

# Getting Beyond



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In this age of heightened consumer awareness and sophistication, improving quality and service is essential for health care organizations that wish to remain competitive. Powerful quality improvement tools exist to help organizations understand their processes and implement changes, and many hospitals and group practices have trained their leaders and staff in these skills (e.g., lean thinking, six sigma and rapid cycle improvement). Why is it, then, that many of these organizations still achieve less-than-ideal results?

While meeting with a group of physicians interested in improving patient access, I was reminded of the reasons behind such failures. The leader of the group came well-equipped with “ammunition” – data that suggested her group’s access problems were rooted in the amount of variability in appointment types and durations. Confident that the data would make

the next steps obvious to even the most stubborn in the group, she proudly presented her findings. The group listened attentively and gained a solid understanding of the situation; however, during the subsequent discussion, finger-pointing and accusations flew wildly as group members were consumed with protecting self-interests and fearful of potential change. In the end, the group chose to take no action on the data, and the access issue persists today. Sound familiar?

Ultimately, our success in process improvement lies in how we react to our findings and observations. When behaviors such as blame, accusation and finger-pointing raise their ugly head, our improvement efforts are doomed. Therefore, our ability to foster a blame-free culture may be the most important prerequisite for sustainable change in quality and service.

# Blame

## in Your Practice

*If your group is prone to blame, accusation and finger-pointing, your improvement efforts will be doomed.*

Because blame is rooted in our emotions, it cannot be abolished simply through policies, procedures or exhortations. Eliminating blame from the culture of a team or organization is a more complex process. It requires the development of three core competencies:

### 1. Develop a process focus.

We all have internal “maps,” or filters, through which we interpret what we observe in the world. Based on past experiences, values, philosophies and cultures, these maps lead to assumptions and inferences that may or may not be accurate but drive our reactions, behaviors, thinking and decision making.

Often, when an undesirable outcome occurs, our map leads us to respond by blaming another individual. Instead, we need to develop a map that leads us first to look at the *process* that caused an undesirable result, rather than attributing the result to the character of an individual.

When we think and act from a place of curiosity, learning, growth and change, we are more likely to focus on fixing processes. On the other hand, when we are attached to self-protection, displacement of blame, micromanagement and intolerance, we are more likely to focus on fixing people, thus diverting energy away from the essential exploration of the processes and systems in question.

**How to evolve toward a process focus.** Even if individuals logically understand this concept, it can be tough to maintain a process focus when the emotional stakes are high. It’s helpful if you discuss this concept with your team – both physicians and staff – when you’re

not in the heat of the moment. For example, commit time at your next staff meeting to talk about how the team responds when things don’t go as planned. Ask them to imagine an event that didn’t turn out well and to think about how they responded. Then discuss the following questions:

- When something doesn’t work out well, do you first ask, “Who did it?” or do you ask, “What part of the process allowed this to happen?”
- Do you immediately ask yourself, “How can I protect myself and save face?” or do you ask, “How can I learn from this?”
- Do you view yourself as external to the problem, or do you consider, “What is my role in this?”
- Do you tend to operate from a place of fear (fear of taking risks, fear of thinking through a problem, fear of punishment, etc.), or do you display courage and pursue growth and learning?

The purpose of these questions is to raise awareness of “the way things are.” After plenty of open dialogue, close the meeting by painting a picture of the way things could be. Talk about the importance of focusing on processes rather than people, about cultivating curiosity and learning, and about resisting the impulse to self-defend.

Some teams may transition to this naturally. Most teams, however, face difficulty in keeping the concept alive when emotions are strong. One helpful tool is the “five whys” technique, which helps teams identify the root cause of an outcome by asking the question “Why?” five times without blaming an individual at any step (see the example on page 33). ➤

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#### About the Author

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Even with these exercises, leadership is essential to maintaining a process focus and redirecting individuals toward this approach when necessary.

## 2. Ensure alignment of purpose.

When a less-than-ideal outcome occurs, individuals often place blame because they question the intent or commitment of another group member. In essence, one person is saying to the other: “You’re not committed to what our group is trying to accomplish. If you were, you would not have done such a poor job.”

There are certainly times when an individual’s self-interests compete with the group’s interests. To respond appropriately to this, it is essential first to acknowledge that individuals in an organization do not exist independent of their personal obligations, needs and interests. Through healthy conversation, seek to understand your team members beyond their identities at work.

At the same time, you can encourage and model self-awareness and self-management, which are necessary for individuals to properly cope with these conflicts. Clarifying individual roles and defining the group’s purpose, vision and values are also important.

### How to evolve toward a shared purpose.

To ensure that group members are committed to a shared purpose, start by engaging them in a conversation about individual needs, desires, values and goals. Frame the conversation by explaining that understanding one another and acknowledging one’s own self-interests are keys to working together effectively. Then pose the following questions and invite team members to share their responses:

- What do you need in life? What do you want in your life?
- What’s really important to you? What are you willing to take a stand for even if it’s not popular?
- What aggravates you? What is the opposite of each of those things?

Effective leaders help group members focus on fixing processes, rather than blaming one another when things don’t go as planned.

When group members commit to a shared purpose, they are less likely to question one another’s intent.

Self-management and self-awareness are key to balancing group interests and self-interests.

## SIX WAYS BLAME DAMAGES AN ORGANIZATION

**Blame hurts morale.** By instilling fear, anger and resentment, blame leads to dysfunctional work relationships and poor morale.

**Blame misdirects the group’s energy and focus.** Rather than focusing on understanding one another, learning and improving, the group focuses on self-preservation, attacking and defending individual interests.

**Blame feeds biases.** Individuals are more apt to notice things that already support their fixed assumptions and biases. Opportunities for innovation and improvement go unnoticed.

**Blame inhibits creativity.** When blame is prevalent, fear exists. When there is fear, individuals tend not to take risks or to think creatively.

**Blame is expensive.** Blame can be costly to an organization, through poor quality, service failures and lost customers. In addition, poor morale and staff turnover add substantially to the costs and waste in a system. Blame also results in lost opportunity costs because of the lack of innovation and improvements in quality and service.

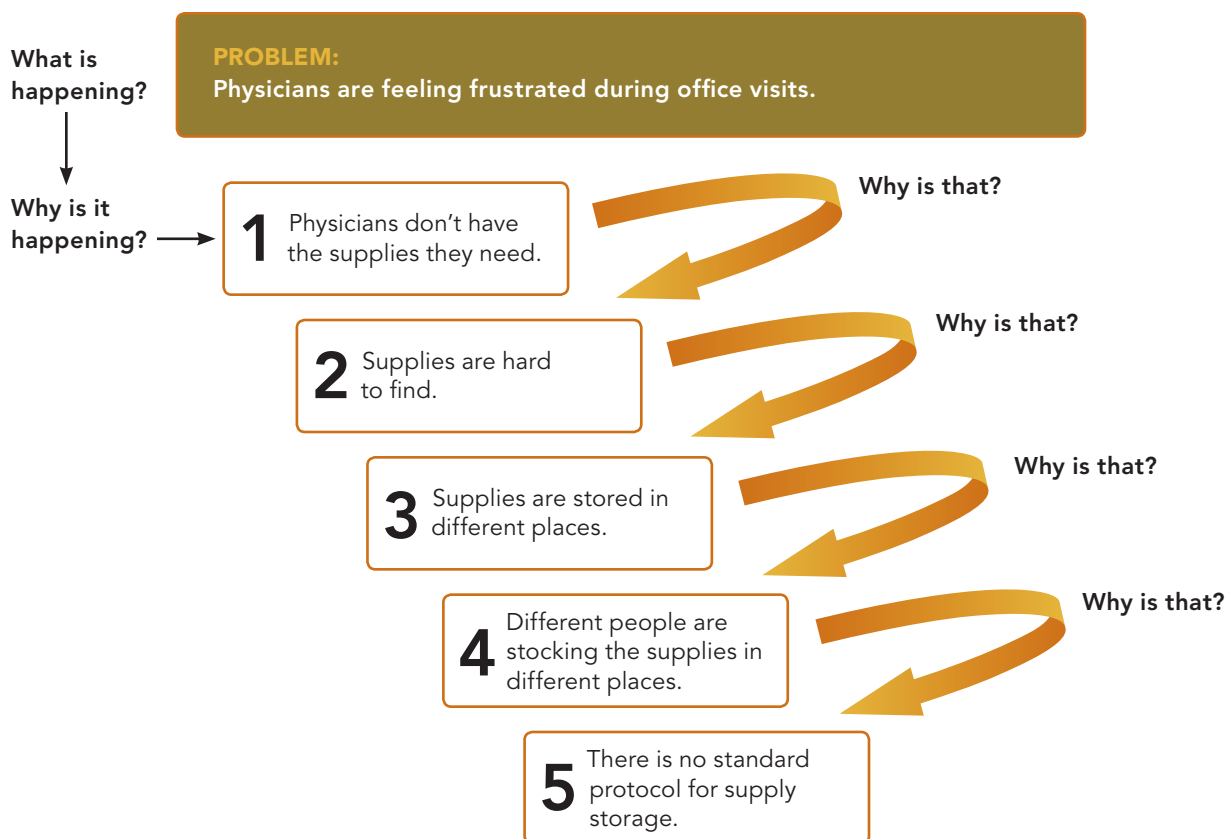
**Blame can kill.** In some cases, blame can lead to the failure to examine problems and address them effectively. People can and do die as a result.

## THE FIVE WHYS TECHNIQUE

The “five whys” technique, developed by Masaaki Imai, helps teams get beyond the obvious symptoms and identify the primary or root causes of a problem. This shifts focus from individuals to processes, and thus lessens the tendency to blame.

When you observe an undesired outcome, the first step you should take is to agree on a problem statement that defines what is happening in a neutral fashion (for example, “There are not enough supplies in the clinic”). Then ask, “Why is that true?” or “Why is that happening?” To each answer, ask “why” again. Continue asking why at least five times.

Notice in the example below that the exercise leads team members to examine their process rather than automatically jumping to a blame-based conclusion to explain the difficulty finding supplies in the clinic (e.g., “It’s my nurse’s fault. She must not care about her job.”). In this case, non-standardized storage is identified as the root cause, and the team can then take steps to improve the process to achieve a more desirable result.



- What are your short-term and long-term goals, both professionally and personally?

Next, outline the group’s purpose. For example, “Main Street Family Medicine is committed to improving the health of our patients, creating a positive work environment for our physicians and staff, and operating a profitable business.”

Then, ask individuals to reflect on how their interests, values and goals relate to those of the group. For example, an individual’s

desire to make a difference in the lives of others would be aligned with the group’s goal of improving patients’ health, or an individual’s need to support his or her family financially would be aligned with the group’s goal of operating a profitable business.

When individuals see how the group’s interests tie into their own interests, they are more likely to be committed to what the group is trying to achieve. In addition, when individuals hear one another’s interests,

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values and goals, they are more likely to be understanding and supportive of one another, which helps eliminate blame.

### 3. Foster effective communication.

A crisis of communication often exists in cultures where blame is observed. The key drivers of poor communication are biased assumptions, which cause individuals to speak before they think and to dismiss one another's ideas or comments without really listening to them.

Suspending assumptions is critical to effective communication. It involves examining your own biases and considering whether they are incomplete before you react or respond. This conveys a respect for others and results in better decision making.

When you suspend assumptions, you also let go of any attachment to a particular outcome or perspective. When individuals grow excessively attached to an outcome or point of view, they tend to overreact when the desired result is not obtained. Organizations that follow "management by objective" (which stresses the importance of meeting strict performance targets) should be extremely cautious in this regard. Over-attachment to an outcome often stifles any joy derived from the process itself and pressures group members to win at all costs. Such approaches are a significant impediment to developing a blame-free culture in which quality and innovation can thrive. W. Edwards Deming, the founding father of quality improvement, agreed.

**How to evolve toward effective communication.** Success in this area depends on achieving a balance between "advocacy" (sharing one's own perspective) and "inquiry" (discovering the perspectives of others, with a spirit of curiosity). Most physicians tend to advocate well, although not always respectfully. To advocate respectfully, consider the following phrases as possible starting points:

- "I'm glad you added this perspective to

our overall understanding. I have one more idea to add to the mix ..."

- "What you're saying makes sense, and I'd like to add an additional perspective. Here's what I see ..."

- "I hear what you're saying. I see things a bit differently. Here's what's different from my view of this situation ..."

Inquiry can be tough, especially when emotional stakes are high. Here are some phrases that can help:

- "Tell me more about that ..."
- "I want to make sure I understand this correctly. What I'm hearing you say is ..."
- "When you say \_\_\_\_\_, I interpret it to mean \_\_\_\_\_. What does it mean to you?"
- "I'm curious about what you're saying. Help me understand ..."
- "What is the result you're seeking right now?"

Individuals often have difficulty implementing these concepts, so it's important for leaders to model this approach and support others as they attempt to learn. Check in periodically to see how individuals are doing with these skills. During team meetings, encourage everyone to seek to understand one another's ideas before adding their own perspective. This helps participants feel that they are valued contributors, that they are respected and that they participated in creating the solution.

### Becoming blame-free

By developing the core competencies of focusing on processes, aligning purpose and communicating effectively, teams can evolve beyond blame-based behaviors and enhance trust among members. This is the essential foundation for health care teams that are seeking to improve processes and outcomes. These core competencies will not develop overnight, but through trial and error, your group can evolve toward a culture free of blame. **FPM**

Send comments to [fpmedit@aafp.org](mailto:fpmedit@aafp.org).

■ Biased assumptions can damage communication within a group.

■ By suspending assumptions, group members can pause to consider their own biases before they react or respond.

■ Group members need to balance advocacy (sharing their own perspective) and inquiry (discovering others' perspectives).