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Optimal Healers: Igniting the Spark and Fanning the Flame. Training Academic Medical Faculty in Optimal Healing

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ABSTRACT

Optimal healing environments (OHEs) require optimal healers to keep them flourishing. Academic medical faculty are in a unique position, through their involvement in education, research, and leadership, to create and perpetuate OHEs. Means by which they might do so using a motivational interviewing model as a framework are discussed. A four-part process to facilitate faculty involvement is described: (1) means of assessing interest in creating OHEs; (2) methods for moving interested individuals beyond a merely intellectual interest to a deeper level of commitment; (3) ways of providing optimal healers with the tools they will need to successfully create OHEs; and (4) perpetuation of OHEs through support networks and educational methods. Resources and examples which can guide the creation of an optimal healing curriculum are provided.

INTRODUCTION

A shift from a disease-oriented model to one focused on health, healing, and prevention is occurring in the delivery of health care. The advances made in disease treatment will be combined with a higher priority of teaching students the importance of facilitating health. Success will result in less disease and morbidity and fewer medical costs. Creating optimal healing environments (OHEs) that emphasize all aspects of health and healing[1] will shorten the time between health span and life span.

The public is demanding this type of care, and there is an increasing need for physicians who can provide it.[2] Academic physicians need to match the expertise developed for treating disease with one that understands the complicated process of how the body heals and the realization that salutogenesis is more complicated than what can be explained through the biomedical model alone.[3]

Educating students about the importance of OHEs requires mentors to develop an understanding of the importance of this foundation in health care delivery. Medical faculty are in a unique position to help this understanding grow (Table 1). Because this approach was not included in the medical school or residency training of most faculty members, a challenge arises in helping develop an understanding that will empower them to teach the concept to others.[4] This paper explores how best to enhance this educational process.

Faculty development is based on the premise that physicians are lifetime learners, constantly trying to improve their understanding of the human condition. The most successful way of learning how to do this has been through the process of collecting evidence that supports a specific way of doing things. By exploring the evidence, physicians become more efficient in choosing the correct medication, performing a procedure without complications, or sifting through the data to come to a conclusion that will best help them treat the disease. The challenge is in realizing to avoid believing that learning more facts is only a small part of what helps us become successful in our job.will make what the patient needs to heal more evident. In actuality, what truly heals another human being is that connection that occurs at a deeper level beyond the evidence, beyond the right or wrong and beyond the randomized trial. The evidence helps create a more ef-

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Table 1. How Academic Faculty Can Facilitate Optimal Healing Environment

1. Ability to participate in and lead teams of providers
   Familiarity with working with groups of practitioners on hospital services and in clinics
2. Skill with teaching
3. Access to the next generation of potential optimal healers
   Medical students
   Residents
4. Research experience
   Familiarity with the existing body of research
   Time allotted for research
5. Professionalism
6. Proven commitment to the advancement of knowledge and understanding

ficient path toward health, but relationships and emotions are what drive the behavior that will allow the evidence to be used more effectively.

It is difficult to teach about health and healing if the faculty member has not explored the meaning of these feelings through the inner exploration of his or her own health.[5] We propose that this exploration of personal health is the most important first step in preparing to help others (colleagues, students, and patients) do the same. The process requires less analytical and critical thinking and more emotional connection.

FINDING DRY WOOD

OHEs cannot exist without optimal healers. The process of educating and empowering these healers can be compared to the steps involved in building a fire (Table 2). First, dry wood must be found in the form of physicians who are interested in and willing to experience a certain degree of change. Changes in physician behavior can involve a complex process, particularly when one's practice style or worldview is subject to alteration.

Helpful insights in the process of change can be derived from research centered on motivational interviewing. In clinical scenarios, motivational interviewing is geared toward helping a person change from negative health-related behaviors (such as substance abuse) to positive ones (e.g., abstinence).[6] As illustrated in Figure 1, the goal in applying this model is to help a person move through the process of change one stage at a time. If physicians are at the precontemplative stage (i.e., not open or interested in change), then the goal is first to try to foster interest. If they are already interested (contemplating change), the next step is to motivate them to take action. Finally, once they are moved to action, it is important to provide the tools needed to perpetuate and maintain the positive behavior.

Table 2. Steps Toward Optimizing Healers: The Fire-Building Analogy

1. Find dry wood: Assess physician readiness for change in perspective/philosophy. Cultivate interest.
2. Ignite a spark: Convert intellectual interest into emotional investment and enthusiasm through individualized self-exploration and personal healing.
3. Fan the flame: Enhance the knowledge and skills healers need to create an optimal healing environment (OHE) with the assistance of a structured curriculum.
4. Keep the fire burning: Perpetuate/maintain existing OHEs. Share what is learned with others. Help to assure that other OHEs will be created. Facilitate ongoing learning. Help optimal healers teach others.

Not all faculty are prepared to make a change. There are several ways to separate those who are contemplating change from those who are not. In fact, many academic physicians have already begun to do so.[7] This may be evident in their past research endeavors, their willingness to consult practitioners who enlist unconventional treatment modalities, and the degree to which their current practice environment already displays qualities of an OHE.

A worthwhile undertaking is to meet these interested physicians halfway, providing them with a widely accessible means of expressing their interest in OHEs. Surveys, mailed to a large cross-section of academic physicians, could be useful as an initial assessment method. More simply, through announcements in some of the more widely read medical journals, potentially interested physicians can be directed to an OHE Web site or mailing address where they could request more information. Ideally, interested parties will comprise a widely varied group, representing all specialties and geographical regions. Their practice settings will range from large tertiary care centers to smaller primary care clinics, and from palliative care centers to emergency departments.

While these physicians' practice circumstances might be varied, there will nonetheless be certain characteristics they would share (Table 3). For instance, they will value moving beyond the conventional biomedical paradigm of care toward a broader, more inclusive practice model shaped by the larger perspectives of the communities they serve. Potential optimal healers will exemplify professionalism, and be well respected among their peers. In addition, they will display such personal qualities as enthusiasm, openness to change and a willingness to pursue personal as well as professional growth. All will be fundamentally concerned with facilitating health and healing for those who seek their services. Ideally, as OHEs become more common, those who were not initially interested in them will become so, and those who are "precontemplative" will become "contemplative."

IGNITING THE SPARK

Once interested physicians are identified, the challenge it to motivate the person into action (i.e., the dry wood must

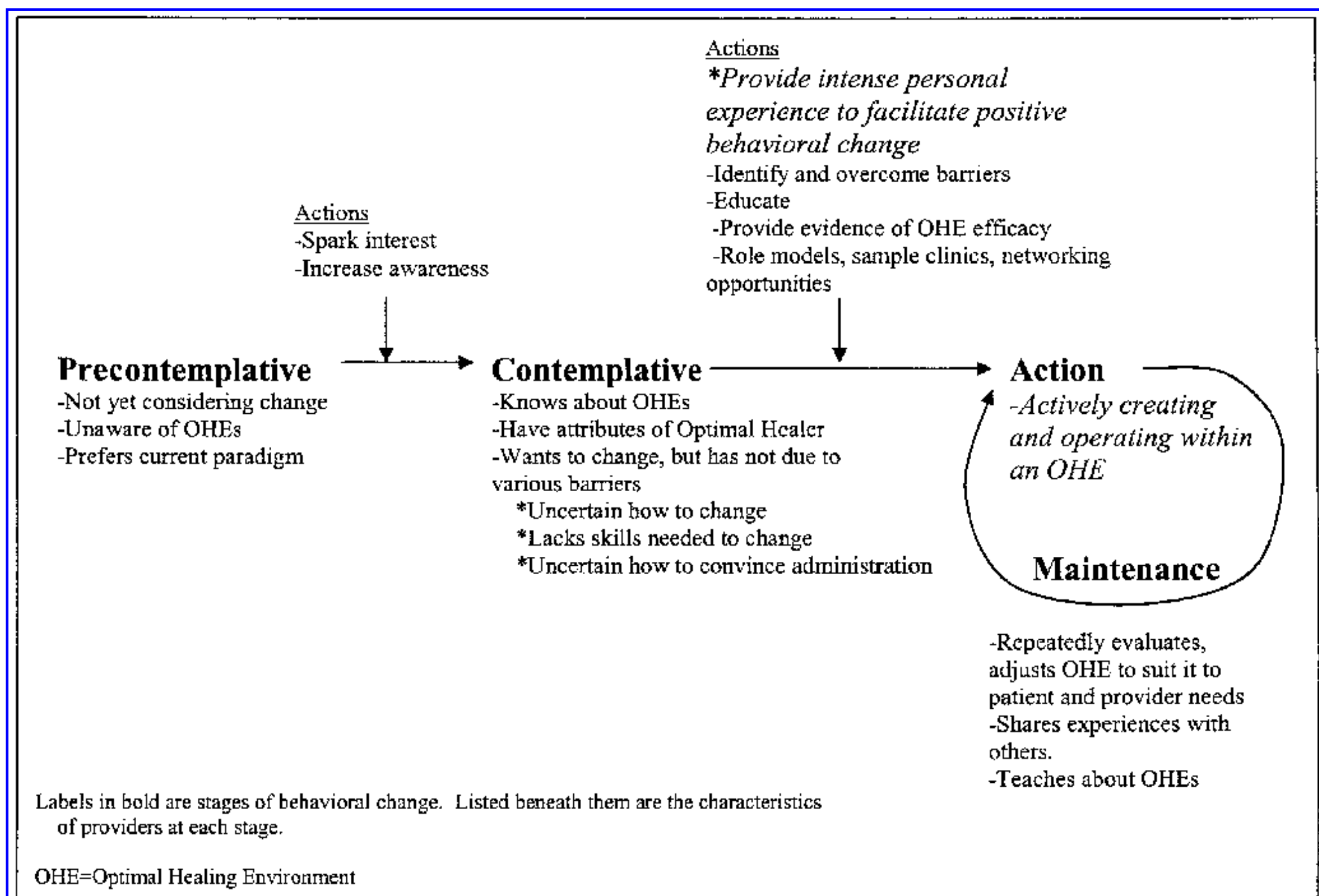


FIG. 1. Creating optimal healers: A motivational behavior change model.

be ignited). Behavioral change requires the person making the change to move beyond intellectually acknowledging the importance of OHEs toward a more emotional, perhaps even spiritual, investment in their creation.[8] The deeper the transformation a physician undergoes, the more likely it will be to engender action.

To some extent, this transformation must be an individualized process. However, it can be facilitated if done in a supportive group environment, perhaps during the course of an optimal healing retreat or medical convention that allows enrollment as part of their Continuing Medical Education time commitment. Such an environment will allow physicians to devote a specific time period to the process without external distractions. Multiple such sessions might be necessary.

Optimal healers-in-training would benefit from having a mentor to provide one-on-one interactions to augment group experiences in which the trainee is engaging. As with any process of transformation, it is often necessary to move people to the edge of their comfort zones; mentors can ensure this process remains a positive experience.

To help open individuals to a deeper understanding of optimal healing, we propose that they be involved in an activity that encourages them to connect with what gives them meaning and purpose in their own lives and careers. To fully create an OHE for others, healers must first experience being in such an environment themselves.[9] In motivational interviewing, one of the key components in changing behavior is to show how the behavior will help or hinder the person's ability to reach their goals. One such challenge would be correcting the inability to spend time listening to the patient's story and focusing on what is needed to facilitate health. In reconnecting with this fundamental behavior, it should be possible to better understand the underlying philosophy of how to create OHEs and become motivated to learn more.

There are many activities that could be used to enhance such an experience. Which activities are used should be individualized to the specific practitioners' needs and preferences and include but are not limited to:

1. *Mind–body modalities*—Mindfulness involves maintaining a focused, open attention to one's inner experiences while remaining attuned to events in the outside world. Mindfulness practices are helpful in preventing burnout and increasing practitioners' sense of meaning. The utility of such

TABLE 3. QUALITIES OF OPTIMAL HEALERS

- Values
  - Openness to change in practice
  - OHEs an important priority
  - Professionalism
  - Community service orientation/commitment
- Capacity to change and grow toward optimizing healing
  - Ability to circumnavigate barriers
    - Financial constraints
    - Time constraints
    - Institutional biases
      - Administrators
      - Third-party payers
      - HMOs
      - Government support (or lack thereof)
  - Sense of what is desirable and useful to patients
- Personal qualities
  - Enthusiasm
  - Willingness to pursue own personal healing journey
  - Characteristics of an "adult learner"
    - Committed to a lifetime of learning
    - Openness to new philosophies and ideas

OHEs, optimal healing environments; HMOs, health management organizations.

practices is increasingly being recognized.[10] Interactive guided imagery experiences could be particularly useful in helping potential optimal healers connect with the parts of themselves that would make them most committed to taking action. Careful reflection through journaling, for instance, could also prove helpful.[11]

2. *Group sessions/discussions*—A group encounter centered around exploring what gives life (and the practice of healing) meaning for an individual can be a powerful experience. The regular weekend programs conducted by the Center for Spirituality and Healing at the University of Minnesota Academic Health Center for renewal and rejuvenation of health professionals,[12] Rachel Naomi Remen's Healer's Art elective for medical students and Finding Meaning in Medicine program for physicians serve as examples and models. The topics at these sessions include exploring what motivates us in our healing practices, self-healing and care of the soul, and reconnecting with parts of oneself that are not nurtured during the rigors of medical training.[13,14]
3. *Healing rituals or ceremonies*—Experiencing a healing ceremony, shamanic ritual or other experience that lends itself to being a "rite of passage" on more than just an intellectual level can prove helpful in the development of optimal healers.[15,16]
4. *Retreats*—Retreats are often used to help members of a group focus on specific tasks or aspects of who they are. They have been shown to foster spirituality and well being in cardiac patients,[17] and they have been advocated as beneficial at the level of organizations as well.[18] Retreats are available in some academic centers for medical students and have been well-received. Lee Lipsenthal, M.D. (Creating Balance in Medical Life, www.healthclassics.com) and James Gordon, M.D. (Mind Body and Spirit Medicine, www.cmbm.org) offer retreats and courses that support this process. Multiple team-building and personal growth exercises can be incorporated into such an experience, and such environments also would facilitate networking among physicians.
5. *Participation in a model OHE*—Immersion experiences involved with participating both as a patient and as a practitioner-in-training in a model OHE is a valuable means of motivating interested providers into action, as well as giving insight into how OHEs might operate. Integrative medicine programs, dedicated to drawing from complementary and alternative medicine as well as allopathic medicine to provide care, have emerged in a number of academic and community medical centers in recent years and may serve as useful models.[19] Another resource is the American Board of Holistic Medicine roster of certified physicians with an OHE foundation.[20] As academic physicians create increasing numbers of OHEs, they would be able to incorporate teaching into OHE function. Knowing the inner workings of such organizations would help providers be better equipped for overcoming institutional and resource obstacles to OHE creation.

As the process of providing physicians with such experiences evolves over time, it will be important to evaluate which methods are most effective. Potential research projects could include surveying physician participants to determine how useful the experiences were for them and/or correlating the physician's experience with the changes they successfully institute in their medical practices. Criteria for the identification and training of mentors will also need to be developed.

FANNING THE FLAME

The next step is to ensure that the fire catches. Interest and enthusiasm are of key importance but only if they bring about tangible results. Academic physicians face a number of obstacles that must be surmounted if OHEs are to be instituted, including financial barriers, time constraints, and institutional opposition or inertia.[21] Research into cost effectiveness, patient satisfaction, and patient outcomes associated with OHEs will be of key importance in helping optimal healers demonstrate the potential benefits of their efforts.[22] Incorporation of a system-wide, outcomes-based evaluation will be needed.[23]

Optimal healers will require education in a number of areas. Table 4 lists many of the requisite skills and knowledge they will need to possess, according to the six components of OHEs outlined in a Samueli Institute diagram.* For in-

*See Optimal Healing Environments graphic by the Samueli Institute. Diagram created in 2003, and Chez and Jonas in this Supplement, pages S-1–S-6.

Table 4. Components of OHEs and Skills that Would Help Providers Create Them

Component	Skills
Intention and awareness[a]	• Familiarity with cross-cultural medicine and how to maximize therapeutic effect for patients within various cultural and religious traditions[b,c]
	• Awareness of placebo literature/self-healing potential and how to help the body heal itself[d,e]
	• Use of intention in one's own practice[f]
	• Personal participation in/ability to guide others in mindfulness practices
Wholeness and energy[15]	• Attitude of unconditional acceptance of those seeking care
	• Ability to guide others toward understanding the body's energetics as a mechanism for healing and growth
	• Personal participation in/ability to guide others in personal growth enhancement[g]
	• Philosophy of holism and patient-centered care[h,i]
	• Interviewing practices which focus on all aspects of the patient
	• Ability to create a healing team that has an underlying holistic approach
Healing relationships[j]	• Skills in relationship-centered care, empathy and rapport building[k,l]
	• Understanding how patients relate to their surrounding communities[m]
	• Skill with involving family[n] or other members of the support system in patient care
	• Ability to guide support groups and help patients to help each other
Health promotion	• Personal experience with living a healthy lifestyle and helping others do the same. Skill in helping others take personal responsibility in their care[o,p]
	• Solid background in preventive care and familiarity with principles of nutrition,[q] exercise,[r] stress management[s] and addictions
	• Ability to effectively educate patients and other providers through information technology, clinic-run education sessions, etc.
Collaborative treatments[t,u]	• Skill in integrative approaches to practice[v]
	• Familiarity with the variety of modalities available and when/where they are most useful[w]
	• Understanding of safety of various modalities
	• Ability to draw together and contribute to a diverse group of providers who can work together to create an OHE
	• Ability to facilitate positive team dynamics and resolve conflicts
	• Knowledge of what treatments are available within their community
Healing spaces[x,y]	• Skill with using architecture, the arts, sensory stimulation, and ambience to maximize healing

OHEs, optimal healing environments.

[a]Wirth DP. The significance of belief and expectancy within the spiritual healing encounter. Soc Sci Med 1995;41:249–260.

[b]Genao I, Bussay-Jones J, Brady D, et al. Building the case for cultural competence. Am J Med Sci 2003;326:136–140.

[c]Andresen J. Cultural competence and health care: Japanese, Korean, and Indian patients in the United States. J Cult Diversity 2001;8:109–121.

[d]Kaptchuk TJ. The placebo effect in alternative medicine: Can the performance of a healing ritual have clinical significance? Ann Inter Med 2002;136:817–825.

[e]Moerman DE, Jonas WB. Deconstructing the placebo effect and finding the meaning response. Ann Intern Med 2002;136:471–476.

[f]Jonas WB, Crawford CC. Science and spiritual healing: A critical review of spiritual healing, "energy" medicine, and intentionality. Altern Ther 2003;9:56–61.

[g]Weinstein E. Elements of the art of practice in mental health. Am J Occup Ther 1998;52:579–585.

[h]Masi AT, White KP, Pilcher JJ. Person-centered approach to care, teaching, and research in fibromyalgia syndrome: Justification from biopsychosocial perspectives in populations. Semin Arthritis Rheum 2002;32:71–93.

[i]Mueller PS, Plevak DJ, Rummans TA. Religious involvement, spirituality and medicine: Implications for clinical practice. Mayo Clin Proc 2001;76:1225–1235.

[j]Branch WT, Kern D, Haidet P, et al. Teaching the human dimensions of care in clinical settings. JAMA 2001;286:1067–1074.

[k]Mercer SW, Reilly D, Watt GC. The importance of empathy in the enablement of patients attending the Glasgow Homeopathic Hospital. Br J Gen Pract 2002;52:901–905.

[l]Griffith CH, Wilson JF, Langer S, Haist SA. House staff nonverbal communication skills and standardized patient satisfaction. J Gen Intern Med 2003;18:170–174.

[m]Karwachi I, Kennedy B, Glass R. Social capital and self-related health: A mixed level analysis. Am J Public Health 1999;89:1187–1193.

[n]Bright MA. Therapeutic ritual: Helping families grow. J Psychosoc Nurs Ment Health Serv 1990;28:24–29.

[o]Ponte PR, Conlin G, Conway JB, et al. Making patient-centered care come alive: Achieving full integration of the patient's perspective. J Nurs Admin 2003;33:82–90.

[p]Little P, Everitt H, Williamson I, et al. Preferences of patients for patient centred approach to consultation in primary care: Observational study. BMJ 2001;322:468–472.

[q]US. Public Health Service Office of the Surgeon General. The Surgeon General's report on nutrition and health. Nestle M, ed. US Public Health Service, Office of the Surgeon General; 1988. Online document at sgreports.nlm.nih.gov/NN/B/C/Q/G/segments.html

[r]U.S. Department of Health and Human Services. Physical activity and health: A report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, National Center for Chronic Disease Control and Prevention; 1996. Online document at www.cdc.gov/nccdphp/sgr/contents.html

[s]Benson H. The Relaxation Response. New York: Avon Books, 1975.

[t]Katon W, Von Korff M, Lin E, et al. Collaborative management to achieve treatment guidelines: Impact on depression in primary care. JAMA 1995;273:1026–1031.

[u]Druss BG, Rohrbaugh RM, Levinson CM, Rosenheck RA. Integrated medical care for patients with serious psychiatric illness: A randomized trial. Arch Gen Psychiatry 2001;58:861–868.

[v]Giordano J, Boatwright D, Stapleton S, Juff L. Blending the boundaries: Steps toward an integration of complement and alternative medicine into mainstream practice. J Altern Complement Med 2002;8:897–906.

[w]Eisenberg DM. Advising patients who seek alternative medical therapies. Ann Intern Med 1997;127:61–69.

[x]Fottler MD, Ford RC, Roberts V, Ford EW. Creating a healing environment: the importance of the service setting in the new consumer-oriented healthcare system. J Healthcare Manage 2000;45:91–106.

[y]Irvine KN, Warber SL. Greening healthcare: practicing as if the natural environment really mattered. Altern Ther Health Med 2002;8:76–83.

stance, in the case of "Intention and Awareness," optimal healers must have a full understanding not only of how intentionality contributes to healing outcomes, but they must also be facile with using it in caring for patients with different cultural and social backgrounds. They must be familiar with placebo literature (the literature on mechanisms of self-healing) and mindfulness practices if they are to assure that intention and awareness are intrinsic to the care their OHE provides. Skills needed to incorporate into patient-centered care will include the importance of relationships, prevention, creating healing spaces, effective use of multidisciplinary teams, and a holistic understanding of influences on health.

Optimal healers must also be able to address logistical considerations in OHE operations. Many physicians will find it necessary to take on administrative responsibilities such as personnel management, resource allocation, and coordination of reimbursement for services an OHE provides. If they are to collaborate with a team comprised of a diverse group of practitioners, optimal healers must be able to coordinate such teams effectively.[24] Similarly, continuity of care, access to care, and ethical issues must be taken into account.

The development of all these skills requires a curriculum. A foundation for this curriculum already exists in the Fellowship Program in Integrative Medicine at the University of Arizona and the Complementary Medicine Program at the University of Maryland. Both expose learners to a number of issues associated with creating OHEs (see Table 5 for a list of potential resources). Information may be delivered through a variety of means, including national conferences and conventions, Web-based resources, regular publications, networking with each other, national or regional membership organizations and Internet-based discussion groups. A published resource guide listing optimal healers and their contact information and a list of useful references would also be of benefit.

KEEPING THE FIRE BURNING

Ideally, these methods will inspire and empower interested physicians to participate more effectively in the creation of OHEs. Simply creating such entities, however, is not sufficient for the long-term viability of OHEs. Rather, an OHE must be continually reshaped and reinvigorated to ensure that it will continue to meet the needs of its patients, providers, and surrounding community as the health care environment changes.

Viability can be better maintained if optimal healers have ongoing outside support. Regular interaction with colleagues through national organizations, conferences, or Web discussion groups will allow practitioners to tap into a supportive environment. It will also provide an opportunity to engage in meaningful dialog regarding what works for maintaining OHEs and what does not. Research into the longevity of OHEs, including qualitative data focused on techniques various OHEs use to perpetuate themselves, will be needed. Ideally, as more information regarding cost effectiveness and patient preferences becomes available, increasing numbers of practitioners, including those not in academic settings, will begin to consider taking on the optimal healer role.

Our current medical economic system does not support the prosperity of OHEs. The focus of facilitating self-healing often reduces the need of those interventions that are most financially rewarded in medical care, such as surgical procedures, medical prescriptions and diagnostic tools. This economic disincentive is also creating a void in the number of students interested in pursuing primary care fields. Al-

TABLE 5. POTENTIAL RESOURCES FOR BUILDING AN OPTIMAL HEALING CURRICULUM AND ASSOCIATED WEB SITES

- University of Arizona Integrative Medicine Fellowship course curriculum.[a] Available at www.integrativemedicine.arizona.edu
- Research conducted for and by the Consortium of Academic Health Centers for Integrative Medicine. Includes websites for members as well as discussion of current *pro bono* research currently being performed by McKinsey regarding how best to create integrative practice environments. www.pcintegrativemedicine.org/stratinit/consortium.asp
- Outcomes of projects funded by National Institutes of Health (NIH) R-25 grants in CAM curriculum development. www.nccam.nih.gov
- Health Canada's publications regarding efforts to integrate health care.[b] www.hc-sc.gc.ca/hppb/healthcare/cahc/index.html
- American College of Graduate Medical Examiners Core Competencies for Residency Training. www.acgme.org
- Society of Teachers in Family Medicine CAM curriculum competencies outlined by Kligler.[c] Available online at www.stfm.org
- Courses offered through the American Board of Holistic Medicine leading to certification in holistic medicine. www.amerboardholisticmed.org
- China's integrated health care system, which has incorporated Western medicine for over 20 years, may offer guidance
- American Medical Student Association CAM modules for student education. www.amsa.org/humed/
- The Bandolier Website's articles on implementing change in clinical practice. www.jr2.ox.ac.uk/bandolier/booth/mgmt/Better2.html

CAM, complementary and alternative medicine

[a]Maizes V, Schneider C, Bell I, Weil A. Integrative medical education: Development and implementation of a comprehensive curriculum at the University of Arizona. Acad Med 2002;77:861–863.

[b]Tartaryn DJ, Verhoef MJ. Combining conventional and complementary and alternative health care: A vision of integration. In: Perspective on Complementary and Alternative Health Care. Health Canada 2001. Online document at: www.hc-sc.gc.ca/hppb/healthcare/cahc/index.html

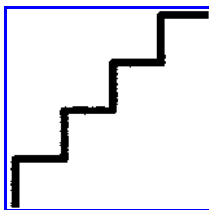
[c]Kligler B, Gordan A, Stuart M, Sierpina V. Suggested curriculum guidelines on complementary and alternative medicine: Recommendations of the Society of Teachers of Family Medicine group on alternative medicine. Family Med 2000;32:30–33.

though economic rewards are an important incentive to debt-laden students, pursuing a career that supports a deeper meaning and calling can trump the almighty dollar. In fact, many primary care residency programs with integrative or holistic orientations seem to be attracting more applicants.† Bringing healing into central focus in education and practice may be the stimulus needed to attract passionate learners to primary care specialties. Finding ways to make OHEs financially viable is essential as learning centers must continue to find ways to reduce the need for those aspects of medical care that cost the most.

It is important for optimal healers to share their flame, their experiences, and their enthusiasm. Teaching is of key importance in keeping the movement toward OHEs flourishing. Over time, those who move through the process of becoming optimal healers will be needed to help others make that same journey. Faculty physicians are in the important position of being able to guide the teaching that residents and medical students receive. Studies indicate that medical students are interested in learning more about holistic care and complementary and alternative medicine, both of which are steadily becoming part of standard medical school training.[25,26] As training programs increasingly incorporate all the components of OHEs as outlined in Table 5, students and residents will be much more likely to become optimal healers themselves.

CONCLUSION: SPIRALS VERSUS STEPS

It is a widely held view among academic physicians that the pursuit of knowledge and understanding follows a linear, stepwise course as research findings build upon one another.



From a more holistic standpoint, the pursuit of knowledge might be thought of as moving in a spiral pattern, drawn ever nearer to one central, overarching truth.

†Observation among family practice residency leaders incorporating an Integrative Medicine curriculum. Conference call among grant participants with the University of Arizona Integrative Medicine Program, December 19, 2003.

Everyone's spiral has its orbit or course, but the central truth toward which we are all moving is the same. Perhaps the path toward knowledge that academic physicians follow may be guided through the methods described above to take on a new form:

This form acknowledges the stepwise advancement of knowledge through scientific research, while realizing a more subjective, qualitative understanding of central truths that surround healing, relationships, and life. The goal of this paper is to find means for drawing optimal healers closer to such truths, while practicing within the realities of our current health care environment—moving from being interested in improving the care they provide to being passionately committed to the formation of an OHE. After the educational process equips the individual with the skills, knowledge and support needed to create and maintain OHEs, their subsequent experiences as healers will help colleagues, students, patients and others to do the same.

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