

Challenges and Opportunities in Achieving Healing

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ABSTRACT

The current health care system in the United States must shift from a primary focus on acute care and cure to also emphasize maintenance of function and the relief of suffering that derives from the ailments associated with chronic disease and illness. To achieve this goal, the individual components of the health care equation must all respond and work in concert. These components include the provider, the venue, the patient, the community, our society, and the fiscal realities of paying for care. However, the barrier for change stems from the marked heterogeneity that exists in the definition of each of these individual components. Thus, the fundamental question is, can our current and future medical care system respond to the imperative of focusing on healing with a particular emphasis on chronic diseases? A solution is the provision of individualized care in a mindful practice and the purposeful cultivation of a healing relationship suffused with compassion and empathy in the therapeutic alliances between patient, provider, and advocates.

INTRODUCTION

We were educated and trained in United States medical schools and residencies. The predominant orientation of our various curricula was on disease and acute care. The invariable focus of our mentors was the diagnosis of the patient's malady and how to cure it. Evidence-based medicine was still on a distant horizon, and past individual clinical experiences, intuitive thinking, and the art of medicine were the determinants of success in practice. Concepts such as a purposeful commitment of society to the maintenance of health and the prevention of illness, the individual's responsibility for obtaining and maintaining wellness, and the opportunity to attain personal healing by melding physical, emotional, and spiritual practices into harmonious balance were on the periphery at best and absent from the discussion in most cases.

American medicine cannot continue to ignore its responsibility to commit its thoughts and resources toward the prevention of disease, the maintenance of wellness, and the process of healing. Because of our successes in public health and in managing acute care, the percentage of the popula-

tion in the 65 years of age and older age group in our country is growing.¹ This extended life expectancy is associated with an increasing prevalence of the noncurable diseases and ailments of aging. Thus, the priority of medicine must shift from a focus on acute care and cure to also emphasize maintenance of function and the relief of suffering that derives from these ailments.^{2,3} Helping the patient attain healing must become one of the essential goals of medical care. Ancillary goals include facilitating the individual's capacity for informed self-care, increasing acceptance of and investing in wellness promotion, and actively curtailing lifestyle-related behavioral and social illness and disease.

The challenge is how to achieve these goals. There are formidable barriers in doing so, although a spirit of optimism requires us to view these barriers as opportunities. From our perspective, the difficulty stems from the marked heterogeneity that exists when one attempts to define the individual components of the health care equation: the provider and venue, the patient, the community and local society, and the fiscal realities of paying for the care. Therefore, not only is a single all-encompassing solution not feasible, but a myriad of individual solutions is required.

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The players and their roles in today's medicine

Providers and venues

It is not possible to provide a generic definition of who is the health care provider. First, there are the major categories of conventional and alternative care providers. Each of these two groups can be divided into long listings of specialties and subspecialties. These individuals may practice in outpatient, inpatient, and home venues, and each use a large variety of modalities, interventions, tools, advanced technological methodologies, and technical skills to implement care. Ramifications of these differences include the inability for many of these subgroups to communicate effectively with each other because of specialized knowledge, use of stylized intramural language, nonshared assumptions as to mechanisms of action of therapeutic interventions, and a wide variation in the availability of clinical data supporting decision making.

It is also difficult to readily define who is entering these various professions in terms of their orientation, motivation, and professional goals. As expected, there is a heterogeneity of personal values and beliefs that can intrude on professional decision making. The different professions also have different requirements as to training and licensure, the extent of direct and indirect supervision, formal and informal documentation, and accountability and self-monitoring. Many providers are associated with professional organizations, a primary purpose of which is to protect that specialty's interests.

Health professionals value their individual autonomy in decision making. But the ever-expanding volumes of medical information and the frequent need to obtain consultation with a colleague plus restricted flexibility for reimbursement can create conflicts and thereby impinge on this characteristic. True integration of care between a team of providers with various titles and backgrounds also impinges on the reality of autonomy in decision making.⁴ One result in our present system can be confusion by both the primary care provider and the patient as to who is the primary decision maker ultimately responsible for the patient's outcome.

Scattered around this country, there are models of what can be achieved when a purposeful focus on healing is integrated into inpatient and outpatient care. These models are created by a culture of leadership and staff who understand the difference between healing and curing and between disease and illness.⁴ Again, there is heterogeneity in these approaches. The two major ones being espoused and debated are the chronic disease management and the chronic care models. Both address control of morbidity, quality of life, and the degree of patient self-management.^{5,6} Both are being assessed through a purposeful focus on obtaining objective evidence of effectiveness and efficacy.^{7,8} Of note, the current criterion required by the legislators who write laws and the payers of care is the ability of the model to survive the exigencies of cost reimbursement and achieve

fiscal balance based on occupied bed or outpatient visit census.

Patients

Similarly, it is increasingly difficult to provide a definition of the typical patient. There is the large diversity associated with traditional demographic variables, such as age, race, gender, ethnicity, and religion. The mix also includes the well, the worried well, the acutely ill, the chronically ill, those who are occupants of chronic care facilities, the underserved, the homeless, the incarcerated, the socially disadvantaged, and recent legal and illegal migrants. A broader definition of a patient must also include the person's significant others, family members, and those living in the same community—all of whom may impact on the care available, received, accepted, and implemented.

There is also a wide diversity in the patient's perspective. This is influenced by language, cultural, economical, educational, social, moral, and emotional variables. This country continues to be a haven for people immigrating from around the world. And many who enter, rather than assimilate, seek comfort in local conclaves that mirror their country of origin.⁹ Many of these cultures have a different orientation and expectations related to the definitions of wellness, prevention of illness, cure, and healing. Individuals can have their own cultural and personal meanings of illness, sickness, and disease, preferences as to what interventions and modalities are appropriate for treatment, and unique understandings of the role of palliation and end-of-life decisions.¹⁰ One result is heterogeneity of belief in the role and benefits of modern biomedicine coupled with the role and value of nonconventional treatments that have been experienced.

The patient's perspective also extends to what priority health has in his or her daily life and existence. Health professionals tend to view a person's health as the primary priority. But the classical studies of Maslow appropriately emphasize a hierarchy of needs that focus on esteem, safety, and belonging as distinct from physiological needs, and with an ultimate goal of self-actualization.¹¹ The individual can also be confronted with life's exigencies, many of which result in excess stress that impact on both the person's priorities and health.¹² The thoughtful provider who seeks to understand these realities of the patient's daily life will avoid the use of words such as noncompliance and recidivism in assessing motivation and then adjusting management goals.

Society

The facts of American society include the absence of a consensus on the right versus the privilege of an individual to health care, a fragmented health care system, and the lack of a universal health care plan. As a result, the individual patient can experience a wide range of care, including those that do not meet acceptable standards of performance or out-

come. There are major issues of inequality related to access to acute and chronic care as a function of geography, ethnicity, education, and income.¹³ The quality of care delivered also can be adversely impacted by the prejudices, biases, and personal beliefs of the provider, in addition to varied levels of training and knowledge. Thus, mutual decision making between provider and patient, based on patient values, preferences, expectations, needs, and desires, may not occur. Importantly, the basic ethical tenets of patient autonomy, provider beneficence, and justice may be absent.

Payors

The fiscal reality is that the cost of both sickness and wellness care is a significant part of the gross national product, and too frequently of a person's personal budget as well. Approximately 45 million Americans are uninsured. The extent of health insurance coverage provided by employers, state and federal governments, or self-insurance can result in an individual with health insurance who becomes ill also being underinsured.¹⁴ Hospitals, clinics, health care systems, and individual practitioners cannot survive in debt, and, as a result, their charges are designed to compensate for invoices not accepted or reimbursed by health insurance. The cycle is perpetuated as the premiums paid to the health insurance industry escalate to assure that the industry maintains its profitability. A theoretical solution is for state and federal commissioners and legislators to enact the required regulation and accountability, but this is difficult to implement and is often perceived as costly.¹⁵

Advocacy

All patients seeking care have spoken and unspoken expectations, needs, and preferences. The challenge for the provider is to solicit them, define them, understand them, and respond appropriately to them.¹⁶ There is a skill in performing these communication functions. These skills require education, training, and supervised experience in a patient-centered clinical setting.¹⁷ We know they are essential to creating a therapeutic alliance but believe they are too often absent in the way medicine is currently practiced.

One solution is for the patient to be supported by an advocate. However, the combination of forces overviewed above suggests a team of advocates is required. Team members would be individuals to deal with the provider and any expanded team of providers, those to deal with the venue's administration, those to deal with community agencies, those to deal with the payers of care, and those to deal with the politicians who write laws. This obviously does not happen. Thus, our answer to the question who is the patient's advocate is: the patient must be an active participant in care and must seek information to achieve that status.⁸ The challenge is to motivate and educate both the patient to comprehend and accept these roles, and the provider to expect

and respond to the patient who demonstrates these roles. Thus, it is a shared responsibility.

COMMENTS

Heterogeneity has been the operative word throughout this paper. It is an adjective we find applicable to every aspect of the health care equation. The fundamental question is, can our current and future medical care system respond to the imperative of focusing on healing with a particular emphasis on chronic diseases? We do not believe there can or should be one size of medical care that fits all. We believe that without purposeful restructuring of our health care system and education of the patient and our society, whatever evolves as a national universal health plan will provide only the most basic aspects of health care with a heavy emphasis on acute care rather than disease prevention, wellness maintenance, or chronic care.

In parallel, there is a need for our health profession schools and residency programs to adjust curricula and to employ and reward clinicians who are appropriate mentors.¹⁷ A new element in such a curriculum is to accept the reality that medical care in an integrated system engages a team of providers with the team's decision maker changing according to the needs of the patient. But changes of this sort take time and purposeful effort on the part of internal champions who are already in leadership roles.⁴ Furthermore, there is considerable competition for the truly limited education time now available to expose the student, resident, and practitioner to the almost overwhelming advances in medical knowledge now taking place.

It is unfortunate that a focus on healing is considered an innovation in health care. It is also unfortunate that this type of innovation is incrementally disseminated at a slow pace in comparison to the more rapid pace of diffusion and acceptance of a new surgical instrument or medication.¹⁸ Furthermore, to become a true accepted standard, any such change must be made not by fiat, legislation, or command, but rather through consensus of all stakeholders on a local level in a community.

The provider's, patient's, and our society's motivation and commitment to accept and engage in the principles we espouse in an optimal healing environment, as depicted graphically on the back cover of this supplement and described by other authors in this supplement, are a critical part of the foundation of any system built around the concept of healing. But even more so, it is the readiness, motivation, and commitment of the individual patient encouraged to achieve healing and provided access to the tools to embark on the journey that must be present. We are not sanguine that can happen, given the current inadequate level of individual commitment to personal health and wellness, the multiple sources of information and misinformation provided to a confused public by the various media, including

the Internet, the incidence of health-related real and relative illiteracy, the background and cultural beliefs of many segments of our society, the ingrained tradition of a sick person expecting a “quick fix,” and the continuing lack of preparation and resources that will be required for appropriate delivery of chronic care.

Nevertheless, it remains an axiom that the provision of individualized care in a mindful practice remains at the heart of medicine and of the therapeutic alliance or partnership between patient and her or his advocate.^{19,20} We are strong proponents of cultivating healing relationships suffused with compassion and empathy in all aspects of one’s life. Each of us, according to which of these roles we occupy at any one time, has the ultimate responsibility to decide our own motivation, commitment, and effort to achieve that healing.

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