Relationship-Centered Care: Transforming the Hidden Curriculum

I. INTRO. Hello, everyone. I would like to thank Dr. Larsen and the department for inviting me to speak with you this evening. I consider this a great honor because each of you makes an essential contribution to our department in your teaching of our learners. Without you as role-models and guides, our students would be immeasurably worse off. So my first point is to express gratitude for myself and on behalf of the department for all that you give to our students.

My second point is to urge you to focus in your teaching on one of the most crucial, yet hard to pin-down, aspects of medicine – helping students build a relationship with their patients. Since I am the director of the Program of Medical Humanities at the School of Medicine, I feel compelled to start with a poem, which for me embodies the enduring and overriding importance of relationship between doctors and patients.

READ POEM – Slide 1: Pause a moment to consider, What is the doctor feeling initially toward this patient? What does he do with these feelings?

2nd slide: And here you have it. This wonderful, creative, innovative treatment plan doesn't work, at least not in the way the physician intended. Nevertheless, it is a wonderful, inspiriting poem. What I particularly love about it is the self-awareness of this physician and his awareness of his patient, his perseverance, compassionate curiosity, and willingness to think outside the box, and his commitment to and non-abandonment of the patient, no matter what. Yet sadly, these are often NOT the qualities that students absorb from their physician attendings and residents in their training as a whole.

II. The Hidden Curriculum
So what I'm urging you all to do is to be a conscious, transparent counterweight to how the doctor-patient relationship appears in the hidden curriculum

- **The formal vs. the hidden 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**
- **Despite our high-flown rhetoric, 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 – opening Pandor'as box**
- **Professionalism is not grounded in a meaningful relationship with 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**

III. Teaching about the Patient-Doctor Relationship
So if students don't necessarily draw the correct conclusions about developing relationship with patients, how can we go about teaching them?

- **When physician-teachers think about the patient-doctor relationship, they often assume students learn about how to develop a relationship with patients through modeling**
  - **Actually, this is completely accurate, and precisely how the hidden curriculum is conveyed**
  - **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"**

IV. "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**

V. Chicken and Egg

- **Introduce behaviors and assume that values, attitudes, and virtues will follow**
- **Cultivate values, attitudes, virtues: may result in appropriate, meaningful behavior, language, and actions**

VI. Relationship-Centered Care
Obviously, I'm not telling you anything you don't already know
I am trying to make explicit what is often tacit, and therefore lost, in the teaching of medical students

- **Genuine relationships in healthcare are morally valuable: We see that in Dr. W's unflagging dedication to his patient**
- **Relationships depend on**

- **Self-awareness and self-knowledge: Dr. W knows himself, he is able to recognize his own frustration and helplessness**
- **Other awareness (empathy, understanding of the other): Dr. W is aware of his patient too, especially of her life-threatening downward spiral**

- **Personhood of both patient and doctor, as well as their roles, is always implicated in relationship**
  - **Patient is a human being, not a scientific object – Dr. W has personal knowledge of his patient, he knows she will like his gift of a puppy**
  - **Physician is also a human being, not merely an active instrument: In giving her the puppy, Dr. W is acting like a doctor, but he is primarily acting like a person, trying to care for another person**
  - **Both physician and patient can suffer or benefit as a result of their encounter: Dr. W is aware of both his patient's and his own suffering, and desperately wants to help alleviate both**
- **Engagement and connection are cornerstones of relationship**
  - **Detachment and neutrality do not further relationship: Dr. W really cares about this patient; he is not afraid to be emotionally connected to her, and in fact uses that connection to spur on his thinking**
- **Communication is more than vertical information transmission**
  - **Communication and its influences are bidirectional and reciprocal: Dr. W "prescribes" the dog in a rather conventional way; but he is able to adjust to the "failure" of this prescription**
- **Medical encounter is not completely predictable or controllable – Dr. W has come to terms with the fact that he cannot control his patient entirely**
  - **Patterns of meaning and relation are constructed moment-by-moment**
  - **Without awareness and ability to work with novelty, these patterns can rigidify or shift chaotically: Dr. W recognizes the dysfunctional pattern of doctor practicing responsible diabetes management and his patient practicing resistance; he also is willing to introduce novelty into his care for his patient; and one gets the feeling that, right up to her death, he continues to pause and to think about her, looking to create new patterns between them that serve both his pt. and himself**

VII. Pedagogy of RCC
How do you teach about relationship?

- **First, be willing to initiate conversations with students about relationship-centered issues in patient care**
- **Second, be transparent about your personhood as a physician, as well as your technical skills and your diagnostic acumen**
  - **Be honest, authentic, and disclosing**
  - **This takes courage**
- **Third, be willing to help your students think about themselves in relation to patients**

- **Create a safe environment where students can investigate their responses and feelings**
- **Engage students in reflective self-questioning**

VIII. Pedagogy of RCC

*** Self- awareness**

- **Share with your student**
  - **What you're thinking and feeling about this patient**
  - **The story you're telling about this patient**
- **Explore your student's thoughts, feelings, stories about the patient**

- **Self-knowledge**
  - **Disclose your own buttons/knee-jerk reactions about certain patients**
  - **Help your student examine her own reflexive reactions**
- **Bidirectional communication**
  - **Assess with your student**
    - **How well you really heard and respected the pt's viewpoint**
    - **How genuinely you tried to incorporate the patient's beliefs and practices into the treatment plan**
  - **Help student reflect on the ways in which**
    - **her interaction with the patient was reciprocal**
    - **her communication was one-way, top-down**
- **Creating patterns; introducing novelty**
  - **Share your observations about the patterns you've created with your patient**
  - **Point out ways that you introduce or take advantage of novelty in your interaction with the patient**
  - **Help your student recognize the patterns she is creating with the patient**
  - **Elicit your student's thoughts about "trying something different" with the patient**
- **Engagement and connection**
  - **Share with your student how you create a sense of "compassionate presence" in the patient encounter?**
  - **Encourage your student to**
    - **Take a breath, empty her mind**
    - **Shift focus from self/evaluator, to patient**
  - **Talk about how you cultivate empathy toward your patient**
  - **Help your student**
    - **Listen to the patient's story, not just medically relevant details of the history**
    - **Write reflectively about the patient**
- **Personhood of the physician**
  - **Disclose about the personal cost of a particular patient-doctor interaction**
  - **Share how you practice self-care**

- **Talk with your student about how she takes care of herself**
- **Let your student know what you got out of a patient encounter in a positive sense**
    - **What you enjoyed about your patient**
- **Ask your student to think about:**
    - **What she appreciates about the patient**
    - **What she is grateful for after the encounter**

VIII. Conclusion

So my plea to you is not to forget about the essential context within which all other medicine occurs – the relationship between pt and doctor; not to assume that students are learning how to create this relationship; and regularly ask them some of the above questions to help them understand how to be like the amazing doctors they admire – you!