

Creating Optimal Healing Environments for Patients with Cancer and Their Families: Insights, Challenges, and Lessons Learned from a Decade of Experience

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ABSTRACT

Optimal cancer care balances the need for scientific knowledge, statistical analysis, and rational thought with the need for wisdom, kindness, compassion, and love. Finding and maintaining this balance is one of the most important challenges inherent in creating optimal healing environments (OHEs) for cancer care. This new medical paradigm, which promotes awareness, healing, and transformation at the deepest levels of the body, mind, heart, and spirit for patients and their families, must make an equal commitment to developing the health, well-being, awareness, and communication skills of medical and other staff members. This paper articulates the insights, challenges and lessons gleaned from the author's experience in creating and directing an OHE with a scientifically based, sensitive, and compassionate approach to healing for patients with cancer and their loved ones.

INTRODUCTION

Cancer is the second leading cause of death in the United States.¹ Within this decade it is expected to become the number one cause, thereby surpassing heart disease. One in three women and one in two men alive today in the United States will be diagnosed with cancer at some point in their lives.² More than 1500 people die of cancer in this country every day. While incidence rates of some specific cancers have declined modestly in recent years, other cancers are increasing in frequency.³ The total number of cases diagnosed each year continues to rise, and with an aging Baby Boomer population the trend is expected to continue.⁴

Cancer is not just a disease of the body. It can wreak havoc on patients' emotions, their psyche, their relationships, and their ability to live and work.⁵ Anxiety and emotional distress have been reported in a significant percentage of patients with cancer,^{6,7} and in their caregivers.^{8,9} These factors, combined with rising costs of increasingly sophisticated diagnostic and therapeutic modalities, contribute

to cancer's growing economic impact. The total financial costs of cancer now exceed \$171 billion per year; over 10% of the entire health care costs for the United States.^{10,11}

Increasing prevalence of cancer and changing expectations about health care have stimulated a burgeoning interest in and increasing demand for complementary and alternative medicine (CAM).¹²⁻¹⁵ Utilization of CAM therapies among individuals with cancer is common, with studies demonstrating that up to 80% of cancer patients use at least one form of CAM therapy at some point in their illness.^{13,14}

Heightened consumer demand, patient frustration, and conventional medicine's limited ability to cure cancer and promote true healing have sparked the need to create a new medical paradigm. The focus must be on the creation of comprehensive, optimal healing environments (OHEs) that promote awareness, healing, and transformation at the deepest levels of the body, mind, heart, and spirit. This paradigm must include a commitment to the healing and transformation of clinical as well as administrative staff, and medical organizations as a whole, while delivering modern, state-of-

the-art medical care in an atmosphere of love, compassion, and integrity. Fulfilling this objective is the great challenge and opportunity before us.

The objective of this article is to identify and articulate the essential elements for creating and sustaining OHEs for cancer care. The Seven Levels of Healing, a comprehensive integrative medicine program designed to promote deep and long-lasting healing and transformation, is also described. Finally, five specific hypotheses for scientific investigation will be described with a goal to transform our current health care system.

A MULTIDIMENSIONAL APPROACH TO MEDICINE AND HEALTH CARE

In Western society there is a culturally sanctioned notion that the purpose of medicine is to fix people, as quickly, inexpensively and efficiently as possible. With respect to cancer, the primary focus is on the physical dimensions of disease, and the goals are to eradicate tumors, normalize blood tests, alleviate pain, and prolong life to the greatest extent possible. These goals do not address the mental, emotional, and spiritual dimensions of human existence that profoundly influence the course of our lives and our ability to heal. This limited view is beginning to change and expand. Central to this process is a growing understanding that medicine is more than a means for healing the physical body. Rather, it is a multidimensional way and opportunity to nurture and heal the mental and emotional dimensions of one's self and to experience the deepest aspects of one's spiritual nature.

The relative and ultimate purposes of medicine

The relative purpose of medicine is to promote overall health and well-being, including the physical, mental, emotional, and social aspects of our common human experience. Its initial concerns are to remove all traces of the cancer if possible and focus primarily on the physical dimensions of existence. This approach is limited, however, because if healing is to be complete, the inner needs and concerns of human beings must also be addressed.¹⁵⁻¹⁹

The ultimate purpose is to help all beings discover the source of wholeness, love, fulfillment, and freedom that lies within themselves. It guides and encourages the discovery of who we are at the deepest spiritual level, far beyond one's transient and ever-changing present identity and circumstances. As medicine moves toward a vision of true whole-person care, it will embrace the ultimate as well as relative purpose of medicine. It will also honor and embrace all the dimensions of human existence, from the biomolecular to the transcendent, and recognize a realm of pure consciousness in which all appearances of duality and separation dissolve.¹⁶⁻¹⁸ Fittingly, this multidimensional vision of healing has roots within many of the world's great spiritual traditions.¹⁹⁻²¹

THE DREAM OF A CANCER CURE

In 1973 the "war on cancer" was declared by President Nixon.²² Researchers have and are continuing to spend billions of dollars pursuing the dream that a designer drug to cure cancer will soon be discovered.²³⁻²⁵ However, there are a number of reasons it is unlikely that a cure for all cancers will ever be discovered. Cancer is a heterogenous group of over 100 different diseases, each with unique characteristics.²⁴ Understanding the subtle biologic, molecular, and genetic distinctions, and learning how they can be utilized for therapeutic gain, is an exceedingly expensive and laborious process.²⁵⁻²⁸

It is possible that we may soon enter an era in which cancer is controlled in individuals for relatively long periods of time, rather than cured, much like other chronic diseases such as diabetes and heart disease. Nonetheless, at present, and for the foreseeable future, up to 50% of all patients with cancer will continue to succumb to their disease. Therefore, understanding and embracing both the relative and ultimate purposes of medicine is important for practical and philosophical reasons and is an essential aspect of the OHE.

THE SEVEN LEVELS OF HEALING

On the journey through cancer, patients and their loved ones inevitably encounter seven distinct, but closely inter-related, areas of inquiry and exploration, which I call "The Seven Levels of Healing."²⁶ These levels represent a map, or topography, of how human beings instinctively seek healing and wholeness in the face of any illness or crisis.

Level One: Education and information

In the face of illness or life challenge, one quickly encounters a series of important questions and a compelling need for answers. The instinctual drive for survival catapults individuals on a search for education and information about what to do next.²⁷⁻²⁹ Recognizing this, this program begins with "education and information."

Modern cancer treatments are highly varied and complex. Lack of understanding about one's diagnosis and treatment options can lead to unnecessary pain, fear, and suffering and to suboptimal outcomes.^{30,31} Most cancer treatment centers and organizations now recognize the importance of providing education and information and specially trained staff to interpret the information.³²

Level Two: Connection with others

Level Two is based on the understanding that connection with others lies at the heart of healing. Numerous medical studies demonstrate that social isolation is a risk factor for morbidity and mortality from all diseases.^{33,34} A variety of

different mechanisms have been proposed as contributing to these increased risks, including psychoneuroimmune, endocrine, and other physiologic responses to stress and social isolation.^{35,36} Over the past two decades, a growing body of evidence has documented the value and benefits of psychosocial support interventions for patients with cancer.³⁷⁻³⁹ The simple act of sharing with other patients with cancer, in a variety of settings including groups, can greatly improve quality of life and reduce feelings of anxiety, depression, isolation, and pain.⁴⁰⁻⁴⁷ Psychosocial interventions may also improve overall survival, although these results remain controversial.⁴¹⁻⁴⁴

Staff members can play an important role in providing critically needed psychosocial support for patients and family members. Support groups can also provide an important opportunity for patients to begin to expand their identity beyond that of being someone who is ill, or a victim of their disease.⁴⁵⁻⁴⁸ For a variety of reasons, many patients and/or family members resist participation in formal support groups.^{46,47} There are numerous other avenues that can provide patients with meaningful support, including religious groups, clergy, clubs and organizations, family and friends.^{48,49} For many, the best approach is to gather support from a combination of sources.

Level Three: The body as garden

Western scientific thought regards the body as a machine. Doctors are the “mechanics” and disease is viewed as a condition that springs from a flaw in the human machinery. In Eastern medical systems, the body can be seen as a garden. Doctors are “gardeners” who seek to discover and heal the roots of disease, planted in the past by a patient’s heredity, food choices, daily activities, environment and ongoing mental processes.

Level Three is the realm in which CAM approaches to healing find their natural home and function. Here, the full range of CAM therapies are not regarded as cancer treatments *per se*, but are utilized to supplement conventional care in safe and rational ways.⁵⁰⁻⁵³ However, special care should be taken with the utilization of herbs, vitamins, and antioxidants that may interfere with the activity of conventional cancer treatments and other medications.^{51,52}

Level Four: Emotional healing

For most individuals given a diagnosis of cancer, nothing is, or ever will be, the same again.^{53,54} An approach to emotional pain or distress that manages it with medications and a minimal amount of self-inquiry or introspection can be associated with a variety of adverse affects on significant aspects of the treatment course and a patient’s general health, and may also influence survival.^{55,56}

In Level Four, the focus and attention of patients and family members is gently redirected from the “external” world of science, medicine and integrative therapies into the “in-

ternal” world of feelings and personal emotional experience. For many people, this transition will not be easy because of the fear, pain, anger, sadness, grief, and turmoil that might be encountered along the way.^{57,58} Nonetheless, safely working through and releasing these energies is an essential component of multidimensional care.⁵⁹⁻⁶¹ Medications can play an important role in the process, particularly on a short-term basis, under the guidance of a qualified physician.⁶⁰ However, the majority of patients and family members who encounter emotional turbulence will benefit more from personal dialogues and one-on-one counseling with an experienced professional.⁶¹

Level Five: The nature of mind

In Level Five, patients and family members begin to develop an understanding of how their conscious and unconscious thoughts and beliefs impact their experience of life at the very deepest levels. The thoughts and beliefs patients have regarding their illness, their relationships with doctors and the treatments they have been offered will significantly impact their ability to assess, choose and respond to care.⁶²⁻⁶⁴ Conscious and unconscious beliefs among family members can also powerfully influence a patient’s choices and decisions about their care, often with negative consequences.⁶³ Similarly, inaccurate assumptions, disempowering beliefs, and the unconscious meaning that patients may give to their illness can inadvertently undermine every aspect of their entire experience on the journey through cancer, and that of their family members.⁶⁴⁻⁶⁷ Without promoting a particular orientation or philosophy, the OHE works gently to help patients uncover their individual thought patterns and beliefs, and to assess the degree to which they are helpful or not.⁶⁸

Level Six: Life assessment

In Level Six, patients and family members are asked to define and prioritize their top 20 goals for the year to come. They are encouraged to explore the purpose of their life and what provides them with the deepest meaning.⁶⁹ If a patient has clear and personally compelling reasons to live, the challenges of cancer become easier to overcome.⁷⁰ By getting very clear about whether they really want to live and why they want to live, patients often find previously unknown reserves of energy and strength which can be extremely valuable on their journey through cancer.⁷¹ In addition, by knowing exactly what their most important goals and priorities are, patients are better able to focus on what is most meaningful in their lives.⁷²

When patients are at the point of being ready to let go of life, family, friends and the health care team must honor and respect that choice and provide comfort and honor in the dying process.⁷³⁻⁷⁶ They will also help the patient address a different set of questions such as, “What do I need to do to complete my life? How can I use this time most effectively?

How can my exit from life benefit my spiritual growth? What can I do to love and support those I care about while I am still alive?"⁷⁴ This sacred process deserves great care and attention, and can profoundly enrich the experience of patients, family members, and caregivers alike.⁷⁵

Level Seven: The nature of spirit

This level relates to spirit and is both the most misunderstood and the most important level. Spirit is the true nature of humankind. Timeless, eternal, and dimensionless, it is the source from which all awareness, all creativity, and, ultimately, all healing flows. Finding one's spiritual essence is an intimate process of self-discovery often taking place in nature, silence, meditation or prayer. It can also take place in communion with friends, family, loved ones or other patients or can happen spontaneously.⁷⁶⁻⁷⁹

In recognizing and experiencing the nature of spirit, OHEs assist patients in discovering that no matter what happens to their body physically, there is another part of them that is timeless and eternal, and that is always whole and completely untouched by their circumstance. When this occurs, patients become less anxious or distressed, the potential for healing deepens and expands, and they are better able to make choices.⁷⁷⁻⁷⁹ In this seventh level, the deepest healing takes place and the ultimate purpose of medicine is achieved.

PHILOSOPHICAL CHALLENGES

Significant philosophical challenges arise in creating and operating OHEs designed to care for cancer patients and their families. The most immediate and compelling philosophical challenges involve creating a genuine consensus about the following fundamental questions:

- What is the purpose of medicine? What are we trying to accomplish, specifically, with all of our work and efforts, and why? Do we accept the notion that there are, indeed, a relative and an ultimate purpose of medicine? Can we agree on their definitions?
- What do we mean by "healing"? How do we define this term?
- What are the roles of consciousness, love, intention and personal integrity in medicine and healing? How important and meaningful are they? How do we define them?
- What are the core values and beliefs of an organization that aspires to be an OHE? To what degree are we willing to accept gaps between what we do, say and believe about these core values and beliefs? What are we willing to accept in the actual conduct of the organization and its individual members?
- To what degree can we measure healing on nonphysical dimensions? How will we know if we are succeeding in our efforts, or not?

Bridging realities

The biggest philosophical challenges will involve "bridging realities" and forging a deeper, common understanding among patients, family, friends, and health professionals about all of these questions and issues. The practical challenges will involve implementing them in real life situations.

Being versus doing

The medical community must acquire an understanding of the two domains of human existence, the domains of doing and being, in which we all abide, simultaneously, whether we are aware of it or not.⁷⁸ The domain of doing relates to our social identity and activities in the world; the domain of being addresses who we truly are, prior to our identities or activities. It also points to how our being is experienced by others, without necessarily doing anything at all. Paying attention to these two domains will be an important part of the evolution of medicine and health care into a multidimensional model. One of the rate-limiting steps in this process is the degree to which physicians and the health-care system will accept the concept of being the kind of resource that can facilitate peace, love and genuine healing in others, in addition to what they do on a day-to-day basis.

The impact of the Baby Boomer generation

Emerging cultural trends and evolving population demographics will continue to drive the evolutionary process of medicine and health care despite the challenges encountered.^{79,80} Compared to the Medicare generation, the Baby Boomer generation has dramatically different views of what constitutes acceptable medical care and acceptable physician-patient relationships. As the Baby Boomer generation ages and develops cancer and other illnesses, they will demand an increasing level of personalized, whole-person care that is fundamentally different from what the current Medicare population has come to expect. This includes access to newer and ever more sophisticated medical technologies, the wide variety of complementary and alternative therapies and greater attention to their personal needs, wishes, desires and their mental, emotional and spiritual concerns.⁸¹ Our present health care system, however, is out of balance and moving in an unsustainable direction.⁸²⁻⁸⁴ Helping our patients, peers, and personnel to recognize and understand the changes that are necessary is essential, and is a significant challenge in creating OHEs.

PRACTICAL CHALLENGES

Financial, political, and cultural challenges also inhibit our ability to create OHEs. Most are related to medical and office staff, government and insurance regulations, economic constraints, medical-legal concerns and research challenges.

Medical and office staff

Providing state-of-the-art medical care for people with cancer is an extremely complex and laborious undertaking that can at times seem overwhelming. The transformation from a standard, mainstream medical practice to one that is multidimensional begins with the vision of the organization, and the degree to which it is embraced by the medical and office staff. An OHE must reconfigure the conventional vertical staffing model, creating a more horizontal, team-oriented care system. Because every staff member plays an equally important role, the contribution of various types of providers must be valued, acknowledged and compensated more equitably.

Historic and cultural conditioning create significant challenges in this area. Most physicians prefer a hierarchical approach to staffing as well as compensation. The nature of current medical training and practice create a system and expectation in which the physicians' role and authority is usually much more highly valued than that of other staff. A practical challenge will be to find physicians who are willing to sacrifice some degree of authority and compensation in order to be a part of a more balanced, multidimensional health care team. This will be difficult until moral and legal risk and responsibility for adverse outcomes is more equitably shared as well. A similar practical challenge will be to find administrators and complementary health practitioners who are willing to compromise some of their previously held beliefs and behavior patterns to serve the higher, common vision of the organization.

Staff training, motivation, and development are another significant challenge. In an OHE, staff members not only have to be expertly trained at fulfilling their conventional job duties, but they must also understand and embody the vision and intention of the organization. This cannot be artificially mandated, but must be a sincere, internal desire of each staff member. The leaders all must share the concepts, philosophies and program components, and they must also embody and model the organization's values.^{85,86}

Finding and building a team of staff members who are all motivated and capable of fulfilling the OHE vision is time consuming and often difficult. Once found, direct training in a multidimensional approach to medicine and methods to provide compassionate, thoughtful and effective communications with patients and their loved ones and training in skillful listening must be repeatedly emphasized as a priority at all times.⁸⁷ Staff members must also be taught how to communicate openly, honestly, and supportively with their fellow team members, especially in tense situations.

Government and insurance regulations

A number of regulatory challenges face the creation of an OHE for cancer care.⁸⁸ These include complex and ever-changing requirements for proper billing, coding, and documentation of health care encounters and interventions man-

dated by government programs such as Medicare and Medicaid.⁸⁹ Staying abreast of evolving ethical concerns and government regulations regarding HIPAA, patient confidentiality, informed consent and other issues is also challenging.⁹⁰⁻⁹³ The ever-changing rules, regulations, and restrictions associated with private health insurance carriers and managed care companies also pose unique and significant challenges to all health providers.⁹⁴

Questions as to how CAM therapies can be safely integrated into a conventional medicine program raise further ethical as well as administrative challenges.⁹⁵⁻⁹⁸ At present, most insurance carriers will not reimburse for nontraditional therapies and interventions. Hopefully, this will change in the coming years.⁹⁹

Economic constraints

Cancer is one of the most expensive illnesses of our time, and costs will undoubtedly increase in the future. The ability to respond to the mental, emotional, and spiritual concerns of patients with cancer and family members is further restricted by the economics of medicine. Rising administrative costs, health and malpractice insurance premiums, and reduced reimbursements have all contributed to the problem. In the era of the 10-minute managed care patient visit, anything but the most limited cursory assessment is often not possible. The financial, administrative and time pressures of health providers in America have increased exponentially over the past decade. Current trends in managed health care suggest that things may only get worse, particularly in the Medicare arena.^{100,101}

Medicare legislation passed in 2003 contains the first of a number of long-anticipated steps in revamping the entire reimbursement structure for cancer care in America. It begins with significant cuts in reimbursement for chemotherapy drugs, a mainstay of conventional oncology revenues, with a disproportionately low increase in fees for evaluation, management and supportive care services.¹⁰²

It is also pertinent that more than 40 million Americans have no health insurance.^{103,104} For them, entry into mainstream health systems to obtain basic, fundamental medical care becomes an ordeal, particularly in the midst of a serious health crisis. In the absence of significant health care reform on a national level, this unfortunate and disturbing challenge is one that OHEs will also continue to face in the coming years.

Medical-legal concerns

Physicians and health care providers are practicing in a time of unprecedented legal risk and litigation.^{105,106} Soaring malpractice premiums have led to early retirement for physicians and the closing of many medical practices.¹⁰⁷ Fear of litigation has changed practice patterns among many providers, leading to escalating increases in unnecessary diagnostic tests and procedures.^{108,109} All of this adds costs

and tension to an already stressful profession. The situation may become even more complex as new medical–legal questions are encountered regarding increased utilization of CAM therapies.¹¹⁰

In oncology, physicians who explore emotional issues with patients also risk opening a Pandora’s box of unresolved guilt, frustration, anger, hostility, and confusion. This is especially true if the provider has not taken the time to address and resolve these same issues in themselves, or if they are unskillful or insensitive in their communications.^{111,112} Navigating through conflicted, dysfunctional family dynamics adds yet another layer of complexity to the challenges of dealing with cancer.¹¹³ Patient demands and expectations can at times be unrealistic,¹¹⁴ and disputes with doctors can degenerate into costly, time-consuming litigation.^{115–117}

Research challenges

Basic and clinical research has led to extraordinary diagnostic and therapeutic breakthroughs that have made an important difference in the lives of millions of people. As such, there is an imperative to continue to encourage participation in conventional clinical trials among appropriate patients. There is an equal imperative to encourage clinical research involving CAM therapies and integrative models of care.^{118,119} Unfortunately, many of the same financial and administrative issues and challenges exist in the area of CAM research as with conventional medical research. The goals, methodologies and overall strategies for CAM and integrative medical research are also still relatively new, and remain a source of controversy and debate.¹²⁰ This complicates the entire research process, as does the dynamic stress that exists between physicians and researchers who embrace integrative approaches to medicine, and those who do not.

LESSONS LEARNED

A decade ago, I fulfilled a dream that was motivated by the painful death of my father from cancer. I created an innovative, state-of-the-art, 6000-square foot OHE complete with examination rooms, a chemotherapy suite, a sophisticated computer system, a Clinical Laboratory Improvement Amendments–certified laboratory, full-time oncologists, nurses, medical assistants, phlebotomists, laboratory technicians, an administrator, billing and insurance personnel, a licensed social worker, massage therapist, acupuncturist, and yoga instructor. It had research programs, an associated nonprofit foundation, a dynamic integrative medicine program, a variety of support groups, a network of local CAM practitioners, and an onsite education/spiritual bookstore. During its existence, the center provided care to more than 2500 patients, and thousands more family and community members.

I gained tremendous insight as a result of this experience. Five lessons I learned from this experience include:

1. “The menu is not the food.” An insightful patient made this simple statement several years ago as he lay dying of metastatic colon cancer. He emphasized that what people ultimately want most from their healing environment is meticulous medical care delivered with genuine love, caring, and compassion. They want to be seen, respected, and accepted for who they are as individuals. These factors are far more important than the physical trappings of the center or the sophistication of its CAM offerings. Others have voiced these exact same thoughts, and it is impossible to overstate how important this lesson is in the creation of an OHE.
2. Three foundational keys: vision, agreements, and communications.¹²¹ These keys are most important in resolving the inevitable encounters with a variety of upsets, obstacles, setbacks and challenges.
 - The organization must have a clear and compelling vision shared and embraced by everyone in the organization.
 - Everyone must accept a set of agreements clearly articulating what all team members can expect from each other in their conduct, behavior, and actions. The agreements must also clearly articulate how challenges or upsets can be addressed by anyone in the organization, and how they will be resolved.
 - Specific tools and agreements must be in place to empower and support all members of the organization to consistently communicate in an open, honest and supportive manner.
 Establishing and maintaining these key elements is costly and time-consuming. However, they significantly impact on the level of cohesion and effectiveness of the OHE and are essential to its long-term success.
3. Staff health and consciousness. The quality of consciousness and the physical, mental, emotional and spiritual health of the staff members, individually or collectively, ultimately determine the success of an OHE. The conscious and unconscious thoughts that staff members have regarding the meaning of health and illness, and the levels of awareness they have about their own multidimensional nature and that of others, can profoundly influence, both positively and negatively, the healing process. Acknowledging this, and supporting the staff to explore and cultivate their health and consciousness on all levels, is a fundamental, paradigm-shifting component of OHEs.
4. Dealing with diversity. It is critical that the entire health care team knows how to interact and communicate effectively with a wide range of human beings who are dealing with a large variety of problems with varying personal and emotional resources. In an OHE that values the

role and contribution of everyone involved, this ability requires knowledge and skills that may have to be taught. It requires a level of flexibility, maturity, and personal integrity that may exceed what some individuals have previously known or aspired to in themselves. This process also points to the distinction between doing and being in all aspects of life. It highlights the difference between acting with intentions of love, kindness, and respect, and being kind, loving and respectful in such a way that others experience it.

5. The need for patience and compassion for self and others. A difficult and painful lesson learned in developing a cutting edge, multidimensional cancer center was recognizing the degree to which many patients, family members, and medical staff do not want, or perhaps are not ready, to heal beyond more superficial levels. Many did not wish to move past the first three levels of the seven levels described above.

Observing this process over the years, it became clear how much easier it is to focus on events and circumstances in the outer world than on our inner reality. Shifting one's focus from the external world, with all of its drama, distractions and diversions, inwardly to the realm of one's own mind, heart, and spirit, is indeed the ultimate hero's journey. Many otherwise brave and courageous souls are not prepared yet to explore the inner dimensions of their lives. The same is true of many otherwise talented and capable staff members. Cultivating multidimensional awareness, healing and transformation takes time, and requires patience and compassion. This is as true for individuals with cancer and their family members as it is for staff members, individual organizations, the entire healthcare system or the world as a whole.

THE FUTURE

The following are five basic hypotheses regarding OHEs that are immediately accessible for scientific testing. They address fundamental questions of quality of life, costs, and survival. They represent initial steps in documenting the costs and benefits of an integrative, multidimensional approach to care.

1. A multidimensional, Seven Levels of Healing approach to cancer care results in statistically significant and identifiable improvements in quality of life.
2. When the Seven Levels of Healing are understood, embraced, and experienced in an OHE, patients live longer than with a conventional approach to cancer alone.
3. Compared to conventional care alone, the benefits to quality of life and survival derived from a Seven Levels of Healing approach come more from the quality of loving-kindness, compassion, and caring experienced by pa-

tients and their family members than from the variety of content offered by integrative programs.

4. A Seven Levels of Healing approach to care that is a part of an OHE will lower overall health care costs by reducing utilization of expensive conventional methods and by enhanced and faster healing.
5. A multidimensional Seven Levels of Healing approach to care will significantly and positively impact the quality of life of physicians and staff as reflected in enhanced work satisfaction, improved personal attitudes and increased sense of well-being.

CONCLUSION

We are presently on the edge of an important expansion in how we understand and think about medicine and healing. The issues surround a paradigm shift from a fundamentally rigid, linear, mechanical model of biology and health to one that is fluid, interconnected, and multidimensional. The implications of this transformation in medicine, health care and healing are extraordinary, and have the potential to transform every aspect of our lives. Wisdom, courage, vision, and humility will be needed to navigate gracefully through the remarkable times that lie before us. In addition, we will all be well served by allowing the gifts of laughter, lightness, and above all else, love, to help guide the way.

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REFERENCES

1. Jemal A, Murray T, Samuels A, Ghafoor A, Ward E, Thun MJ. Cancer statistics, 2003. *CA Cancer J Clin* 2003;53:5–26.
2. Ries LAG, Reichman ME, Lewis DR, Hankey BF, Edwards BK. Cancer survival and incidence from the Surveillance, Epidemiology, and End Results (SEER) program. *Oncologist* 2003;8:541–552.
3. Howe HL, Wingo PA, Thun MJ, Ries LAG, Rosenberg HM, Feigal EG, Edwards BK. Annual report to the nation on the status of cancer (1973 through 1998), featuring cancers with recent increasing trends. *J Natl Cancer Inst* 2001;93:824–842.
4. Merrill RM, Weed DL. Measuring the public health burden of cancer in the United States through lifetime and age-controlled risk estimates. *Ann Epidemiol* 2001;11:547–553.
5. Holland JC, Rowland JH, eds. *Handbook of Psychooncology: Psychological Care of the Patient with Cancer*. New York: Oxford University Press, 1990.

6. Stark D, Kiely M, Smith A, Velikova G, House A, Selby P. Anxiety disorders in cancer patients: Their nature, associations, and relation to quality of life. *J Clin Oncol* 2002;20:3137–3148.
7. Rossi Ferrario S, Zotti AM, Massara G, Nuvolone G. A comparative assessment of psychological and psychosocial characteristics of cancer patients and their caregivers. *Psychooncology* 2003;12:1–7.
8. Cameron JI, Franche RL, Cheung AM, Stewart DE. Lifestyle interference and emotional distress in family caregivers of advanced cancer patients. *Cancer* 2002;94:521–527.
9. Blanchard CG, Albrecht TL, Ruckdeschel JC. The crisis of cancer: Psychological impact on family caregivers. *Oncology (Huntingt)* 1997;11:189–194.
10. National Heart, Lung, and Blood Institute. Fact Book Fiscal Year 2002. Online document at: www.nhlbi.nih.gov/about/02factbk.pdf
11. Brown ML, Lipscomb J, Snyder C. The burden of illness of cancer: Economic cost and quality of life. *Annu Rev Public Health* 2001;22:91–113.
12. Eisenberg DM, Kessler RC, Foster C. et al. Unconventional medicine in the United States. Prevalence, costs, and patterns of use. *N Engl J Med* 1993;328:246–252.
13. Bernstein BJ, Grasso T. Prevalence of complementary and alternative medicine use in cancer patients. *Oncology (Huntingt)* 2001;15:1267–1272.
14. Richardson MA, Sanders T, Palmer JL, Greisinger A, Singletary SE. Complementary/alternative medicine use in a comprehensive cancer center and the implications for oncology. *J Clin Oncol* 2000;18:2505–2514.
15. Hawkley LC, Cacioppo JT. Loneliness and pathways to disease. *Brain Behav Immunol* 2003;17(Suppl 1):S98–S105.
16. Godman David, ed. *Be as You Are: The Teachings of Sri Ramana Maharshi*. London, England: Arkana Books, 1991.
17. Nisargadatt M. *I Am That*. Bangalore, India: Nesma Books, 1997.
18. Goswami A. *The Self-Aware Universe. How Consciousness Creates the Material World*. New York: Jeremy P. Tarcher/Putnam, 1995.
19. Huxley A. *The Perennial Philosophy*. New York: Harper and Row, 1970.
20. Hixon L. *Coming Home: The Experience of Enlightenment in Sacred Traditions*. Burdett, NY: Larson Publications, 1995.
21. Smith H. *Forgotten Truth: The Common Vision of the World's Religions*. San Francisco: HarperSanFrancisco, 1992.
22. Rettig RA. *Cancer Crusade: The Story of the National Cancer Act of 1971*. Princeton, NJ: Princeton University Press, 1977.
23. Sporn MB. The war on cancer: A review. *Ann NY Acad Sci* 1997;833:137–146.
24. DeVita VT, Hellman S, Rosenberg SA, eds. *Cancer: Principles and Practice of Oncology*, 6th ed. Philadelphia: Lippincott, Williams, & Wilkins, 2001.
25. Colburn WA. Biomarkers in drug discovery and development: From target identification through drug marketing. *J Clin Pharmacol* 2003;43:329–341.
26. Geffen JR. *The Seven Levels of Healing: A Body, Mind, Heart and Spirit Program for Transforming the Whole Person*. Niles, IL: Nightingale-Conant Corp, 2001.
27. Mills ME, Sullivan K. The importance of information giving for patients newly diagnosed with cancer: A review of the literature. *J Clin Nurs* 1999;8:631–642.
28. Harris KA. The informational needs of patients with cancer and their families. *Cancer Pract* 1998;6:39–46.
29. van der Molen B. Relating information needs to the cancer experience: 1. Information as a key coping strategy. *Eur J Cancer Care* 1999;8:238–244.
30. Jefford M, Tattersall MH. Informing and involving cancer patients in their own care. *Lancet Oncol* 2002;3:629–637.
31. Czaja R, Manfredi C, Price J. The determinants and consequences of information seeking among cancer patients. *J Health Commun* 2003;8:529–562.
32. Matthews SC, Camacho A, Mills PJ, Dimsdale JE. The internet for medical information about cancer: help or hindrance? *Psychosomatics* 2003;44:100–103.
33. Sorkin D, Rook KS, Lu JL. Loneliness, lack of emotional support, lack of companionship, and the likelihood of having a heart condition in an elderly sample. *Ann Behav Med* 2002;24:290–298.
34. Ornish D. *Love & Survival: The Scientific Basis for the Healing Power of Intimacy*. New York: HarperCollins, 1998.
35. Cacioppo JT, Hawkley LC. Social isolation and health, with an emphasis on underlying mechanisms. *Perspect Biol Med* 2003;46(3 Suppl):S39–S52.
36. Spiegel D, Sephton SE. Psychoneuroimmune and endocrine pathways in cancer: Effects of stress and support. *Semin Clin Neuropsychiatry* 2001;6:252–265.
37. Weis J. Support groups for cancer patients. *Support Care Cancer* 2003;11:763–768.
38. Cunningham AJ. Group psychological therapy: An integral part of care for cancer patients. *Integr Cancer Ther* 2002;1:67–75.
39. Spiegel D. *Living Beyond Limits: New Hope and Help for Facing Life-Threatening Illness*. New York: Random House, 1993.
40. Rehse B, Pukrop R. Effects of psychosocial interventions on quality of life in adult cancer patients: Meta analysis of 37 published controlled outcome studies. *Patient Educ Couns* 2003;50:179–186.
41. Ross L, Boesen EH, Dalton SO, Johansen C. Mind and cancer: Does psychosocial intervention improve survival and psychological well-being? *Eur J Cancer* 2002;38:1447–1457.
42. Lillquist PP, Abramson JS. Separating the apples and oranges in the fruit cocktail: The mixed results of psychosocial interventions on cancer survival. *Soc Work Health Care* 2002;36:65–79.
43. Cunningham AJ, Edmonds CV, Jenkins GP, Pollack H, Lockwood GA, Warr D. A randomized controlled trial of the effects of group psychological therapy on survival in women with metastatic breast cancer. *Psychooncology* 1998;7:508–517.
44. Kogon MM, Biswas A, Pearl D, Carlson RW, Spiegel D. Effects of medical and psychotherapeutic treatment on the survival of women with metastatic breast carcinoma. *Cancer* 1997;80:225–230.
45. Adamsen L. 'From victim to agent': The clinical and social significance of self-help group participation for people with life-threatening diseases. *Scand J Caring Sci* 2002;16:224–231.

46. Krizek C, Roberts C, Ragan R, Ferrara JJ, Lord B. Gender and cancer support group participation. *Cancer Pract* 1999;7: 86–92.
47. Thiel de Bocanegra H. Cancer patients' interest in group support programs. *Cancer Nurs* 1992;15:347–352.
48. Johnson J. An overview of psychosocial support services. Resources for healing. *Cancer Nurs* 2000;23:310–313.
49. Guidry JJ, Aday LA, Zhang D, Winn RJ. The role of informal and formal social support networks for patients with cancer. *Cancer Pract* 1997;5:241–246.
50. Vickers AJ, Cassileth BR. Unconventional therapies for cancer and cancer-related symptoms. *Lancet Oncol* 2001;2: 226–232.
51. Smith M, Boon HS. Counseling cancer patients about herbal medicine. *Patient Educ Couns* 1999;38:109–120.
52. Drisko JA, Chapman J, Hunter VJ. The use of antioxidant therapies during chemotherapy. *Gynecol Oncol* 2003;88: 434–439.
53. Holland JC, Lewis S. *The Human Side of Cancer: Living with Hope, Coping with Uncertainty*. New York: Harper-Collins, 2000.
54. Muzzin LJ, Anderson NJ, Figueredo AT, Gudelis SO. The experience of cancer. *Soc Sci Med* 1994;38:1201–1208.
55. Watson M, Haviland JS, Greer S, Davidson J, Bliss JM. Influence of psychological response on survival in breast cancer: A population-based cohort study. *Lancet* 1999;354:1331–1336.
56. Gilbar O. The connection between the psychological condition of breast cancer patients and survival: A follow-up after eight years. *Gen Hosp Psychiatry* 1996;18:266–270.
57. Angelopoulos NV, Tzivariidou D, Nikolaou N, Pavlidis AN. Mental symptoms, hostility features and stressful life events in people with cancer. *Acta Psychiatr Scand* 1995;92:44–50.
58. Lee-Jones C, Humphris G, Dixon R, Hatcher MB. Fear of cancer recurrence—A literature review and proposed cognitive formulation to explain exacerbation of recurrence fears. *Psychooncology* 1997;6:95–105.
59. Spiegel D. Healing words. Emotional expression and disease outcome. *JAMA* 1999;281:1328–1329.
60. Joshi N, Breitbart WS. Psychopharmacologic management during cancer treatment. *Semin Clin Neuropsychiatry* 2003; 8:241–252.
61. Barsevick AM, Sweeney C, Haney E, Chung E. A systematic qualitative analysis of psychoeducational interventions for depression in patients with cancer. *Oncol Nurs Forum* 2002;29:73–84.
62. Buchanan J, Borland R, Cosolo W, Millership R, Haines I, Zimet A, Zalcberg J. Patients' beliefs about cancer management. *Support Care Cancer* 1996;4:110–117.
63. Zhang AY, Siminoff LA. The role of the family in treatment decision making by patients with cancer. *Oncol Nurs Forum* 2003;30:1022–1028.
64. Degner LF, Hack T, O'Neil J, Kristjanson LJ. A new approach to eliciting meaning in the context of breast cancer. *Cancer Nurs* 2003;26:169–178.
65. Richer MC, Ezer H. Living in it, living with it, and moving on: dimensions of meaning during chemotherapy. *Oncol Nurs Forum* 2002;29:113–119.
66. Luker KA, Beaver K, Leinster SJ, Owens RG. Meaning of illness for women with breast cancer. *J Adv Nurs* 1996;23: 1194–1201.
67. Bolen JS. *Close to the Bone: Life-threatening Illness and the Search for Meaning*. New York: Simon and Schuster, 1996.
68. Skott C. Expressive metaphors in cancer narratives. *Cancer Nurs* 2002;25:230–235.
69. Jones LB. *The Path: Creating Your Mission Statement for Work and for Life*. New York: Hyperion, 1996.
70. Frankl VE. *Man's Search for Meaning*. New York: Washington Square Press, 1985.
71. Ventegodt S. The life mission theory: A theory for a consciousness-based medicine. *Int J Adolesc Med Health* 2003; 15:89–91.
72. Fein E. The intention of living fully: An alternative to fighting cancer. *Adv Mind Body Med* 2003;19:15–16.
73. Singh KD. *The Grace in Dying: A Message of Hope, Comfort, and Spiritual Transformation*. San Francisco: Harper-SanFrancisco, 2000.
74. Block SD. Perspectives on care at the close of life. Psychological considerations, growth, and transcendence at the end of life: The art of the possible. *JAMA* 2001;285:2898–2905.
75. Kubler-Ross E. *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy, and Their Own Families*. New York: Touchstone, 1997.
76. McVay MR. Medicine and spirituality: A simple path to restore compassion in medicine. *S D J Med* 2002;55:487–491.
77. Lin HR, Bauer-Wu SM. Psycho-spiritual well-being in patients with advanced cancer: An integrative review of the literature. *J Adv Nurs* 2003;44:69–80.
78. Geffen JR. Being and doing in the practice of medicine: Embracing the deeper dimensions of healing. Plenary Talk. Comprehensive Cancer Care Conference II: Integrating Complementary and Alternative Therapies. Arlington, VA. June 12, 1999. Document online at: www.cmbm.org/conferences/ccc99/transcripts99/geffen.html
79. Karner TX. Caring for an aging society: Cohort values and eldercare services. *J Aging Soc Policy* 2001;13:15–36.
80. Yancik R, Ries LA. Aging and cancer in America: Demographic and epidemiologic perspectives. *Hematol Oncol Clin North Am* 2000;14:17–23.
81. Mechanic D. The changing elderly population and future health care needs. *J Urban Health* 1999;76:24–38.
82. Rosenthal B. Broken and unsustainable: The aging of Baby Boomers means a cost crisis in long-term care. *Contemp Longterm Care* 2003;26:22–25.
83. Sandy LG. Homeostasis without reserve—The risk of health system collapse. *N Engl J Med* 2003;347:1971–1975.
84. Vladeck BC. Medicare: Can its benefits be sustained as cost of coverage grows? *Geriatrics* 2001;56:50–54.
85. George B. *Authentic Leadership: Rediscovering the Secrets to Creating Lasting Value*. San Francisco: Jossey-Bass, 2003.
86. Cox A. *Redefining Corporate Soul: Linking Purpose and People*. Chicago: Irwin Professional Publishing, 1996.
87. Fallowfield L, Jenkins V. Effective communication skills are the key to good cancer care. *Eur J Cancer* 1999;35:1592–1597.
88. Einhorn LH, Levinson J, Li S, Lamar L, Kamin D, Mendelson D. American Society of Clinical Oncology 2001 presidential initiative: Impact of regulatory burdens on quality cancer care. *J Clin Oncol* 2002;20:4722–4726.
89. Xistris DM, Houlihan NG. Impact of reimbursement and health care reform on the ambulatory oncology setting. *Semin Oncol Nurs* 1994;10:281–287.

90. Welker J, Podleski JM. Preparing the front office staff to carry out HIPAA privacy procedures. *J Med Pract Manage* 2003;19:67-70.
91. Christensen D. Final regulations set for patient privacy protection. *J Natl Cancer Inst* 2002;94:1521-1523.
92. Coulson KM, Glasser BL, Liang BA. Informed consent: Issues for providers. *Hematol Oncol Clin North Am* 2002;16:1365-1380.
93. Miyaji NT. Informed consent, cancer, and truth in prognosis. *N Engl J Med* 1994;331:810.
94. Valadez AM, Sportsman S. Impact of managed care on oncology. *Semin Oncol Nurs* 2002;18:149-153.
95. Adams KE, Cohen MH, Eisenberg D, Jonsen AR. Ethical considerations of complementary and alternative medical therapies in conventional medical settings. *Ann Intern Med* 2002;137:660-664.
96. Eisenberg DM, Cohen MH, Hrbek A, Grayzel J, Van Rompay MI, Cooper RA. Credentialing complementary and alternative medical providers. *Ann Intern Med* 2002;137:965-973.
97. Cohen MH. Complementary and integrative medical therapies, the FDA, and the NIH: Definitions and regulation. *Dermatol Ther* 2003;16:77-84.
98. Monaco GP, Smith G. Informed consent in complementary and alternative medicine: Current status and future needs. *Semin Oncol* 2002;29:601-608.
99. Pelletier KR, Astin JA. Integration and reimbursement of complementary and alternative medicine by managed care and insurance providers: 2000 update and cohort analysis. *Altern Ther Health Med* 2002;8:38-39.
100. Gerszten PC. Oncology in the era of managed care. *J Oncol Manage* 1998;7:21-23.
101. Emanuel EJ, Dubler NN. Preserving the physician-patient relationship in the era of managed care. *JAMA* 1995;273:323-329.
102. Centers for Medicare and Medicaid Services. Medicare Program Revisions to Payment for Drugs and Physician Fee Schedule Payments for Calendar Year 2004 (CMS-1372-FC). Online document at: www.cms.gov/regulations/pfs/2004fc/1372fc/1372fc.asp
103. Radzwill M. The health insurance crisis in the United States: Lack of access and the ripple effect. *Manage Care Interface* 2003;16:28-34.
104. Thrall TH, Scalise D. America's uninsured: Rethinking the problem that won't go away. *Hosp Health Netw* 2002;76:30-34.
105. Mello MM, Studdert DM, Brennan TA. The new medical malpractice crisis. *N Engl J Med* 2003;348:2281-2284.
106. Taylor S, Thomas E. Lawsuit hell: How fear of litigation is paralyzing our professions [cover story]. *Newsweek*, December 15, 2003:43.
107. Weber DO. Malpractice insurance rates reach boiling point: Physicians burned by lawyers, lawsuits and jury awards. *Physician Exec* 2002;28:12-14.
108. Brachfeld J. "Defensive medicine" and malpractice suits. *Arch Intern Med* 2002;162:2631.
109. Rubin RJ, Mendelson DN. How much does defensive medicine cost? *J Am Health Policy* 1994;4:7-15.
110. Cohen MH, Eisenberg DM. Potential physician malpractice liability associated with complementary and integrative medical therapies. *Ann Intern Med* 2002;136:596-603.
111. Arora NK. Interacting with cancer patients: the significance of physicians' communication behavior. *Soc Sci Med* 2003;57:791-806.
112. Baile WF, Kudelka AP, Beale EA, Glober GA, Myers EG, Greisinger AJ, Bast RC Jr, Goldstein MG, Novack D, Lenzi R. Communication skills training in oncology: Description and preliminary outcomes of workshops on breaking bad news and managing patient reactions to illness. *Cancer* 1999;86:887-897.
113. Kissane DW, McKenzie M, McKenzie DP, Forbes A, O'Neill I, Bloch S. Psychosocial morbidity associated with patterns of family functioning in palliative care: Baseline data from the Family Focused Grief Therapy controlled trial. *Palliat Med* 2003;17:527-537.
114. Neuenschwander H, Bruera E, Cavalli F. Matching the clinical function and symptom status with the expectations of patients with advanced cancer, their families, and health care workers. *Support Care Cancer* 1997;5:252-256.
115. Ryan M. Medical malpractice: a review of issues for providers. *Hematol Oncol Clin North Am* 2002;16:1331-1350.
116. Guthrie TH. Breast cancer litigation: an update with practice guidelines. *Breast J* 1999;5:335-339.
117. Collins MM, Fowler FJ Jr, Roberts RG, Oesterling JE, Annas GJ, Barry MJ. Medical malpractice implications of PSA testing for early detection of prostate cancer. *J Law Med Ethics* 1997;25:234-242.
118. White JD. Complementary and alternative medicine research: A National Cancer Institute perspective. *Semin Oncol* 2002;29:546-551.
119. Richardson MA, Straus SE. Complementary and alternative medicine: Opportunities and challenges for cancer management and research. *Semin Oncol* 2002;29:531-545.
120. Carter B. Methodological issues and complementary therapies: Researching intangibles? *Complement Ther Nurs Midwifery* 2003;9:133-139.

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