

Toward Optimal Healing Environments in Health Care

WAYNE B. JONAS, M.D.,¹ and RONALD A. CHEZ, M.D.²

ABSTRACT

The 2nd American Samuelli Institute symposium was held January 22–25, 2004. The focus of this meeting was an exposition of optimal healing environments (OHE) in American health care. Fifty-five (55) invited guests participated; most had written one of the papers in this Supplement. The conduct of the meeting revolved around small group discussions and two plenary sessions. The ensuing dialogue refined and organized the definitions, components, and research protocols associated with creating and implementing an OHE. This Supplement contains both the invited papers and an abstract of the plenary session discussions.

BACKGROUND

We believe an emphasis on healing is key to the future medical management of chronic illness and the establishment of sustainable approaches in health care. Defined as the process of recovery, repair, and return to wholeness, healing is the foundation for a vision of medicine that integrates diverse approaches from around the world for the alleviation of suffering, the enhancement of well-being and the treatment of chronic illness.

Healing is facilitated through the development of proper attitudes and intentions in both the provider and the recipient, use of personal self-care practices, creating healing relationships, applying the knowledge of health promotion and maintenance, and the appropriate integration of complementary and conventional medicine practices.

We currently define an optimal healing environment (OHE) as one in which the social, psychologic, spiritual, physical, and behavioral components of health care are oriented toward support and stimulation of healing and the achievement of wholeness. In our opinion, these components include:

1. Conscious development of intention, awareness, expectation, and belief in improvement and well-being;
2. Transformative self-care practices that facilitate personal

integration and the experience of wholeness and well-being;

3. Techniques that foster a palpable healing presence based on compassion, love, and awareness of interconnectivity;
4. Development of listening and communication skills that foster trust and a bond, sometimes called the “therapeutic alliance,” between practitioner and patient;
5. Instruction and practice in health promotion behaviors that change lifestyle to support self-healing and the development of social support and service;
6. Responsible application of integrative medicine via the collaborative application of conventional and complementary practices in a manner supportive of healing processes;
7. The physical space in which healing is practiced, including characteristics of light, music, architecture, and color among other elements that can influence the impact on an OHE.

The primary mission of the Samuelli Institute is to support basic and clinical research in the science of healing. Our goal is to support a collaborative research effort to develop, implement, and evaluate the impact of an OHE in specifically identified health care settings. It is our opinion that rigorous research on healing has been published infrequently. Thus, we believe there are two major difficulties in

Samuelli Institute for Information Biology, ¹Alexandria, VA, and ²Corona del Mar, CA.

moving forward in these fields of scientific inquiry: (1) the lack of standard definitions of an OHE and the components that fit under this term and (2) lack of quality research protocols that focus on healing and the environment in their hypotheses, design, measurement, and analysis. One solution is the creation by consensus of both standardized definitions and research guidelines to allow a rational and systematic research agenda to be put into place.

PURPOSE AND GOALS OF THE 2ND AMERICAN SAMUELI INSTITUTE SYMPOSIUM

The purpose of this symposium was to develop consensus among a group of distinguished scientists, clinicians, and philosophers with demonstrated interest, experience, and wisdom in and about healing. The objectives of the meeting included to refine the definitions of an OHE and the seven component areas we have listed above, to provide recommendations for protocol design for research in the area of OHE, and to provide current examples of programs that deliver these elements in an OHE.

We solicited authors to prepare drafts of the papers in this Supplement related to one of three categories. The first category was oriented toward the background of OHE. The authors were asked to provide a critical, but not all encompassing, overview of the field including what research had been published that had merit, the dominant challenges to conducting research in the area, and what research now needs to be done to advance the knowledge about the topic. These papers constitute the first 11 papers in this Supplement, and range from the definition of an OHE and the roles of awareness and transformative practices to the components of such an environment to organizational structures that support them.

The second major category contains papers directed specifically at the development of research protocols for the implementation and testing of approaches designed to foster and enhance healing in nonpatient populations in the health care environment. Thus, the subjects include training of health providers and health service organizations. The challenge is to design research related to care between physician and patient, healer and healee, clinical team and patient and support system, and employer benefits and employee that focus on compassion, positive empathy, altruism, and unlimited love. Is there an optimal combination of didactic and experiential learning that results in the ability to distinguish between the strategies of curing and the strategies of healing? Is there a curriculum that can be differentiated from courses that teach the interdependence of psychological, social and biologic factors in health and illness?

The content of the third category is a series of papers containing recommended guidelines for clinical research protocols on specific patient populations. These papers purposely

focus on various disease and illness entities. The orientation is toward first identifying common or basic elements that apply to all such clinical protocols, and then providing specific recommendations, guidelines, and checklists based on the particular condition. The maladies range from patients with disabling cardiovascular disease, cancer, and diabetes to those with chronic pain syndromes and substance abuse. One focus of this research is how to validate the belief that effective, empathic care requires the team of providers, including administrators and managers who set the environment and resources for care, to work together in a healing community for the benefit of the patient. Another focus is to create hypotheses that test issues of establishing patterns of teamwork, shared values, learning from each other, accepting the other's expertise, communicating openly and effectively, helping integrate services at individual and systems level, confronting issues of hierarchy, specialization, and privilege and entering into noncompetitive supportive relationships with colleagues.

WORK PRODUCT FROM THE 2ND AMERICAN SAMUELI INSTITUTE SYMPOSIUM

The papers in this Supplement are the primary and dominant results from this meeting. They provide a rich and diverse amount of information, knowledge, and wisdom for readers committed to the concept of an OHE, and desirous of performing research in this area. We hope they serve as a firm foundation for future growth and development in the area.

A second product relates to the following working definitions of an OHE. This material was created initially as a draft that was reviewed by the attendees prior to the meeting. Figure 1 accompanied the prose descriptions, and served as a graphic representation.

The figure and the prose were the basis of discussion at both the small group sessions and the two plenary sessions. Following the format of the graphic, the following definitions and descriptions emerged from the discussions at the meeting.

The mind and spirit

Spirituality is the experience of being connected to something greater than one's own individual self, beyond the limits of personal ego boundaries. People can obtain a feeling of peace, meaning and purpose in life when they perceive a personal connection and contribution to something larger than themselves. This sense of coherence can be fostered with various spiritual and traditional religious practices. In the latter case, it is termed religiosity. However, frequently the experience of spirituality does not occur within the context of formal religions, or individuals choose to keep it outside such domains.



FIG. 1. This graphic represents the components of an optimal healing environment (OHE). There are seven major elements. The central five vertical columns are separated by thin, soft lines because each category is not truly separate, but rather integrated with all the others. Various aspects of Healing Spaces and Healing Places similarly are all encompassing. Under each column are four sections. The symbol is first followed by the goal associated with the heading. Examples of some elements of the goal are followed by examples of what can be achieved from specific programs. The background contains the Samueli Institute logo and a heart to illustrate the central role of compassion and service in bringing these components together to create optimal healing.

For the purpose of OHE descriptions, there are two key aspects of spirituality that relate to healing, fostering awareness and intentionality.

Awareness is the state of being conscious and “in touch” with processes inside and outside of one’s personal ego boundaries. Techniques to facilitate awareness are often derived from formal traditions, including meditation, mindfulness, spiritual paths, didactic dialogue, journaling, and art.

Intentionality or healing intention is the mindful determination by one or more participants through both intuitive and conscious action to improve the health of another person or oneself. It involves using intentional thought processes and personal learning to increase awareness, and then to establish hope, belief and expectation in the possibility of whole-

ness and increased well-being. Both the teaching of spiritual traditions and the findings of modern psychology indicate that positive beliefs help to bring about positive health change. Expectation and belief in recovery and wellness are key stimuli of both behavior and physiologic action toward healing. The latter can be fostered by learning about the power of inherent self-healing capacities and mindfulness practices. An environment purposely oriented toward healing can facilitate this process.

Psychophysiological aspects

Psychophysiology is the coordinated interaction of both psychological and biologic processes. It is in the area of psy-

cho–physiology that two components of healing are fostered and applied; the experience of healing presence and healing energy. Both arise from a sense of personal integration or wholeness, and can be fostered by mind–body–energy exercises and practices.

Healing presence is a deep emotional state and physical experience of being fully present and whole. It is claimed in many healing traditions that this state enhances wellness and improves recovery and repair processes. In the West, the concept is understood as physical and emotional wholeness from which deep personal engagement, caring and communication emerge.

Healing energy is the experience or sensation of a force or “energy” that occurs when the body and mind are at peace and working harmoniously. In the East, the concept of deep healing presence is sometimes conceptualized as bioenergy, and is said to be accumulated, stored and transmitted between healer and patient. Eastern concepts such as *qi*, *ki*, or *prana*, ancient Western concepts such as mana, pneuma, the spirit, life force or vital force, and more recent concepts such as bion, orgone, or paraelectricity are examples of the latter. In most traditional healing practices, this energy is said to derive from spiritual sources and to arise from the cultivation of compassion and altruistic love. Energy practices, yoga, *tai chi* and *johrei*, are techniques from the East that help individuals increase the power of healing energy.

Personal wholeness is the experience of well-being that occurs when the body and mind are at peace and working harmoniously. This sense can be developed and fostered with various mind/body practices that reinforce wellness and recovery. Personal growth through integration sessions and workshops are a common approach in the West.

Social aspects

Immersion in healing relationships is one of the most powerful ways to stimulate, support, and maintain wellness and recovery. Family, friends, and community generally form the primary relationships. The worksite, school, community and health care settings can also facilitate relationships that support healing and wellness.

Healing relationships are the social interactions that foster a sense of belonging, well-being, coherence, and healing. Characteristics of such interactions involve empathy, compassion, beneficence, caring, love, reassurance, comfort, warmth, trust, confidence, credibility, honesty, courtesy, respect, harmony, challenge and communication. For the purposes of OHE, there are two domains in which healing relationships occur: the therapeutic alliance and social supportive interactions.

The therapeutic alliance encompasses the embodied social and psychologic interactions that facilitate healing between practitioners and recipients. Semiformalized approaches that foster the therapeutic alliance include “person-centered” and “relationship-centered” care.

Nonclinical social interaction involves the household, family, friends, support groups, and community. To various degrees, each setting can work to provide a sense of belonging, caring, and coherence in the patient’s life.

Behavioral aspects

Health behaviors are actions taken by individuals and groups that can either enhance or destroy wellness and prevent, treat, or foster disease. These actions primarily involve addictive behaviors, diet choices, physical exercise and relaxation, leisure and work or school activities.

Health promotion and disease prevention refers to behavioral and lifestyle training programs targeted toward establishing habitual behaviors that support well-being or healing and prevent or treat illness. These programs are often established at worksites, schools, community centers, churches or hospitals and clinics. They typically involve five areas: (1) management of negative addictions (smoking, alcohol, drugs, unhealthy sexual behavior, violence) and fostering positive addictions (relaxation methods, healthy sexual behavior, establishment of social support networks); (2) healthy eating; (3) regular and appropriate physical exercise; (4) stress management techniques and balancing work, leisure and family activities; and (5) screening for preventable disease.

Integrative medicine

Integrative medicine is the coordinated application of a variety of healing, prevention, and treatment modalities in therapeutic settings. These modalities include those from conventional medicine, complementary and alternative medicine, and traditional and culture-specific practices. The careful selection of appropriate preventive and therapeutic approaches is key to obtaining and maintaining wellness and healing. From the perspective of OHE, approaches that support and stimulate the inherent healing and self-recovery capacities of a person are primary but curative treatments are also often needed as well. The ideal system would match the individual patient or client and support persons with the most appropriate treatment strategy derived from the panoply of global health care systems.

Integrative and collaborative medicine requires coordination of multiple service components and the availability of information, evidence, resources and infrastructure to appropriately apply them. These components include: (1) availability of knowledgeable and competent practitioners; (2) appropriate facilities, equipment, and supplies for practice; (3) reliable, quality products; (4) supportive organizational and professional settings; (5) information about safety, effectiveness, and interactions of treatment modalities; (6) training in appropriate communication and partnership skills for appropriate selection of interventions; and (7) economic resources for delivery and availability of services.

*Physical and organizational aspects
(healing spaces and places)*

Both the physical space and the leadership environment (the place) are key to delivery of effective OHEs.

Healing spaces can contain a variety of components that foster or detract from wellness and recovery. These include architecture, color, and relationship to nature, sound, music, art, and light. Designing community, personal, and sacred spaces that incorporate all the aspects of a healing environment are integral to the support of health.

Healing places in a health care setting require the understanding, experience, and support of the leadership and organizational decision makers for successful implementation of an OHE. Health care managers and leaders ideally should have the experiences contained in the OHE domains, and practice self-care, personal wellness, and prevention approaches in their own lives.

The third and last work product from this meeting was the thoughts expressed in the plenary sessions. At these two sessions, reports were provided to the entire group from each of six small group sessions. Each small group was composed of authors from the three major categories into which the 24 invited papers were divided. Each morning, the group discussions were guided by the information and opinions posited by these authors and then challenged and modified based on the dialogue generated. The five major areas of discussion included comments about the OHE graphic, the role of the patient, the role of the provider, the role of the organization and tools for assessment.

Graphic. The OHE graphic provoked a considerable amount of discussion, including a number of questions. Those asked included: Do all of the seven domains have equal weight and priority? Is there a hierarchy of importance or significance? Do the first three of the middle five reflect process and the other two process? Are the first three being and the other two doing? Can the domains be divided into functions of the internal and external environment?

There were also suggestions on editing the graphic. These included the substitution of healing behaviors for behavioral medicine, and eliminating addiction management as too specific an area. It was agreed that healing spaces and healing places are two different parts of the domain, and have different effects on human behavior. The belief that meaning belongs in its own column rather than as a causative or intermediate variable was expressed. It was posited that the word energy in the second column should be replaced with wholeness and vitality, if for no other reason than to make the terms more understandable with broader applicability as energy has so many connotations including the physical science one.

There was also the recommendation that wholeness and energy be separated into two domains to reflect inner and outer healing directed toward personal wholeness. This was coupled with the suggestion to broaden the concept of en-

vironment. That is, to enlarge the term past the visible connotation of location to encompass the invisible such as intention and awareness. This would allow a purposeful focus on how one marshals inner resources and motivation, the role of societal pressure, and the role of interaction of the individual with nature and the planet.

One part of the discussion examined connectiveness, the ability to be connected with the spiritual self as a critical element of the ultimate healing relationship. It was pointed out that American values tend to be oriented toward separation and individualism, independence, and the nuclear family and thus appear contradictory to the concept. This was extended to asking if connectiveness was a proxy for spirituality and then further to asking what was the relationship between intention and awareness to spirituality, or the spiritual experience, as they are not invariably related and should be separated.

Patient. Comments related to the patient in an OHE focused on the role of empowerment including self-awareness, self-reflection, and knowledge of one's own value system, the degree of compatibility between the person's value system and what they are actually seeking to accomplish with health care, the meaning and perspective of healing to the individual patient and how to identify an individual's health beliefs and then avoid imposing one's own view. The latter is particularly important for recognizing those individuals who have no interest in being healed but rather desire a quick cure or fix.

Moving past the individual patient, there were several recommendations to increase emphasis on the social determinants of health. The long lists of potential determinants included income, education, racism, sexuality, gender, religion, social support system, the personal experience history of life and relationships, geography including rural versus urban, language and culture, hardiness and readiness to change, and a personal sense of the burden of disease and disability. For the individual in an OHE, there can also be important measures and qualitative analyses related to empathy, compassion, love, kindness, forgiveness, hope, deception, mindfulness, serenity, self-awareness, and reflection. In considering research on patient-centered care, one effect of this litany of variables is probably the necessity to stratify people in the randomization scheme. This in turn suggests a need for a screening device to determine who is most likely to benefit based on exclusion and inclusion factors.

An important potential barrier to an OHE was the acknowledged disparities in individuals' usual source of health insurance, usual source of medical care, rates of hospitalization, appropriateness of care, access to care, preferences related to medical care, socioeconomic status and living environment. There was uncertainty if it is possible to create public health approaches that facilitate lifestyle changes across broad elements of society. Further, in this form of democracy, it was not clear how one differentiates the impact and influence of commercial interests in implementing or not

any one intervention or change, or the political local, state, and federal policy influences or the impact of the media in all of its various forms. The question arose if the health care strategy that enhances partnerships includes societal consciousness and commitment with social activism, the sharing of power and the elimination of disparities. It was concluded that it is necessary to make cultural adjustments in the present system if we are to achieve good medicine.

Provider. There were several participants who thought it appropriate to substitute the term healing partnerships for healing to emphasize the role of an active partner. This was a reflection of the need to make an investment toward a common goal, while recognizing there can be an imbalance in the relationship or a hierarchy.

A variable worthy of research was the question of how to initiate or enhance healing within the provider. How does one inculcate the traits of compassion, empathy, patience, ability to listen and ability to communicate? Also, how does one discern the role of bias, stereotyping, prejudice, and clinical uncertainty to the outcome? Data were presented that identified four essential themes for the individual provider: caring deeply about coworker relationships and the setting, attachment to the original motivation or dream to become a health professional, managing responsibility in the meticulous and complete care of the patient, and avoiding bad outcomes. Thus, it was acknowledged there are endogenous and exogenous individual factors to measure in this facet of OHE research.

The role of training is a prominent aspect of this element. Questions were related to assessing the relative effect of the original selection of the physician or nurse student, the impact of acculturation during the training process, the role of mentors and the role of observational experiences. Of interest was the question of a need for the system to provide extrinsic reward for invoking and performing in an OHE, that is, whether there is a need to create value to the OHE plan by rewarding providers for caring, hope and support? And if this is so, could this ever be sufficient if the individual is impoverished intrinsically?

Organization. The group recognized the importance of the organizational structure in implementing and maintaining an OHE. Current organizations include large employers, hospitals, clinics, health care systems, health insurers, and managed care organizations. The elements that were thought to be important for success among these groups were vision toward the goals, a strategic plan to achieve the goals, support of the leadership, stable funding, an evaluative culture, and the appropriate demographics of both the providers and the subjects. Other elements included the nature of responses to opportunities, risk-taking ability, the type of response to resistance, flexibility, and adaptability, and the stakeholders' understanding of the concepts and rationale for the implementation of an OHE.

It was suggested that in starting an OHE, it might be most efficient to link its creation to a specific condition. The next

steps would be to identify the individuals who would benefit from the intervention, determine their readiness and motivation, and then let those individuals designate what they think are the appropriate outcome measures as a function of their needs. The result could be considered a congruence of fit.

Assessment tool. The competent, rigorous, and effective performance of clinical research in the area of OHE requires appropriate tools for measurement. A number of the papers in this Supplement contain essential elements and outcome measures that can be extrapolated from existing assessment and evaluation scales, all of which have been validated. The value of a healing environment measuring tool or scale centers around a focus on three main areas: health outcomes, process outcomes and financial outcomes. The groups for which these three outcomes would be pertinent would be patient, provider, organization and society.

Another facet of measurements with purposeful concrete perspectives would be the linking of biologic, physiologic, and disease-specific markers. This would provide tangible outcomes such as money, value, long-term consequences of health behavior, preventive strategies, quality-of-life measurements such as pain and functional status and patient satisfaction as quantitative analyses. Each of these, and others, would then be directed toward the target level for assessment of implemented strategies being explored: communities, medical practice, hospital schools, closed systems such as health maintenance organizations and the patient-provider dyad or therapeutic alliance.

CONCLUSION

The ability to conceive of, design, create, and implement an OHE will always begin with the individual, whether it be the healer, the healee, a significant other, and/or the community as an entity. Thus, we conclude this introduction to this Supplement with the following quotation from Pierre Elliot Trudeau:

Perhaps the rediscovery of our humanity, and the potential of the human spirit which we have read about in legends of older civilizations, or in accounts of solitary mystics, or in tales of science fiction writers—perhaps this will constitute the true revolution of the future. The new frontier lies not beyond the planets but within each one of us.

Address correspondence to:
Wayne B. Jonas, M.D.
Samueli Institute for Information Biology
1700 Diagonal Road, Suite 400
Alexandria, VA 22314

E-mail: wjonas@siib.org