HEALTH PROFESSIONS EDUCATION

and

RELATIONSHIP-CENTERED CARE

Report of the

Pew-Fetzer Task Force

on Advancing Psychosocial Health Education

Acknowledgments

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Message from Fetzer Institute

Since its publication in 1994, the monograph, Health Professions Education and Relationship-Centered Care, has enjoyed wide circulation and consistent demand. Because of the continuing interest in relationship-centered care and the relevance of the principles outlined in the monograph, it is being reprinted in its original form. However, many things have changed since 1994. For example:

- More people are without access to the health care system than ever before.
- There is growing dissatisfaction with the health care system among professionals, patients, and policymakers.
- The health care system continues to change and evolve as it struggles to reduce costs and improve quality. Patients must frequently change providers, disrupting relationships and affecting quality of care.
- Academic health centers are under enormous pressure with clinician faculty being pressed to produce clinical income, reducing the time they can spend with patients and students.

Research is demonstrating that relational variables are important in improving health care outcomes. Could it be that all of these factors point to the need for a health care system that is based on relationships and a health care education system that includes those relationships as part of its professional curriculum? Relationship may be one part of the antidote for the problems outlined above. For example, many people who are unable to afford medical coverage are disenfranchised from the current medical system and cannot afford technological care. However, they may still have access to caring professionals and the healing aspects of relationship. Patient satisfaction and provider satisfaction can both be enhanced by relationships between patients and providers. Studies are showing that relational variables may be effective in healing and may improve quality of care. And although relationships may be difficult in the short run because of turmoil and turnover in the health care system, in the long run it may be one way of positively affecting quality of care.

Since this monograph was published in 1994, a number of things have occurred. One significant event is the formation of a network of individuals and organizations that are interested in relationship as it affects health care and society at large. Participants in the Relationship-Centered Care Network are interested in maintaining relationship as a central part of their practice or teaching, and often do so in organizations that primarily emphasize the technological aspects of medicine and health care. These professionals, educators, and administrators are sometimes isolated in their work and their colleagues sometimes hold a different set of values leading to further isolation. A network of like-minded individuals offers support, connection with others, and a vehicle for further conceptualization of the concept of relationship-centered care. Joint and collaborative projects have emerged from the network, including courses in relationship-centered care at several major medical schools. In addition, a number of books and articles have been written. Much of this work culminated in the National Relationship-Centered Care Gathering in December 1998, an event attended by 200 health professionals who met to learn about, talk about, and experience relationship-centered care. The programs involving the relationships between staff and patients, staff members of different disciplines, and staff and the community have been implemented at hospitals, in residency training programs, and at medical schools in

several universities.

Books, videos, and other materials focusing on relationships in medicine and health care continue to appear. Foundations including the Picker Institute, the Arnold B. Gold Foundation, the Kenneth B. Schwartz Center, and the Bayer Institute are focusing on some aspect of relationship-centered care. Other groups, such as the American Academy of Physician and Patient, are adopting a relational focus like the Academy's premier training in 1999 devoted to relationship-centered care. While all of this is going on, regional and local groups are creating study circles, community forums, regional collaborations, and project-oriented groups to promote relationship-centered care in their geographical areas.

Relationship-centered care has embedded in it a strategy of change that is different from what our culture often embraces. Relationship-centered care is not an attempt to reform the health care system. Most reform efforts meet the system head-on, using a somewhat adversarial approach. Relationship-centered care employs what has been called the "movement model" of change.[1] The strategy is meant to support and encourage individuals who have a readiness to engage in this kind of work, thus allowing them to go into the institutions, practices, universities, and other organizations that they represent with renewed vision, vigor, strength, and the support of a caring network. The strategy focuses on the individual who reaches a point in his or her career in which he or she refuses to live a "divided" life - divided, for example, between the provision of excellent (defined as relational) care and the practice in many health care settings of curtailing interviews after a few minutes and of using technology as the deciding force. These individuals determine that they can no longer support the institutional bottom line, look for new goals and reward systems and, eventually, if the movement succeeds, find them provided by society. As more people make this choice, the rewards will eventually come from the health care system itself - and this is already happening.

In order to be truly relational, we believe that health care and health care education must occur in a relational environment. At the Fetzer Institute, we have tried to create such an environment by presenting relationships as the "bottom line." True, we, as all other organizations, have goals to meet other than relationship. Few organizations mention relationship in their mission statement, and we are all familiar with the way financial incentives drive health care delivery and health care education. But these organizations also can include relationship as a "bottom line," while making money and delivering the highest-quality health care and health care education. Part of the dilemma of the health care system is how to provide quality health care and still make a profit, while honoring and respecting both providers and patients. We believe that our health care organizations must do both.

For more information about relationship-centered care, please visit the Relationship-Centered Care Network web site at www.fetzer.org/rcc.

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1 Parker Palmer. Courage to Teach, Exploring the Inner Landscape of a Teacher's Life. San Francisco, CA: Jossey-Bass, 1998.

Preface

THE PEW COMMISSION-FETZER INSTITUTE PARTNERSHIP

THE AIM OF THE FETZER INSTITUTE is to explore the relationship of the physical, mental, emotional, and spiritual dimensions of life in search of opportunities to develop health care approaches that expand the scope of medical science and give individuals greater control over their own health. The Institute supports basic research to investigate the links between mind and body and works with schools in developing programs that will lead to a better understanding of the mind's capacity to influence health.

THE PEW HEALTH PROFESSIONS COMMISSION, a program of The Pew Charitable Trusts, believes that the skills and values of our nation's health care workers have a fundamental impact on the quality and effectiveness of health care. Consequently, the education and re-education of health professionals must be a part of any health care reform. The goal of the Commission is to assist health professions schools to develop missions and programs that are responsive to the health care needs of the public. The Commission has delineated a set of competencies that are important for practitioners in a changing health care system (Shugars et al., 1991). These competencies reflect the complexity of contemporary health care in their attention to both population and individual perspectives and to both biomedical and psychosocial concerns.

IN JANUARY 1992, the Pew Health Professions Commission and the Fetzer Institute, recognizing their common goals and interests, began working in partnership to examine ways to develop health professions curricula that promote an integrated approach to health care that affirms the interaction of biomedical and psychosocial factors in health. The Pew-Fetzer collaboration has

involved two undertakings—formation of a task force and the carrying out of a parallel research project. The Pew-Fetzer Task Force on Psychosocial Health Education was formed to serve in an advisory capacity to the Pew Health Professions Commission and the Fetzer Institute in the development of an agenda for encouraging the development or expansion of educational programs that reflect an integrated biomedical-psychosocial perspective. The Pew-Fetzer Study of Biopsychosocial Curricula in Health Professions Education has had as its goal the broadening of our understanding of how schools can help students learn and apply an integrated approach to health care. The findings of the study—described in Appendix B—have informed the work of the task force and will serve as a foundation for networking and resource-sharing.

THE PEW-FETZER TASK FORCE, at its first meeting in November 1992, was charged with the following tasks:

- *Identify the scope of issues involved in an approach to health care that addresses the interdependence of psychological, social, and biological factors in health and illness.*
- *Identify the aspects of these issues that are particularly relevant for health professions education across a wide range of practitioners—including nurses and nurse practitioners, physician assistants, physicians, dentists, allied health professionals, psychologists, social workers, public health workers, pharmacists, and others.*
- *Identify barriers to the integration of psychosocial issues with biomedical issues in health professions education.*
- *Develop strategies to overcome such barriers.*
- *Make specific recommendations and state priorities for action that will be useful to the Pew Commission, the Fetzer Institute, and others.*

Robert F. Lehman,
President
Fetzer Institute

Edward H. O'Neil,
Executive Director
Pew Health Professions Commission

Introduction

WE BEGAN OUR WORK AS A TASK FORCE in the midst of intense national debate in the United States over health care reform, a debate focused on access and financing and much less on the actual dynamics or quality of care. Although the current United States health care system benefits many health care professionals, most patients, and substantial segments of society, there are palpable signs of a growing need to enhance the quality of the care process from the perspectives of both the patient and the practitioner. Hearing growing uncertainty and disenchantment being voiced by practitioners and patients alike, we attempted to develop an understanding of these problems and struggled to find possible solutions. As our dialogue emerged and matured, it came to focus on relationships.

THE FOUNDATION OF CARE GIVEN BY PRACTITIONERS is the relationship between the practitioner and the patient, a relationship vitally important to both. This relationship is a medium for the exchange of all forms of information, feelings, and concerns, a factor in the success of therapeutic regimens, and an essential ingredient in the satisfaction of both patient and practitioner. For patients, the relationship with their provider frequently is the most therapeutic aspect of the health care encounter. Patients express their feelings regarding the importance of their relationships with their doctors or other practitioners when they fiercely defend the opportunity to maintain relationships with their practitioners of choice and routinely rate their own doctors higher than they do doctors in general. Similarly, most practitioners readily acknowledge the gratification they derive from the special nature of their caring relationships with patients. When practitioners express concern over potential threats to the practitioner-patient relationship posed by new arrangements for care, they are reaffirming the impor-

tance of this relationship. Additionally, the placebo effect and a willingness to watch and wait attest to the power of the trusting relationship between practitioner and patient.

RELATIONSHIPS THAT PRACTITIONERS FORM with the communities they serve and with other practitioners with whom they work are equally important. As we reconceptualize health, recognize the many ways in which health can be improved, become aware of the relatively low health status of the American population, and cope with shifting patterns of illness and death (Tarlov, 1992), it is increasingly critical to improve both community-oriented health care and collaborative care provided by different practitioners working together. Determinants of health and illness lie not only within individuals, but also within our social, economic, environmental, cultural, and political contexts. Contemporary patterns of illness are complex and require multiple therapeutic approaches by practitioners from a variety of disciplines and professions. In order to fully attend to all of the factors influencing health in a coordinated way, effective working relationships among practitioners are essential.

FOR ALL OF THESE REASONS, *we feel that a primary focus on ways to enhance and enrich the relationships that are relevant to health care through both education and practice is of critical importance.* Our focus on relationships as a central feature of health care builds on the traditions of the nursing profession (Benner & Wrubel, 1989; Peplau, 1952) and the concepts of the biopsychosocial and patient-centered care models (Engel, 1977; Levenstein, 1988; McWhinney, 1989). While acknowledging that these models have influenced our thinking substantively, we also assert the need for a new phrase, *relationship-centered care*. In using this terminology, we affirm the centrality of relationships in contemporary health care and their importance in the context of any health care reform debate. Although always central to health care, relationships that practitioners form with patients, communities, and other practitioners have not generally been

explored or taught explicitly. Despite nursing's long history of emphasizing caring relationships in its practice and ethos, this focus has not become a defining force in health care. The biopsychosocial model, while helping to focus attention on the integrated nature of illness systems (i.e., that an illness incorporates biological, psychological, and social aspects), ironically also invites multidimensional analysis and reductionism, further objectifying the patient and the illness experience. The patient-centered model, while promoting a more whole-person approach, does not explicitly embrace the community and interdisciplinary aspects of health care that are of such importance today.

THE PHRASE "RELATIONSHIP-CENTERED CARE" captures the importance of the interaction among people as the foundation of any therapeutic or healing activity. Further, relationships are critical to the care provided by nearly all practitioners (regardless of discipline or subspecialty) and a source of satisfaction and positive outcomes for patients and practitioners. Although relationships are prerequisite to effective care and healing, there has been little formal acknowledgment of their importance and few formal efforts to help students and practitioners learn how to develop effective relationships in health care. In this document, we describe the concept of relationship-centered care in the context of modern health care and offer a framework for understanding the centrality of relationships. We also describe how health professions education might begin to help students and practitioners learn about relationship-centered care and offer a set of principles designed to guide curricular and programming activities in health professions education.

Contemporary Challenges for Health Care

Illness is an integral experience that can only be artificially reflected into biological, psychological, social, and spiritual dimensions. This deepened perspective will shape care in the future.

Our Diverse, Multicultural Society: Its Complexity and Impact on Health Care

As we begin to refine our understanding of health to encompass determinants of well-being beyond the biomedical, we must recognize the impact on health care of our society's enormous—and growing—socioeconomic and cultural diversity. Indicators of health status and health care utilization provide evidence that minorities, the poor, the unemployed, and the undereducated are at greatest risk for poor health (Council on Graduate Medical Education, 1992). In 1978, 24.5 million Americans, representing 11.4% of the population, lived below the federally-defined poverty line. By 1990, that number had climbed to 33.6 million, or 13.5% of the population (U.S. Bureau of the Census, 1992). Simultaneously, the disparity between rich and poor grew. The share of total income going to the quintile of households with the lowest income fell from 4.1% in 1970 to 3.9% in 1990. During the same time period, the share of income of the highest

quintile rose from 43.3% to 46.6% (McKenzie, 1992).

With regard to racial and cultural diversity, it has been estimated, for example, that the Hispanic and African-American populations in the United States will represent 26% of the total population by 2005. The proportions of other ethnic minority groups also will continue to grow. In certain states—particularly California, Texas, Florida, and New York—cultural diversity will be greater than in others (Oxford Analytica, 1986). Although America traditionally has been perceived as a great melting pot of people and cultures, the process of assimilation and acculturation no longer can be taken for granted: many minority communities are maintaining separate identities and cultures. Poverty, limited opportunities for education and employment, and poor health also set apart some minority groups. In 1990, 32% of African-Americans had incomes below the poverty line (U.S. Bureau of the Census, 1991).

Differences in understandings and terms of reference across cultures create challenges for both health care practitioners and patients. Rapid and dramatic changes in communities resulting from migration, immigration, and demographic changes have made it difficult for practitioners to adjust to and learn about effective ways to care for patients from other cultures. Culture also determines our approaches to health, beginning with symptom interpretation and initial entry into the formal health care system. Mo (1992), for example, describes the story of an elderly unmarried Chinese woman who complained for several years of pain in her hip and lower back. She was not taken to the doctor because back pains are a common complaint and not considered serious. Finally, when the pain became too great, she was taken to the hospital, where she was diagnosed with metastatic breast cancer. Because she had never married, she had never had a breast exam or Pap smear. To do so would have been an acknowledgment of her sexuality, the idea of which was not only immodest but repugnant to her as a single woman.

Cultural norms can affect care after entry into the system as well. For example, in some cultures, taking medication when one does not feel or appear sick is considered pointless. In a family with tuberculosis, then, parents may not think it appropriate for a child to take prophylactic medication when the child does not seem to be ill, resulting in further illness and disability. Language barriers and legal issues (e.g., fear of having one's

illegal alien status discovered) compound the problems involved in cross-cultural health care.

Evolving Constructs of Health and Illness

Health care in the United States, with its success in biomedical science, has made enormous advances in confronting the challenges presented by specific diseases of individual patients. There is growing recognition, however, that many equally daunting challenges to health care remain. Many factors have converged to create demand for a more integrated approach to care, one that takes into account the multiple factors that interact to promote health or cause illness, and that requires individual responsibility for one's own health as well as collective responsibility for the health of the population at large. Patterns of illness and mortality have changed: chronic illnesses and lifestyle-related health problems now are predominant. *We are coming to understand health not as the absence of disease, but rather as the process by which individuals maintain their sense of coherence (i.e., sense that life is comprehensible, manageable, and meaningful) and ability to function in the face of changes in themselves and their relationships with their environment* (Antonovsky, 1987).

The corollary to this understanding of health is the construct of illness, which places the patient's experience—not the organ system or pathophysiological state—at the center of what it means to be healthy or sick. As such, illness is an integral experience and can only be artificially reflected into biological, psychological, social, and spiritual dimensions of experience. It is this deepened perspective on health and illness that will shape care in the future. In the face of a growing chronic disease burden and the aging of the population, such a perspective promotes a deeper and more humane approach to care by encouraging practitioners to help people—even those for whom there is no cure or those who may be dying—become as wholly functional as possible. As society continues to refine and redefine its understanding of health and health care, several questions arise. How can health care practitioners reform their approach to patient care to correspond with these new foundations? How can health professions education programs develop a cadre of practitioners who approach patient care in a manner that addresses the complex interconnected processes in health and illness? How can educa-

tional programs address values and beliefs related to patient care?

The Emerging Health Care System

Consideration of new constructs for health and illness—and the approaches to care that such constructs imply—must occur within the context of emerging changes in the national health care system. Even without the passage of federal or state reform proposals, the health care market is undergoing a fundamental realignment of its institutions and professionals into integrated systems of care. Proposals to reform the health care system typically focus on three issues—cost, quality, and access—and the complex restructuring of finance and delivery systems that will result, it is hoped, in cost containment, quality improvement, and expanded access. As important as these issues are, however, health care system reform also must address the skills, attitudes, and values that health care practitioners will need to function effectively in a new system (O'Neil, 1993). Although the new system may have the potential to allow integrated, comprehensive care, such care will not necessarily occur unless we attend specifically and explicitly to the day-to-day work of the practitioner and the education required to do that work.

American health care often is based on an individual, disease-oriented, subspecialty-focused model that has led to a focus on cure at all costs, resulting in care that is fragmented, episodic, and often unsatisfying for both patients and practitioners. We are at risk, in a new health care system, of reproducing the same attenuated patient-practitioner relationships and professional isolation. Although certain aspects of the emerging health care system, such as an emphasis on health promotion and disease prevention and attention to outcomes of care, may facilitate a more integrated approach, other elements may do the opposite. Information systems and computer-based decision support systems, defining patients as consumers, viewing health care delivery as a managerial rather than professional enterprise, cost-containment efforts, pressures for greater productivity and throughput, and increased reliance on sophisticated technology all have the potential to inhibit the development of the relationships that practitioners need to form with patients in the context of their communities and with other

practitioners in order to provide comprehensive, integrated care. If we are in the process of a health care system redesign, can the new system produce integrated care that accommodates the diverse perspectives of those we serve, and can it promote—rather than erode—caring activities?

Redefining Health Care in a Changing Environment

Practioners' relationships with their patients, their patients' communities, and other health care practitioners are central to health care and are the vehicle for putting into action a paradigm of health that integrates caring, healing, and community. ❄

*Philosophical Foundations**

Contemporary health sciences and health professions education still are operating to some extent within the legacy of an inadequate scientific paradigm (Engel, 1988). This paradigm separates bodily conditions of the human from mental states, life events, relationships, and environmental conditions that may be viewed as influencing disease but are seen as secondary to determinants and causes of disease at the molecular or cellular level. When medical scientists find causal relationships between these states, events, relationships, or conditions and the material conditions of the body, these causal relationships are considered anomalies and the issue is to find the physical and chemical equivalent of the effect. When it reduces problems to the level of organ or cell or molecule, biology—the science of life—tacitly excludes psychology, ethology, and ecology.

* *The task force is grateful to Ian R. McWhinney, M.D., for articulating the concepts discussed in this section.*

The body is viewed as a mechanism. Comprehensive, contemporary health care that recognizes and addresses multiple, inseparable influences on health requires a different paradigm (see, for example, Cunningham, 1986; Engel, 1977; Foss & Rothenberg, 1987; Freymann, 1989; McWhinney, 1988; von Uexküll & Pauli, 1986; von Uexküll et al., 1993; White, 1988).

In the alternate paradigm, living beings are viewed as organisms rather than machines, with properties that no machine has: those of growth, regeneration, healing, learning, and self-transcendence. Even medical therapies that are most machine-like would be ineffective without the innate healing powers of the organism. Living beings, including people, are self-organizing systems, maintained in a state of dynamic equilibrium by a continuous information flow within themselves and between themselves and their environment. Living systems at any level behave purposefully to maintain coherence under conditions of constant change, both within and outside the system. A circular flow of information provides sensory information on the state of the being and its relationship with its environment and relays information to effectors of behavior. Information, which may be transmitted in many forms from chemical to verbal, transcends the traditional mind-body division. Information is transmitted in coded form and must be decoded by the receiving system before the meaning is acted on. The meaning of the coded message depends on its context as well as on the capacity of the recipient to interpret the information. This principle applies at all levels, from cellular to interpersonal, and thus meaning, like information, is a term that transcends the mind-body division.

This organismic paradigm has implications for our notions of disease causation, therapy, healing, and the relationship between healer and patient. Recent work at the frontiers of psychology, neurology, and immunology has demonstrated neural networks and receptors in the cells of the immune system (Ader et al., 1991). The immune system in animals can be conditioned to respond to an inert substance in the same way that Pavlov's dogs salivated at the sound of a bell. The immune system is therefore susceptible to the organism's interpretation of the meaning of a stimulus. Individual people have shown that they can alter their immune response both voluntarily and under hypnotic suggestion (Black et al., 1963; Smith et

al., 1983; Smith et al., 1985). The most plausible explanation of the beneficial effect of placebos—an anomaly within the mechanistic paradigm—is that it is a response of the organism to the symbolic meaning of a therapeutic relationship. There is abundant and growing scientific evidence, not only for the effect of relationships on health, but also for the physiological basis of these effects.

The doctrine of specific etiology has been a dominant feature of the mechanistic paradigm, one cause being sought for each disease, based on the model of infectious diseases (Dubos, 1980). This way of thinking can still be seen in controversies about the cause of newly described syndromes like chronic fatigue syndrome. In the organismic paradigm, etiology is viewed as a complex web of interacting causes, even when a proximal cause can provide the opportunity for therapeutic intervention. Rather than forces acting on a passive being, external agents may be triggers releasing processes that are already inherent in the person. The cause that precipitates an illness may be different from the causes that maintain it (i.e., the causes of chronicity, delayed healing, or death). This challenges the healer to identify the factors inhibiting healing and help the patient to strengthen and release his or her own healing powers. Since supportive relationships are one of the factors promoting healing, the relationship between healer and patient assumes major importance. Just as the relationship has the power to do good, it also has the potential for harm if, for example, the patient feels misunderstood, demeaned, or rejected.

The previously dominant paradigm of science has assumed that the observer is outside the phenomena being observed. The extension of this assumption in the health sciences—especially medicine—has been the notion that the physician can be a detached observer of the patient, whether acting as investigator or therapist. In the alternative paradigm, the observer stands within—and participates in—the observed phenomena. Living beings do not simply register sensory signals, but rather they interpret them. Perception is not a passive process. It always involves interpretation in the context of the observer's mental set. A living being therefore constructs its own environment or subjective world and accommodates itself to its perceptions. Modern medicine has constructed a subjective world of abstractions—diseases—that is often distant from

the subjective world of patients. This world of abstractions has enabled medical scientists to control the phenomena of illness with a great deal of success; this success, however, will not be complete if the subjective worlds of physician and patient are not consistently brought closer together. "Science," wrote Merlau-Ponty, "manipulates things and gives up living in them" (1964, p. 159).

A change of paradigm requires that physicians and other health professionals acknowledge and value their capacity to be self-reflective; that is, make explicit their ability to reflect on their own interpretations of the phenomena of illness and the importance of doing so. In this way, they can become more open to different ways of responding to the experience of their patients, especially their sufferings. Healer and sufferer are not separate and independent units. Each is an observer of the other: each interprets and constructs a subjective world, and these worlds are modified by the dialogue between them. Both healer and sufferer are changed in the process. Healer and sufferer, human and environment, form an inseparable unit of interdependent subjects. The notion of "subjective" and "objective" as different categories of knowledge becomes untenable. When the knower participates in the known, all knowledge is personal (Polanyi, 1958). *The need for the health professions to become more reflective or contemplative disciplines calls, therefore, for a profound change in professional education, from a curriculum dominated by abstractions and intellectual analysis to one balanced between intellectual analysis and the depths of human experience.* Moreover, intellectual analysis should be founded on a scientific paradigm that allows irreducible mental events and processes to be taken into account as etiologic factors in health and disease.

To be therapeutic, the relationship between healer and patient should have as its foundation a shared understanding of the meaning of the illness. This requires the healer to respond to the experience of the patient. In some cases, the healer also must be able to understand the meaning of the illness to and through a person who is close to the patient, such as a parent, caregiver, or spouse. This may occur, for example, when the patient is a small dependent child or intellectually handicapped. It also occurs when the patient and practitioner speak different languages, requiring a translator to serve as the conduit between the two. In such cases the healer must be able to enter

the mind and heart of the third party rather than relate directly or solely to the patient. Accounts written by thoughtful patients suggest that many health care professionals—especially physicians—have a limited capacity to sense meaning, especially at the affective and spiritual levels (Frank, 1991; Hawkins, 1993; Price, 1994; Toombs, 1992). Since different health professions construct different (although perhaps overlapping) worlds of health and disease, it is necessary for professionals to work together in relationships with one another, rather than merely to refer patients to one another.

In light of this new paradigm, we find that describing an integrated approach to health care as merely attending to psychosocial concerns *in addition to* biomedical concerns both is misleading and perpetuates the reduction of complex problems and situations to abstractions. Even the term biopsychosocial—widely used to denote an integrated approach to care—could be taken to imply that human experience consists of three separate realms. The way in which we describe an integrated approach also has a fundamental bearing on the ways in which we recommend that health professions education change. The capacity in a healer to sense meaning is not in the first instance a discrete competency to be learned, but rather a different way of seeing or an awakening to a different way of being a healer. Only when this has occurred can competencies be learned and applied. Specifying what must be added on to biomedical content obviously is insufficient. Including additional courses in the behavioral sciences to enable future practitioners to deal more effectively with psychosocial problems misses the point if they are treated as a separate branch of knowledge from biomedicine. For example, why should the effect of conditioning on immune response not be taught in a course on physiology? Why should the placebo response not be dealt with in clinical pharmacology? Is the human experience of blindness not appropriate for the course on ophthalmology? Why should an account of the meaning of the illness for the patient not be an essential feature of clinical diagnosis? We must reject terminology that promotes continued separation of the human experience into biologic and psychosocial components. In effect, we must reject the very terminology that has described our group and its work: the Pew-Fetzer Task Force on Psychosocial Health Education. We instead must struggle to find new

ways to speak of—and teach—a transformed approach to health care, an approach that has as its center the relationships within and among persons within which truly comprehensive and contemporary care can occur. The biggest "psychosocial" problem facing us may be the need for our own personal transformation—to understand and promote change within ourselves.

Relationship-centered Care

Practitioners' relationships with their patients, their patients' communities, and other practitioners are central to health care and are the vehicle for putting into action a paradigm of health that integrates caring, healing, and community. These relationships form the context within which people are helped to maintain their functioning and grow in the face of changes within themselves and their environments. Practitioners' relationships with individual patients both allow and demand attention to each person in all of his or her complexity—especially the meaning of health and illness to that person—rather than only to a disease or organ system within that person. Relationships with the community and with other practitioners are necessary in order to address fully the multiple manifestations and causes of illness and to promote the well-being of the whole person. Such relationships permit attention to a wider variety of options for caring and healing beyond the subspecialty cure focus that has become the norm. In addition, relationships among practitioners provide the moral, ethical, and spiritual basis for support and self care.

Consider, for example, the case of a 45-year-old woman who developed ischemic heart disease that led to a coronary artery bypass (described in McWhinney, 1989). After her surgery, when she returned to her profession as a piano accompanist, she experienced sharp chest pain whenever she played the piano. After many ECGs, showing no change, and visits to the doctor, she was advised to give up her profession. Her husband and son dealt with their anxiety by avoiding the subject of her illness. She became depressed and lost her interest in life and was treated with anti-depressive medication that caused unpleasant side effects. At this stage, she saw another physician who began by asking what her illness—especially its

effect on her work—meant to her. She said that if she could not continue with her music, she would rather die. Although she had been assured that the chest pain was not cardiac, the repeated ECGs suggested to her that there were some doubts. Her new physician enlisted the help of a physiotherapist who had an interest in pain and a cardiologist who would provide unequivocal reassurance and put a stop to the repeated ECGs. The doctor also brought the family together for an open discussion and saw the patient each week. A year later, she had resumed her work, regained her interest in life, and ceased taking medication.

This case illustrates the difficulty of dividing illness into biomedical and psychosocial components. There were good anatomical reasons for her pain, which was brought on by an interaction with her environment, i.e., piano playing. Threatened loss of her music invoked grief, which was manifested in the body. Withdrawal of her husband and son exacerbated her grief, which reinforced her pain. Therapy was both physical and symbolic, the latter in the form of support by doctor and family. The key was the doctor's effort to understand the meaning of the illness. The relationships that the doctor formed with the patient and her family and with the physiotherapist and cardiologist were critical as well.

In other cases, relationships with the community might also be of critical importance. With regard to treating a patient with illness related to cardiovascular disease, for example, a practitioner might need to mobilize resources to counter the effects of poverty and isolation for an individual patient or for a group of people (for example, those living in a public housing complex for the elderly). Other areas of involvement might include advocating for smoke-free environments, exercise and recreational facilities, screening clinics, lipid-lowering options on restaurant menus, and so on.

Relationships with other practitioners are important in promoting attention to the many dimensions of the illness experience. Within a community of practitioners, members must be able to interpret one another's work, resolve conflicts related to the care of the patient, allow responsibilities and leadership to shift as the patient's needs change, and provide support for one another. A comprehensive team approach—in its capacity to prevent relapse or premature morbidity—also may prove more cost-effective than tradi-

tional subspecialty care. The team of practitioners who might be involved in caring for the person with illness associated with cardiovascular disease might include, for example, a psychologist and a massage therapist in the stress reduction clinic, generalist and specialist physicians and nurses, a health educator in the stop-smoking program, a nutritionist, a chaplain, a physical therapist in the cardiac rehabilitation exercise program, pharmacists, community leaders, public health workers, firefighters who teach cardiopulmonary resuscitation, and others, all working together to provide comprehensive care. The team, however, cannot divide the patient into psychological, social, biological, and spiritual parts and treat each discretely while ignoring the rest. Each team member must recognize and act upon the interconnectedness of the emotional, social, physical, and spiritual aspects of well-being and illness—perhaps emphasizing one of these perspectives, but aware that his or her relationship and work with the patient has an effect on the patient's overall well-being. The physician, for example, cannot treat a discrete physical ailment and simply refer social issues to a social worker and psychological issues to a psychologist. Within the context of the physician-patient relationship, the physician's support for the patient is in fact a social and emotional issue that affects the patient's well-being and capacity for healing.

Dimensions of Relationship-centered Care

The following interrelated relationships are essential within a reformed system of health care, and each involves a unique set of tasks and responsibilities:

• THE PATIENT-PRACTITIONER RELATIONSHIP. The work of the practitioner within this relationship includes organizing information about the patient and his or her care; providing comprehensive biomedical care; critically reflecting on practice to increase self-awareness; practicing from a caring, healing ethic and perspective that seeks to preserve the dignity and integrity of the patient and the patient's family; listening and communicating openly and effectively; seeking to eliminate abuses arising from power inequalities with regard to race, sex, education, occupation, and socioeconomic status; encouraging the active collaboration of the patient and family in decision-

making, care, and treatment; and promoting health and preventing illness in the individual and family.

• THE COMMUNITY-PRACTITIONER RELATIONSHIP. The community is a central context for health and human development that has the potential for producing injury or healing. Individuals simultaneously belong to multiple communities formed by neighborhoods, cultures, work groups, or circumstances. As an example of the latter situation, a person hospitalized for an extended period of time becomes part of the hospital community. Through their relationships with—and memberships in—various communities, practitioners have a voice and substantial responsibilities in the work that focuses on the cultural and environmental determinants of health (Inui, 1992). They need to understand the broad social, political, cultural, economic, and political determinants of health; recognize and act in accordance with the values, norms, social and health concerns of the community; develop a sense of community responsibility; be able to recognize harmful elements within the community; and work to change harmful aspects of the community and improve its health.

• THE PRACTITIONER-PRACTITIONER RELATIONSHIP. Effective, empathic care requires a community of practitioners who commit themselves to working together to serve the complex matrix of individuals' needs in health and illness. Relationships among practitioners include those within or across disciplines, and those between practitioners and practitioners-in-training. These relationships require teamwork, shared values, learning from and making use of the expertise of others, helping others learn and develop, integrating services at individual and systems levels, and setting aside issues of specialism, hierarchy, and privilege. Such relationships serve the needs of practitioners as well as patients: building communities enables health care providers to care for one another and give and receive the support and encouragement that produces personal and professional maturation and more effective patient care.

Creating Relationship-centered Care

Specialized scientific knowledge that separates and distinguishes the various professions has formed the core of most traditional definitions

of professional practice. Increasingly, however, scholars are realizing the importance of a transformed perspective on professional practice and education that focuses not only on the technical knowledge unique to each profession, but also on the competence required to work within the "indeterminate zones of practice," which are those aspects of practice that surround technical knowledge as it is applied to a unique situation or individual (Harris, 1993; Schön, 1987). For the health professions, such competence often revolves around the complexities and uncertainties involved in caring for people's health in relationships with patients, communities, and other practitioners. Here we attempt to delineate the knowledge, skills, and values that allow practitioners to enter into and work more competently within these relationships. In depicting knowledge, skills, and values in this way we risk misinterpretation: we are not advocating the acquisition of a collection of discrete proficiencies, but rather are attempting to define the constellation of factors that constitute a transformed way of being a health care professional.

KNOWLEDGE, SKILLS, AND VALUES FOR THE PATIENT-PRACTITIONER RELATIONSHIP. To work effectively within this relationship, the practitioner must develop knowledge and skills in, and attribute value to, each of the following four areas: (a) self-awareness and continuing self-growth, (b) the patient's experience of health and illness, (c) developing and maintaining relationships with patients, and (d) communicating clearly and effectively. See Table 1 for a summary. For the practitioner-in-training, these four areas form a developmental sequence or process, beginning with *self-awareness*, self-knowledge, and self-care, which serve as the foundation for subsequent development within other areas and ultimately as the foundation for all caring and healing relationships. Valuing self-awareness and developing a capacity for reflection are critical. Who practitioners are as persons is most relevant to the quality of care that they give and to the quality of the relationships that they are able to form. Without self-knowledge, a practitioner's own emotional responses to patient needs may act as a barrier to effective care and can result in harm to the patient. Self-care is essential: over the course of a lifetime of service, the practitioner

is a resource for an enormous number of people. It is only reasonable that practitioners should treat themselves with the same respect and care given to any important resource.

Self-awareness on the part of the caregiver provides the basis for understanding one's own health and relationships and sets the stage for understanding *the patient's experience of health and illness and the meaning of the experience to the patient*. This involves appreciating the patient as a whole person, recognizing the importance of knowing an individual's life and illness stories and their meaning, being able to imagine the life of the patient, and comprehending the role of family, culture, and community in the individual's development. Recognizing the whole person perspective of health and well-being—emotional, physical, social, and spiritual—is essential, as is the ability to recognize that the many threats and contributors to health are, to the patient, dimensions of one reality, not separate realities. Such threats and contributors may be biological, psychological, behavioral, social, economic, spiritual, environmental, or even practitioner-related. The practitioner must be able to view health and illness in the context of the individual's lifelong process of growth and development.

Appreciating the patient's experience of health and illness and his or her need for and right to care and respect creates the conditions for preserving the dignity and integrity of the patient within the practitioner-patient relationship. In order to *develop and maintain caring, healing relationships with patients*, the practitioner requires capacities and abilities in several areas. Along with technical knowledge and skills related to biomedicine, the practitioner must be able to attend fully to the patient, establish and sustain respect for the patient's dignity, integrity and uniqueness, and accept and respond compassionately to his or her own distress and the patient's pain. The practitioner must value the person's right to self-determination in the context of his or her life and relationships, respect the person's own power and self-healing processes, and recognize the potential within the patient's relationships with family members and other patients (e.g., through self-help groups). The practitioner also must be prepared to respond to the moral and ethical challenges that arise in the relationship and must understand threats to the integrity of the relationship and the potential for conflict. The presence of power—and its potential for abuse

as well as for responsible and ethical use—must be recognized (see, for example, Brody, 1992).

Finally, successful relationships with patients require providers *to communicate clearly and effectively*. Practitioners first must know the elements and impact of effective communication. Necessary skills include the ability to impart information, listen openly and nonjudgmentally, learn, facilitate the learning of others, and encourage the expression of—and accept—the patient's emotions.

AREA	KNOWLEDGE	SKILLS	VALUES
Self-awareness	Knowledge of self Understanding self as a resource to others	Reflect on self and work	Importance of self-awareness, self-care, self-growth
Patient experience of health and illness	Role of family, culture, community in development Multiple components of health Multiple threats and contributors to health as dimensions of one reality	Recognize patient's life story and its meaning View health and illness as part of human development	Appreciation of the patient as a whole person Appreciation of the patient's life story and the meaning of the health-illness condition
Developing and maintaining caring relationships	Understanding of threats to the integrity of the relationship (e.g. power inequalities) Understanding of potential for conflict and abuse	Attend fully to the patient Accept and respond to distress in patient and self Respond to moral and ethical challenges Facilitate hope, trust, and faith	Respect for patient's dignity, uniqueness, and integrity (mind-body-spirit unity) Respect for self-determination Respect for person's own power and self-healing processes
Effective communication	Elements of effective communication	Listen Impart information Learn Facilitate the learning of others Promote and accept patient's emotions	Importance of being open and nonjudgmental

Table 1
Areas of knowledge, skills, and values for the patient-practitioner relationship

KNOWLEDGE, SKILLS, AND VALUES FOR THE PRACTITIONER-COMMUNITY RELATIONSHIP. Forming a relationship with a patient requires establishing a relationship with the patient's community as well. A great many health concerns that individuals bring to the patient-practitioner relationship have their origins in the community and its institutions, are affected by characteristics of the community, or can best be addressed within the community. In addition, by working to solve community problems not associated with one particular patient, health care practitioners can have a positive impact on the health of many.

The knowledge, skills, and values necessary for practitioners to effectively participate in and work with communities fall in four areas: (a) the meaning of community, (b) the multiple contributors to health and illness within the community, (c) developing and maintaining relationships with the community, and (d) effective community-based care. Table 2 summarizes these areas. With regard to the *meaning of community*, the practitioner must learn about various models and definitions of community as well as myths and misperceptions of community. Perspectives on community from the social sciences and humanities can help the developing practitioner better understand and interact with communities. These include concepts from sociology and cultural anthropology, the concept of social justice, and the general perspective of systems theory as applied to the understanding of community dynamics. In addition, knowing the impact of demographic, political, economic, and industrial trends on community life and health and learning about similarities and differences between rural and urban communities are significant in helping practitioners understand the communities in which they live and work. Given the changing nature of communities, the practitioner must be capable of continuous self-directed learning and active participation in community development and dialogue. He or she also must value and respect the integrity and diversity of the communities that form the context of patients' lives.

One can identify *multiple contributors and threats to health within the community*. Practitioners must know the history of the community—including the migration histories of its people and the history of how its resources (natural and man-made) have been safeguarded or abused—and the implications of this history for

the health status of the community. Also important is knowledge of the physical, social, economic, political, and occupational environments within the community, their effect on health, and recognition of the internal and external forces that influence the overall health of the community. Practitioners also need to affirm the relevance to health care of all determinants of health and affirm the value of health policy in community education, public safety, transportation, and so on. The ability to assess community and environmental health using multiple approaches is critical to developing effective working relationships with communities. Such approaches include using public health indicators, self-assessment strategies, quality of life measures, cultural measures, and indicators of environmental factors. Practitioners must be able to identify factors that improve or maintain health as well as those that are harmful. Also important are recognizing and assessing the efficacy of both formal and informal care-giving and assessing community policies that affect health.

Developing and maintaining relationships with the community forms the foundation for effectively caring for the community's health. Practitioners should understand the history of practitioner-community relationships and of health care and health care institutions in the community, and the often long-standing isolation of the health care community from the community at large. To develop and maintain relationships with the community requires first the ability to maintain an open stance that encourages community members to seek input from health care practitioners in the process of community decision-making. In addition, it requires being able to communicate ideas effectively to promote mutual understanding, listen openly to others, use strategies for empowering others, learn continuously, and facilitate the learning of others. Open-mindedness and honesty about the limits of health science must be maintained. Practitioners also must develop both a sense of responsibility about contributing health expertise and sensitivity to existing beliefs when doing so.

Effective community-based care requires that practitioners understand various types of care, both formal and informal, including lay care, self-help groups (e.g., Alcoholics Anonymous), nonallopathic traditions of care, home care, and care given in community-based institutions such as schools, hospitals, clinics, workplaces,

churches, migrant health centers, nursing homes, homes for the aged, group homes, and halfway houses. Also important is knowing about the effects of institutional scale (large vs. human-scale) on the community health care system and the positive impact of continuity of care within communities of practitioners and within the broader community. Critical to effective community-based care is the practitioner's skill in collaborating with other individuals from both professional and lay organizations and in building and working within heterogeneous teams or healing communities of practitioners. Practitioners must be committed to working to change the community for the better and have the skills to implement effective change strategies. Value must be placed on community members' leadership in defining needs and allocating resources.

AREA	KNOWLEDGE	SKILLS	VALUES
Meaning of community	Various models of community Myths and misperceptions about community Perspectives from the social sciences, humanities, and systems theory Dynamic change—demographic, political, industrial	Learn continuously Participate actively in community development and dialogue	Respect for the integrity of the community Respect for cultural diversity
Multiple contributors to health within the community	History of community, land use, migration, occupations, and their effect on health Physical, social, and occupational environments and their effects on health External and internal forces influencing community health	Critically assess the relationship of health care providers to community health Assess community and environmental health Assess implications of community policy affecting health	Affirmation of relevance of all determinants of health Affirmation of the value of health policy in community services Recognition of the presence of values that are destructive to health
Developing and maintaining community relationships	History of practitioner-community relationships Isolation of the health care community from the community at large	Communicate ideas Listen openly Empower others Learn Facilitate the learning of others Participate appropriately in community development and activism	Importance of being open-minded Honesty regarding the limits of health science Responsibility to contribute health expertise
Effective community-based care	Various types of care, both formal and informal Effects of institutional scale on care Positive effects of continuity of care	Collaborate with other individuals and organizations Work as member of a team or healing community Implement change strategies	Respect for community leadership Commitment to work for change

Table 2
Areas of knowledge, skills, and values for the community-practitioner relationship

KNOWLEDGE, SKILLS, AND VALUES FOR THE PRACTITIONER-PRACTITIONER RELATIONSHIP. The quality of the relationships among members of a service community affects the capacity of everyone within it to form effective relationships with patients and communities. Comprehensive care that addresses the multiple contributors to health and illness requires the collective work of many people from a wide range of professions. Forming a practitioner community that encompasses diverse professions requires knowledge, skills, and values related to (a) self-knowledge, (b) traditions of knowledge in the health professions, (c) team and community-building, and (d) working dynamics of groups, teams, and organizations. Table 3 provides a summary. Just as *self-awareness* must be the foundation of effective relationships with patients and their families, so must it be the foundation of effective relationships with other practitioners across the spectrum of health professions. Awareness of and respect for *traditions of knowledge in the health professions* also is critical. Practitioners should know about the healing approaches of other professions and cultures, be aware of historical power inequities across professions, be able to identify similarities and differences among the traditions of members of the community, know the value of others' work, and continuously learn from the experience of working with people from other disciplines and healing traditions. Affirming and valuing diversity are necessary as well.

In order to engage in the process of *team and community-building,* practitioners must begin by affirming the shared mission, tasks, goals, and values of the team or community. Perspectives from the social sciences can form the foundation of knowledge necessary to begin team-building, which also requires that practitioners be able to listen openly, communicate effectively, and learn cooperatively. Diversity must be recognized, valued, and utilized. Not only will team or community members bring different traditions of knowledge to the group, but they also will bring different skills, cognitive styles, ways of perceiving, and degrees of readiness to learn and function as team members. The effect on team development of sometimes enormous differentials in salary and status across professions must be recognized and dealt with.

Finally, practitioners must attend to the knowledge, skills, and values related to the *working dynamics of teams, groups, and organizations.* The

social sciences offer a body of knowledge and a range of perspectives—including systems theory—for understanding the dynamics that revolve around issues of membership and leadership, norms, goals, problem solving, and group behavior. Skills in collaborating with others, working cooperatively, and resolving conflicts in a democratic manner are key. Underlying these skills is the capacity to share responsibility in a thoughtful—not compulsive—way. Members of the group or community must remain open to others' ideas, display an attitude of humility, and value the mutual trust, support, and empathy of all participants. In addition, they must exhibit a capacity for grace, which represents an attitude of decency, thoughtfulness, and generosity of spirit toward others.

AREA	KNOWLEDGE	SKILLS	VALUES
Self-awareness	Knowledge of self	Reflect on self and needs Learn continuously	Importance of self-awareness
Traditions of knowledge in health professions	Healing approaches of various professions Healing approaches across cultures Historical power inequities across professions	Derive meaning from others' work Learn from experience within healing community	Affirmation and value of diversity
Building teams and communities	Perspectives on team-building from the social sciences	Communicate effectively Listen openly Learn cooperatively	Affirmation of mission Affirmation of diversity
Working dynamics of teams, groups, and organizations	Perspectives on team dynamics from the social sciences	Share responsibility responsibly Collaborate with others Work cooperatively Resolve conflicts	Openness to others' ideas Humility Mutual trust, empathy, support Capacity for grace

Table 3
Areas of knowledge, skills, and values for the practitioner-practitioner relationship

Summary

Understanding the three dimensions of relationship-centered care creates a more integrated and comprehensive view of health care. The relationships that practitioners form with the patient, with the community, and with other practitioners all are critical and require balanced attention. When in balance, all three relationships are strengthened. When one is pre-eminent, the others are diminished. Health care is an activity that involves many people—patients, families, caregivers, organizational managers, community leaders, etc.—within a complex matrix of personal, professional, and community relationships. It is not a grand machine, a complex of physical facilities, advanced pharmaceuticals, surgical techniques, or an administrative system, however wonderfully conceived. It is instead an essentially human activity, undertaken and given meaning by people in relationships with one another and their communities, both public and professional.

New Directions for Health Professions Education

Health professions education must help developing practitioners become reflective learners and professionals who understand the patient as a person, recognize and deal with multiple contributors to health and illness, and understand the nature of healing relationships.

The Central Task of Health Professions Education

The central task of health professions education—in nursing, medicine, dentistry, public health, pharmacy, psychology, social work, and the allied health professions—must be to help students, faculty, and practitioners learn how to form caring, healing relationships with patients and their communities, with each other, and with themselves. The knowledge, skills, and values necessary for effective relationships with patients, communities, and other practitioners, as described above, must become the focus of educational programs. Health professions education programs must help developing practitioners mature as reflective learners and professionals who understand the patient as a person, recognize and deal with multiple contributors to health and illness, and understand the essential nature of healing relationships.

Didactic instruction is insufficient. Effective relationship-centered care and effective educational

programs and processes must parallel one another so that students, faculty, and practitioners are immersed in a learning environment. The educational environments we construct will reinforce our teaching-learning agenda or belie our every intent. Relationship-centered care is reflected in learner-centered education. The caring relationship between practitioner and patient is modeled by the nurturing environment that students, faculty, and practitioners themselves create through the quality of their relationships. Goals and objectives of learning and teaching that are mutually established by a community of educators and students can be used to teach the parallel process of collaborative goal-setting within practitioner-patient relationships. Developing a capacity for reflection on practice is modeled by helping people evaluate the strengths and limitations of their prior learning and set goals for future learning. The health professions education institution must become an organization that pervades the community health care system, just as the health care system pervades the community. As such, the institution is not a self-contained set of buildings but is an institution without walls, embedded in the values of—and continually assessing its relevance to—host cultures and communities.

Refocusing education to include both the acquisition of technical knowledge and skills and the development of the capacity to enter into relationships for care requires attention to both the formal and the informal curriculum. The formal curriculum should reflect the discrete areas of knowledge, skills, and values that need to be addressed and also should reflect thoughtful planning for the most effective methods for helping students develop necessary knowledge, skills, and values. Excellence in educational planning and teaching must be valued and rewarded. In addition, attention must be paid to the informal curriculum—the environment, climate, and process of learning. The institution's educational framework must be formed by explicitly stated values that grow from a moral climate emphasizing caring as a legitimate basis for action. The institutional framework should promote and reward informal discourse, collaboration, and relationships among people across programs, professions, communities, and levels of preparation, all learning from one another. This requires emphasizing, exploring, and valuing a great diversity of human resources. Experiences must be provided that help people

learn how to think integratively about the multiple influences on health and illness and to see an integrated, singular reality.

Educational Strategies

The task force has considered the kinds of educational strategies most conducive to helping students, faculty, and practitioners develop the knowledge, skills, and values needed to practice relationship-centered care. The strategies described here are examples and should not be construed as representing an exhaustive description of the universe of appropriate educational approaches. Certain strategies are common to the learning required across all three relationships, and others specifically address a particular relationship.

STRATEGIES RELEVANT TO ALL THREE RELATIONSHIPS. The *apprenticeship* is the critical, core learning experience. Through participation in the daily life of a practitioner-mentor, the learner can develop a long-term relationship through which to learn both by example and by shared, guided reflection on practice and the principles that guide practice. In the apprenticeship, the care of patients and the care of the learner become models for one another. Opportunities for guided reflection can encourage and support personal and professional awareness that leads to continuous growth and development. Such opportunities for reflection also can assist learners and their mentors to cope with the stresses and ethical challenges presented by practice. Through an apprenticeship the learner can develop long-term relationships with patients and families in the context of their communities and daily lives, with curriculum content centered on individual, family, and community health problems. Long-term relationships with patients can allow students to follow individuals through the entire continuum of health care, from home to tertiary care. Interdisciplinary settings are essential to foster the building of teams and the practitioners within them. Finally, the apprenticeship model can embody many principles of effective adult learning in its focus on the problems of actual practice and responsibility and the needs, strengths, and experience of the individual learner (Wilson, 1993).

A second learning strategy relevant to all relationships is the use of *non-competitive, formative assessments* of individuals' educational attainments

and development. A focus on mastery of knowledge and skills rather than norm-referenced grading can serve to reinforce the overarching emphasis on personal and professional development. Such a focus can encourage a non-threatening evaluation method that reinforces an emphasis on relationship-building. Multiple methods—quantitative and qualitative—can be used to assess the wide range of knowledge, skills, and attitudes involved in working within relationships.

Ongoing *support for practitioner and faculty development* is another important educational strategy. Continuing education to develop practitioners and faculty as exponents and exemplars of relationship-centered practice and education can help them better serve their patients, become better teachers and role models, and work more effectively with other practitioners within the healing community. Small group learning experiences may be a fruitful avenue of exploration for promoting faculty development.

Finally, routine *use of information management and dissemination systems* to inform quality improvement activities involving all participants in care is a universally important strategy. It can assist in the integration and analysis of data related to the many influences on health and illness and the multiple practitioners and institutions involved in comprehensive health care. Such systems would serve as tools to organize and analyze information about patterns of practice, outcomes, the origins of variations in care, and the need for quality improvement activities involving patients, system managers, and health workers. In addition to their importance for practitioners-in-training, such information management and dissemination systems provide support for practitioners in linking them to a larger community of practitioners as well as to technical assistance and sources of information.

STRATEGIES RELEVANT TO THE PATIENT-PRACTITIONER RELATIONSHIP. Educational strategies particularly suited to helping students learn about the patient-practitioner relationship can be grouped within a four-stage process. The first stage of the learning process is characterized by *strategies to promote introspection and reflection* to encourage self-awareness and self-knowledge. Such strategies—including counseling, journal writing, peer mentoring, wellness programs, and support groups—allow learners to reflect on work and learning experiences and represent structured oppor-

tunities to optimize individual and professional growth. The second stage is associated with *strategies to promote skills in observation and listening*. Learning activities in this stage include explorations of literature, including patients' and practitioners' stories, and other means to develop knowledge of others and positive regard for patients within the context of their lives. Third, *strategies to promote interaction* involve a constellation of experiential methods, including role play and work with patients and families. Finally, *strategies to promote effective practice* include opportunities for concrete experiential practice of skills in interdisciplinary settings and with clinical role models who demonstrate a whole person approach to care.

STRATEGIES RELEVANT TO THE COMMUNITY-PRACTITIONER RELATIONSHIP. The primary strategy with regard to helping people enter and work effectively within practitioner-community relationships is the *use of the community-based clinic or practice as the fundamental health professions education institution*. Longitudinal attachment of the learner to a community practice can allow continuity both with patients and with a health care team. Long-term experiences within chronic illness, rehabilitation, or special needs facilities are useful as well. Using community health care settings also provides opportunities for community members, students, faculty, and practitioners to learn together about community characteristics and problems and to work collaboratively to advocate for changes to solve those problems. Interdisciplinary community projects—from needs assessment to intervention to evaluation of outcomes—can be a powerful means for learning about effective relationships between practitioners and communities. Another educational strategy related to the community-practitioner relationship is to *recruit faculty for professional and cultural diversity*. Exploration of professional diversity can serve as a model for the examination of cultural diversity.

STRATEGIES RELEVANT TO THE PRACTITIONER-PRACTITIONER RELATIONSHIP. A comprehensive educational program to promote knowledge, skills, and values with regard to this relationship might take the form of an intensive, developmental learning experience involving learners from multiple health care professions and encompassing three strategies: (a) an introductory course, (b) experiential learning in an interdis-

ciplinary health care community, and (c) a debriefing seminar. Figure 1 depicts these strategies and their position within a continuous cycle of education, research and evaluation, and improvements in the quality of health care and the curriculum.

The first strategy is to provide an *introductory course* that includes (a) a seminar to address the foundational knowledge, skills, and values for work within relationships among practitioners and (b) observations of effective teams or healing communities and reflection on those observations. The second strategy is to *provide experience in an interdisciplinary community, or well-functioning team, of practitioners.* This might take the form of a team clerkship involving small groups working in a problem-based, community-oriented, cross-disciplinary setting, servicing real needs, and with horizontal patient care teams. Finally, a *debriefing seminar* would be held to provide opportunities for reflection and discussion on experiences, the development of self-knowledge, team dynamics, social issues, empowerment, and the health care system. An integral part of the overall program is action-oriented research and evaluation focused on team and educational effectiveness and evaluation of the strategy itself and its impact on the community, students, program as a whole, and faculty.

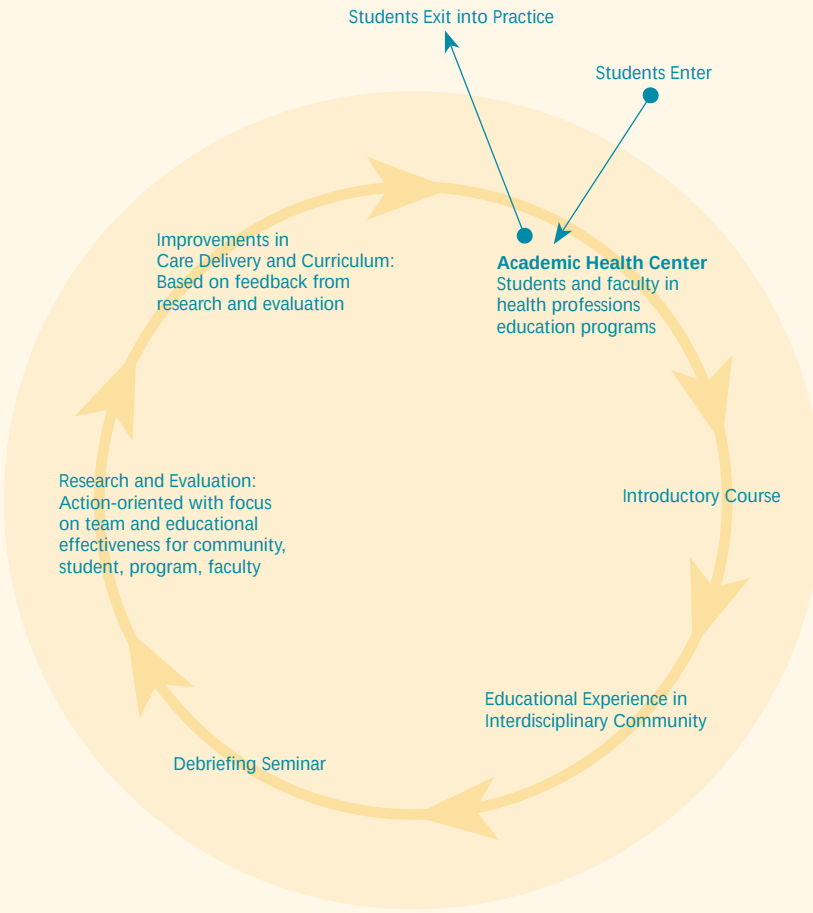

Figure 1
Proposed educational program to address the practitioner-practitioner relationship

Barriers and Facilitators

While many barriers exist to the creation, development, and maintenance of educational programs that teach a relationship-centered approach to care, the task force also identified factors that could serve to facilitate the building of such programs. Although it is easy to construct long lists of discrete barriers and facilitators, they also can be discussed in more general

terms. Clearly, institutional and professional values, missions, and philosophies play an important role in furthering or inhibiting a relationship-based approach. Health professions schools and disciplines that focus on highly specialized biomedical research within a tertiary care setting, for example, may be more likely to have difficulty explicitly incorporating relationship-centered content than are schools and disciplines that focus on providing community-based care to a distinct population. Although relationship-centered care is important in the professional lives of both subspecialist and generalist practitioners, the focus of subspecialist training may leave less time for explicit development of the knowledge, skills, and values associated with such care. Likewise, a focus on pathology rather than on health promotion or whole person care may affect the ease and ways in which relationship-centered care can be addressed. Not to be ignored are the external factors that strongly influence the development and maintenance of institutional values, mission, and philosophy—and the learning activities that they underlie—including funding sources, the political and economic environment, the availability of community health care, the adequacy of human services resources and models, and professional licensing and accreditation requirements.

Institutional values, missions, and philosophies play a role in determining the culture and structure of the institution, which in turn influence the degree to which an educational program addresses elements of relationship-centered care. Faculty and student roles and rituals, the language that is used to describe patients and their care, faculty reward systems, curriculum structures, involvement of the institution in the local community, and student evaluation methods all are affected by the underlying values, mission, and philosophy of the institution. Not only does the academic focus differ across schools, but resources are geared to different purposes. In a tertiary care, basic science research-based culture that focuses on the diagnosis and treatment of diseases, for example, resources may not easily be available for the development of community-based or interdisciplinary educational opportunities for students. Communities that historically have been ignored by academic health centers may be unwilling to develop partnerships and welcome students. Leadership patterns and styles also are part of the culture and help determine whether relationship-centered care can be addressed.

The values and behaviors of individual administrators, faculty, and students also affect and are affected by the institutional culture and can serve to facilitate or block attention to relationship-centered care. For example, for faculty, many factors may affect the capability to engage in relationship-centered care, including previous highly competitive educational experiences, fear of practicing or teaching in an unsafe neighborhood, traditional models of professionalism, lack of faculty development opportunities, lack of respect for community practitioners or cultures, sexism, racism, and information overload. Conversely, self-care and introspection, openness to others' stories and traditions, willingness to accept diversity, and exposure to community role models may facilitate faculty members' interest in developing programs to teach relationship-centered care. For both pre-professional and graduate students, attention to relationship-centered care may be inhibited by prior and current competitive educational experiences, the nature of professional licensure requirements, and the faculty role models encountered.

Recommendations

The task force identifies relationship-centered care as the vehicle for putting into action a paradigm of health that is focused on caring, healing, and community. To develop educational programs that address relationship-centered care, we recommend that health professions schools focus on the three relationships delineated earlier and begin to work across the following four areas: (a) curriculum development, (b) faculty and practitioner development, (c) patients and communities, and (d) research. Curriculum development might occur through developing exemplary care delivery systems in which students and practitioners participate, experimental curricula or alternative pathways, or community-based training sites. Faculty and practitioner development can build recognition for, further develop, and draw on the expertise and experience that currently exist, both within the health care community and in fields outside of health care. Programs for faculty and practitioners might include conferences, peer consultation, workshops, and electronic or print networking. Efforts focused on patients and communities might involve forging links with various

communities and their members through, for example, collaboration with community boards, development of public education programs that help people learn to establish productive relationships with their practitioners, and collaborative work to identify and address community problems. Research and a cadre of well-trained researchers are needed to explicate the dimensions of a relationship-centered approach to care and the means to most effectively help people learn such an approach.

Each of these four areas overlaps and affects the others. Efforts that target faculty and practitioner development, for example, also have an impact on curriculum, patients, and research directions. Research occupies a unique position as it must address two needs. First, it must be an essential part of all programs in the other three categories as a means to assess program effectiveness and outcomes. Second, research that addresses fundamental dimensions of relationship-centered care, curriculum development, and methods of teaching relationship-centered care must undergird and guide all program development efforts. Research efforts, then, are intrinsic to education and practice.

Within the framework suggested here, a great diversity of programs is to be expected and welcomed. Individual schools must develop their own unique ways of addressing relationship-centered care and ensure that their programs grow out of their own distinct history, culture, and characteristics. Whatever the specific focus, however, the programs developed to address relationship-centered care should be evaluated with regard to their implicit adherence to six important principles. These principles are as follows:

1. *Health professions educators must view health care as the effort to help restore, maximize, or expand function and meaningfulness in all aspects of life, rather than only to cure pathology. It is critical to understand how the patient sees the illness as it affects his or her life.*

2. *Health professions education must be based on clear, explicit values that are centered on relationships and a commitment to service.*

3. *The quality of the relationships that practitioners form with patients and their families, with communities, and with students and fellow practitioners across professions is of primary importance to ensuring effective, comprehensive education and health care.*

4. *The richest teaching environment is the community, close to the context of patients' lives.*

5. *Learning depends on reflecting on one's experience. Preparation in—and strong encouragement of—such reflection needs to be part of both formal and informal health professions education.*

6. *New methods of care and education that are guided by an integrated approach must be evaluated to determine their effectiveness and impact on the patient, the practitioner, the community, the student, and the faculty.*

In conclusion, we believe that this document can serve as a useful framework for program development. Ultimately, each institution must develop its own strategies for helping students learn a relationship-centered approach to care. We hope that this report proves valuable in giving direction to program development efforts and that health professions educators will continue the work begun here by delineating, implementing, and evaluating a variety of educational approaches.

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Appendix A

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Appendix B

SUMMARY OF THE PEW-FETZER STUDY OF BIOPSYCHOSOCIAL CURRICULA IN HEALTH PROFESSIONS EDUCATION

Carol P. Tresolini, Daniel A. Shugars

IN JANUARY 1992, the Pew Health Professions Commission and the Fetzer Institute jointly initiated a research project to study the incorporation of biopsychosocial, or mind-body, issues in health professions education. In its first report, the Commission outlined a set of competencies that will be required of practitioners in a changing system and that health professions schools should address in their curricula (Shugars et al., 1991). These competencies reflect the importance of knowledge and skills in both the biomedical and psychosocial domains. For the Fetzer Institute, with its commitment to promoting a wider and more integrated view of health and health care, the development of health professions education programs that incorporate a mind-body perspective is of critical importance.

THE BIOMEDICAL MODEL has formed the foundation and defined the character of contemporary American medical practice and education (Ludmerer, 1985). There is a growing perception, however, that the biomedical model cannot fully reflect the broad clinical realities of modern health care and that practitioners must

have knowledge and skills that reflect the interdependence of biomedical and psychosocial factors in health (White, 1988). Some health professions schools provide opportunities for students to learn about the interaction of psychosocial factors with physiological factors in the maintenance of health and the treatment of illness. Little comprehensive information is available, however, about these programs or how to incorporate them successfully in the curriculum. The purpose of this study was to learn about how schools can help students learn an integrated approach to patient care and begin to explore ways to encourage its broader incorporation. Specifically, our goals were to: (1) define the scope of social, cultural, contextual, behavioral, and psychological issues relevant to health care and health professions education, (2) identify programs that teach students an integrated approach to patient care, (3) gather information about program characteristics (content, organization, teaching methods. etc.), (4) identify barriers and facilitators to the development of programs reflecting an integrated approach to health care, and (5) establish a system to disseminate information about such programs.

FIVE INTERRELATED STEPS constituted the method of this study. Although our concern is with all health professions, we made medical education our initial object of attention. We plan to widen our focus to other health professions in the future. The five steps of the project are summarized below.

STEP ONE

Define the scope and nature of the biopsychosocial issues relevant to health professions education

TO BEGIN TO DEFINE the scope of issues relevant to health professions education, we examined the literature concerning the need for a new model that integrates psychosocial and biomedical factors. As we have described elsewhere (Tresolini & Shugars, 1994), several models have been proposed to describe an approach to patient care that extends beyond the primary biomedical focus

to integrate psychological, social, and behavioral factors in health. Engel's biopsychosocial model (1977), perhaps the most widely known, provides a structure for studying and addressing the dynamic interrelations of social, cultural, community, family, interpersonal, behavioral, psychological, and physical systems that promote or inhibit health in an individual. Biobehavioral and social scientists also, study by study, are building a framework for a broader approach to health care by investigating the impact of discrete personal behaviors, social and economic conditions, and psychological characteristics on particular aspects of physiological functioning and health (Ader et al., 1991; Hamburg et al., 1982; House et al., 1988). Foss and Rothenberg (1987) offer an alternative to both the biopsychosocial model and the biobehavioral approach. Their infomedical model describes a dynamic system with interactive biological, psychological, and contextual levels of organization. Finally, the population perspective goes beyond looking at the interaction of systems as they affect individuals to focus attention on the needs of populations and the individuals within those populations. This perspective highlights the importance of social, cultural, economic, and political factors in addition to physiology and genetics in assessing contributions to individuals' health (Showstack et al., 1992). In this model, the physician's role explicitly includes an expanded set of functions on both the clinical and societal levels (Inui, 1992).

BASED ON THIS LITERATURE REVIEW, we developed a model that describes the multiple factors that influence health—social-contextual, psychological, physiological, behavioral, and spiritual—and the multiple strategies that therefore can be used to maximize health. These strategies include biomedical therapies, improvements in patient-caregiver interactions, alternative and adjunctive therapies, social support, and various initiatives in public health, social policy, economics, and public policy. The model also outlines the health outcomes of attending to multiple influences on health and using multiple strategies in health

care. The model holds implications for health professions education in that it suggests both areas of content knowledge and areas of skill development that should be addressed in order to maximize health outcomes for individuals and populations. The product of this step of the research project is a report entitled "An Integrated Conceptual Model for Health Professions Practice and Education" (Tresolini & Shugars, 1992).

STEP TWO

Characterize the nature of an integrated approach to health care and how it can be incorporated in health professions education

HAVING EXPLORED VARIOUS MODELS for extending health care beyond the biomedical model, we turned our attention to investigating how medical schools can best help students learn an approach to health care that reflects the integration of psychosocial and biomedical factors in health (Tresolini & Shugars, 1994). The following questions guided this step of the research project:

- How are the scope and character of an integrated approach defined by experts in the field?
- What are the various ways in which integrated approaches are being included in medical curricula?
- How can integrated approaches be fully incorporated?
- What are the barriers and facilitators to the incorporation of an integrated perspective in medical curricula?

WE USED A QUALITATIVE RESEARCH DESIGN and collected data through semi-structured interviews with 22 experts in the field as well as through document review. Documents reviewed included books, articles, curriculum guides, evaluation instruments, and conference proceedings that were written, edited, or developed

by interviewees, as well as documents cited by interviewees as being significant to them in developing ideas about an integrated perspective or incorporating such a perspective in medical education.

RESPONDENTS' DEFINITIONS of an integrated approach to health care included (1) a broader scientific model for understanding health and illness, and (2) a more inclusive approach to medical practice than is offered by the biomedical model. Both micro (patient level) and macro (community level) approaches were deemed important. Interviewees described many existing programs that incorporate an integrated approach, including the following: courses in the behavioral sciences and the humanities, problem-based courses with objectives in the psychosocial domain, longitudinal courses on the doctor-patient relationship and medical interviewing, community-based clinical rotations, support groups, and Balint groups. Existing programs were described, however, as limited, incomplete efforts.

IDEAL CURRICULA TO FULLY INCORPORATE an integrated approach were envisioned by the respondents to be *patient-centered* (e.g., case-based, with early clinical experience), *integrated* (e.g., intertwined clinical and basic sciences, including the social sciences and humanities, content reflecting mind-body integration, teaching by generalists) *developmental* (e.g., attending to students' development as individuals and reflective practitioners), and *population-based* (e.g., based in the community's culture and in the context of patients' lives). Many barriers to the establishment of such curricula were cited by the interviewees, including faculty and administrator attitudes, the lower status of the generalist fields, funding difficulties, and the diffuse nature of the organizational structure. However, certain factors also were identified that could facilitate the establishment or extension of such programs, including public pressure for reform of health care and strong, credible, visionary leadership.

STEP THREE Delineate program characteristics through studies of exemplary programs

THE THIRD STEP was designed to examine in depth selected programs that were identified as model programs by the interviewees in the preceding step. The work of this step of the research project has been presented at a meeting of the American Educational Research Association (Tresolini et al., 1994). Six schools were identified as doing an outstanding job in providing opportunities for students and residents to learn an approach to health care that incorporates, in an integrated fashion, both biomedical and psychosocial factors. Five of these schools agreed to participate in the study, and site visits were made to interview faculty, administrators, students, and residents, and to review related documents. The following questions guided our study of these programs:

- In what ways does each school help medical students and residents learn an integrated approach to patient?
- What institutional characteristics are associated with teaching and learning an integrated approach?
- What factors or characteristics facilitate the introduction and maintenance of integrated programs?
- What factors or characteristics represent barriers to the introduction and maintenance of integrated programs?

Qualitative analysis of the data focused on identifying themes related to these questions. In general, these programs help students learn an integrated approach to care through attention to: (1) the patient-practitioner relationship (helping students learn to develop effective, humane relationships with their patients), (2) the responsibilities of the practitioner to the community (knowing the community and addressing health

issues at the community level), (3) the needs of students as developing professionals (reflection, self-awareness, nurturing), and (4) working in concert with a multitude of practitioners in other medical specialties and other professions. Addressing these four areas seems to promote attention to a wide range of influences on health and strategies for dealing with illness. The most striking institutional characteristic was the strong articulation of mission, goals, and values, which were voiced by administrators, faculty, and students. In each case, the underlying mission guided and facilitated the teaching of an integrated approach. Interviewees cited several factors as important in facilitating the introduction and maintenance of programs that teach an integrated approach: (1) institutional mission, (2) effective leadership, and (3) increased national attention to primary care. Although inadequate funding and support for research were mentioned as barriers, interviewees indicated that they proceed with program development in this area as best they can with existing resources.

STEP FOUR Broaden the knowledge base

IN ORDER TO GATHER more extensive information about what other medical schools are doing to help students learn an integrated approach to patient care, we conducted a two-step survey of American and Canadian allopathic and osteopathic schools. In the first stage of the survey, we sent short questionnaires to curriculum deans, asking them to identify the courses or programs that address the patient-practitioner relationship, the community-practitioner relationship, interdisciplinary teamwork, and student development, both personal and professional. We then followed up with the faculty who were identified as responsible for those courses or programs to collect specific information about course goals, students, faculty, teaching methods, student and program evaluation methods, and settings. We initially conducted telephone interviews with fifty faculty to explore the various course and

program characteristics, and then we developed a mail survey instrument based on the data from the telephone interviews. We mailed the survey instrument to an additional 400 faculty, 65% of whom responded.

THE FACULTY WHO ARE PRIMARILY RESPONSIBLE for courses and programs that address these issues are most often affiliated with the departments of family and community medicine, medicine, and the dean's office, but faculty from psychiatry and the behavioral sciences were also represented in the respondent group. The patient-practitioner relationship was the most frequently addressed of the four areas, followed by student development, the community-practitioner relationship, and interdisciplinary teamwork. The course goals that were most frequently mentioned were development of communication and patient relationship skills; acquisition of basic clinical skills and the ability to provide comprehensive, coordinated clinical care; and the development of the ability to incorporate a biopsychosocial perspective in patient care. Teaching methods most often cited were small group sessions, clinical precepting, lecturing, and problem-based learning. The courses described by the respondents are held both in various community settings and within the confines of the academic medical center. Most of the courses are for medical students only, but approximately 20% also include students from other health professions, including nursing, physician assistant, public health, allied health, social work, dentistry, and pharmacy. Most courses also involve faculty members from various clinical and basic science departments, allied health, community agencies, and others. The student evaluation method most frequently mentioned by the respondents was preceptor assessment. Program evaluation methods most often cited were student and instructor evaluations.

STEP FIVE **Develop strategies for promoting health professions education programs that incorporate an integrated approach to patient care**

THE GOALS OF THE FINAL STEP of the research project were to (1) develop a means for networking and information-sharing among faculty who are involved in helping students learn an integrated approach to care and (2) develop additional ideas for the strengthening of health professions education programs in this area. With regard to the first goal, we designed an electronic relational database to house information about programs that incorporate an integrated perspective in their curricula. This will be used to facilitate information dissemination, encourage networking among educators and institutions, and provide assistance to schools interested in establishing or expanding programs.

TO ACHIEVE THE SECOND GOAL, we cosponsored an invitational conference, "Health Professions Education and Relationship-centered Care: A Pew-Fetzer Conference," which was held May 12-13, 1994. Participants in the conference included those who were identified in the course of the research and task force projects as being involved in the development of programs that help students learn an integrated approach to patient care. After several opening presentations, the conference centered around small group working sessions to identify critical issues and form program development strategies. This conference served as the first step in developing a network of health professions educators who we hope will continue to share and generate ideas. At the time of this writing, a document detailing the conference proceedings is being compiled and will be disseminated to conference participants, health professions schools, and others who express interest.

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Appendix C

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