flicts are likely to have consequences for all maternity care providers and have an impact on the patient-provider relationship in ways that could challenge even the staunchest patient advocate — the family physician.

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References

1. Flamm BL, Lim OW, Jones C, Fallon D, Newman LA, Mantis JK. Vaginal birth after cesarean section: results of a multicenter study. Am J Obstet Gynecol 1988; 158:1079-84.
2. Flamm BL, Newman LA, Thomas SJ, Fallon D, Yoshida MM. Vaginal birth after cesarean delivery: results of a 5-year multicenter collaborative study. Obstet Gynecol 1990; 76:750-4.
3. Flamm BL, Goings JR, Liu Y, Wolde-Tsadik G. Elective repeat cesarean delivery versus trial of labor: a prospective multicenter study. Obstet Gynecol 1994; 83:927-32.
4. Boucher M, Tahilramaney MP, Eglinton GS, Phelan JP. Maternal morbidity as related to trial of labor after previous cesarean delivery, a quantitative analysis. J Reprod Med 1984; 29:12-6.
5. Meehan FP, Magani IM. True rupture of the cesarean section scar (a 15 year review, 1972-1987). Eur J Obstet Gynecol Reprod Biol 1989; 30:129-35.
6. van Amerongen D. Vaginal birth after cesarean section. Experience in a community-based practice. J Reprod Med 1989; 34:531-4.
7. Craigin EB. Conservatism in obstetrics. NY Med J 1916; 104:1-3.
8. Miller ES, Partezana J, Montgomery R. Vaginal birth after Cesarean: a 5-year experience in a family practice residency program. J Am Board Fam Pract 1995; 8:357-60.
9. McClain CS. Why women choose trial of labor or repeat cesarean section. J Fam Pract 1985; 21:210-6.
10. Abitbol MM, Castillo I, Taylor UB, Rochester BL, Shmoys S, Monheit AG. Vaginal birth after cesarean section: the patient's point of view. Am Fam Physician 1993; 47:129-34.
11. Kahn K, Fiske M, DiMatteo R, Bradley M, Edwards C, Gifford D, et al. Mother's thoughts about cesarean as compared with vaginal deliveries and the effect of those thoughts on method of delivery. Abstract presented to the Association of Health Services Research Annual Meeting, San Diego, CA, 13 June 1994.
12. Joseph GF Jr, Stedman CM, Robichaux AG. Vaginal birth after cesarean section: the impact of patient resistance to a trial of labor. Am J Obstet Gynecol 1991; 164:1441-7.
13. Minor AE. The cost of maternity care and childbirth in the United States, 1989. Washington, DC: HIAA Research Bulletin (Pub No R1589), December 1989.
14. Charges for a cesarean section: United States, 1990. Stat Bull Metrop Insur Co 1992; 73(1):12-8.
15. Data from the Oregon Department of Human Resources. Portland: Office of Health Policy. Patient Discharge Database System.
16. Gold RB, Kenney AM, Singh S. Paying for maternity care in the United States. Fam Plann Perspect 1987; 19:190-206.
17. Enthoven A, Kronick R. A consumer choice health plan for the 1990s. Universal health insurance in a system designed to promote quality and economy. N Engl J Med 1989; 320:94-101.
18. Finkler MD, Wirtschafter DD. Why pay extra for cesarean-section deliveries? Inquiry 1993; 30:208-15.
19. Danforth DN. Cesarean section. JAMA 1985; 253:811-8.
20. Porreco RP, Klaus MH, Shearer E, Petitti D, Hohe P, Boylan PC. Commentaries: the cesarean section rate is 25 percent and rising. Why? What can be done about it? Birth 1989; 16:118-22.
21. Barclay L, Andre CA, Glover PA. Women's business: the challenge of childbirth. Midwifery 1989; 5:122-33.
22. Spellacy WN. Vaginal birth after cesarean: a reward/penalty system for national implementation. Obstet Gynecol 1991; 78:316-7.
23. Darby M. Reimbursement has small impact on c-section rates. In: Report on medical guidelines and outcomes research. Alexandria, VA: Capitol Publications, 1992:8-10.
24. Sims PD, Cabral D, Daley W, Alfano L. The incentive plan: an approach for modification of physician behavior. Am J Public Health 1984; 74:150-2.
25. Stafford RS. Alternative strategies for controlling rising cesarean section rates. JAMA 1990; 263:683-7.

Relationship-centered Care: Beyond The Finishing School

Andrew D. Hunt, the first dean of the College of Human Medicine at Michigan State University and later the founding director of its Medical Humanities Program, used to decry the "finishing school" view of ethics and humanities in medicine — according to which students would first learn "real" medicine and then, as a sort of afterthought, would be given a course in ethics or humanities, as young ladies of an earlier era were sent to finishing school to learn how properly to hold a teacup. Hunt believed that ethics and

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humanities would never be fully appreciated by students and faculty so long as their *essential* connection to the practice of medicine went unrecognized in the design of the curriculum.

Despite many efforts by thoughtful people over a long period, we might be at the same "finishing school" stage of teaching the psychosocial aspects of medicine, both in medical school and in our own residencies. How often, for instance, do residency curricula include a separate series of psychosocial conferences? These would be marvelous if they resulted from the view that certain psychosocial topics needed to be developed in special depth, but they usually reflect instead the fear that without such a series, the psychosocial dimensions of medical care would never be addressed at all in a didactic fashion.

I have argued previously that this problem in marketing the biopsychosocial model within medical education will never improve with the publication of further academic reports but that it will get better only when the entire environment of US health care is reformed so as to restore primary care to the central role that it deserves.[1] I must now amend my earlier stance to call attention to a recent report that could provide a major boost of energy for those in family practice who would like to have one more go at major educational reform, at least while we are waiting for the practice environment to move in a positive direction.

Health Professions Education and Relationship-centered Care,[2] the work of a task force that included two distinguished family medicine educators, offers an opportunity to rethink radically how we organize medical teaching to show what sort of activity medicine really is. The simple, straightforward, and potentially revolutionary proposal of the task force (sponsored by the Pew and Fetzer foundations) is that health care is most fundamentally a matter of human relationships:

> The central task of health professions education — in nursing, medicine, dentistry, public health, pharmacy, psychology, social work, and the allied health professions — must be to help students, faculty, and practitioners learn how to form caring, healing relationships with patients and their communities, with each other, and with themselves.[2, p. 39]

For each of the three pivotal relationships — with patients and communities, with other physicians, and with other health professionals — the report offers specific lists of knowledge, skills, and values that should be the focus of education. It concludes with six guiding principles:

1. Health professions educators must view health care as the effort to help restore, maximize, or expand function and meaningfulness in all aspects of life, rather than only to cure pathology. It is crucial to understand how the patient sees the illness as it affects his or her life.
2. Health professions education must be based on clear, explicit values that are centered on relationships and a commitment to service.
3. The quality of the relationships that practitioners form with patients and their families, with communities, and with students and fellow practitioners across professions is of primary importance to assuring effective, comprehensive education and health care.
4. The richest teaching environment is the community, close to the context of patients' lives.
5. Learning depends on reflecting on one's experience. Preparation in — and strong encouragement of — such reflection needs to be part of both formal and informal health professions education.
6. New methods of care and education that are guided by an integrated approach must be evaluated to determine their effectiveness and impact upon the patient, the practitioner, the community, the student, and the faculty.[2, pp. 48-49]

Without specifically supporting primary care or family practice, the report provides the strongest possible rationale for placing the primary care disciplines — especially those with the strongest sense of their community base — at the very core of the educational process. On this view, what is truly "basic" to medicine is human relationships, not anatomy, physiology, and biochemistry. Scientific knowledge is clearly essential for the physician but needs to be reorganized so that the students perceive much more clearly how the knowledge supports and potentiates those key relationships. The ideal medical curriculum is one organized around primary care, which is the set of medical specialties that defines itself primarily by the ongoing relationship with the patient, not by

organ system or use of procedures.[3,4] The ideal academic medical center is a community-based network engaged actively in primary care outcomes research.[5]

Examples of why a relationship-centered educational process would be beneficial are easy to find once one is willing to grasp the essential challenge. Consider, as one example, a recent, cogent analysis of medical error.[6] At one level, the analysis urges medicine to adopt some of the proven methods, long used in industry, to assure higher levels of safety; and in so doing, medicine must inevitably come to view errors only in part as a matter of individual responsibility and much more as a function of systems design. Thus, if we want to do something serious about preventing errors that harm our patients, we must start to think much more in systems terms — which is to say, the network of relationships among ourselves, our patients, and our fellow providers. Moreover, we need to get much more in touch with the *human* aspects of these relationships, as well as to reflect much more thoughtfully upon our own humanness. We will never effectively reduce medical error so long as we imagine that physicians are potentially perfectible, so that each commission of a mistake is a trigger for denial, self-blame, and withdrawal into anguished isolation. As other industries have learned, we must instead realize that all humans make mistakes and then ask how we can design systems that best allow us to learn from our mistakes and minimize their tragic consequences.

The call for relationship-centered education also coheres well with some recent criticisms of how medical ethics has been taught. The focus on rules and principles, however useful they might be in resolving ethical dilemmas, suggests in the end that human relationships are somehow irrelevant to ethical analysis. We are being challenged today to develop new views of ethics in which caring, relationships, and the human life context are taken much more seriously.[3,7]

While we do a much better job of relationship-centered teaching than do most other medical specialties, the Pew-Fetzer report challenges us to improve upon our record. For one thing, we certainly need to do a much better job at the level of our national organizations in forging a partnership with the nursing profession, as daunting as that task might be politically. For another, we need to assure that time and space for thoughtful reflection are built-in features of both the medical school and the residency experience. Finally, especially as managed care comes to dominate the medical marketplace, we must attend much more carefully to the human as well as the technical dimensions of the relationships between primary care physicians and subspecialist consultants and make the formation of positive, mutually respectful relationships an explicit part of our educational programs.

I strongly encourage family medicine educators first to study the Pew-Fetzer report and next to circulate it as widely as possible within their institutions. I believe it provides a very effective framework for the next wave of educational reform, which we must promote if our health care system is ever to be truly healthy.

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References

1. Brody H. A policy imperative for primary care: reflections on Keystone II. Fam Med 1990; 22:42-5.
2. Health professions education and relationship-centered care. San Francisco: Pew Health Professions Commission, 1994.
3. Brody H. The healer's power. New Haven: Yale University Press, 1992.
4. *Idem*. My story is broken, can you help me fix it? Medical ethics and the joint construction of narrative. Lit Med 1994; 13:79-92.
5. Brody H, Sparks HV, Abbett WS, Wood DL, Woodland WC, Smith RC. The mammalian medical center for the 21st century. JAMA 1993; 270:1097-100.
6. Leape LL. Error in medicine. JAMA 1994; 272:1851-7.
7. Nelson JL. Taking families seriously. Hastings Cent Rep 1992; 22(4):6-12.

Happy Residents, Happy People, Or Both?

The author Robert Coles produced a lifetime of work, beginning with *Children of Crisis: A Study of Courage and Fear*,[1] describing the strength of chil-

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