

Designing Relational Models of Collaborative Integrative Medicine That Support Healing Processes

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ABSTRACT

The concept of optimal healing environments (OHE) includes a variety of elements that require exploration, definition, measurement, and interpretation. One key element is the relationships between healer and patient/client and between healers themselves. These complexities mean that models of OHE that include relationship dynamics as resources in the healing processes need information to help planning, execution and measurement. This paper examines aspects of a proposed model of optimal healing that utilizes relational dynamics as central to healing processes. The dynamics of relationships between healers and clients are critical to the effectiveness of healing as a process of transformation. Conscious examination of healers' emotional availability in relationship-centered care may be important in determining primary roles in delivering care.

PREAMBLE: TOWARD WORKING IN AN OPTIMAL HEALING ENVIRONMENT

The idea of optimizing healing as a potential solution to an undefined aspect of our present health care system's problems has begun to receive attention. It has resulted in a variety of efforts that are collectively attempting to examine what required elements or ideal characteristics in a given environment support healing processes most effectively. Internal and external environments become resources, potentially measurable, in the healing process.

This paper examines relationships and their environmental influences on healing processes. Although our context primarily is that of common provider/client encounters, "relationships" in this context may mean everything from cell-to-cell communication to the uncertain realities and implications of nonlocal consciousness communication.

We start by proposing a model of health care that is based on our view of how the healing experience occurs in individuals. Aspects of this model exist in the literature, but as a whole it is untested. We then generalize from this model to illustrate how a larger system model that explicitly supports this might be developed. We also draw parallels and

examples between the concepts we raise for discussion and real life examples of relationships, aligning them with the classification of the following fundamental interactions:

- Within client/partner/patient (their relationship to themselves, their illness and their wellness)
- Between patients and healers
- Between healers and other team members, where they exist
- Between teams and the system or setting in which they work.

While strong relationships characterize much in the way of healing encounters, they are not valued systemically in American health care. The adage, "anyone can administer a modality, but healing takes place in the context of a relationship," serves to highlight a distinction between repair and healing. Repair and healing are both legitimate goals, and can be found on a continuum that to some extent may reflect the degree of conscious participation of the client in the process. Conscious participation is dependent on an intentional inventory of assets and deficits (emotional availability and unavailability). Thus, healers need to examine

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their own internal relationships and the degree of coherence that exists in their values, beliefs, and actions. Without this application of consciousness the capacity for healing is limited, diminished or even damaged.

Placing cardinal value on the role of relationships in the healing process, our end conclusions are:

- That a relationship with a caregiver should be the primary way that health care is delivered
- That the definition of primary care should consider the trusting relationship as a principal tool
- That this relationship should proceed with a sense of shared responsibility and shared accountability for the clinical outcomes
- That this care should be delivered in a system and setting where all participants allow for, seek to develop and reward emotional engagement with clients.

BALANCE AS A GOAL OF HEALING

The role of the skill levels of healers is overrated. The burden of transformation and incorporation rests with the one being healed, receiving the healing or participating in the healing process. Healing must occur within an individual, and “healers” are just one factor that facilitates or inhibits this process. The healer and their relationship to the client/partner is one of many factors used by the individual to heal.

We propose that healing should be tested against balance, which in this context is the experience of coherence. Balance is a state of dynamic tension, a complex interplay between opposite capacities with functional changes associated with each extreme. It is synonymous with the term homeokinesis. At every point on the scale of a given index of balance there is a functional norm that alters capacity and responsiveness. Balance in the realm of healing is the least restricted state of an organism: that is, it creates the most responsiveness to stimuli and challenges because it is the most flexible—most coherent.

Our model of the balance-focused healing process with identifiable relational aspects is dependent on the following dimensions in order that coherence can replace chaos in the physiologic, emotional, and spiritual makeup of the client/partner:

- Sources of imbalance (disorder) must be identified.
- Personal responsibility for healing must be assumed.
- Weaknesses in the client must be identified, supported by their own strengths, and supplemented by those of the caregiver(s).

Balance as a goal in healing requires a transformation of the relationship between strengths and weaknesses. Weaknesses must be supported, and strengths adjusted where in-

appropriate dominance is present. Balance-focused healing has three basic advantages:

1. It is the model by which individuals take responsibility for their own healing and receive the help to do so.
2. It implies that healing and change are the same process and therefore have similar requirements for support and resource development.
3. It is a process that appears to hold true across a variety of systems and cosmologies.

Many interventions can be classified as creating strengths all along the repair-healing continuum. Physical and chemical interventions create strengths as do acupuncture, psychotherapy, homeopathy, chiropractic and osteopathic manipulations, prayer, and so on. The healer’s connection to and involvement with the client facilitates the creation of strength. Thus, applying a drug is a strength as is assisting flow in a meridian, structural adjustments, patient consciousness and beliefs that they can heal, offering support in times of crises. Strengths, when supported and developed, aggregate into emotional and physiological coherence. Collating areas of function (strengths) into a new, revised whole allows transformation and, thus, healing.

Weaknesses to which strengths may be applied are also evident within all levels of patient functioning, including what resources patients can or cannot access (lack of social support, physical exhaustion, emotional distress, bodily constitution, mental attitudes), what types of wounding or physical symptoms they are manifesting (e.g., lack of serotonin, low blood sugar, need for surgery or therapy), and what attitudes they carry about physical and spiritual dimensions as framed by culture and experience. Weaknesses, like strengths, exist at all levels of the patients’ makeup and can interrupt the healing process at any time. Most failures of healing occur when weaknesses have not been identified and needed supports not provided.

In the process of optimizing healing, it is important to examine how accurately the assessment of weaknesses or deficiencies and the determination of potential strengths have been accomplished, and how effectively the two inventories are compared. It is here that the healer’s own availability bears examination, for a lack of conscious work on healers’ own internal capacities, wounds, limitations and functional perspectives can inhibit efforts to optimize healing.

SHOULD ALL HEALING HAVE THE SAME GOAL?

Optimal healing conveys a pledge that holds both promise and peril. The promise is that the optimal path will create the optimal experience and lead to the optimal outcome. The peril lies in the pledge of an optimal response for people who expect to be passively cared for and have their illness

treated by someone external to them. The system presently encourages this attitude by paying for services while expecting no accountability from those who are interested in abdicating responsibility.

Symptom-based care is a fundamental driving model for the current health system, and is reinforced by the economic model for service delivery compensation. At the same time, many conditions with a high level of potential chronicity need to be treated at a presymptomatic state. Goals of care are an important element of an optimal healing encounter in that they can be a profound structural element in care design, and in the context of therapeutic processes that are foreign experiences for patients, offer a map that helps establish expectations. It must be remembered, however, that goals are influenced by values, and these are not normally identified as variables in care design.

Effective processes of healing are often intrinsic to the patient and their resources, and sometimes require no interventions at all. We are accustomed to providing care and judging effectiveness in that provision. A provider's most appropriate goal, however, may simply be supporting the patient in their own processes.

Perhaps the central issue to be addressed when care is being designed is to seek to answer this question: Is the procedure or the patient central to the process? If the procedure is central, then the patient can really not be more than a passive recipient of an intervention. If, however, the patient is central, even a mortally critically important service is instead an opportunity to establish a stronger communion between one's wellness and lack of wellness, increasing the opportunity for strengthening inner coherence.

TRANSFORMATIONAL PROCESSES IN HEALING: THE FORMULA FOR CHANGE

Healing, whether optimal or not, is a process of change, and there are steps of change needed for a client to embark on a healing journey. Patient/partners going through the changes involved in healing need to be fully engaged to optimize the restorative internal connection experience. The Formula for Change is one description of a way to describe the steps by which internal barriers can be changed and how new patterns can be laid down in the nervous system of a client to create a healthier lifestyle.

The Formula for Change describes the ways in which healing is consciously and internally embraced. It involves the learning of acceptance, to be able to see the problem as a whole and not as a judgment or something negative about the self, and taking responsibility for those parts of the problem that one can, and then working with those parts first. It also involves being willing to be open to other answers, both from within the self and from others, and being willing to act on those solutions to get the feedback necessary and to adjust accordingly. It is a proactive and participatory model

of learning and experimentation, and one in which the person is not reactive to their condition, but involved in a problem-solving approach.

From the perspective of relationships, the Formula for Change is a structure in which a patient/partner is repeatedly drawn back to both an awareness of where chaos or incoherence exists internally, and the necessity to draw upon the strength of their healthy side, rather than the limitations of their unwell side. It is specifically exclusionary of those outside that intrinsic relationship. Thus, healers are bystanders who cannot intervene, but can support and foster that relationship.

The Formula for Change has four elements: acceptance, responsibility, release, and change. Acceptance is the entry point to the process of healing. It requires an awareness of the client's current state and present condition to allow for conscious participation. The relational quality for the healer is the degree to which the healer can move into acceptance not only about the patient/partner's condition but also their own. It is difficult to foster an optimal healing experience for someone when either what they are going through or what a healer is going through is the source of unexplored or unresolved conflicts. Thus, acceptance is an important entry point to the process of healing, because of the degree to which a lack of exploration of this can inhibit the optimal process.

Responsibility comes from acceptance, and is the ability to know what can be healed and what cannot. It is a statement of awareness and also of ownership. It is the difference in being responsible *for* the problem and *to* the problem. To heal requires being responsible *to* the disease as an active state of chaos. On the part of the client/partner, the relational quality at work is a requirement that a present time perspective be used. On the part of the healer, the relational quality at work is their awareness of where they lack the ability to respond, and from that to know where they are unable to foster optimal healing.

Release is the act of moving through the phase of exploring incorporation, adaptation, and transition. This is the period of greatest uncertainty, because normal release phases can involve experimentation that tests the utility of adaptations that derive from the healing process. This phase is called "formless" because the path of the healing process cannot be mapped in advance. It is the phase that for many people becomes a place where healing stops, because either barriers to the experiments are not identified or managed or the fear associated with the process of exploration and the testing of new states of identity becomes too great to handle. On the part of the client/partner, the relational quality at work is often the extent to which they have established a support structure or community around them. On the part of the healer, the relational quality that is important is the degree to which they can see the needs of the client/partner clearly enough independent of their own considerations to assist in establishing a safe experience for the client/patient's phase of greatest formlessness.

Change is the final step in the Formula, where healing involves the necessity of experiencing a new state and reordering functional mechanics. It means moving the acquired information into the physical experience—“in” the body. It is the process of consolidation of a new state after the formlessness of experimentation has produced results that have been tested and found appropriate. If the process has been used consciously, this phase is one in which a profound and deepened awareness of a variety of aspects of the problem they have tried to heal become known, and a new sense of identity, that reinterprets previous experiences and problems in new ways to fit with the refined sense of coherence, is enabled. On the part of the client/partner, the relational quality at work in this phase has two aspects. One is the degree to which they are able to communicate within themselves about the new functional order. The other is the degree to which they are able to communicate outside themselves, as with family and friends, about their new functional order. Establishing coherence often requires a variety of processes that reorder a number of aspects of a patient’s life. For healers, the relational quality at work is the degree to which they are open to the changes the client/partner has chosen to incorporate. The healer moves their position in the process away from a role of ensuring a safe container for the healing experience to becoming a bystander as the client/partner develops a new sense of their own functional relationship system.

RELATIONSHIPS IN THE REALM OF HEALING: SUPPORTING TRANSFORMATIONAL PROCESSES

Optimizing a healing environment in which the healing abilities of the client are addressed and fostered is enhanced with attention to client–healer relationships. This supportive relationship can serve different roles, depending on the needs extant.

The relationship can support healing through providing modeling

Here, the healer provides the client with a structure for an emotional stance toward their own healing. A model for how to accept the healing process as it will occur in them, how to educate themselves about such a process, how to approach healing, what they can do, and what others have to do for them. In moments of crisis, there is a need for a reassuring presence in order for emerging emotions to be tolerated. The relationship is the medium through which the model is demonstrated and adopted. Additionally, the healer is often the first connection the client has with coherence where a biologic system holds the intention to heal and shares that order with the client.

Chaos is an energetically turbulent state, while the coherence model is not.

The relationship can support healing through providing memory

The healer is often the first person to focus on the development of resources for the client, specifically those needed to move forward in the healing process. What can the client bring to the healing process? What strengths does the client have, what skills, what resources? Can they be responsible *to* the illness, not necessarily responsible *for* it? The development of “states of well-being” or positive affect states related to the strengths, skills, and resources the client has is an important part of the mobilization of the client’s internal healing process. Without this, the client remains dependent on others for their strengths and for the motivation to heal. Often it is the personal, accepting, and empathic role of the healer that provides the earliest state of well-being, the sense of safety and attunement necessary for healing in the optimal healing environment (OHE).

The relationship can support healing by providing perspective

There is a need for healers to understand from their own perspective the process of healing—their perspectives on processes by which order is brought to a disordered system, and neutrality in seeing how the client’s own healing abilities can be fostered as a way to maintain that order. This is an egoless task, and one in which (1) the healer can model acceptance; (2) the responsibility for healing is gradually passed on to the client in appropriate stages; (3) the healer can “get out of the way” when the client begins to bring in other answers to their problems and appear to find their own paths; and (4) the healer can support changes that bring life to the client and foster a lack of dependence on the healer.

RELATIONSHIPS IN THE REALM OF HEALING: DARK SIDES OF THERAPEUTIC ENCOUNTERS

The “dark” nonconscious and nonincorporated sides of relational interactions complicate and contaminate healing. They can involve several areas of problems from the healers’ perspective where healers do not:

- Understand these processes from a personal level and therefore are not able to “match” clients’ needs at any of the stages of change
- Arrive at their own level of acceptance and are carrying judgment or criticalness about the client/partner
- Know how to move away from any dependent relation-

ship based on their own modeling and shift that locus to the client

- Make room for clients' answers about problems, or
- Know how to facilitate and reinforce new healthy behaviors.

Similarly, dark sides of relationship dynamics from the patient/client/partner's perspective can mirror the issues of the healers, where they are:

- Unwilling to engage healers' "safe containers" when necessary to explore healing
- Unable/unwilling to come to a level of acceptance about their own conditions ("not knowing" what needs to be healed within them)
- Trapped in the release phase, unable to use their own resources to explore, test, and ultimately incorporate new behaviors, changes, or wound resolution
- Unwilling/unable to see the importance of the centrality of their own answers, or
- Unable/unwilling during the control phase of the Formula for Change to reorder their own states to focus on the new reality of healed wounds, traumas, or experiences.

BRINGING CONSCIOUSNESS TO THE THERAPEUTIC RELATIONSHIP PROCESS

With the potential of both positive and negative aspects of the therapeutic relationship to affect the healing process it is important that a level of conscious inquiry be brought to the process. Without this, the dangers of the darker sides of the therapeutic relationship remain potentially more active and at risk for contaminating the healing process. To avoid this, an assessment should be accomplished with three basic components:

1. Examination of the healer's awareness of his or her own internal balance between the capacity to support a client's healing processes and their resistance or inability to support it
2. Exploration of the client's awareness of his or her own internal balance between the capacity to engage with a healing process and their resistance or inability to engage it.
3. Examination of the host institution or physical setting's awareness of its own balance between its capacity to support a healer/client healing process (relationship) and its inability or limitations to do so.

This assessment should not provide static data but rather a dynamic of the developing or emerging relationships at every level. It must also be asserted that the outcomes of these assessments and examinations are not mandates for change or to be viewed as defects, but more for identifying and defining parameters within which transformational

processes can take place. Success will be enhanced if all participants hold an agreement that prizes, values and utilizes consciousness, intentionality and communication. There also cannot be a great disparity between the degree to which the participants value and use these elements. Specifically, a conscious relationship between a healer and client will be limited in a setting that is "institutionally unconscious," intentionality held by the client will be constrained by a healer that does not support the energetic focus of the client, and healers that withhold communication from clients limit clients' abilities to hold all required information. There also cannot be much of a disconnection between the explicit commitment to perform the examination and the intention to actually use the information—process integrity matters.

Emotional components that underscore this in ways that are both seen and unseen should also be discussed. If emotions are the language of the body, and the body–mind of a client is a blending of both that emotional language and the unemotional language of the soul, then healing is likely to require some processing of emotions as well as the intellect. As part of a healer's attempt to support optimal healing processes, the emotions of the healer are not just important, but a critical element of their client's healing as well. The classic model and culturally valued achievement of healers compartmentalizing their emotions so as to dispassionately deliver the "right care" is in this model a detriment to the healing process. On the other hand the degree to which they are emotionally engaged (as opposed to invested) with their client/partners may be actually part of an index of effectiveness. In situations where the emotions of clients require support and the establishment of a stronger "container" for the experience, healers' emotional engagement may actually be critical for success.

The breadth of the spectrum of communication available between healer and client/partner and accessible to both is an important aspect in optimal healing. Patients need to access varying states of resource (strength) in a healing process. Thus, access to states of well being are critical elements of the transformational experience that once incorporated become sources of strength in the healing process. Relational interactions are an important source of these states of well-being, including the creation of safety, comfort, conflict-free experiences, empathic resonance and the experience of being seen, heard and listened to. Positive affect states form the basis of much needed energetic organization for healing with stress in life.

This requirement is not without consequence. Healers need healing much more often and more deeply than any part of our current system acknowledges or supports. As healers' experience of their own capacities develops and deepens in the course of their career, their own needs require increased attention. Developing that capacity may come to be a resource requirement of the system in general if OHEs are to be developed and maintained.

RELATIONSHIPS IN CARE MODELS: WHAT TO DO WITH THE RESULTS OF AN EXAMINATION

We believe that relational connections have a role in assisting healing in at least three general ways that pervade the experience. They:

1. Form the container for the client's healing processes, and are the way in which a client examines the task before them and either feels supported in it or not
2. Are a major factor in the client's emotional responses to the healing task itself, and whether or not they are ready for anything beyond the most basic repair approaches
3. Establish the basis for healers to educate clients about the primary role of clients' efforts in the establishment of OHEs. These need to be created by the client with the assistance of the healer, and are supported and maintained for some time after the primary interventions have been made.

These connections are expressed through at least three noncorresponding roles that need to be fulfilled in an OHE. One role is that of information gathering. This role helps ensure that questions are asked and answers provided that help construct the right experience. Another role is that of intervention. The third one required is support for the overall healing process. Taken together, these three roles are a way through which the effectiveness of relational dynamics is expressed.

Creating an OHE that models these ideals and considerations requires a foundation. One way to create this is to explore the establishment of a values-based structure to serve as a framework for developing OHE models. An organization might consider processes to answer questions such as:

- How aware are healers of the balance they hold internally between their capacity to support a client's healing processes and their resistance or inability to support it?
- How aware are healers of the balance they hold internally between their capacity to engage with a healing process and their resistance or inability to engage it?
- How aware is the host institution or physical setting of its own balance between its capacity to support a healer/client healing process (relationship) and its inability or limitations to do so?

If shared values already exist, there may be no need to explore new policy development processes and relationship-centered care can be modeled more quickly. These models, and how the roles above are filled, will also vary based on the number of providers involved. In creating new patient-centered models processes need to be developed to ensure that the relationships in and around the patient are given

high priority. If the model focuses on mobilizing the internal healing abilities of the client, the center of the process needs to be the client and a means to determine their goals. If this is the core relationship, providing and understanding effective care will come out of processes that assess, deliver and measure which modalities, approaches and people most appropriately support that relationship and the care provided within it. Protocol elements for processes that support this include:

- Determining how clients have entered the system and where the locus of control exists
- Assessing where clients are in terms of their resources for healing
- Determining who is most likely to be the optimal agent to discover clients' resources in this process
- Determining who can optimally fill the role of delivering the initial interventions.

In an OHE, protocols, pathways, processes, and policies need to support essentially one thing. The healer who is most emotionally available and who is most conscious of their own resource assets and limitations for a given client is the provider who becomes a primary caregiver. This is a decision not based on profession, scope or autonomy, but on basic relational strengths.

BUILDING ON THE FOUNDATION IN DIFFERENT SETTINGS

Different clinical settings will require different expressions of relationship-centered care. General types of settings include those with one provider and no support staff or one with support staff, settings with more than one provider (monodisciplinary or multidisciplinary) and support staff and settings with teams of providers.

The challenge in a setting of one provider is to ensure the quality and effectiveness of any examination or assessment that takes place, because there are no checks and balances on the relationship in the clinical setting that are outside of the primary relationship. Where support staff are present, some of the roles can be delegated or assumed. In fact, it is not unusual in some clinical settings to see stronger relationships between patients and support staff than between patients and legally designated primary caregivers.

In settings where there are multiple providers, multiple disciplines, or explicit teams of caregivers, some roles also can be delegated. More importantly, this environment can offer the opportunity to provide a patient/client with more options as far as their primary clinical relationship is concerned. Relationship-centered care in this instance is an important operational solution for the challenge faced by many integrative clinics, namely, who serves as the primary caregiver for a given client?

In a health team or multidisciplinary environment, provider team members who are not in a primary role move to support roles that seek to maintain the qualities of consciousness and intentionality. Teams can have components of information gathering, support for the overall healing process and intervention delivery. Support for the healing process role is a multifaceted responsibility that oversees the process until the client is able to do that without the higher level of support.

Team approaches to this process have real advantages, including helping the healer support the client and allowing healers to look at their own effectiveness in a way that does not create shame or blame—thus supporting work with difficult and frustrating clients. Conscious or unconscious treatment resistance is a natural part of patients in true healing processes, but facing it on a daily basis is draining and requires the support of colleagues. Working with clients who do not know how to assume responsibility for their healing or continue self-destructive lifestyle choices that undermine the healing process often requires the support that can be found in a team. Healers often make the mistake of poor self-care, and the team is one way to look at that issue in a positive supportive way. The challenge in a team model environment comes with the complexity of multiple providers and personalities interacting. The need for facilitation in the process of examination, internal assessment, and establishing and supporting the primary care relationship grows substantially.

INTEGRATIVE PROCESSES IN RELATIONSHIP-CENTERED CARE

Integrative strategies take on new dimensions when the primary relationship through which care is delivered is determined by the relational strengths of providers. Current challenges in integrative health care are commonly framed in terms of problems associated with trying to determine which modalities or professions should serve which roles in a clinical setting. The customary primary political and cultural role held by medical physicians in most integrative settings is difficult to modify, but becomes problematic when multiple paradigms and cosmologies of health and healing are discordant. Goals of symptomatic improvement and elimination or control of a pathogen by applying the modality of a medicinal prescription is different from efforts to balance *qi* which in turn is different from removing sources of nervous system interference or stimulating sympathetic inhibition through effleurage.

Solutions commonly examined in bringing these different cosmologic elements together in a clinical setting often have to do with seeking the right combination of modalities—a natural extension of the medical team approach, substituting complementary and alternative medicine (CAM) professionals or modalities for medical specialty care. These delivery

models are influencing research agendas associated with exploring the potential contribution of CAM professions in traditional medical settings, because as in most integrative team-based care approaches where the right mix of modalities is sought, efficacy studies then focus on evaluating contributing modalities in isolation from their normal professional context. Acupuncture is taken out of Traditional Chinese Medicine (TCM), for example, and adjustments from comprehensive chiropractic management. Modalities, however, have relationships to their cosmologic environments.

In relationship-centered care, professions and modalities are secondary considerations to the strength of the primary relationship, so the questions of clinical efficacy are secondary to relational efficacy. One possibility in this model is that therapeutic plans are based on the cosmology of the provider who has the strongest relationship with a client/patient, and other team members' contributions are not clinical in nature. Integration is created by how the other team resources fill the additional roles that serve to support the primary caregiver role.

Testing team function back against the qualities of healing relationships requires a determination about whether the individual assessments have been accomplished in the healers' own exercises of their assets, wounds, resources and voids as well as inventories of their relationships to other healers in the team. Opportunities for support created by team care, despite the added complexity, actually offer greater assurances that healers can be healed, because the rest of the team is engaged with participating in monitoring the effectiveness of the primary care relationship from the standpoint of values of relationship-centered care. At the same time, it is an "ego-less" construct, because clinicians potentially may have no direct role with a client.

A VISION OF THE FUTURE

If there is one lesson to be learned from the complexities associated with clinical research into the effectiveness of complementary and alternative modalities and professions, it is potentially that modalities are compromised when extracted not just from their normal cosmologic settings, but also from their normal relational ones. If care is truly to be patient-centered, then the relational needs of the patient, client, or therapeutic partner must be a central component of the intake, diagnostic, therapeutic, assessment, and financial compensatory processes employed. Also, if OHEs are not just an idealized goal but actually required ways of providing the most cost-effective health care services when the broadest view is used of a person's wellness and recovery from illness and wounds, the relational context for delivering that care must be a design element on which all else is dependent.

The implications of this are extensive. Curricula of health care professions that have culturally valued dispassionate di-

agnostic processes would need to revalue emotional engagement and reward students for their relational accessibility. Curricula of health care professions that already can claim the territory of relationship strength as part of their effectiveness probably can no longer leave it as a given, but must more explicitly explore refining and testing aspects of their relational development, and more importantly prepare themselves culturally for sharing these strengths with other professions who rediscover their value.

If the effectiveness of healers in relationship-centered care is dependent in part on their awareness of their emotional strengths, assets, wounds, and inhibitions, educational processes of all health care professions would need to be restructured so that students would emerge healthier than when they enter. Also, if relationship-centered care is to be the critical element in case management and care design, culturally and politically dominant structures that place and legally reinforce the primacy of physician decision-making need to be rethought.

The present system is not working from almost any perspective, and different futures must be designed. Market-based solutions are struggling to find the right combination of customer-friendly services to differentiate competitors from each other and make insurance products appealing to consumers who are increasingly forced to make decisions based on cost alone. With consumer preferences currently construed to value multidisciplinary care, models that test different versions of these services are proliferating. Yet these are becoming more widespread at the same time as economic market forces are exerting inexorable downward pressure on service diversity, and subsets of existing sponsored health insurance benefits are more and more the only option available to employers and employees. Solutions to the dire economic forces that are present and worsening are mostly focused on shifting a greater share not just of the costs to consumers, but also responsibility for choices of preventive and acute care resource consumption. Ways in which consumers' accountability for the expenses of those choices, lifestyle decisions that adversely affect health and that can directly be attributable to rising health costs are emerging, and preserving individual privacy will become more and more of a challenge. The long-term effects of "consumer-driven" and "consumer-directed" health plans are poorly understood, but at the very least are going to challenge current actuarial models and produce great uncertainty. Consolidation of our nation's health care marketplace may have some benefits as products homogenize over time, but may have unintended and less positive effects as well. And the variety of cost-drivers in our current system has not been agreed on in any national conversation, let alone potential solutions.

There is cause for hope. Some of the conversations that

are a backdrop for creating a future that values relationships are currently taking place. Evolutionary forces are already present and visible in healthcare education. Basic questions about the fundamental direction of our national health care research agenda are beginning to be raised from the political margins of the power structure. And a generational shift in providers raised in recent years is challenging cultural norms with a stronger voice.

It has been widely interpreted from data regarding consumer election of complementary and alternative approaches to care that consumers were "voting with their feet" by withholding information from their medical physicians, testing new and different approaches, and essentially managing their own care. While effectiveness of care and modalities clearly matter, the relational context of the provision of these services may in fact have mattered more to people. What we may be seeing are the effects of people in search of connections they initially had with traditional providers from which they now feel deprived. If and how the current system is able to reconfigure itself to focus on what is probably going to come to be viewed as a necessary option of relationship-centered care will be an interesting process. Whether it becomes an option as a marketplace innovation or a central design element may affect our system's survival.

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Appendix 1. Unanswered Questions

Some of the following questions may form the basis for other investigations:

1. **What can be known about healers' internal limits and capacities?**
 - a. Can healers' limits in terms of supporting healing relationships be assessed?
 - b. If assessed, should anything be done about wounds and limits?
 - c. Is this a personal assessment, or should it be adopted in 'the system'?
2. **What can be known about client/partners' internal limits and capacities?**
 - a. Can client/partners' internal wounds that pertain to healing be assessed in the context of a clinical relationship focused on physical healing?
 - b. If assessed, how should the relevance of these internal wounds be determined in measuring clinical outcomes?
 - c. If they profoundly affect (positively or adversely) clinical outcomes, what are the ethics of providers' responsibilities to the client/partner as well as to the system?
3. **What can be known about expanding healer function and empathy?**
 - a. Should processes that expand provider capacity including the ability to relate to the client in ways that enhance their capacity for healing be considered important or critical in optimal healing?
 - b. If empathic states enhance clinical outcomes, and providers have capacity for greater empathy that they avow, what are the ethical implications?
4. **What can be known about expanding client/partner function and affinity?**
 - a. Should processes that expand client/partner capacity for affinity for self be considered important or critical for optimal healing?
5. **What can be known about conscious and unconscious goals?**
 - a. On the part of the healer, can 'end points' of world views regarding health and healing be assessed? Do they have relevance in clinical relationships with the prospect of transference of expectations?
 - b. On the part of the client/partner, can 'end points' of world views regarding health and healing be assessed? Do they have relevance in clinical relationships with the prospect of client/partner vulnerability to transference of expectations?
6. **What can be known about the clinical halo effect of a values-based system or environment?**
 - a. If client/partners are healing in a mainstream environment compared to a supportive values-based environment, are there any differences in clinical outcomes?

Appendix 2. Testable Hypotheses

1. Internal assessment of wounds and emotional capacities on the part of health care students improve clinical outcomes.
2. Values-based clinical environments enhance clinical outcomes.
3. Third-party payer strategies that support values-based clinical outcomes create positive financial returns.
4. Patient/client/partners who assess their emotional wounds and capacities demonstrate improved clinical outcomes.
5. Collaborative clinical care teams that establish a supportive internal dynamic provide improved care.