FACULTY APPRECIATION DINNER
Relationship-Centered Care: Transforming the Hidden Curriculum

As clinical faculty, all of you play an indispensable role in the education of our medical students. As family doctors, I believe you have a unique opportunity to teach students about the core of medical practice – the doctor-patient relationship. More than 10 years ago, research from my esteemed colleague Mike Prislin found that during the family medicine longitudinal clerkship, one of the most important thing students learned enhanced communication and relational skills. Now that we no longer have a longitudinal clerkship, it is especially important to ensure that this critical aspect of medicine is somehow conveyed to students by the people they trust and respect most – you.

Since I direct the UCI-SOM Program in Medical Humanities, I want to start with a poem that for me embodies a relational orientation toward the practice of medicine. Here is a doctor who thinks about his patient, is frustrated but also unfailingly committed to his patient, comes up with out-of-the-box interventions, and will not abandon her no matter the challenges he faces.

The second half of this talk refers to the hidden curriculum, and the importance of transforming it in ways that further connection and relational commitment to the patient. But what do we mean by this term?

The Hidden Curriculum – what is it?

- **The formal vs. the informal curriculum**
- **The discrepancy between**
  - **what is taught in lectures and preclinical courses and**
  - **how authoritative figures and role models actually behave, prioritize, express values**
- **From students' point of view – how things *really* work**
  - **Gap leads to cynicism and disillusionment**

The Hidden Curriculum – how do students understand it?

- **It's not really about the patient**
  - **"Strong work" is being efficient, dispo'ing pts, keeping pts off the service**
  - **Listening to the pt's story just complicates things**
- **Professionalism is not about how you care for the patient but is much more superficial**
  - **Doing scut-work for your superiors in a gracious manner**
  - **Being well-groomed and neat**
  - **Not questioning authority; not making waves**

What Happens to Teaching about Relationship Issues in the Hidden Curricilum?

- **Physician-teachers often assume students learn about the dr/pt relationship through modeling**

- **Even excellent role-models say they don't know how to teach what they do**
- **Students are often dazzled but baffled by outstanding role-models:**
- **"How did they do that?"**

- **When relationship-centered issues are addressed, it is often from a behavioral perspective**
  - **Welcome: "Hi, I'm Dr. X. How are you doing today?"**
  - **Attention: eye contact, nodding**
  - **Empathy: "That must be hard"**
  - **Compassion: "I'm sorry for your loss"**

Behavioral Relational Skills

- **Benefits**
  - **Easily teachable**
  - **Easily replicable**
  - **Easily observable and measurable**
- **Limitations**
  - **Superficial**
  - **Performative**
  - **Emanates in response to external demands, not personhood**
  - **Acting "as if" rather than authentic feeling**

Which Comes First?

- **Introduce behaviors and values, attitudes, and virtues will follow**
- **Cultivate values, attitudes, virtues and appropriate, meaningful behavior, language, and actions will emanate**

Relationship-Centered Care

- **History**
  - **1990s Pew Health Professions Commission: Pew-Fetzer Task Force**
- **Principles**
  - **Relationships in health care should include the personhood of participants, as well as their roles**
  - **Affect and emotion are important components of relationships**
  - **All health care relationships occur within expanding webs of reciprocal influences**
  - **Genuine relationships in healthcare are morally valuable**

Implications of RCC

- **Self- awareness**
  - **To form relationships, must have self-awareness and self-knowledge**
- **Personhood is always implicated**
  - **Patient and doctor may both suffer or benefit as a result of their interaction**
- **Engagement and connection instead of detachment and neutrality**

- **Patient is a human being, not a scientific object**

- **Communication is more than vertical information transmission**
  - **Communication is bidirectional**
- **Medical encounter is not completely predictable or controllable**
  - **Patterns of meaning and relation are constructed moment-by-moment**
  - **Without awareness and ability to work with novelty, they can rigidify or shift chaotically**

Pedagogy of RCC (How can you teach RCC?)

- **Self- awareness**
  - **Interrogating self about thoughts, feelings, stories about patient**
  - **How am I feeling toward this patient?**
  - **What is the story I'm telling about this patient?**
- **Self-knowledge**
  - **I know I have this button**
  - **I remember that under *x* circumstances, with patients who are *y,* I tend to behave in *z* ways**
- **Communication is reciprocal, not entirely predictable**
  - **Am I really respecting pt's viewpoint, or am I saying "Yes, but…"**
  - **Am I thinking about the patterns the pt and I are creating?**
  - **If needed, can I introduce or take advantage of novelty in our interaction?**
- **Engagement and connection**
  - **Compassionate presence**
    - **Shifting focus from self/evaluator, to patient**
    - **Meditation, art training attentional exercises**
  - **Empathy and moral imagination**
    - **Listening to the patient's story, not just the medically relevant details of the history**
    - **Reading, sharing stories**
    - **Reflective writing**
- **Personhood of physician**
  - **Cost of the patient-doctor interaction**
    - **Self-care**
  - **Benefits of the patient-doctor interaction**
    - **What do I appreciate in this patient?**
    - **What am I grateful for after this encounter?**