PERSPECTIVES

Relationship-centered Care

A Constructive Reframing

Mary Catherine Beach, MD, MPH[1,2] *Thomas Inui, ScM, MD*[3] *and the Relationship-Centered Care Research Network**

[1]Division of General Internal Medicine, Johns Hopkins University School of Medicine, Baltimore, MD, USA; [2]Phoebe R. Berman Bioethics Institute, Johns Hopkins University, Baltimore, MD, USA; [3]Regenstrief Institute, Indiana University School of Medicine, Indianapolis, IN, USA.

All illness, care, and healing processes occur in relationship—relationships of an individual with self and with others. Relationship-centered care (RCC) is an important framework for conceptualizing health care, recognizing that the nature and the quality of relationships are central to health care and the broader health care delivery system. RCC can be defined as care in which all participants appreciate the importance of their relationships with one another. RCC is founded upon 4 principles: (1) that relationships in health care ought to include the personhood of the participants, (2) that affect and emotion are important components of these relationships, (3) that all health care relationships occur in the context of reciprocal influence, and (4) that the formation and maintenance of genuine relationships in health care is morally valuable. In RCC, relationships between patients and clinicians remain central, although the relationships of clinicians with themselves, with each other and with community are also emphasized.

KEY WORDS: patient-provider relations; patient-provider communication; relationship-centered care.
DOI: 10.1111/j.1525-1497.2006.00302.x
J GEN INTERN MED 2006; 21:S3–8.

The Pew-Fetzer Task Force on Advancing Psychosocial Health Education was recruited to its task in early 1992, shortly after the Pew Health Professions Commission completed its analysis of the evolution of health care systems and the dynamics of the medical care marketplace. The Pew Health Professions Commission had posited a future vision for education in the health professions, attempting to bridge workforce demands of health care delivery systems on the one hand, and the health of the public conversely.[1] In retrospect, it could be argued that the "tectonic plates" under the landscape of medical care and medical education at that time were poised for a readjustment. This shift might be characterized as a movement from a "supply-side" rationale toward a "demand-side" rationale for curriculum and training in the health professions.

While biomedical science would remain the cornerstone of the educational and scientific enterprises within academic medical centers, it was also becoming apparent that understanding patient preferences and measuring patient satisfaction should have some degree of impact on medical school curricula and residency training. Delivery systems began using patient reports of care experience as one of the parameters for characterizing the performance of clinicians, groups, and delivery system subunits. The Association of American Medical Colleges included population-based knowledge and skills among its key objectives for medical school education.[2] While still emphasizing the need for foundational knowledge in the biomedical sciences, schools of medicine and other health profession schools also began to focus on what the public and the marketplace-expected graduates to know and do. The longer-term impact of this "demand-side" shift in professional preparation is evidenced today by the widespread use of patient satisfaction as a measure of clinician performance (and in some organizational settings, as a specific driver of physician compensation). Patient reports are also used as a means of evaluation in residency programs, organizational accreditation, professional certification, and re-certification in certain disciplines.

When the Pew-Fetzer Task Force set to work, it was also apparent that the philosophic framing of medical care was ripe for reconsideration. An evidence base for "patient-centeredness" was accumulating.[3] Patient-centered medicine, a term originally coined in 1969 by Balint [4] to describe the belief that each patient "has to be understood as a unique human-being," was further developed by Stewart and colleagues[5–8] in the mid-1980s as a mode of care that sought to articulate the doctors' and patients' agendas, to find and explore common ground, and to explore both the disease and illness experience. Soon after, patient-centered interviewing[9] was adopted as the standard for effective patient–physician communication, and remains so to this day.[10] The widespread acceptance of patient-centeredness also provoked a question in some minds: if "patient-centered care" was a new objective, what had we been practicing before: *doctor*-centered care? Rhetoric aside, many social scientists had long been observing that the balance of power and discre-

The authors have no conflicts of interest to report.

**The members of the Relationship-Centered Care Research Network are: Richard Frankel, Judith Hall, Paul Haidet, Debra Roter, Howard Beckman, Lisa A. Cooper, William Miller, Dave Mossbarger, Dana Safran, Dave Sluyter, Howard Stein, and Penny Williamson.*

Address correspondence and requests for reprints to Dr. Beach: Johns Hopkins University School of Medicine, 2024 East Monument Street, Suite 2-500, Baltimore, MD 21287 (e-mail: mcbeach@jhmi.edu).

Received for publication August 29, 2005
and in revised form September 13, 2005
Accepted for publication September 13, 2005

tion in medical care was precisely that—care centered on the preferences and values of the doctor.

At the end of its deliberations—after exploring the evidence base for patient-centered care, normative patterns of care, and the broad range in preferences of clinicians and patients regarding the character and quality of their interactions—the Pew-Fetzer Task Force[1] asserted yet a third framing for health care process in its final report, one that they described as "relationship-centered care." In taking this action, they meant to do more than balance the rhetoric. Noting patients' and clinicians' discontent with, and even alienation from, prevailing systems of care, the Task Force sought to develop a *values* foundation for the work of the health professions. In the current era (just as in the past), the social role and privileges of the healer seemed to be founded upon meaningful *relationships* in health care, not just on technically appropriate transactions within these relationships.

Principles of Relationship-Centered Care

Relationships provide the context for many important functions and activities in health care. Within relationships, we exchange information, allocate resources, arrive at diagnoses, choose treatments, and assess the outcomes of care. None of these is carried out solely by 1 party; all are mediated by the qualities of the manifold relationships that link patient, clinician, team, organizations, and community. Relationship-centered care (RCC) is built upon 4 related principles that are described below.

Principle 1: Relationships in Health Care Ought to Include Dimensions of Personhood as Well as Roles. In the clinical encounter, RCC makes explicit that both the patient and the clinician are unique individuals with their own sets of experiences, values, and perspectives. In RCC, clinicians remain aware of their own emotions, reactions, and biases, and monitor their own behavior in light of this awareness. While the "doctor-as-person" notion has been described by Mead and Bower[11] as integral to patient-centered care, this idea has been underdeveloped in most accounts of patient-centeredness. In addition to the explicit recognition that clinicians bring their personhood into the encounter, RCC emphasizes the importance of *authenticity*, in the sense that clinicians should not, for example, simply act as if they have respect for someone; they must also aim actually to have (internally) the respect that they display (externally).

Principle 2: Affect and Emotion Are Important Components of Relationships in Health Care. Relationship-centered care recognizes the central importance of affect and emotion in developing, maintaining, and terminating relationships. In RCC, emotional support is given to patients through the emotional presence of the clinician. Relationship-centered care therefore challenges the notion of detached concern, in which stepping back to maintain affective neutrality breaks the bond that holds people together. Rather than remaining detached or neutral, clinicians ought to be encouraged to empathize with patients, because empathy has the potential to help patients experience and express their emotions,[12,13] to help the clinician understand and serve the patient's needs,[14] and to improve patients' experience of care.[15,16] Affect and emotion have been understudied in the medical encounter; however, studies outside of medicine suggest that improved understanding and use of emotion by physicians could enhance medical care processes and outcomes.[17]

Principle 3: All Health Care Relationships Occur in the Context of Reciprocal Influence. Health and health-related actions do not occur in isolation but are related to one another in time, space, and content. As such, the smallest unit of measure in RCC is an interactional exchange. Furthermore, clinicians are undoubtedly benefited by the opportunity to know their patients, and RCC encourages clinicians to grow as a result. While achievement of the patient's goals and the maintenance of health are the more obvious focus of any encounter, allowing a patient to have an impact on the clinician is a way to honor that patient and his or her experience. In RCC, clinicians ought *not* to aim for a sort of Aristotelian "friendship" between unequals (in which the physician remains the "expert"), rather the participants are encouraged to develop a sort of Aristotelian "friendship" based on virtue, that is one wherein the 2 parties develop each other's character, and assist in the attainment of moral virtue.[18] This does not preclude that the patient's goals take priority (which ought to be the case); it simply acknowledges that the clinician also benefits in serving the patient.

Principle 4: RCC Has a Moral Foundation. The formation and maintenance of relationships in health care is morally valuable for several reasons. First, unlike customer relations in which individual and organizational gain are paramount, *genuine* relationships are morally desirable because it is through these relationships that clinicians are capable of generating the interest and investment that one must possess in order to serve others, and to be renewed from that serving. Although one could argue that physicians have fiduciary duties to patients that arise through some sort of contract (rather than through the formation of a genuine relationship), it tends to be true that, humans are more morally committed to those with whom they are in a personal relationship. Furthermore, rather than considering this partiality to be a moral weakness, some have argued that such enhanced commitment to those with whom we have a personal relationship with is morally desirable.[19] In addition, as a *human* participant, the clinician behaves more genuinely than if he or she were acting out a role. This sort of honesty is morally desirable as an end in itself, and it allows the patient to assess her impact on the clinician accurately, rather than being misled by a particularly good role performance.

Dimensions of RCC

In suggesting that an explicit focus of care ought to be on relationships, we embrace and expand the principles of patient-centeredness within the patient-clinician relationship, and we also consider the relationships of clinician-clinician, clinician-community, and clinician-self as foundational and intrinsic to health care. Below, we provide a general description of these dimensions of RCC. A more detailed description of the relationship-centered clinician's knowledge, attitudes/approach, and behaviors, as well as the anticipated outcomes of RCC, is presented in Table 1. In the table, we have highlighted the areas of RCC that we also consider to be part of patient-centered care.

The elements listed in Table 1 are those that we consider to be integral to RCC. There are many other variables (attitudes, behaviors, personal characteristics, outcomes) that

Table 1. Clinician Knowledge, Attitudes, Behaviors, and Anticipated Outcomes of Relationship-Centered Care*,†

	Clinician-Patient Relationship	Clinician-Clinician/Hierarchichal Relationship	Clinician-Community Relationship
Knowledge	Each patient is a unique individual Psychosocial, emotional, and lifestyle issues are integral to medical care Patients differ in their values, preferences, and expectations for care Patients' perspective, culture, and personality are relevant to the process of care Each relationship is unique and is a product of the work of each participant The manner in which a clinician participates in an encounter fundamentally affects the course, direction, and outcomes of care both episodically and longitudinally	Power inequities across health disciplines Power of understanding the other's perspective Healing approaches of various health disciplines Team-building dynamics and approaches to shared leadership	Diverse constructs/models of community Community perceptions of healthcare (including myths and misperceptions) Local community dynamics—demographic, economic, political, history of land-use, migration, occupation Local environments (social, political, economic, occupational, physical, educational, public safety) and their impact on health History of practitioner-community relationships Isolation of the health care community from the community at large Relationship of formal and informal healthcare
Approach, Philosophy, and Attitudes	Value partnership with patients View patients as experts Acknowledge that patients deserve respect View the provider-patient relationship as a therapeutic vehicle Value the achievement of mutual respect and unconditional positive regard Acknowledge that affective engagement, rather than affective neutrality or detached concern, can further the therapeutic bond and its efficacy Acknowledge that clinicians and patients are both active human participants (not just role occupants) who co-construct their relationships Acknowledge that relationships are reciprocal and involve mutual tasks, duties, and responsibilities	Affirm importance of self-awareness Value diversity and interdisciplinarity Appreciate importance of shared mission Is open to others' ideas Affirm importance of, mutual respect, and trust Believe in importance of sustaining capacity for recognition, reconciliation, and prevention of error	Respect for community integrity, cultural diversity, and multiple determinants of health Understand health-relevant policy Is open-minded Is honest about the limits of medical care Appreciate responsibility to contribute health expertise to public dialogue Respect for community leadership Appreciate responsibility to work for the health of the public
Behaviors	Show respect to patients Find out about patient's values, expectations, preferences, and background Tailor approach to the patient based on knowledge of patient Help patient get story across, listen well (nonjudgmentally) Respond to patient's emotions, show empathy Seek common ground as a point of departure for formulating therapeutic plans Attend to/monitor one's own behavior as an influence on the other(s) Be aware of and acknowledge own feelings and biases (emotional self-awareness) Acknowledge the importance of relationships to the therapeutic process and outcome for both partners Acknowledge need to take both participants' values, attitudes, and personality into account Acknowledge areas of agreement and disagreement on values, expectations, etc. Monitor the state of the relationship Acknowledge the importance of the relationship to one's own well-being	Reflect on self and personal/professional needs Continually learn from personal experience and that of others Learn cooperatively Derive personal meaning from the work of others Communicate effectively to other members of the team Listen actively to understand and engage other members of the team Work collaboratively, share responsibility Recognize and work to resolve conflicts Provide space in meetings for new thoughts, ideas Employ appreciative inquiry to imagine improvements Continuously examine whether the organizational values are reflected in day-to-day work	Participate in community dialogue and development Participate in activities intended to ascertain the relationship between health care providers and community health, community health status, and the impact of health care delivery systems on community health Participate in the development of health-enhancing community policy Communicate actively in matters of relevance to community health—listening openly, empowering others, contributing health expertise, facilitating the learning of others Participate actively in the implementation of community health strategies, health teams, and health care organizations
Outcomes	Patient feels honored, respected, attended to, etc. Patient likes and is satisfied with provider Patient has lower anxiety Patient has trust in provider Patient adheres to treatment Patient remembers information, advice Patient is more actively engaged	Productive resolution of disagreements Minimal staff turnover Improved ease of staff recruitment Colleagues reach personal and professional goals regularly Team members report being treated fairly and respectfully	Enhanced collaboration between formal and informal health care "systems" within the local community Greater depth of understanding of the community's health care resources, as well as vulnerabilities Greater prevalence of organizational policies that promote community health

(continued)

Table 1. (Continued)

	Clinician-Patient Relationship	Clinician-Clinician/Hierarchichal Relationship	Clinician-Community Relationship
	Mutual attunement and harmony Informed decision making Added depth and vitality to interactions Clinician becomes a source of social and emotional support for the patient Patient becomes a source of professional reward/gratification for the clinician Protection against professional burnout Greater agreement on treatment plans	Enhanced capacity for working across a broad array of challenges Enhanced patient safety and quality of care	Greater participation of health care organizational personnel in civic service Enhanced community health

*Shaded areas indicate features of care that we consider part of both patient-centered and relationship-centered care.
†Categories (knowledge, approach, behaviors, and outcomes) are evolving and interactive.

might be correlated with RCC, but are not central to their definition. For example, future research might explore the question of what kinds of life experiences and educational approaches lead to the adoption of an RCC outlook, or under what circumstances RCC-related behaviors have the best impact (race- or gender-concordant dyads, or routine vs emergent care, for example). Whatever those experiences or circumstances are, they are *correlates* of RCC and *not* part of the definition. Similarly, the anticipated outcomes of RCC are not included among its defining elements. Whether, and under what circumstances, RCC leads to favorable outcomes is an important empirical question for future investigation, but the achievement of favorable outcomes is not its defining feature.

The elements described in Table 1 are also intended to be illustrative rather than comprehensive, in that there are many more attitudes and behaviors that could be added. Some omitted variables may be nested under the more general elements listed, meaning that they are not so much left out as simply embedded in the higher-order concepts listed. While each bullet may appear to be a static category, we recognize that thinking, feeling, and action are interactive processes. For example, we value partnership with patients and we show this by reflecting on what matters most to them. One final point is to acknowledge that it is not possible to dictate by definition how much of a given attitude or behavior is optimal in practice. For many of the elements listed below, the optimal amount or intensity would depend on the circumstances, and we assume that the reader will understand that the notions of "to an appropriate degree" and "in an appropriate manner" are implicit throughout, with the determination of what is appropriate being an empirical matter left for later investigation.

Clinician-Patient Relationship. Relationship-centered care recognizes that the clinician-patient relationship is the unique product of its participants and its context. In RCC, the quality of communication between patients and clinicians is not viewed as a result or outcome of 1 single party, but as an interactive process that is dependent on the efforts of both participants. One "standard" for mutual knowledge, intimacy, task-sharing, and communication style, for example, is unlikely to be appropriate for obstetrical labor and delivery care, care near the end of life, substance abuse detoxification, preoperative evaluation, care of a person with depression, and keeping up with child's vaccinations. Even a particular doctor and patient who work together over a significant period of time (or through changing circumstances) are likely to need to adjust to the ways in which they come together and work over time. For example, in RCC, a particular physician behavior, like self-disclosure[20,21] or empathy,[12,15] is not viewed as "good" or "bad"—rather it is evaluated to the extent that it emerges from and contributes to the relationship between the patient and clinician.

Clinician-Clinician Relationship

Relationship-centered care recognizes that the relationships that clinicians form with each other, especially within hierarchical organizations, contribute meaningfully to their own well-being as well as the health of patients.[22] When the culture of an organization diverges from the core principles of relationship-centeredness, the practitioner is forced to engage with patients in a manner sometimes quite different from how he or she is treated. The energy and enthusiasm that a practitioner brings into the consultation with a patient is profoundly influenced by the practice and larger organization's values and integrity. Relationship-centered care emphasizes that clinicians ought to listen, respect colleagues, appreciate the contributions that colleagues from other disciplines bring, promote sincere teamwork, bridge differences, and learn from and celebrate the accomplishments of their colleagues.

Practitioner-Community Relationship. Because the root causes or determinants of health are multiple (biologic, environmental, social, psychological, behavioral, economic, and medical care-related), the clinician and clinical team will need to "reach into" many sectors, form meaningful relationships with others, and sustain these "therapeutic partnerships" if effective care for illness is to be possible. Relationship-centered care emphasizes the importance of practitioners' relationships with communities of patients such that the practitioner understands the local community dynamics, appreciates the importance of the community in contributing to the health and well-being of its members, and participates in community dialogue and development.

Clinician Relationship with Self. The least-explored dimension of RCC may be "relationship with self." By this phrase, we refer to the individual's capacity for self-awareness, depth of self-knowledge, and capacity to create and sustain personal integration ("wholeness" or integrity) in complex and challenging circumstances. To state the obvious, entering into any positive relationship with others first requires self-awareness and integrity. Working to improve someone else's health, further-

more, requires a resourcefulness and resilience on the part of the clinician that has its deepest roots in the practitioner's right relationship with self and self well-being. Given our frenzied lives, and the objectivist, positivist stance that pervades our scientific culture, it may be difficult to find and sustain the time and will for reflection on self and well-being. In the words of the Pew-Fetzer Task Force report:[1] "The biggest 'psychosocial' problem facing us may be the need for our own personal transformation—to understand and promote change within ourselves."

Establishing the Importance of RCC in Medical Education

A recent publication from the Institute of Medicine (IOM)[23] incorporates a brief synopsis of the substantial evidence base that suggests that the underlying characteristics of relationships in these 4 dimensions affect the process and outcomes of medical care. Among the highest priorities for inclusion in the curriculum of medical schools are content from, as the IOM report describes them, 2 major content categories: (1) physician-patient interactions, including basic and complex communication skills; and (2) physician role and behavior, including ethical guidelines; physicians' personal values, attitudes, and biases as they influence patient care; physician well-being; social accountability and responsibility; work in health care teams and organizations; and linkage with community resources to enhance patient care. The congruence between these IOM topics and Pew-Fetzer Task Force relationship categories is self-evident.

It would not be appropriate to recount the IOM literature review here, but a few examples of the literature reviewed by the IOM Committee might be helpful. The IOM "physician-patient interactions" domain deals not only with efficient exchange of information, but also with building trustworthy *clinician-patient* relationships for such challenging situations as being with a dying patient, helping patients cope with bad news, discussing advance directives, assessing and managing emotional disorders, supporting behavioral change, and still others. *Clinician-clinician* relationships are at the core of the IOM category "work in health care teams and organizations," including the complex array of interdisciplinary and intersecting relationships required for implementation of the chronic care model, now thought to be the most effective approach to controlling chronic disease. *Clinician-community* relationships are central to the IOM category "use of and linkage with community resources" with examples drawn from programs for breast and prostate cancer, vaccination, tobacco control, and access-enhancing programs for the uninsured. Finally, several IOM categories are focused sharply on the physician's need to understand and be *in right relationship with him/herself*, with examples drawn from the professional development literature, mindfulness programs, and programs designed to avoid cynicism and burnout. The IOM report asserts that each of these subject areas is important enough to become part of the basic education of all physicians, largely, basing this assertion on the literature that establishes links between these matters and health. While the evidence base supporting this linkage is still incomplete, the scientific foundation for asserting the importance of RCC has moved well beyond conjecture and philosophy.

Conclusion

Relationship-centered care is health enhancing. It is founded upon, proceeds within, and is significantly influenced by the web of relationships that promote the well-being, and full functioning of patients. In RCC, the patient is often our central concern, but is not considered in isolation from all others. Instead, while the clinicians' first responsibility is to prevent and alleviate illness, we do this work mindful of the contributions of the family, our team, our organizations, and our community to what can be accomplished. Similarly, we must be mindful of the impact of what we do with patients on the well-being of all others involved, including their integrity, functional capacity, resilience, and financial stability. Finally, we do this work in full knowledge that our own well-being and function need to be sustained if we are to continue to serve others vigorously.

The authors would like to thank the Fetzer Foundation for its support of this initiative.

REFERENCES

1. **Pew-Fetzer Task Force on Advancing Psychosocial Health Education.** Health Professions Education and Relationship-Centered Care. San Francisco: Pew Health Professions Commission; 1994.
2. **Association of American Medical Colleges.** Learning Objectives for Medical Student Education: Guidelines for Medical Schools. Washington, DC: Medical School Objectives Project. Available at: http://www.aamc.org/meded/msop/msop1.pdf Accessed March 7, 2005.
3. **Roter DL, Hall JA, Katz NR.** Relations between physicians' behaviors and analogue patients' satisfaction, recall, and impressions. Med Care. 1987;25:437–51.
4. **Balint E.** The possibilities of patient-centred medicine. J R Coll Gen Pract. 1969;17:269–76.
5. **Levenstein JH, McCracken EC, McWhinney IR, Stewart MA, Brown JB.** The patient-centred clinical method. 1. A model for the doctor-patient interaction in family medicine. Fam Pract. 1986;3:24–30.
6. **Stewart M.** Towards a global definition of patient-centred care. BMJ. 2001;322:444–5.
7. **Brown J, Stewart M, McCracken E, McWhinney IR, Levenstein J.** The patient-centred clinical method. 2. Definition and application. Fam Pract. 1986;3:75–9.
8. **Stewart M, Brown J, Weston W, McWhinney I, McWilliam C, Freeman T.** Patient-Centered Medicine: Transforming the Clinical Method. London: Sage; 1995.
9. **Lipkin M Jr., Quill TE, Napodano RJ.** The medical interview: a core curriculum for residencies in internal medicine. Ann Intern Med. 1984;100:277–84.
10. **Committee on Quality Health Care in America.** Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academics Press; 2001.
11. **Mead N, Bower P.** Patient-centredness: a conceptual framework and review of the empirical literature. Soc Sci Med. 2000;51:1087–110.
12. **Coulehan JL, Platt FW, Egener B, et al.** "Let Me See If I Have This Right . . . ": words that help build empathy. Ann Intern Med. 2001;135:221–7.
13. **Beckman HB, Frankel RM.** Training practitioners to communicate effectively in cancer care: it is the relationship that counts. Patient Educ Couns. 2003;50:85–9.
14. **Halpern J.** From Detached Concern to Empathy: Humanizing Medical Practice. New York: Oxford University Press; 2001.
15. **Eide H, Frankel R, Haaversen ACB, Vaupel KA, Graugaard PK, Finset A.** Listening for feelings: identifying and coding empathic and potential empathic opportunities in medical dialogues. Patient Educ Couns. 2004;54:291–7.
16. **Levinson W, Gorawara-Bhat R, Lamb J.** A study of patient clues and physician responses in primary care and surgical settings. JAMA. 2000;284:1021–7.
17. **Roter DL, Frankel RM, Hall JA, Sluyter D**. The expression of emotion through nonverbal behaviour in medical visits: mechanisms and outcomes. J Gen Intern Med. 2006;21:S28–S34.

18. **Aristotle.** Books VIII–IX, In: Ross WD, (trans.), ed. Nicomachean Ethics. London: Clarendon Press; 1952.
19. **Friedman M.** What Are Friends For? Feminist Perspectives on Personal Relationships and Moral Theory. Ithaca, NY: Cornell University Press; 1993.
20. **Beach MC, Roter D, Larson S, Levinson W, Ford DE, Frankel R.** What do physicians tell patients about themselves? A qualitative analysis of physician self-disclosure. J Gen Intern Med. 2004;19:911–6.
21. **Beach MC, Roter D, Rubin H, Frankel R, Levinson W, Ford DE.** Is physician self-disclosure related to patient evaluation of office visits? J Gen Intern Med. 2004;19:905–10.
22. **Suchman AL, Deci EL, McDaniel SH, Beckman HB.** Relationship-centered administration. In: Frankel R, Quill T, McDaniel S, eds. Biopsychosocial Care. Rochester, NY: University of Rochester Press; 2003.
23. **Committee on Behavioral and Social Sciences in Medical School Curricula.** Improving Medical Education: Enhancing the Behavioral and Social Science Content of Medical School Curricula. Washington, DC: National Academies Press; 2004.