adaptive systems.³⁷⁻³⁹ The Prevention and Competing Demands study further corroborated the complex adaptive systems framework, and highlighted the particular importance of mindfulness and feedback in reciprocal interactions.^{40,41} These 2 descriptive studies informed the Study to Enhance Prevention by Understanding Practice (STEP-UP), where individualized approaches to practice change were used and led to sustainable improvement in the delivery of preventive services.⁴² Next, a postintervention descriptive study of the STEP-UP practices, entitled Insights from Multi-method Practice Assessment of Change over Time, showed the importance of facilitative leadership, quality relationships, and capacity for problemsolving or sensemaking for assuring positive sustainable practice improvement.⁴³ Finally, in the intervention study entitled, Using Learning Teams for Reflective Adaptation, the following 7 relationship qualities that seem to differentiate thriving practices from others were identified: mindfulness, diversity of mental models, heedful interrelating, a mix of rich and lean communication, a mix of social and task-related interactions, mutual respect, and trust. Measure-

ment tools for these relationship qualities are currently being developed and tested, and trials relating their effect on clinical and organizational outcomes have begun.⁴⁴

- *Mindfulness* refers to organizational and employee awareness of self and others, of relationships, and of what is happening elsewhere in the organization, along with openness to new ideas and different perspectives (emotional intelligence).⁴⁵
- *Diversity of mental models* refers to valuing of multiple, varied ways of thinking and efforts to capitalize on these to enhance group problemsolving and creativity.⁴⁶
- *Heedful interrelating* occurs when individuals' interactions are rooted in ongoing awareness of how their work and that of others contribute to practice goals.⁴⁷
- *A mix of rich and lean communication* implies an appropriate mix of rich face-to-face communication for uncertain, emotionally charged issues, and more lean impersonal communication such as e-mail for clear, simple messages.⁴⁸
- *A mix of social and task-related interactions* indicates that conversations appropriately include a blend of social and task-related discourse such that some are typically personal and social and based on friendships outside of work and others are specific to work functions.⁴⁹
- *Mutual respect* is demonstrated when behavior observed up, down, and across the organization is characterized by honesty, tactfulness, and valuing of each other's contribution.⁴⁷
- *Trust* represents the judgment that others in the practice are capable and committed and that one can risk being vulnerable in the presence of peers.⁵⁰

These 7 relationship qualities are interdependent and mutually reinforcing and help to create a supportive and collaborative organizational culture with a greater capacity for problemsolving and continual learning. Each has also been described in the organizational literature. The qualities appear vital to the financial, operational, and clinical success of primary care practices.

A Proposed Model of Relationship-centered Organizations

There are many theories about the structure and functioning of organizations.⁵¹⁻⁵³ While no prior theory has focused explicitly on relationship-centeredness and its effects on organizational performance, there are several streams of theoretical work from the organizational and management literature that similarly emphasize the importance of relationships and collaborative culture in organizational success. They underscore the importance of understanding organizations as complex adaptive systems characterized by emergence, self-organization, co-evolution, and nonlinearity^{54,55}; as complex responsive processes of relating^{56,57}; as learning organizations^{58,59}; or as webs of collaborative conversations.⁵⁰

After reviewing these theoretical streams and considering available empirical evidence, 5 themes emerged as central to a model of relationship-centered organizations. These are illustrated in Figure 1. First, a model of relationship-centered organizations recognizes that at the core of every organization, giving the organization its particular life and character, is its *web of relationships*. The web of relationships refers to the particular patterns and qualities of relating within an organization. Relationship-centered organizations pay attention to these patterns

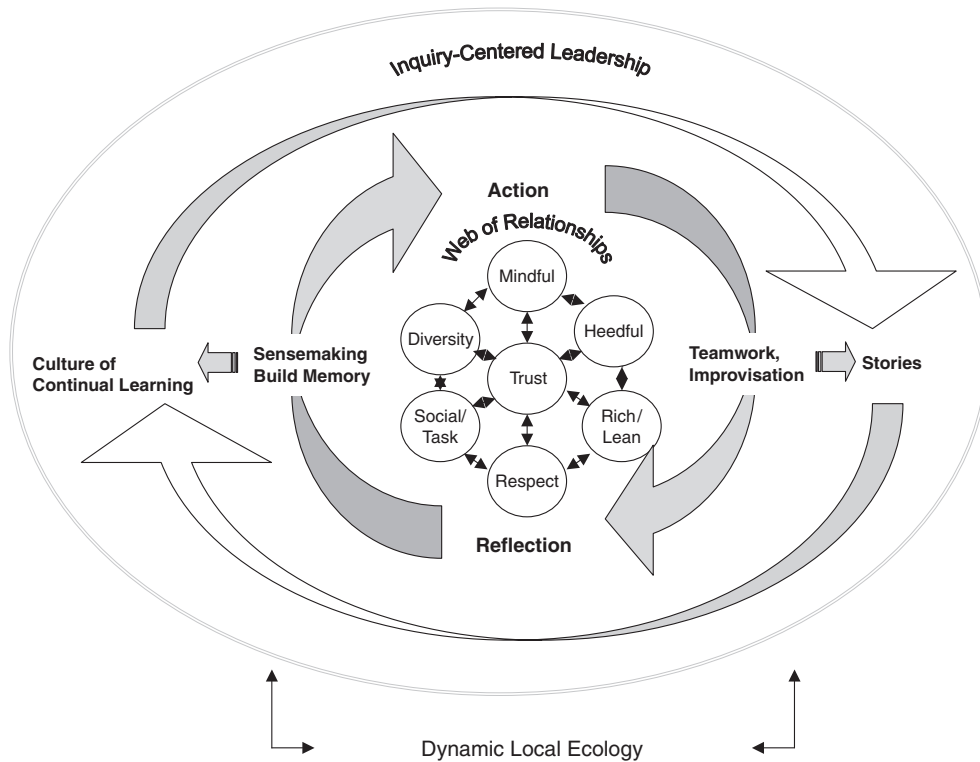


FIGURE 1. A model of relationship-centered organizations.

and qualities and recognize that they are the essence of the organization, holding the potential for what the organization or medical practice can accomplish. The center of Figure 1 depicts the 7 relationship characteristics noted above. These characteristics form the core of our proposed model of relationship-centered organizations. To understand an organization and consider its capacity for change, it is necessary to assess the extent to which its web of relationships exhibits these qualities.

The web of relationships forms the basis for an organization's *action* and for *cycles of reflection*. Action is the easy part as this is what all organizations and practices are about. What is often missing, particularly in very busy medical practices, is dedicated time for reflection. This is a time when teams can identify and solve problems, share knowledge, and fortify relationships. The work of building teams and group memory can enhance collective and individual thinking⁶⁰ and inform creative solutions as circumstances arise in the rush of daily practice.

Action/reflection cycles nurture the development and maintenance of a supportive, collaborative *culture of continual learning* that contributes to, and is reinforced by, emerging conversations and *stories* of change, stability, and problem-solving. An organization's stories reveal its identity and values.⁶¹ Successful practices and health care organizations appear to recognize that change is a given. They understand that every element of the organization—from its patients, staff, and bureaucracies to the illnesses presented and the clinical knowledge base it relies on—are continually changing and presenting new challenges. Stories of past changes, if harnessed properly, represent a cultural storehouse for learning, and an important source of resilience and of building capacity for organizational change. Relationship-centered organizations recognize this and use stories purposefully to help shape their continued growth and evolution. If one were to observe a rela-

tionship-centered practice, it might appear to be like a superb jazz ensemble.⁶² Everyone gets their moments to solo with creative accompaniment, well-executed passing off, and attention to the rhythms of action, contemplation, and relationship.

Next, our model of relationship-centered organizations recognizes the importance of *inquiry-centered leadership*.⁵⁰ This style of leadership, also referred to as facilitative, servant, or adaptive leadership, pays particular attention to asking questions, encouraging others to ask questions, facilitating conversations, and welcoming many viewpoints. In other words, inquiry-centered leadership models and motivates the 7 key relationship characteristics and creates time and space for reflection.

Finally, relationship-centered organizations are mindful that they are rooted in a particular place and that they thrive by continually interacting with a *dynamic local ecology*. Relationship-centered health care organizations pay special attention to the communities and local circumstances of their patients, as well as those of their employees and their families.

CONCLUSIONS

The elements of our proposed model of relationship-centered organizations suggest that if one wishes to change an organization and its culture, one must understand and potentially alter its web of relationships to enact the 7 relationship characteristics, develop and sustain inquiry-centered leadership, and implement regular action and reflection cycles.

What does this mean for Drs. Pantrof and Slade and the Clinton IPA as they seek to change their organizations' culture and behavior? The Clinton IPA and SHP interactions already exhibit many of the characteristics of the proposed model of relationship-centered organizations. Together, they produced favorable results that seemed implausible at the outset, given

the opposing views of the 2 organizations. They met together and purposefully used structures and processes of collegiality, shared-visioning, and partnership to address the task at hand. The crucial roles of communication, inquiry, listening, and conflict management are clear. They modeled the key relationship qualities and developed new stories describing the desired changes. And they participated in the local ecology, exploring and connecting with other possible stakeholders in their community.

By contrast, key elements of relationship-centeredness were notably absent from the interactions of Drs. Pantrof and Slade. Dr. Pantrof left their meeting feeling dejected and defeated rather than energized and empowered. If anything, his interactions with patients that afternoon and in the following days were likely to have been negatively affected by his interaction with Dr. Slade as he sank deeper into a sense of being driven to produce something that has been externally imposed. A different scenario is possible. As a practice leader, Dr. Slade might receive training in inquiry-centered leadership, including techniques for group facilitation and collaborative problemsolving.⁶³⁻⁶⁶ She might have created small teams in each practice comprised of clinicians, front-office staff, and clinical staff, who meet weekly and whose function is to formalize the reflection-action process. Initially, with the help of a facilitator, these teams might become adept at communication and problem-solving skills that foster a collaborative learning culture characterized by the 7 relationship qualities noted above. As a member of one of the teams, Dr. Pantrof might be found contributing to practice initiatives that, over time, improve the quality of his patient interactions, the quality of his professional life, his interactions with colleagues, and ultimately, the organization's performance.⁴⁴

In summary, a relationship-centered theory of organizations stands classic organizational theory on its head. Classic organizational theory holds an underlying premise that life and organizational circumstances can be controlled and tamed; that individuals are independent and autonomous actors even when they function in a group; that final knowledge and truth are attainable; and that rational knowing is best. A relationship-centered framework of organizations, drawing from recent advances in organizational theory, acknowledges the complexity and unpredictability of life and circumstances. It recognizes that for human beings, there is no true separation—only interdependence. It embraces a view that through collective thinking and effort, there are innumerable good ways of reaching particular goals, and it does so in ways that empower, energize, and enliven the organizational community.

Cast in this light, both the theory and available evidence suggest that meaningful progress toward relationship-centered health care must not only attend to the settings in which clinicians practice but also to the settings in which they are educated and trained. Present training, particularly of physicians, stresses individual responsibility and achievement—embedding a deeply held view that excellence is achieved through individual flawlessness in clinical knowledge, judgment, and skill.⁶⁷ In other words, training currently mirrors classic organizational theory.

Both the proposed model of relationship-centered organizations and empirical evidence supporting its benefits highlight the fact that neither individual excellence nor technology-based solutions alone will yield desired breakthroughs in quality or safety. Rather, the theory and evidence highlight the importance of attending to relationships as part of the foundation of an or-

ganization—as fundamental to its functioning and potential as its information systems and other infrastructure components—and equally in need of continual monitoring and attention. Future research can help to illuminate the mechanisms through which human interaction quality is linked to valued organizational outcomes, and identify specific characteristics and features of organizations that give rise to relationship-centered culture. In the meantime, available evidence suggests that relationship-centered theory and practice in health care offer the potential for breakthroughs in quality of care, quality of life for those who provide it, and organizational performance.

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