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Up close and (inter)personal: Insights from a primary care practice's efforts to improve office relationships over time, 2003–2009

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Abstract

A growing body of literature suggests that interpersonal relationships between personnel in health care organizations can have an impact on the quality of care provided. Some research recommends that the fundamental practice transformation that is being urged in this current climate of health care reform may be aided by strong interpersonal practice relationships and communication. There is much to be learned, however, about what is involved in the process of addressing and improving interpersonal relationships in primary care practices (PCP's). This case study offers insights into this process by examining one PCP's efforts to address interpersonal office issues over the course of its participation in two back-to-back quality improvement (QI) intervention studies. Our analysis is based on extensive qualitative data on this practice (observational data, interviews, and audio-recorded QI meetings) from 2003–2009. By tracing common themes and patterns of interaction over an extended period of time, we identify a variety of facilitators of and barriers to addressing interpersonal issues in the practice setting. We conclude by suggesting some implications from this case for future QI research.

Keywords

interpersonal relations; interpersonal communication; quality improvement; organizational change; case study

INTRODUCTION

In this climate of health care reform efforts, primary care practices (PCP's) are being urged to redesign their delivery systems^{1–3} Some of the major themes in the practice transformation discourse revolve around increased “collaboration, coordination and movement of information to maximize patient care.”⁴ These types of changes, which are encouraged in the broadly endorsed patient-centered medical home (PCMH) model of practice transformation, require a sweeping re-imagination of entire practice systems and practice roles.^{5–7} To achieve such a vision of change, Nutting et al.⁸ underscore that “creat[ing] a strong communication and relationship infrastructure ... is paramount to transformation success.”

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Attending to interpersonal relationships in the practice setting is additionally supported by a growing body of research that suggests that the quality of interpersonal office relationships can impact the quality of care provided^{9–18}. Included in this body of work are studies that specifically link interpersonal factors with a variety of desired organizational or clinical outcomes. For instance, Stevenson et al.¹⁹ find an association between the perception of good team work and successful improvement in diabetes care. Hung et al.'s²⁰ study associates participatory decision-making with higher productivity and lower staff turnover. Nembhard and Edmondson²¹ find that a sense of psychological safety mediates an association between inclusive leadership style and greater engagement in quality improvement initiatives in the practice setting. And, Risser et al.²² find that medical errors can be reduced through improved teamwork.

While such research contributes to the evidence that systematically working on interpersonal relationships can be a valuable practice investment, much of this research does not illuminate what is involved in the process of working to improve interpersonal relationships within the practice setting. This may be, in part, because such change processes can require considerable time, longer than most studies allow. As Pettigrew²³ argues, much research on organizational change is limited by “snapshot time-series data” which encourage studies to focus on “the intricacies of narrow changes rather than the holistic and dynamic analysis of changing.” He therefore recommends analyses that consider both “temporal and contextual” factors, noting that there are “remarkably few studies of change” that do so in a substantial way. Miller et al.²⁴ similarly argue – in their efforts to study primary care practices as complex adaptive systems – that “[f]uture research needs to include more in-depth case studies of practices over time.” Because they understand practices to be “much more than a set of independent variables influencing some dependent variables,” they suggest methodology that is sensitive to the interdependent parts of the system that evolve in nonlinear ways over time.

Our analysis is able to reap the analytic benefits of this methodological approach by taking advantage of extensive qualitative and longitudinal data on a single PCP that participated in two, back to back QI interventions from 2003–2009. Both of these intervention studies shared the philosophy that the quality of interpersonal relationships can impact the quality of care as well as the practice improvement process. This case study thus offers a nuanced examination of the process involved in one practice's efforts to address its interpersonal issues in the context of these consecutive interventions and suggests some provisional consequences of these efforts. We conclude by identifying a variety of facilitators and barriers to these interpersonal change efforts and suggest some implications from this case for future quality improvement (QI) research.

METHODS

The data come from two 5-year QI intervention studies conducted by the Department of Family Medicine at The University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School.

Study Descriptions

The first QI intervention, Using Learning Teams for Reflection and Adaption (ULTRA), was funded by the National Heart Lung and Blood Institute from 2002–2008. Sixty PCP's throughout New Jersey and Eastern Pennsylvania were randomized into either an intervention or delayed-intervention (control) group. The aim of this study was to improve patients' adherence to clinical guidelines for multiple chronic medical conditions by improving physician/staff working relationships and enhancing patient care processes. The goal of the second intervention study, Supporting Colorectal Cancer Outcomes through

Participatory Enhancements (SCOPE), was to improve colorectal cancer screening rates. Twenty-five New Jersey PCP's participated in this 5-year (2005–2010), National Cancer Institute-funded study and were randomized into intervention and delayed-intervention (control) groups.

Both interventions utilized the “MAP/RAP” model of practice improvement.^{25–27} For the Multi-method Assessment Process (MAP) the facilitator-researcher spent 3–7 days observing practice operations and relationships, interviewing practice members, and developing rapport with practice members. These observations were followed by a Reflective Adaptive Process (RAP) that involved up to 12 facilitated team meetings with representatives from different functional areas of the practice. The facilitators' role included guiding the team in choosing a focus for their improvement efforts, encouraging reflection and open communication, and supporting the team's implementation and monitoring of their improvement plan.

The study design for both interventions was informed by the theoretical assumption that practices are complex adaptive systems.^{24, 28–29} From this perspective, the practice is viewed as a web of relationships in which interconnected agents interact in unpredictable ways that contribute to organizational change. The RAP approach allowed for the intervention to be tailored to the unique conditions, cultures, and goals of the practice. To assess change over time, each study had one-day follow-up practice assessments at 6 months post-intervention, and then annually for up to 3 years. (See table 1 for study timelines).

These two intervention studies were approved by the University of Medicine and Dentistry of New Jersey's Institutional Review Board. The names of the practice and participants have been changed to protect confidentiality.

Data collection

The ULTRA qualitative data included audio recordings of the RAP meetings and depth interviews from MAP as well as the facilitator's fieldnotes of observations, depth interviews, and follow-up assessments. For SCOPE, qualitative data included audio recordings of RAP meetings as well as fieldnotes of the RAP meetings and practice observations. Approximately 200 pages of Word document fieldnotes and 18 hours of audio-recorded RAP meetings and interviews were collected from this practice over the course of the two studies.

Data Analysis

Analyses were conducted by a multidisciplinary team of analysts: the lead author (JH) was the facilitator for this practice in the SCOPE intervention; the second author (EKS) was the director of the SCOPE study and also conducted follow-up assessments in this practice for the ULTRA study; the third author (EC) was a member of the SCOPE study research team who participated in weekly meetings to offer clinical guidance and support to facilitators; the fourth author (BC) was the principle investigator for both studies.

We approached this analysis through an immersion/crystallization process³⁰. The first two authors (JH and EKS) conducted the primary analysis of the data, reading fieldnotes and listening to audio recordings together to begin identifying recurring themes and patterns of interaction by triangulating similar comments from multiple practice members and the facilitators' recorded observations. Through an iterative process, major themes were identified across the two interventions and a code list was developed and then used to code all the textual data. Disagreements were resolved through discussion. The relationships between these codes were explored through the SCOPE and ULTRA data sets. Quotations and examples were then selected to illustrate the patterns observed in the data. The other two

authors (EC and BC) were enlisted to check our interpretation and to refine the analysis through their critiques. As a member check, a draft of the paper was then shared with the lead physician in the practice under study to request her input.

RESULTS

Setting

The practice studied was a physician-owned primary care practice, located in an upper middle class town in New Jersey. It was a solo-practice for several years, but by the start of the ULTRA study it had 3 physicians and 12 staff; at the beginning of the SCOPE study, there were 5 physicians and 9 staff members. All physicians and several of the staff worked part-time. Throughout both studies, the patient volume was approximately 250 office visits per week.

Findings

Two interpersonal issues were raised as problematic by various practice members during both the ULTRA and SCOPE interventions: tension between the front staff and the lead physician, and poor office communication. These issues surfaced through confidential interviews with practice members, open discussions during RAP meetings, and in the course of the facilitators' observations. We draw on the ULTRA data primarily to illustrate the practice's initial conditions with regards to these issues and rely on the SCOPE data to elaborate on these conditions and the extent to which they changed over time.

Initial Conditions: ULTRA Data

Tension between the front staff and the lead physician: At the start of ULTRA, the issue of tension between the front staff and the lead physician surfaced as one of the practice's problematic issues. Early in the MAP process, the facilitator noted in the fieldnotes that the front desk staff "feel they are often not supported by the practice leadership." This tension was also explicitly articulated in the first RAP meeting when the front desk representative stated with a frustrated tone of voice that Dr. L, the lead physician, consistently "takes the patient's side" whenever patients have complaints about the front staff:

If I say [something] to a patient, by the time it gets to the [doctor], it gets turned around ... and it's like I was wrong!"

Dr. L responded by stating that she feels that the front staff is not reliable. She explained that when patients complain to her about the front staff, she would like to be able to say "I have a great front staff ... Listen to them; they're right." She added, "I would like to say that, and I would like to be able to trust them, but I still have some concerns."

This issue was not further discussed at this time, but at the end of the meeting one of the team members stated that she thought it was worthwhile to address the interpersonal issues that had come up. She stated, "I felt a little tension [in the meeting] today," but then added, "but it was necessary; you have to be open." This issue was only referred to briefly twice more during the ten remaining team meetings.

In the eighth meeting, the facilitator prompted the team to revisit this issue of trust between "the front and the back." In the subsequent exchange between the front desk representative and Dr. L, the chronic tension was articulated: The front desk representative stated, "You have to trust us ... we're not trying to fight (with the patients)." Dr. L replied doubtfully, "I'd like to think you guys cooperate as best you can ... if that's the case." That meeting ended with the office manager sharing her belief that discussing communication and relationships is "the most important thing!" Despite this sentiment (which was supported by

two other team members' expressions of agreement) there was no further discussion of interpersonal communication or relationships for the rest of the ULTRA intervention. Instead, the team devoted their meeting time to discussing scheduling issues (their chosen focus for the intervention) and testing pilot projects to address some of the scheduling problems they identified. They did not seem to view office tensions and communication issues as integral to this selected focus, and therefore they addressed such issues only sporadically and briefly over the course of the ULTRA intervention.

Poor Office Communication: In addition to the tension between the front staff and the lead physician, several practice members reported that the practice suffered from poor office communication. In private interviews with the facilitator during the initial assessment, several people expressed this view in such comments as, "Communication is weak in this practice;" "Things are not communicated well." "Communication is done by word-of-mouth." This assessment was also articulated by the business manager in the first ULTRA RAP meeting:

The doctors may make a decision that impacts the front, and the front may make a decision that impacts the doctors in the back, [and] we're not communicating them.

In response, the front desk representative shared her perspective that the front staff feel it is unsafe to communicate with Dr. L:

How can we communicate if we don't feel comfortable communicating here?
People at the front telling the doctor what the situation is? There's no comfort zone.

While this comment initiated a small amount of immediate discussion, it was short-lived.

An additional way in which effective office communication was hindered in this practice was that they rarely held staff meetings. The facilitator's fieldnotes mention that several practice members felt that staff meetings would improve office communication and that "the staff has asked for more meetings." One of the reasons cited for the lack of meetings was that Dr. L tended to devalue meetings. A striking example of this attitude occurred at the end of the ULTRA intervention when the team was discussing their desire to continue meeting regularly after the intervention ended. In the midst of this conversation, Dr. L questioned: "[Do] we really find meetings helpful or not? Is it worth the time for all these people to sit here or not?" Implied in this comment, Dr. L suggested that perhaps it had not been "worth" the effort.

In a private interview during the initial assessment, Dr. L offered some insight about the origins of her attitude toward meetings. She explained that her reasons for having initially chosen to go into practice as a solo-practitioner was that she expected it would give her "control" over her schedule and practice. In this recollection, she acknowledged to the facilitator that she believes her "head is still back there" [when she was working alone] and has not fully accepted the reality of the larger practice. After years of practicing independently, the value of including others in practice decisions had not been clear to her.

The ULTRA intervention thus ended with two chronic interpersonal issues having been raised explicitly within the team setting, but there was no further progress made in addressing these issues nor were concrete plans made to do so in the future.

SCOPE Data

Similar Issues: The baseline assessment data for the second study (SCOPE) found that several practice members felt that the same two issues continued to be problematic for this practice. The tension between the front staff and lead physician was evidenced, in part, by the turnover of 14 front staff employees since the ULTRA intervention had ended. There

was a sense of exasperation when two of the administrative staff members talked about this excessive turnover: “We’ve tried everything and it’s not working ... We’ve tried hiring different ages, races, backgrounds.” “I just don’t understand it ... they [the front staff] just aren’t able to do the job ... We’re really frustrated.”

Poor communication also continued to be a problem in the office. Several practice members reported that meeting regularly during the ULTRA intervention had helped improve practice communication, and yet there had been only two meetings of any kind that year. In a private interview during the baseline assessment for SCOPE, one of the physicians portrayed Dr. L’s approach to office communication as being “off the cuff,” explaining that Dr. L tends to make practice decisions on the spot with little discussion. An administrative staff member attributed Dr. L’s resistance to office meetings by explaining that she does not want to “pay people to sit around.”

Working through the Issues: Signs of Change

Tension between the front staff and lead physician: In contrast to ULTRA, the SCOPE RAP team directly and consistently addressed these interpersonal issues in the intervention. The most significant example with regards to the tension between the front staff and Dr. L was that the RAP team chose to focus their QI efforts on “empowering the [front desk] staff” to be active participants in the practice’s “prevention mission.” The rationale was that if the front staff could feel empowered to actively promote prevention, they may feel more invested in their work. The hope was that this could help to improve the ongoing tensions between “the front and the back.”

The second physician on the team, Dr. W (and emergent “team champion”), offered a perspective that was instrumental in helping the team to make the explicit connection between focusing on the front staff’s feeling of involvement in the practice and the team’s goal of improving preventive care. As she explained:

We need to share [this perspective] with our staff; we need to empower them to feel like they understand the whole prevention issue and why that’s important for us ... Just kind of give people the feeling like they understand and maybe are excited about prevention and health maintenance ...

Seeing patients is about more than getting patients in and out. It is about providing a health care environment that is like a health care home. I think that’s where the empowerment comes in; you want to help people to understand that it’s about more than just coming in, doing the work, and going home.

The team’s decision to focus on empowering the front staff is particularly significant when considering that the SCOPE intervention was introduced as a clinically-focused intervention, intended to help the practice identify ways to improve cancer screening. While most practices in the study tended to choose projects that revolved around improving screening documentation procedures or patient education, the flexible nature of this research design allowed this practice to find a way to pick up on the chronic relational issues that had been broached in the ULTRA intervention.

Dr. L. displayed ambivalence toward the “staff empowerment” focus. While she went along with the team’s decision to focus on this approach to practice improvement, she often struggled in the weekly RAP meetings to fully see its relevance. She would often begin the meetings by expressing doubt or confusion about the relevance of “staff empowerment,” but by the end of the meeting she would frequently express a changed perspective. For instance, in the fourth meeting, she acknowledged this pattern and shared her insight with the group: “I’m always distracted in the beginning [of these meetings]...but by the end I think, ‘Yes!

We're going to do something worthwhile!" Despite this recognition, she began the very next meeting by calling into question the value of staff empowerment: "Is this really useful?" By the end of the same meeting, she expressed great enthusiasm for the project: "This is really inspiring ... I never thought the front would care ... about this [participating in prevention]... It's a very exciting thought!"

This ambivalence seemed to be compounded by the lack of trust Dr. L felt toward the front staff. As the intervention progressed, however, Dr. L was increasingly forthcoming with her feelings, which gave the team an opportunity to openly address her reservations. One example of this occurred when the team was brainstorming about the possibility of having the front staff talk with patients about prevention. Dr. L expressed:

It makes me very nervous what the front is saying ... I just don't have the trust of the front desk, as maybe you can tell from my remarks.

This comment created an opening for an explicit conversation about these trust issues that had been touched upon in the ULTRA intervention. The office manager confronted Dr. L by reminding her, "You've always been like that [not trusting the front staff]." Dr. L expressed that she feels she has had "good reason." This discussion then moved into a reflection on Dr. L's trust and comfort-level with the front desk staff's responsibilities. While the question of front staff responsibilities was not resolved in that conversation, Dr. L and the team were willing to keep it on their agenda for their next meetings. Being able to discuss her reservations openly in the team setting seemed to enable Dr. L to repeatedly move beyond initial resistances to become increasingly inspired by idea of encouraging staff empowerment.

Poor office communication: The team's focus on "staff empowerment" in the SCOPE intervention also had consequences for the communication, both on the team and within the entire practice. In particular, this QI focus prompted frequent and extensive conversations about problematic office dynamics. One example occurred during the sixth meeting when Dr. W shared a conversation that she and the office manager had had the day before about the importance of "social investment" in creating the office change they are seeking:

For us to feel invested in something, we need sort of to have that family feeling... You want to be in an office where you feel like, 'Yeah, I want to share my good news with these people' as opposed to my life being a totally separate issue from her...Feeling invested is the first step to feeling empowered.

After a couple of team members voiced their agreement, Dr. W went on to describe the practice where she previously worked and explained that they retained staff a long time because the staff members were invested in the practice and proud of where they worked. She concluded, "I'm not sure if our staff can say that." This discussion led to a lengthy conversation about the possibility of creating what Dr. L called an "office culture change," where people "feel part of the office ... that they're connected to the other people." This idea of an "office culture change" was commonly referenced in subsequent meetings when discussing their practice change goals.

In addition to the increased communication about office dynamics that took place during the SCOPE QI meetings, there was also a greater recognition of the need for practice-wide communication. An illustration of this occurred later in this same (sixth) meeting when the office manager encouraged Dr. L to speak directly with the front desk staff about her vision for the practice. She elaborated:

I ask you all the time what you want, what you're trying to accomplish ...

I think it would make a difference if they [the front desk staff] heard from you. I don't know when they actually hear from you unless it's things that are wrong, truthfully. The only time the front hears from you is if you need something from them.

Without defensiveness, Dr. L acknowledged the accuracy of this statement by jokingly justifying her lack of interaction with the front: "Yeah 'cause the front is *so* far away; it's miles away!"

Two meetings later, Dr. L shared with the team what she was planning to say to the staff in the upcoming office-wide meeting that they had scheduled. She shared her reflections with the team by first describing the history of the practice and explaining how different the office was when she was the only doctor and had only one employee for many years. She emphasized that she could decide anything she wanted at any moment. She concluded by sharing a personal insight about how she sees that she has been behaving as a solo-physician even though that is no longer the case. She summarized this insight by acknowledging: "So, if I seem a little ... [pause; seemingly searching for words] well, it's because my head hasn't completely caught up to the way it is now." The team voiced appreciation for her acknowledgement with enthusiastic remarks: "Interesting!" "That makes so much sense!" "Great insight!" They agreed that this was an insight that the whole practice needed to hear.

6-MONTH FOLLOW-UP

Challenges to sustainable change

The SCOPE intervention ended with signs that the team had gained greater mutual understanding and enthusiasm to work on changing the office culture, but by the time of the 6-month follow-up assessment several new circumstances posed severe challenges for the practice's continued efforts. First, Dr. W left the practice to open her own practice. This was a significant loss for the team, as Dr. W had demonstrated tremendous enthusiasm for the team's focus on "empowering the staff." Dr. L summarized the significance of this loss for the project when she acknowledged, "We lost our team champion." An additional challenge was that the practice began to implement a new EMR system just after the SCOPE intervention ended. Several practice members described the transition as a "disaster" that had created a chaotic environment in the practice for the past several months. Adding to the difficulty, the practice also began to face severe financial struggles that had begun in the months after the SCOPE intervention ended. Both the billing manager and Dr. L were convinced that their current financial hardship was related to the economic recession. They indicated that the financial situation was demanding a great deal of their attention, for survival reasons. Due to these circumstances, the team decided to temporarily suspend work on their staff empowerment project and made plans to revisit this decision in four months.

Signs of sustained intervention impact

While these conditions challenged the team's ability to stay engaged with the QI work after the intervention ended, some signs of sustained intervention impact were seen at the 6-month follow-up assessment. Specifically, Dr. L expressed a different attitude toward her long-standing ambivalence about office meetings. She explained that she will no longer resist office meetings and has therefore given the office manager authority to plan meetings as she sees fit. She acknowledged that when it is left up to her, meetings "never happen; it just doesn't occur to me." She followed this reflection by articulating a significant change in her attitude about office meetings: "Other people find them useful, so they are useful." This acknowledgement suggests a change in her approach to her role as practice leader in that it demonstrates a willingness to consider other practice members' desires and priorities, despite her own inclinations. She concluded this discussion by reflecting on the value of the

intervention for contributing to her changed perspective: “It [the intervention] was like another way to look at things. It was good to get me out of a kind of tunnel vision.”

The office manager, with her new authority to schedule meetings, explained that she has scheduled monthly meetings with the physicians and administrative staff for the past four months and she has plans to initiate a monthly office-wide meeting as well. According to Dr. L, the physicians and administrators have said they are finding these meetings valuable and intend to continue them. For a practice that has struggled so much with securing leadership support for instituting meetings of any kind, this is a notable change.

In addition to increasing the opportunities for communication, these monthly meetings have also begun to have a concrete impact on clinical processes. Two of the agenda items during their first couple of physicians’ meetings included implementing a cancer screening prompt in their new EMR system and establishing a uniform place for documenting screening information, which Dr. L feels will make screening easier and more consistent. This suggests that the physicians are using these meetings as an opportunity to discuss and implement desired clinical changes.

DISCUSSION

In the current health care environment where PCP’s are under pressure to transform their delivery of care, strong communication and collaborative working relationships within practices may be more important than ever. While research and professional association recommendations³¹ acknowledge that interpersonal factors can play a role in successful practice change, there is much to be learned about what is involved in the process of realizing such interpersonal change. This case study offers insight into this process by observing one practice’s efforts to address their interpersonal issues over an extended period of time.

Through our exploration of this practice’s participation in back-to-back interventions, we identified several factors that seemed to serve as either facilitators of or barriers to this practice’s interpersonal change efforts. While we cannot know with absolute certainty why the SCOPE team was able to more extensively address the practice’s long-standing interpersonal issues, our analysis points to a trio of possible contributors: the practice’s prior experience with the RAP process, the presence of a “champion” on the team, and flexible study designs that were tailored to the evolving needs and interests of the practice. Factors that seemed to serve as barriers to such efforts included the array of challenges to practice survival that many PCP’s are currently facing, as well as physicians’ professional socialization that tends to underemphasize the value of investing in building strong interpersonal office relationships.

Facilitators for interpersonal change efforts

Prior RAP experience—One of the factors that appeared to contribute to the SCOPE team’s extensive efforts to address the practice’s interpersonal issues was that this team may have benefitted from the ULTRA RAP team’s experience. Of course we do not have a control case to determine the extent of this influence, but there is evidence to suggest that this practice’s prior RAP experience had a positive influence on the SCOPE team. One of the ways this prior experience seemed to impact their experience was by familiarizing the SCOPE team with the RAP process. In a sense, the ULTRA intervention may have served as a type of warm-up that allowed the practice to make some initial efforts at addressing interpersonal issues within the team setting; and, since these attempts did not result in any (known) negative consequences, it is possible that this experience helped the SCOPE team to feel emboldened to pursue these issues more extensively. Because addressing

interpersonal issues can feel particularly risky in a setting where there is an inherent power differential³² the practice's collective experience of having formally addressed interpersonal issues in a team setting may have contributed to the SCOPE team being better equipped to more extensively address the practice's interpersonal issues

Team Champion—Another factor that may have contributed to the SCOPE team's more extensive efforts to address the practice's chronic interpersonal issues was that the second physician on the SCOPE team, Dr. W, became a team "champion" (e.g., "a passionate advocate for the team's work").³³ Dr. W fit this description in numerous ways. For instance, she felt so strongly that the practice could benefit from the intervention that she committed to participating in the weekly team meetings even though they were held on her day off. She also had former work experience that she felt had taught her the value of investing in improving office relationships, and she was often able to effectively communicate to the team the perspective she had gained from that experience.

Dr. W's perspective about the relevance of interpersonal relationships for the practice's budding prevention mission seemed to encourage the team to discuss, with increasing depth, the issues revolving around interpersonal communication and the chronic tensions in the practice. These team discussions also seemed to have an impact on Dr. L's understanding of how empowering the staff could be important for building a prevention culture in the practice. For instance, often after Dr. W would eloquently explain how she saw this connection, Dr. L would express a deeper sense of appreciation for the team's goals and, at times, demonstrate great enthusiasm and a sense of inspiration.

A tailored study design—An additional factor that facilitated the SCOPE teams' explicit efforts to address the practice's interpersonal issues was that the two studies were designed to allow the interventions to be tailored to the unique needs, culture, and interests of each individual practice.³⁴ This helped to harness the team's interests and commitments by allowing them to select what they felt most ready and motivated to address. This flexibility may be particularly important in efforts to work on improving interpersonal issues because practices likely differ in terms of their readiness to address such issues. Our analysis suggests that the SCOPE team was more prepared and had more "resources for change"³⁵ available to support their efforts to address their interpersonal issues than did the ULTRA team, and the tailored intervention design helped the practice to make best use of their unique configuration of assets.

Specifically, having the freedom to define their practice improvement focus in a way that inherently included attending to interpersonal relationships allowed the SCOPE team to draw on the concerns most salient to the majority of the group, to take advantage of their team champion who was highly motivated and experienced in working on interpersonal office issues, and to maximize the practice's cumulative experience with addressing interpersonal issues in a RAP process. Defining their project as they did helped to keep the focus of the SCOPE team's conversations revolving around their chronic interpersonal issues. This consistent focus on such issues throughout the intervention not only encouraged extensive discussion of these interpersonal problems, it also seemed to help Dr. L to increasingly see the value in treating interpersonal relationships as central to their improvement efforts. The numerous team discussions that revolved around the possible causes, consequences, and solutions to the practice's persistent interpersonal issues played an important role in encouraging Dr. L's self-reflection about her resistance to office meetings, which ultimately led to her change in attitude about the value of meetings. In contrast, interpersonal issues were not conceptually integrated into the ULTRA RAP team's stated focus of scheduling issues. This may have contributed to the minimal and sporadic attention that the ULTRA team paid to interpersonal issues.

Barriers to addressing interpersonal office issues

Practice survival—One of the biggest barriers to working on improving interpersonal issues that this case highlighted is that it can be difficult to prioritize interpersonal issues under the challenging conditions in which PCP's currently exist. For example, practices are often overwhelmed with demanding schedules to compensate for lower reimbursements;⁵ they are burdened by increasing administrative tasks as insurance coding procedures have become more complex and clinical practice guidelines have multiplied³⁶; and they often struggle to transition from paper to electronic systems with inadequate support.³⁷ Given the current state of crisis in primary care,³⁸ it is understandable that practices would relegate systematic work on interpersonal relationships to the bottom of the priority list.

A major consequence of this barrier for both the ULTRA and SCOPE teams was that it limited the lead physician's motivation to address interpersonal office issues. This was evidenced most dramatically by Dr. L's explanation for the decision to temporarily put their improvement project "on hold" a few months after the intervention ended: the cumulative pressure of urgent financial concerns and the stress involved in implementing a new EMR system made it impossible for them to continue committed work on increasing staff empowerment through the prevention culture they had begun to initiate. In other words, this combination of stressful factors detracted Dr. L and the team from continuing to invest in systematically addressing interpersonal relationships.

Professional socialization—While clearly the challenges and demands that PCP's currently face pose significant limits on the time and attention available for working on interpersonal issues, there also seems to be an attitudinal aspect that can serve as a barrier to investing practice resources into interpersonal relationships. When there are practice survival issues at stake, it is understandable that the inclination would be to focus on financial security before devoting resources to improving interpersonal relationships.³⁹ What this perspective does not consider, however, is that improving interpersonal relationships may in fact be an important element in helping to secure some of a practice's basic survival needs. This possibility is highlighted by this case study, for example, when considering the costs to the practice of such high front staff turnover for so many years; the associated cost may very well be greater than the cost of devoting time to regularly address interpersonal office relationships.

Such reasoning, however, does not seem to be the predominant mental model in the field. This was evidenced in this case, for instance, in Dr. L's response to the ULTRA RAP team's idea of committing to meeting regularly after the intervention ended: "[Do] we really find meetings helpful or not? Is it worth the time for all these people to sit here or not?" The implication in this statement is that attending to the interpersonal component of practice life in the context of office meetings is not necessary work, but rather it is a luxury. This assumption is likely not simply a reflection of Dr. L's personal mindset; it may be more accurate to view it as a product of physicians' professional socialization. As Leslie et al.⁴⁰ point out, many of the competencies needed for effective leadership (including "communication ... fostered collaboration, empowerment of others, and establishment of trust") are typically not taught in medical training programs. On the contrary, they note that "much of traditional medical curricula have emphasized autonomy in decision making, the individual physician-patient relationship, and hierarchical cultural processes ..." Such professional socialization likely played an underlying part in Dr. L's struggle to consistently recognize the value of investing in improving interpersonal office relationships.

Study limitations

One of the limitations of this analysis is that there were a variety of differences between the ULTRA and SCOPE interventions that could have influenced the extent to which interpersonal issues were addressed in the two interventions. For instance, the two interventions had different clinical emphases, different durations, some different team members (except for Dr. L and the office manager), and different external facilitators. While it is likely that such factors influenced the course of the two interventions, it is beyond the scope of this analysis to try to determine the extent of their possible impact.

This analysis is also limited by the fact that we cannot comment on the long-term sustainability of the changes we observed by the end of the second intervention because only one (6-month) follow-up assessment of this practice is complete. Therefore, the signs of possible intervention impact that we have observed so far are necessarily provisional.

An additional limitation is that we are unable to account for change that may have occurred independent of the interventions. Some amount of organic change is inherent in the life course of all organizations, and there is of course no definitive way to determine if any of the changes we observed would have occurred in the absence of the interventions or not. The quantity and depth of our data, however, give us confidence in associating the interpersonal changes we identify with the practice's experience in these consecutive interventions.

Finally, it is worth commenting on the first author's role as both SCOPE facilitator for this practice and research analyst. This dual role has the potential to serve as both a strength and a limitation for this analysis. On the one hand, the facilitation afforded a personal experience with the practice that may have allowed a more nuanced understanding of the interpersonal dynamics of the SCOPE RAP team than an outside analyst might be able to gain. On the other hand, the emotional involvement with this practice may have introduced additional bias into the analysis. We made efforts to minimize such bias, however, by working with a team of analysts who challenged the interpretation throughout the analysis.

CONCLUSION

The signs of progress and the sources of struggle we have observed over time with regard to this practice's efforts to address their interpersonal issues, prompt us to consider some possible implications for future QI research. One such implication is that our understanding of practice change processes may benefit from assessments of intervention effectiveness that attend to interpersonal issues and are not limited to clinical outcomes alone. This suggestion resonates with Werner and McNutt's⁴¹ argument that current QI assessments limit our knowledge about QI processes by comparing practices "on measures that do not reflect the learning that is required to really improve care." Ovreteit and Staines¹⁸ similarly suggest that limiting assessment to clinical measures may miss important changes in interpersonal and process changes that may in fact be precursors to changes in clinical measures. Tracking such changes would require extensive observation at a single site over an extended period of time using qualitative research methods.

Additionally, this case highlights that it can take a great deal of time and effort to make significant changes in interpersonal relationships within the practice setting. While we saw definite progress in this practice's willingness to address their interpersonal issues over time, this practice's chronic interpersonal issues were far from resolved by the end of the SCOPE intervention. Their progress was primarily in voicing their longstanding tensions and communication issues more extensively and in gaining leadership support for working systematically on improving these issues. The extent to which the RAP team's increased

understanding and communication about these issues translated into sustained changes in the general practice culture, however, remains a question. Undoubtedly, such change would require ongoing work to sustain; and, with the variety of unpredicted obstacles that arose at the end of the SCOPE intervention, it is possible that work may be left undone. Thus, an important implication of our analysis is that the current calls for practice transformation may be underestimating what it will take to lastingly change office culture and communication.

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Table 1

ULTRA and SCOPE timelines