The influence of health care organizations on well-being

INTRODUCTION

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.\(^{1(68)}\)

Within health care 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 article is to call attention to these internal factors to enable people involved with health care 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, and observers—anyone, in fact, 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, and
- 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, yet powerful, dynamic is also at work: Organizations selectively direct our attention toward some phenomena and away from others. This determines what we perceive, which then affects our interpretations, expectations, and behavior. They in turn affect 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 person’s evolving matrix of experience, values, and meaning, but we can get a sense of it from the convergence of 3 different approaches. Self-determination theory identifies 3 basic psychological needs of individuals: competence, autonomy, and relatedness. These are similar to the hierarchy of needs—self-actualization, esteem, “belongingness,” and love—identified by the psychologist Abraham Maslow.4 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.5 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.6

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.7

We are now ready to consider how health care organizations affect individuals’ well-being. In light of the definitions above, we can state the question as: How do organizational conversations in health care 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 health care 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 2 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—thereby 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 health care 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.11

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 responsibility 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.”12 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.3,13

THE “PATHOLOGIZING” GAZE
A third aspect of organizational conversations in health care 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 what is working well. Most attention is directed toward 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 less than they could be.

ALTERNATIVES FOR HEALTHY ORGANIZATIONS:
A PERSONAL NARRATIVE
So far, this article has 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 a 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 nationwide 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.”14,15 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 while we all were drumming on pots and plastic containers after returning home from a performance of African dance
that an idea suddenly emerged: Howard could 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 it 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 start, speaking openly about his nervousness about 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 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 improving 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, and supported by ongoing reflection and attention to process. And it worked. We all experienced a 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.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.6 Although leaders have more leverage, other individuals can also influence the conversation through their own words and behavior. Other specific activities that may foster constructive organizational conversations are shown in the box.

Leland Kaiser recently offered an inspiring description of the spiritual nature of health care organizations and leadership.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 health care organizations to foster such experience, what justification is there for an organization to do anything less?

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References

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