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OBSERVATIONS

## Transforming Preprofessional Health Education Through Relationship-Centered Care and Narrative Medicine

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### ABSTRACT

*Issue:* The Institute of Medicine identified health care education reform as a key to improving the error prone, costly, and unsatisfying U.S. health care system. It called for health care education that no longer focuses exclusively on the mastery of technical skills but teaches students the *human dimensions* of care and develops their ability to collaborate with patients and colleagues to alleviate suffering and improve health. When should this educational reform begin, by what frameworks should it be guided, and which methods should it employ are important questions to explore. *Evidence:* There is increasing evidence that practitioners' relational skills, such as empathy and reflection, improve patients' health outcomes. Efforts to shift education toward patient-centered care in interprofessional teams have been made at the professional level, most notably in medical schools. However, reform must begin at the preprofessional level, to start cultivation of the habits that support humane care as early as possible and protect against empathic decline and the development of counterproductive attitudes to collaboration. The conceptual basis for reform is offered by relationship-centered care (RCC), a framework that goes beyond patient-centered care and interprofessional teamwork to focus on the reciprocal human interactions at the micro, mezzo, and macro levels of care. RCC identifies practitioners' relationships with patients, colleagues, community, and self as the critical interpersonal dimensions of healthcare and describes a foundation of values, knowledge, and skills required for teaching each dimension. The teaching of these foundations can be facilitated with techniques from narrative medicine, a compatible care model that conceptualizes health care as a context in which humans exchange stories and thus require narrative competence. *Implications:* We suggest beginning the educational reform at the preprofessional level with the implementation of a formal curriculum based on the 4 RCC dimensions with students expected to gain beginner levels of competency on these dimensions in addition to evidence-based principles of health sciences. This requires interprofessional collaboration among health professions, social science, and liberal arts faculty and training of health professions faculty in narrative medicine. Next, we suggest engaging in incremental change in the organizational culture with professional development and team-building activities. Although we need systematic research on the efficacy of the components of the transformation, their impact on students' learning, and their costs, it is important to engage in efforts to prepare professionals who are able to respond to the complex health needs of individuals and society in the 21st century.

### KEYWORDS

relationship centered care;  
narrative medicine;  
preprofessional education

### Introduction

A patient recently shared that when he was diagnosed with prostate cancer at a highly advanced cancer center, he was told that its severity rated 9 on a 10-point (Gleason) scale. When the devastated patient asked the physician what that meant, the answer was, "It is better than a 10." This reply, experienced as an empathic failure, added to his reluctance to undertake crucial hormonal treatment that had highly undesirable side effects. There are an estimated 440,000 untold stories of hospitalized Americans who die each year because of medical errors of communication, omission, and

commission.<sup>1</sup> The Institute of Medicine (IOM)<sup>2</sup> identified reform in the education of all health professionals as a critical step toward improving the unsatisfying, error-prone, fragmented, and inefficient and inequitable U.S. healthcare system.<sup>3–5</sup> IOM called for education that shifts focus from exclusive mastery of technical skills to the teaching of the *human dimensions* of care and developing students' ability to provide patient-centered care in interprofessional teams.

The call for an educational shift is related to the change in the nature of our health challenges and the mounting evidence that interpersonal skills are critical to

health outcomes.<sup>6</sup> Despite the spectacular results of the technological advances in surgery and drugs, which made them the core of the healthcare system, the United States is facing an epidemic of chronic diseases related to diet, lifestyle, level of physical activity, and use of drugs or alcohol.<sup>7</sup> The prevention and treatment of these chronic conditions cannot be achieved by practitioners' quick and highly specialized technical interventions. It requires practitioners' engagement in interprofessional collaboration and long-term relationships with individuals, families, and communities to foster changes in attitude, behavior, culture, and resource allocation. This realization is clearly evident in the Affordable Care Act (2010),<sup>8</sup> the recent legislation that requires cultural transformations in the healthcare system toward cross-functional collaboration and partnership with patients. In this article we argue that educational transformation should begin at the preprofessional level, and we offer conceptual frameworks with related teaching methods to guide curricular design for preprofessional programs.

### The case for preprofessional educational transformation

Desired changes in health professionals' education toward patient-centered, team-based care are being instituted at the graduate and postgraduate levels, most notably in medical schools. Inspired by the movement of *medical humanism*, humanities content has been infused into curricula to train physicians "to understand the patient as a person, focusing on individual values, goals and preferences with respect to clinical decisions."<sup>9(p554)</sup> Professional programs and health care settings are engaging in *interprofessional education* (IPE) "where the members of more than one health or social care profession, or both, learn interactively together, for the explicit purpose of improving interprofessional collaboration or the health/well being of patients/clients, or both."<sup>10(p2)</sup>

Although there is a great need to continue to transform health care education all along the professional trajectory, there are compelling arguments to begin educational reform of future health professionals as early as possible. First, negotiating the complexity of the interpersonal relationships involved in care requires habits of reflection and self-awareness, and the cultivation of such habits is a lengthy process.<sup>11</sup> Second, there is evidence that caring qualities that students bring to their education tend to erode during the course of training.<sup>12</sup> Medical students show a decline in empathy in their 3rd year of study,<sup>13</sup> and students in health professions, such as medicine, pharmacy, nursing, dentistry, and veterinary medicine, experience a decline in empathy already in their 1st year of study.<sup>14</sup> Because the decline is partly

related to learning environments where success depends on mastery of high-volume, fact-based information,<sup>14</sup> and because students who begin their education with lower empathy scores are at greater risk,<sup>13</sup> early exposure to empathic care principles in the course of health education could serve as a protective factor. Third, there is a need to counteract the negative stereotypes about other professional disciplines that students may bring to their education<sup>15</sup> or develop in their discipline-specific studies.<sup>16</sup> Early learning about teamwork can protect against obstacles to effective collaboration, such as reluctance to engage in shared decision making, that students may develop as they go deeper into their professional siloes.<sup>17</sup> Therefore, we argue that preparation for effective practice in the intersubjective domain of health care must start at the preprofessional level.

### Conceptual frameworks

Whereas McNair<sup>18</sup> suggested the value-based professionalism framework as a way to prepare preprofessional students for humane care, we argue for a broader framework that rests on a bio-psycho-social-cultural perspective. This claim is bolstered by the recent (2015) inclusion of a section on the psychological, social, and biological foundations of behavior in the Medical College Admissions Test to "communicate the need for future physicians to be prepared to deal with the human and social issues of medicine."<sup>19(p1)</sup> We suggest reforming *preprofessional* education with relationship-centered care (RCC), a framework that identifies the critical relationships and competencies involved in effective and humane care.<sup>20,21</sup> We further argue that techniques from narrative medicine,<sup>22</sup> a compatible care model that focuses on the exchange of stories in healthcare, can sensitize students to human suffering and facilitate the teaching of RCC.<sup>23,24</sup> Relying on the work of key principles in each field, we describe RCC and narrative medicine next.

### Relationship-centered care

The RCC model was originally developed by the Pew-Fetzer Task Force on Advancing Psychosocial Health Education, which recognized "the interaction among people as the foundation of any therapeutic or healing activity" and assumed that "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."<sup>21(p11)</sup> Beach, Inui, and their colleagues,<sup>20</sup> who expanded the model, argued that most healthcare functions, including diagnosis and treatment, as well as allocation of resources, "are mediated by the qualities of the manifold relationships

that link patient, clinician, team, organizations, and community.”<sup>(pS4)</sup> The capacity to form healing and collaborative relationships is thus a central requirement for effective health care practice.

Beach and Inui<sup>20</sup> specified the four principles on which RCC is built. The first principle emphasizes that the care interaction involves a relationship between a practitioner and a patient who are both full human beings and thus bring unique and diverse needs, values, and perspectives. For quality care, practitioners ought to practice *self-awareness* and monitor their behavior and hidden biases. The second principle highlights that the interactions in the process of care always have an affective component that needs to be acknowledged. The patient’s illness experience is emotionally charged and, therefore, the *emotional presence* and *empathic responses* of clinicians must be mobilized in the service of healing. The third principle posits that the encounter in the care situation involves *reciprocal influences* among all participants. Clinicians cannot view the care situation as a unidirectional act in which they, as experts, influence their patients. They need to be *open* to the possibility that the care encounter with patients (and colleagues) will be mutually transformative, offering them opportunities to grow as people and professionals. The fourth principle asserts that the cultivation of a healing relationship is a moral obligation. It highlights the belief that through *genuine relationships*, not just engaging in role performance, clinicians develop the identification with the patient’s suffering, which drives them to alleviate it. The recognition of the common humanity of the practitioner and the patient is at the root of the moral commitment *to be of service* to the patient and to be renewed by this service.

Beach and Inui<sup>20</sup> also identified the four relationship dimensions that are critical to health: practitioner–

patient, practitioner–practitioner, practitioner–community, and practitioner–self. These dimensions correspond to the domains that have been empirically found to enhance the process and outcome of health care<sup>25</sup> and go beyond patient-centered care (micro) and interprofessional teamwork (mezzo) to include interactions at the community (macro) level of care. RCC is a systemic/ecological approach that recognizes that the four dimensions are interconnected so that the cultivation of a positive relationship in one is likely to enhance the quality of relationships in others.<sup>26</sup>

### Narrative medicine and its compatibility with RCC

Originally introduced in the context of physician training as an ideal model of service, narrative medicine is compatible with RCC in its care characteristics, principles, and dimensions (Table 1). Like RCC, narrative medicine highlights the value of forming connections in the act of caring for patients.<sup>22,27</sup> Like RCC, narrative medicine emphasizes that healthcare occurs in an intersubjective domain but conceptualizes this domain more specifically as one where people exchange stories. Addressing the physician–patient interaction, Ofri<sup>28(p1006)</sup> suggested that, “no matter how efficient medicine becomes, no matter how computerized, automated, algorithmed, wireless, evidence based or ‘QA’ed it becomes, medicine will always boil down to one caregiver with one patient, in one room, with one story.” Effective healthcare, therefore, requires narrative competence defined as “the ability to acknowledge, absorb, interpret, and act on the stories and plights of others.”<sup>22(p1897)</sup>

Narrative medicine shares RCC’s value-based principles. RCC’s first principle, that the personhoods of both practitioner and patient are involved in the care interaction, is echoed in narrative medicine’s assertion that clinicians are

**Table 1.** Key components of RCC and their narrative medicine equivalents.

Care	RCC	Narrative medicine
<b>Characteristic</b>		
Value	Human relationships	Personal connections
Focus	Human interactions/relationships	The stories exchanged
Effectiveness	Forming collaborative relations	Narrative competence
<b>Principle</b>		
1	Practitioner & patient are people	Practitioner & patient are narrators
Requires	<i>Self awareness</i>	<i>Reflection/Self-examination</i>
2	Affective component is critical	Stories are fraught with suffering
Requires	<i>Emotional presence &amp; empathy</i>	<i>Complete presence &amp; empathy</i>
3	Reciprocal influence among equals	Reciprocity in meaning construction
Requires	<i>Openness to transformation</i>	<i>Openness to mutual transformation</i>
4	Relationships are a moral imperative	Narratives have the power to move
Requires	<i>Commitment to serve and grow</i>	<i>Trustworthiness &amp; altruism</i>
<b>Dimension</b>		
1	Practitioner – patient	Clinician – client
2	Practitioner – practitioner	Clinician – colleagues
3	Practitioner – community	Clinician – society
4	Practitioner – self	Clinician – self

Note. RCC = relationship-centered care.

narrators, not neutral experts offering “objective data.” The principle’s implication that quality care requires self-awareness is evident in narrative medicine’s call for the clinicians’ engagement in self-examination and reflection to fully grasp their actions as they respond to patients’ stories.<sup>18</sup> RCC’s second principle’s assertion that patients’ emotional suffering requires the practitioner’s empathy is reflected in narrative medicine’s assumption that clinicians must accompany patients through their illness experience with empathy and genuine concern for their pain and loss.<sup>22</sup> RCC’s third principle, that caring relationships involve reciprocal interactions among equal participants who share the potential for growth, is evident in narrative medicine’s concept of narrative reciprocity. It implies that the care situation is an interaction between equal participants who collaboratively construct meaning rather than one where the expert practitioner dictates meaning to a patient, and that “authentic engagement is transformative to all participants.”<sup>22(p1898)</sup> RCC’s fourth principle, that practitioners’ engagement in genuine relationships with their patients strengthens their moral commitment to serve them, can be found in narrative medicine’s assumption that patients’ narratives have the power to touch practitioners’ hearts and move them to deeply care for them.<sup>22</sup>

Narrative medicine also identifies four primary narrative situations: physician–patient, physician–colleagues, physician–society, and physician–self, where care involves an exchange of stories.<sup>22</sup> These resemble RCC’s relationship dimensions, albeit with primary focus on the physician as the practitioner and the physician–patient dyad. There is mounting empirical evidence that narrative methods, including close reading of literary works, “slow” viewing of artistic creations, and engagement in creative writing can deepen clinician’s ability to develop collaborative and healing relationships with patients, colleagues, and the self.<sup>24</sup>

### Teaching RCC dimensions

In the following sections we describe the four RCC dimensions; their narrative situations; and the values, knowledge, and skills associated with teaching them (Figure 1).

#### The practitioner–patient dimension

RCC identifies the practitioner–patient relationship as the focal point of the web of relationships that

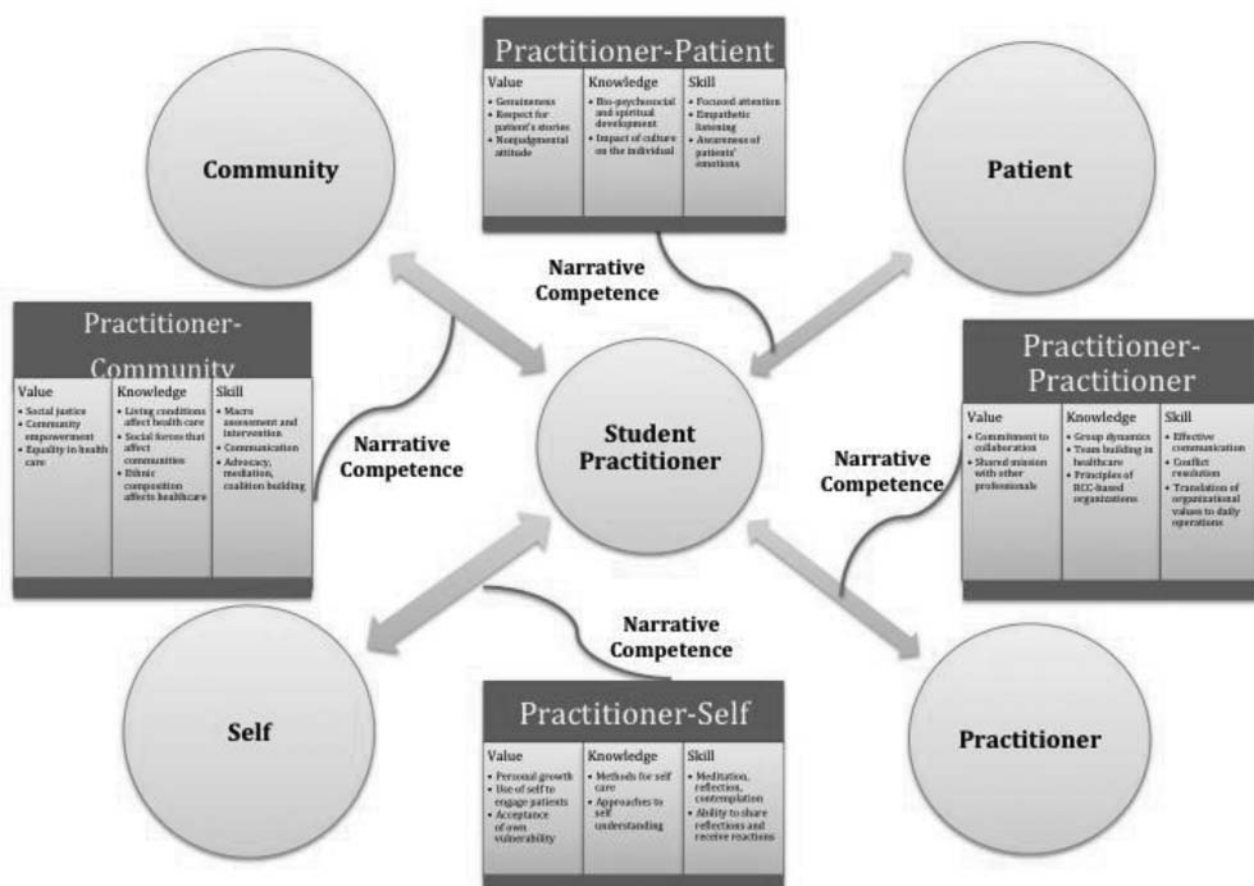


Figure 1. Building relationship-centered competencies in preprofessional education via narrative techniques.

characterizes healthcare. RCC principles require that we teach practitioners to focus their attention on patients' subjective illness experience rather than on a depersonalized disease and attend to patients' diverse emotional and cultural needs rather than impose their own needs and worldviews.<sup>20</sup> They need to be mindful of what *they* bring to the interaction with patients because "the manner in which a clinician participates in an encounter fundamentally affects the course, direction, and outcomes of the care both episodically and longitudinally."<sup>16(p55)</sup> They need to see that the care relationship, although focused on the relief of pain and suffering for patients, can be rewarding and transformative for them. As Coffin, the chaplain of Yale University, said to his surgeon after recovering from a serious illness, "We patients do more for you doctors than you do for us."<sup>29(p73)</sup>

Narrative medicine similarly implies that we need to teach students that the practitioner–patient relationship is the central "narrative situation" and the practitioner's task is to make sense of patients' stories gleaned from their words, facial expressions, bodily signs, medical records, and the stories other people tell about them. The practitioner needs to attend to what is said and what is left unspoken and to form a complete and coherent picture out of the details collected. With genuineness and empathy, practitioners must tune into patients' stories and accompany them in the search to find meaning in the illness experience.<sup>22</sup> We need to teach students that inviting patients to tell their stories may facilitate their healing, as the articulation of their predicament allows them to regain some of the control lost in the grip of illness or injury,<sup>22</sup> and engaging them in coleadership of their health is critical to their safety.<sup>1</sup>

RCC emphasizes that teaching students to develop healing practitioner–patient relationships goes beyond skills training. It requires a value-based education so students embody the desired behaviors rather than play a prescribed role. Students must cultivate respect for patients' dignity and worth, their right to self-determination, and their capacity for self-healing.<sup>20</sup> They must adopt a nonjudgmental stance toward the meaning patients ascribe to their illnesses<sup>21</sup> and commit to making the emotional investment required to develop healing partnerships with patients and significant people in their lives.<sup>30</sup> Knowledge for effective practice on this dimension is related to understanding that warmth, trust, and genuineness characterize transformative relationships and that building such relationships requires empathy and respect for the patient's experience.<sup>21</sup> To better understand patients' experience, students need knowledge of biological, psychological, social, and spiritual processes of human development and functioning. They

also have to understand the impact of culture on the ways individuals experience symptoms and express them, make sense of their distress, determine when to seek help and from whom, and make decisions about treatment options.<sup>20</sup> To set the values and knowledge associated with the practitioner–patient relationship in motion, students need to learn the skills of focused attention, empathic listening, tuning into patients' emotions, self-monitoring, and negotiation of value differences, as well as the instillation of hope, trust, and faith.<sup>21</sup>

Narrative medicine points out that teaching students to develop healing practitioner–patient relationships requires cultivation of character. To listen to patients' stories and accompany them on their journey, students need to develop the "courage and generosity to tolerate and bear witness to unfair losses and random tragedies"<sup>22(p1899)</sup> These qualities can be facilitated through the skills of close reading and reflective writing.<sup>13</sup> Engaging with the humanities, particularly literature, allows students to deepen their skills "as readers, interpreters and conjurers of the worlds of others."<sup>22(p1899)</sup> Writing reflections about care situations, in real-life settings or in movies, helps students recognize and process the emotionally charged experiences of attempting to alleviate suffering.<sup>31</sup>

### ***The practitioner–practitioner relationship***

RCC argues that students need to learn that positive outcomes for patients and professionals require mutual respect and shared decision making among practitioners of different disciplines rather than the exclusive dominance of a single profession, traditionally reserved to physicians. Practitioners need to form collaborative relationships with the health professionals who work with them within an organizational structure, as well as those they interface with outside their organization.<sup>20</sup> As the IOM report notes, "Effective response to the often-complex individual, family and society's health needs requires collaborative efforts on the parts of all care providers," and practitioners need to "cooperate, collaborate, communicate, and integrate care in teams."<sup>2(p4)</sup>

RCC also emphasizes that effective care and avoidance of harm require collaborative relationships along the vertical dimensions of health care organizations. Because "behavioral patterns spread from the senior leaders to everyone else,"<sup>30(p39)</sup> effective care requires a leadership that builds RCC culture. It means adopting Relationship-Centered Administration that brings RCC's emphasis on partnerships with mutual respect and shared decision making as well as attentiveness to relational processes to the organizational level.<sup>30</sup> As the IOM<sup>2</sup> notes, an organizational culture focused on understanding interactional

dynamics and monitoring relationship processes is a key component in identification of medical errors that present unacceptable barriers to effective care.

Like RCC, narrative medicine implies the need to teach students that health care teamwork, characterized by honesty and trust, allows “multiple professionals to amplify their individual discipline’s power to help.”<sup>32(p307)</sup> Charon<sup>22</sup> emphasized physicians’ professional obligation to acknowledge their interdependence as they rely on one another for feedback on competence and ethical judgment. She lamented that instead they are isolated from one another and from their colleagues in other health professions and seem to act on “narrow competitive drives toward individual distinction or reward.”<sup>(p1900)</sup> She called on physicians to “kindle and enforce the intersubjective kinship bonds among health care professionals.”<sup>(p1900)</sup>

Education for this RCC dimension requires helping students cultivate a commitment to the values that underlie healthy collegial relationships and organizational practices. To become supportive team members, students must embrace humility, generosity, kindness, and thoughtfulness. They have to become keenly aware of their *shared* mission to offer optimal care for the patient, regardless of differences in care practices and professional status. They must embrace their ethical obligation to monitor self, colleagues, and the organization for identification and prevention of errors.<sup>20,21</sup> For effective practice on this dimension, students need to understand the group dynamics of membership, leadership, norms, goals, roles, and decision making. They need to learn the principles of team building in the context of professions that approach healing differently and carry unequal power as well as building an organizational culture that supports RCC.<sup>20</sup> To build practitioner–practitioner relationships, students must develop the skills of effective communication and conflict resolution. In addition, they need skills for monitoring the degree to which their personal and professional needs are met in the context of teamwork and the degree to which organizational values are reflected in day-to-day operations.<sup>20,21</sup>

Narrative medicine offers effective methods for the IPE that is crucial to improving students’ openness to work in multidisciplinary health care teams with trust and mutual understanding.<sup>32</sup> The techniques include close reading of literary works with participants from multiple disciplines and reflective writing on teamwork simulation exercises.

### **The practitioner–community relationship**

RCC requires that we teach students that high-quality health care involves a collaborative working relationship between practitioners and the communities they serve.

Although the patient-centered care model alludes to the importance of advocacy for population health,<sup>2</sup> the *macro* dimension of care and the social determinants of health are easily missed without direct identification. Students need to know that community is where health and illness begin and that one’s zip code might be more critical to one’s health than the genetic code.<sup>33</sup> As Manchanda<sup>34</sup> eloquently put it, we must educate health care professionals who know to “look upstream” for the community sources of ill health rather than focus exclusively on symptomatic relief for individuals “down the river.” They must understand that substandard housing and food insecurity are key sources of ill health and that effective care requires community change that reduces these risk factors. They must be prepared to implement Culturally and Linguistically Appropriate Services to meet the needs of minority populations and improve health equity.<sup>35</sup>

Narrative medicine suggests that we need to teach students about the importance of the practitioner–community narrative situation and the relationship between medical practitioners and society at large.<sup>22</sup> Practitioners need to engage in open and honest conversations with society about what constitutes optimal care and what kind of medical system is desirable.

Education for this RCC dimension requires socializing students to believe that advocacy for change in patients’ social and physical environments is a powerful health care tool and that community integrity and leadership are critical for equitable health policy and availability of services.<sup>25</sup> Students need knowledge about communities as dynamic systems affected by economic, social, and political forces so that they can understand that when processes such as gentrification take place, poorer members experience high levels of stress and their health is threatened. Students have to learn that their ability to care for patients will depend on knowledge of the ethnic composition of the community, the prevailing health beliefs, the care options available, and the history of the relationships of care providers with the community.<sup>20,21</sup> For this RCC dimension, students need to learn macro assessment skills such as identifying community health needs and the impact of care policies and programs on community health, and intervention skills such as advocacy, mediation, empowerment, coalition building, and confrontation required for community activism.<sup>20</sup>

Manchanda’s<sup>34</sup> work illustrates effective use of narrative methods for teaching about this narrative situation. In TED talks and a Google book, he recounted a version of an old parable about the futility of helping a community where children are swept down a river by trying to pull out the drowning victims one at a time while failing to recognize that someone is throwing them into the

river upstream. He tells stories about inner-city people with health problems for whom the intervention of a community health specialist to fix problems such as mold-producing water leaks might be the best medicine.

### **The practitioner–self relationship**

RCC indicates that we need to teach students that a relationship with self, which means the development of self-knowledge, self-awareness, and integrity<sup>20</sup> is critical for all other RCC relationships and requires engagement in self-care activities.<sup>36</sup> They need to hear Sweet's<sup>37</sup> story about becoming better attuned to patients and making more astute diagnoses as a result of deep realizations she brought back from pilgrimage journeys. Sweet argued that a health care environment driven by technical competence with little time for reflection is less efficient than premodern "slow medicine," with its emphasis on time for close observation and deep reflection. Students need to learn that obstacles to teamwork lie in temptations to abuse one's power, protect self-interests, or satisfy greed as well as pride impulses, and it is only through awareness of one's own behavior and its impact on other team members that one can overcome these barriers.<sup>38</sup>

Narrative medicine emphasizes that practitioners need to work on their relationship with self, because the ability to offer the self is the key to patients' healing. Charon<sup>22</sup> argued that the "most potent therapeutic instrument is the self, which is attuned to the patient through engagement, on the side of the patient through compassion, and available to the patient through reflection."<sup>(p1899)</sup> Therefore, we need to teach students that practitioners cannot assume a neutral and detached position relative to the patient. They must be fully present and open to patients' stories and be aware that such presence requires careful monitoring of their own motives and behaviors.

As in the case of the other three RCC dimensions, teaching the practitioner–self relationship requires more than skills training. Students need to *value* self-awareness, self-growth, and self-care. They must believe in the power of the proper use of self, not just biomedical tools, to engage patients in the process of healing and make a commitment to working on themselves.<sup>20</sup> They must cultivate the moral habit of approaching the world with compassion and monitor the temptation to abuse power or enhance self-esteem at the expense of others. They must develop awareness and acceptance of their own vulnerability and through it connect with other human beings regardless of status and power differentials. Students need to learn about self-understanding from psychological and philosophical approaches as well as self-care methods such as engagement in artistic creation,

prayer, and walks in nature.<sup>36</sup> The skills of meditation, reflection, and contemplation are crucial for students to develop self-knowledge, get attuned to their own vulnerability, and identify their unmet needs.

Narrative medicine methods such as close reading of great literary narratives, viewing of paintings and films, and writing of reflective responses are effective in teaching future practitioners the habits of "presence, recognition, and donation of self to the situation of the other."<sup>39(p 522)</sup> These methods help students engage in self-examination and increase their ability to perceive complex reality with less distortion from preconceived notions and protective blinders. Small groups in which students share their reflections and receive their peers' reactions are particularly effective in facilitating the development of self-knowledge and increasing one's capacity to tolerate the pain and uncertainty experienced in caring for patients.<sup>22,24</sup>

### **Curricular design in preprofessional health education**

The RCC and narrative medicine frameworks have been applied in reforming medical education, and these efforts can inform the transformation of preprofessional education. In 1999, Indiana University Medical School (IUMS) embarked on a bold, multiphased educational transformation to embody the school's vision of RCC-based health care.<sup>40,41</sup> The initial phase focused on creation and implementation of a competency-based formal curriculum with emphasis on relational dimensions such as effective communication, the social and community contexts of health care, as well as self-awareness, self-care, and personal growth. In 2014, IUMS adopted the six Accreditation Council for Graduate Medical Education categories, which reflect the four relationships dimensions.<sup>42</sup> For example, *interpersonal communications skills* relate primarily to the practitioner–patient/family and practitioner–practitioner relations, *system-based practice* relates to the practitioner–community relations, and *professionalism* as well as *practice-based learning and improvement* relate to the practitioner–self relationship. The initial change, which required investment in leadership, administrative support, and infrastructure, was internally covered with existing funds. The later phases required major investment in a complete change of organizational culture to ensure that the learning environment supports the formal curriculum.<sup>40,41</sup> Columbia University School of Medicine has reformed its education to include a required course in humanities for 1st-year medical students. It has invested in the development of a narrative medicine faculty that offers several choices for the mandatory 1st-year humanities course, elective



seminars for 4th-year students, as well as intensive workshops and a graduate program for health professionals interested in bringing narrative medicine to their educational institutions or practices around the world.<sup>27</sup>

Thus, the first step in reforming preprofessional education requires the revision of the formal curriculum. We suggest building a formal undergraduate curriculum based on the four RCC dimensions with students expected to gain beginner levels of competency on these dimensions in addition to evidence-based principles of health sciences. We further argue that the curriculum redesign can begin on a small scale with modification of a common course and the addition of one mandatory course. The freshmen introduction to the health professions course can offer the fundamentals of RCC, present the different professions as partners in care, and include narrative medicine exercises such as dyads engaged in telling and listening to one another's stories or sharing of reflective writing in response to poetry, literature, medical writings, or works of art (Table 2 and the appendix). Building on this introduction, the curriculum needs to include a second mandatory course for upper division students to begin developing RCC competencies. This course reviews RCC and narrative medicine and teaches the knowledge, values, and skills related to the four dimensions using experiential exercises for relational skills and narrative medicine activities in all sessions (Table 3). The curriculum development must include a generation of assessment tools and continuous development of learning experiences for these two RCC courses and beyond. For example, faculty can collaborate to design service learning engagements that develop the practitioner–community

relationship competency<sup>34</sup> and can be integrated into health sciences courses.

The narrative experiences in the RCC courses must fit the students' stage of personal and professional development. The exercises and assignments in the introductory course need to progress from the more generic, such as *What's in a Name*, to ones that require more self-disclosure such as *The Patient Perspective: A Personal Medical Narrative*. Instructors may choose to read poems or present a painting and offer students prompts for reflections. It is important to establish ground rules of confidentiality, no obligation to share reflections (option to pass), and respectful responses to what is being shared.<sup>23</sup> In the second course, the personal narratives exercises should be geared more specifically to increasing self-awareness and involve students in small-group discussions of their written reflections to focus attention on the process/narrative features of the text and thus generate a more nuanced understanding of the situation.<sup>43</sup> Students must learn that the way people *frame* their story is highly valuable to further understanding their experience. The discussions include questions directed to the listeners (e.g., *What seemed to be the trigger for the reflection? Can you see a personal struggle?*)<sup>44</sup> and to the writer (e.g., *What made you choose to tell this story? How did you decide where to start and where to end?*)<sup>43</sup>

We believe that the transformation can begin with existing resources and budgets given the current emphasis in higher education on interdisciplinary collaboration and the availability of liberal arts and social sciences faculty alongside the health professions faculty in a preprofessional university or college setting. The social work profession, with its values such as the centrality of human relationships and social justice,<sup>45</sup> as well as its systemic/ecological foundation,<sup>26</sup> is uniquely suited for teaching RCC. Teaching the relational skills involves the use of experiential learning methods of role-plays, simulations, analysis of video clips of professionals interacting with patients, and analysis of students' observations of professionals they shadow.<sup>46</sup> Narrative skills can be taught by health professions faculty trained in narrative medicine as well as English, visual arts, and film faculty. In our school of health professions and nursing, we have embarked on such a reform with initial collaboration between the leaders of health sciences and social work, intensive workshops in narrative medicine at Columbia, assistance from the chair of the English Department, and input from nursing faculty.

The next stage of reform is the transformation of the context of learning, the informal curriculum,

**Table 2.** Key topics in HSC 101 Introduction to the Health Professions.

Topics
Models of healthcare
• Biomedical, patient-centered, RCC
Introduction to RCC and narrative medicine
• Four dimensions of RCC
• Narrative medicine as a method to build relationships
Introduction to narrative reflection through art, literature and poetry
• Opportunities to reflect and begin writing narrative through art and literature
Opportunity to read, write, and share medical narrative
• Read medical narrative
• Receive and share medical narratives through dyad
• Explore the RCC dimensions through medical narratives
Overview of the health professions
• Understand the basic skills and competencies of professionals that comprise the health care team
• Hear from professionals through guest lectures
• Begin to see health professionals as future colleagues
Introduction to cultural competency
• Confront personal cultural biases
• Discuss disparity of health care outcomes
• Explore ways cultural differences impact health care delivery

Note. HSC = health sciences courses; RCC = relationship-centered care.

**Table 3.** Key topics in SWK 30/HSC 102.

Week	Topics	Week	Topics
1	Models of healthcare <ul style="list-style-type: none"> <li>• Pre-modern model</li> <li>• Biomedical or practitioner-centered model</li> <li>• Patient-centered model</li> <li>• Relationship-centered care model (RCC) and Narrative medicine</li> </ul>	8	Practitioner-Practitioner Relationship: Collaboration and teamwork <ul style="list-style-type: none"> <li>• The need for and obstacles to interdisciplinary collaboration</li> <li>• Basic group dynamics/dimensions of assessment</li> </ul>
2	1. RCC & NM definitions, principles and dimensions 2. Additional perspectives <ul style="list-style-type: none"> <li>• Bio-psycho-social-spiritual perspective</li> <li>• Systems (proximate and distal sociocultural elements)/Ecological</li> <li>• Developmental perspective</li> <li>• Strengths perspective/positive psychology</li> <li>• Diversity</li> </ul>	9	Practitioner-Practitioner Relationship – building effective teams <ul style="list-style-type: none"> <li>• Principles of effective group functioning</li> <li>• The use of narratives in multiprofessional team building</li> </ul>
3	Narrative competence <ul style="list-style-type: none"> <li>• Close reading and reflective/creative writing definitions</li> <li>• Narrative features of poetry and prose</li> </ul>	10	Practitioner-Organization Relationship: A collaborative culture <ul style="list-style-type: none"> <li>• The need for collaborative organizations</li> <li>• Basic organizational dynamics/dimensions of assessment</li> <li>• RCA – Relationship-Centered Administration</li> </ul>
4	1. Relationship building skills <ul style="list-style-type: none"> <li>• Warmth</li> <li>• Genuineness/authenticity/trustworthiness</li> <li>• Caring/empathy/"I statements"/acceptance/positive regard</li> <li>• Affirming strength/partnership and power sharing</li> </ul> 2. Practitioner-Self relationship: Strategies to increase self awareness	11	Practitioner-Organization Relationship: Organizational change <ul style="list-style-type: none"> <li>• Leadership for change</li> <li>• Relational change methodologies</li> </ul>
5	Patient-Practitioner Relationship: The patient's experience <ul style="list-style-type: none"> <li>• Witnessing the singularity of the patient without judging</li> <li>• Active listening to the subjective experience of the patient</li> <li>• Learning from the patient – she is the expert on her life</li> <li>• Recognizing emotions and distress in patient and self</li> <li>• Accurately receiving and representing the patient's narrative</li> </ul>	12	Practitioner-Community Relationship: A collaborative approach <ul style="list-style-type: none"> <li>• The social, political, economic &amp; cultural determinants of health and well-being</li> <li>• Basic community dynamics/dimensions of assessment</li> </ul>
6	Patient-Practitioner Relationship: Effective communicating/interviewing <ul style="list-style-type: none"> <li>• Affective engagement to promote patient's emotional expression</li> <li>• Assessing the strengths of and challenges to the relationship (power)</li> <li>• Agenda setting and contracting for self-determination and self-healing</li> <li>• Motivational interviewing</li> </ul>	13	1. Practitioner-Community Relationship: Community change <ul style="list-style-type: none"> <li>• Principles of effective community care</li> <li>• Strategies for community change (collaboration/confrontation)</li> <li>• Narratives of community involvement in health care/advocacy</li> </ul>
7	Patient-Practitioner Relationship: Cultural competence <ul style="list-style-type: none"> <li>• Diversity elements – e.g. culture, age, sexual orientation, ability</li> </ul>	14	Course and learning Assessment

Note. SWK = social work courses; HSC = health sciences courses; RCC = relationship-centered care.

which requires a cultural transformation of the organization where preprofessional education is offered. It is critical that the institution's mission and vision statements reflect the commitment to RCC, and the current emphasis on IPE can be used to lobby for such a commitment. The complete cultural transformation efforts undertaken by IUMS required major investment of external funding sources in hiring external consultants and allocating time and resources for personal and professional development, as well as team-building activities.<sup>40,47</sup> However, the effort can begin with incremental steps and grass roots efforts of faculty and administrators who embody the principles of RCC and model them in daily interactions of the institution. The IUSM initiative identified effective methodologies for cultural transformation including team meetings to create healing relationships and the Courage to Lead professional development programs to raise self-awareness.<sup>41</sup> Thus, the transformation of the informal

curriculum may involve Courage to Lead workshops for key faculty and administrators.

Much systematic research on the efficacy of transformational components, their impact on students' learning, and their potential costs is needed. But it is important that we initiate preprofessional educational transformation so that we can prepare health professionals who are able to respond to the complex health needs of individuals and society in the 21st century.

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## Appendix

**Table A1.** HSC 101 Classroom activities and learning outcomes.

Activity	Purpose	*HSC 101 LO
“Interview your classmate”	<i>Begin to recognize classmates and colleagues as community-members. Students typically use question and answer style</i>	LO 2
Lecture introducing definition and concepts of RCC and NM	<i>Conceptual foundation pertaining to RCC and NM</i>	LO 1 LO 2
<sup>48</sup> Rita Charon TEDx Talk: Introducing narrative medicine	<i>Gain an appreciation for the effectiveness of NM as improved healthcare. Students reflect on listening techniques vs. question and answer style used in interview assignment</i>	LO 2
“What’s in a name?” Students write a paragraph describing his or her preferred name and shares with a partner. Listener writes an interpretation of the storyteller’s feelings about the name.	<i>Practice close listening skills and ability to derive conclusions from listening to narrative. Students also develop skills in writing narrative when they write the story of their own name.</i>	LO 3
<b>Reflections on art and poetry</b> Present students with examples of art, poetry, film. Students should not focus simply on a description of the piece. Discussion recognizes different interpretations and points of view. “Aphasia” by Noah Capurso <sup>49</sup> “When Someone Deeply Listens to You” by John Fox <sup>50</sup> “The Doctor” by Sir Luke Fildes <sup>51</sup>	<i>These activities develop reflection skills and the students’ ability to interpret beyond the concrete. The art and poetry choices need not be directly related to medicine. Any pieces that stimulate reflection and inspire class discussion are appropriate. As many of these experiences as can be fit in the schedule can be done.</i>	LO 3
<b>The Patient Perspective: Personal medical narrative</b> Students write a narrative of their <i>own medical experience</i> and share their story with a partner. After, the students write a short reflection in class about the impact of sharing and listening to medical narratives.	<i>This assignment allows the student to practice writing narrative and to explore the practitioner-patient relationship from the patient perspective.</i>	LO 1 LO 2 LO 3
<b>The Practitioner Perspective 1: Responding to medical narratives</b> Students read medical blogs that highlight the RCC dimensions. Student should include a brief acknowledgement of the different RCC dimensions they observe. New York Times and Medscape sites	<i>Students read healthcare narratives and reflect on the impact of the RCC relationships on the practitioner and the patient experiences and on health care delivery.</i>	LO 1 LO 2 LO 3
<b>Lecture on cultural competence</b> Cultural competence is explored at the individual, institutional, and federal level including an overview of Culturally and Linguistically Appropriate Services mandates. Case studies in which cultural biases or assumptions prevent excellent medical care are discussed. “The Spirit Catches You and You Fall Down” by Anne Fadiman <sup>52</sup>	<i>Students are encouraged to examine cultural biases and values as they pertain to healthcare and connect those values back to RCC. Students look for examples of relationships that helped and opportunities for those relationships to be developed in case studies.</i>	LO 4
<b>Lectures by healthcare professionals in a variety of fields</b> Lectures by professionals are an opportunity for collegial interactions.	<i>The RCC practitioner-colleague relationship is developed through an appreciation of the strengths and roles of healthcare professionals.</i>	LO 4
<b>The Practitioner Perspective 2: Personal medical experience</b> Students recall a medical experience that they had as a <i>practitioner or official observer</i> (such as a shadowing experience) and focus on the impact the RCC dimensions had on the experience.	<i>This assignment is an opportunity to synthesize all the dimensions of RCC by reflecting on the experience from the practitioner point of view.</i>	LO 1 LO 2 LO 3 LO 4
<b>*LO 1. Understand the different models of practitioner care</b> <i>Define the following models</i> Biomedical, Patient-centered, Relationship-centered care  <i>Explore the limitations of the current health care system</i>	<b>*LO 3. Develop skills in RCC and Narrative Medicine</b> <i>Develop skills in self-reflection and narrative</i> <i>Observe the narratives of others and create own</i> <i>Apply skills in creating narrative in medicine</i>	
<b>*LO 2. Define RCC and Narrative Medicine and explain the goals</b> <i>Define Narrative Medicine</i> <ul style="list-style-type: none"> <li>• “The effective practice of healthcare requires the ability to recognize, absorb, interpret, and act on the stories and plights of others.”</li> </ul> <i>Explain the impact of RCC and NM on health care delivery</i> <ul style="list-style-type: none"> <li>• Improves outcomes of healthcare for patients</li> <li>• Enhances practitioner satisfaction reducing burnout</li> </ul>	<b>*LO 4. Understand how personal values and social norms affect health care delivery</b> <i>Define cultural competence as it pertains to health care</i> <i>Analyze the impact of cultural biases on health care delivery</i> <i>Apply concepts of cultural competence in recognizing others’ narratives</i> <i>Recognize and value the importance of the varied health professions in health care delivery</i> <i>Recognize and value the importance of the four dimensions of RCC in health care delivery</i>	

Note. RCC = relationship-centered care; NM = narrative medicine.