

Operationalizing the Concept of the Optimal Healing Environment in Clinical Settings: The Importance of “Readiness”

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ABSTRACT

Creation of an optimal healing environment (OHE) in a clinical setting is a multifaceted undertaking and subject to a wide variety of developmental influences. While comprehensive definitions for OHE might provide sufficient guidance for communicating philosophy and values and developing patient–practitioner processes, direction for creating a supportive administrative structure or establishing an evaluation/research strategy is less defined. Operationalizing the concept of OHE by breaking it down into components such as values, structure, process, and measurement of outcomes, proved to be a useful framework for analyzing the evolution of our integrated care program. Future OHE initiatives may benefit from using this type of framework to assess readiness among cocreators prior to development and implementation, as a guide for ongoing evaluation of an OHE postimplementation and as a basis for comparing OHEs across a variety of clinical settings.

INTRODUCTION

Over the past decade, a combination of societal trends has prompted the reexploration of healing as a primary goal in our delivery of health care. This paradigm shift is framed by the needs of an aging population, increasing prevalence of chronic illness, and heightened interest in complementary and alternative therapies. Surveys of complementary and alternative medicine (CAM) use suggest that Western medicine is often unable to provide the symptom management that patients seek for their chronic illnesses, and that the public perceives CAM to be “more natural” and have fewer side effects than Western medicine. There is also an increasing concern about the rising costs of “high-tech medicine,” which hopefully is related to increased attention to disease prevention and health promotion strategies and the need for people to take responsibility for their own health. These factors have lead administrators, clinicians and patients alike to hypothesize about optimal healing environments (OHE). And because the interests of these stakeholders’ are so interdependent, and each has the potential to uniquely contribute to the creation of an OHE, we refer to them as “cocreators” throughout this paper.

The definition of OHE proposed by the Samueli Institute (see pp. S-1–S-6) does an excellent job of capturing the philosophy and values underlying this paradigm shift.

Guiding the development, implementation, and evaluation of a clinical program requires a foundation that operationalizes definitions. The next challenge is the successful translation of the concept from paper into practice. This is especially true in fields where there is not yet a widely accepted definition for the core concept. In this paper, we propose that successful, widespread introduction of OHE in clinical settings will demand not only a definition for OHE that addresses a wide variety of cocreator perspectives, but also identifies strategies for operationalizing that definition. The main strategy we will discuss is the concept of “readiness” among three cocreator groups as a prerequisite to developing an OHE. These readiness factors have been summarized in Table 1. We also ask the reader to consider an implementation approach that uses the definition as a guide to communicate values, create structure, develop process, and measure outcomes. Last, the paper describes a research approach that connects all cocreators as members of a “living laboratory,” that supports continual evolution of the clinical OHE unit through

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TABLE 1. FACTORS IN ASSESSING “READINESS”: A SUMMARY OF EXAMPLES

	<i>Decision makers</i>	<i>Clinical practitioners</i>	<i>Prospective patients</i>
Communication values	<p>Have an experiential understanding of “integration”</p> <p>Engaged in own transformative, self-care practices</p> <p>Feel “safe” enough in own professional environments and committed enough to philosophy and values of OHE to challenge the status quo</p>	<p>Has an experiential understanding of “integration”</p> <p>Engaged in own transformative, self-care practices</p> <p>Believe that: All people have intrinsic ability to heal Personal transformation can be facilitated but not prescribed Intangibles such as hope, expectation, love, etc. make an impact on healing Respect for diversity is key</p>	<p>Have some notion about what OHE might look like for them, i.e.:</p> <p>Shared decision making Access to credible information Enough time to feel heard Support for integrative approach</p> <p>In alignment with philosophy and values of OHE (e.g., not expecting to find “silver bullet”; accept that health is hard work)</p>
Develop process	<p>Ability to develop the vision for an OHE from a set of defined beliefs and values</p> <p>Provide leadership to “operationalize” the definition including recruitment and team-building strategies</p>	<p>Committed to ongoing skill development of communication as a powerful healing intervention.</p> <p>Ability to work in an interdisciplinary style (see supportive and detracting characteristics in paper)</p>	<p>Open to assessment of broader determinants of health (comprehensive health history and enrollment process)</p> <p>Willingness to participate in research process; function as member of “living laboratory”</p>
Create structure	<p>Create administrative structures to enable the vision</p> <p>Acknowledge conditions and services that support self-healing beyond the walls of the clinical setting</p> <p>Understanding impact of physical space on healing</p> <p>Have access to stable funding; ability to attract expert clinical practitioners and researchers</p>	<p>Member of a self-regulating profession or professional association—code of ethics; standards of practice; research literacy; continuing competency</p> <p>Willingness to participate in research process; function as member of “living laboratory”</p>	<p>Acceptance of the existing structure as described during the orientation sessions: types of services/practices available; hours of operation; physical surroundings; geographic accessibility</p> <p>Also willingness to provide ongoing constructive feedback toward evolving these components of structure</p>
Measure outcomes	<p>Demonstrate willingness to measure “relevant” indicators of success (i.e. improved QoL or evidence of personal transformation)</p>	<p>Evidence of professional curiosity/interest in understanding the relationship between patient and provider relationships and patient outcomes</p>	<p>Identify (self-expressed) health goals; participate in measurement of outcomes</p>

OHE, optimal healing environment; QoL, Quality of Life.

hypotheses generation, testing and timely feedback of new knowledge.

The opinions expressed in this paper are grounded in the authors’ lived experience of developing, implementing, and evaluating an evidence-based, healing-oriented care program between 1997 and 2003. Although referred to as an

integrated care program, the foundational beliefs and values for this initiative were identical to those embedded in the Samueli Institute’s definition. Accordingly, we discuss some examples of strategies that were used to develop readiness among cocreators of this initiative with reference to the research, literature, and people that shaped the authors’ un-

derstanding of the process. Key facilitators and barriers in the creation of an OHE are examined in the context of “cocreator readiness.”

FRAMING THE DISCUSSION

The term readiness is being used increasingly by holistically oriented clinical practitioners to describe a patient’s ability and willingness to engage in the process of personal transformation.* To date, it is not conceptually well defined in the literature,¹ and its roots are often associated with Prochaska’s Transtheoretical Model of Change.² Historically applied in clinical programs that addressed smoking cessation, weight loss and addiction, readiness is usually described as a “state.” A more recent study in the nursing literature suggests that readiness may be both a state and a process,¹ involving the synergistic alignment of a greater number of variables than proposed by change theorists to date.^{3,†} These variables may range from basic needs for food, shelter, and safety, and a social support network, to family-acquired religious beliefs and values, hardiness, spirituality, literacy, and hope. The authors of this paper found that an expanded concept of readiness provided a useful way to frame the discussion about prerequisites for cocreating an OHE.

The second idea that has been used to frame this paper involves deconstructing the concept of an OHE by looking at it from four distinct viewpoints. As part of a funded workshop to facilitate collaborative, international research on integrative health care delivery, the authors and colleagues proposed that the definition of integrative health care based on existing definitions from the literature be operationalized.^{4,5} We discovered that every paper focused on one or two particular aspects of delivering integrative health care but none proposed a comprehensive definition.

Four clear themes were identified. Most authors communicated something about the values and philosophy of providing integrative health care: holistic in approach, shared decision making between patients and practitioners, emphasis on responsible self-care, and quality of life as an important outcome. Some described integrative health care by its structure: multidisciplinary team approach, shared patient health records, esthetically soothing physical space, and formal linkage with an academic institution. Others focused only on process: how communication between practitioners would take place, what the therapeutic relationship would look like, or of what the patient’s healing journey would consist. Fi-

nally, some authors identified what outcomes would be indicators of success and described how they could be measured.

Despite a seemingly reductionist approach, these themes allow an analysis of a complex concept for the purpose of operationalizing it in administrative, clinical, and research contexts. For this reason, we will also use this approach to frame the following discussion.

ASSESSING READINESS IN DECISION MAKERS

Compared to patients and clinical practitioners, administrative decision makers are often overlooked as cocreators of OHEs. However, their leadership role in developing the vision for an OHE from a set of defined beliefs and values, and then creating an administrative structure to enable that vision, is an important one. First, an experiential understanding of integration is a critical prerequisite for administrative decision makers of OHEs. Tataryn and Verhoef⁶ supported this view when they described the need for integration to occur simultaneously at a number of different levels in order to support a truly integrative health care system. The Samuelli Institute definition of an OHE also recognizes that healing “is facilitated through the development of proper attitudes and intentions in both the provider and the recipient.” As cocreators of an OHE, administrative decision makers must be considered providers by extension. For these leaders, engaging in “transformative, self-care practices that facilitate personal integration and the experience of wholeness and well-being”[‡] is integral to the level of advocacy in which they will likely engage.

Administrative decision makers must feel safe enough in their professional environment, and committed enough to the philosophy and values of an OHE, to challenge the status quo when required. Criteria for assessing this might be a demonstrated willingness to measure relevant indicators of success (such as improved quality of life or evidence of personal transformation), in addition to conventionally prescribed outcomes, which generally measure the financial viability of a program. Another example might be the support of primary program goals that favor healing, without losing sight of cure as a priority where it is possible. Acknowledgement of conditions and services that support self-healing beyond the walls of the clinical setting (e.g., love and companionship, forgiveness, spirituality, sense of purpose, meaningful employment, literacy, and geographical access) is another indicator of readiness to create an OHE, as is an understanding of the impact that physical space has on healing.

A decision maker’s access to committed and stable funding is also an indicator of readiness to implement an OHE.

*Mulkins AL, Verhoef MJ. Transforming experiences among cancer patients: Barriers and facilitators. (in preparation).

†Post-presentation discussion with Koithan MS and Warber SL about concept of “readiness” and assessing readiness re: facilitating personal transformation and changes in health behaviour. November 2003, London, UK.

‡Samuelli Institute definition of OHE extracted from letter of invitation/background document July 28, 2003.

The ability to attract expert clinical practitioners and researchers at start-up, especially to work within experimental models of care delivery and research, is easier when financial commitment is visible. When any new health care initiative is unable to plan strategically beyond 1 year because of financial uncertainty, survival tactics tend to supersede strategic visioning. In a qualitative study of clinical practitioners working in an integrative health care setting, “financial instability” was listed among the top five barriers to creating an OHE.⁷

ASSESSING READINESS IN CLINICAL PRACTITIONERS

While characteristics of readiness among clinical practitioners can be assessed across all four perspectives of an OHE—philosophy and values, structure, process and outcomes—philosophy and values are of key importance and probably the most difficult to assess. As with administrative decision makers, experiential understanding of integration is a critical prerequisite for clinical practitioners working in an OHE. Practitioners who have a balanced life in terms of nurturing their own mind, body, and spirit are better able to role model a healthy lifestyle for their patients. Those who are aware of their own personal transformation or “healing journey,” particularly if it was triggered by a health crisis, usually demonstrate a greater capacity to facilitate that same awareness for patients. Other philosophies and values that are congruent with both the Samuelli definition of an OHE and characteristic of those practitioners we would consider “most ready” to cocreate an OHE include: a belief that all people have an intrinsic ability to heal; an understanding that personal transformation can be facilitated, but not prescribed; a belief that “intangibles” such as hope, expectation, conscious intent, and love can significantly impact healing; and a deeply held respect for diversity.

In our experience, initiating an OHE using a combination of the self-regulating professions establishes a professional structure in the clinical setting. Self-regulated professionals include chiropractors, massage therapists, naturopathic physicians, registered nurses, clinical psychologists, medical doctors, registered dietary nutritionists, registered music and art therapists, acupuncturists, and doctors of Traditional Chinese Medicine. Continuing competency, ethical behavior, standards of practice, and research literacy are some of the components that contribute to the professional capacity and legitimacy of an OHE, and could be used as criteria for assessing readiness among clinical practitioners. It has also been our experience that clinical practitioners who reject professionalism as being too “mainstream” are not ready for an OHE.

Listening and verbal communication skills, while important, are not on their own criteria for readiness. The willingness to view these skills as a tool—necessary to forge therapeutic relationships—is key. While feeling heard is of-

ten cited as being “the strongest medicine,” true criteria for readiness is the practitioners’ recognition of communication as a powerful healing intervention, and their commitment to ongoing skill development in this context.⁸ Clinical practitioners who resist examining their communication practice and plead “unconscious competence”⁸ as a result of extensive clinical experience, are also not ready for an OHE.

Readiness to work in an interdisciplinary style is a complex prerequisite that can be assessed in a number of ways. From a structural perspective, establishing a credentialing policy for the OHE permits an objective assessment of the practitioners’ education and experience, and facilitates monitoring of issues such as licensure, insurability and continuing competency.⁹ As there is a scarcity of literature available that addresses clinical team building for an OHE, administrators and funders tend to theorize about optimal hiring practices while relying on a conventional, human resources approach. However, readiness to participate as a member of an interdisciplinary team relates more to process than structure, and involves the assessment of subtler practitioner characteristics.

When hiring for our own facility, the Tzu Chi Institute’s Integrated Care Program, we found that a lengthy but informal group interview process provided a good initial opportunity to “see” the prospective practitioner. Characteristics of a potential provider/colleague we identified as being supportive of an OHE include: previous positive experience providing health care within a collaborative, team-based model; a demonstrated preference for “listening” rather than “telling”; self-confidence complemented by a modest ego; curiosity and evidence of life-long learning; positive recognition by professional peers; and evidence of precontemplation about OHEs/integrative health care and/or ability to articulate a personal vision of OHE. Characteristics that we learned detracted from an individual participating in an OHE included defensiveness about professional self-worth, expression of territoriality around scope of practice, and evidence of painful or prolonged employment within a marginalized health profession.

ASSESSING READINESS IN PROSPECTIVE PATIENTS

The real question about readiness in prospective patients of an OHE is not, “Are they ready?,” but “How will we recognize readiness?” and then, “How can we facilitate readiness?” Armed with the ability to recognize readiness, administrative decision makers and clinical practitioners may be able to improve health outcomes by facilitating readiness through program orientations or intake processes, or at least

⁸Plenary presentation by Dr. David Reilly MD, FRCP, MRCGP, FFHOM, Lead Consultant Physician, Glasgow University, Scotland, UK at Tzu Chi Institute conferences Art and Science of Healing II: Integration of Conventional & Complementary Medicine, Vancouver, British Columbia, Canada: October 2001.

⁹Credentialing policy developed for the Tzu Chi Institute for Complementary and Alternative Medicine 1998.

accurately target those patients who are most likely to do well in an OHE.

Through our experience of enrolling and providing integrative health care services to close to 1500 patients at the Tzu Chi Institute, we were able to confirm that people seek unconventional/innovative health care services for a wide variety of reasons. Some are disillusioned by their experiences in the conventional health care system and are looking for an alternative. Others seek the elusive “silver bullet” cure for persistent health concerns. Most, however, have some notion of what an OHE might provide for their needs. Common themes identified through our research⁹ included the opportunity to engage in shared decision making with care providers, access to current, credible information about complementary and alternative therapies, enough time to “tell their stories” and support for taking an integrative approach to their own health.

We learned that the more closely aligned a patient was with the philosophy and values underpinning our program, the greater their satisfaction with the experience. After this realization, we hypothesized that alignment of philosophy and values might also be a predictor of positive health outcomes. As a result, orienting prospective patients to the philosophy and values of a clinical program became part of the standard process at the Institute. As described in the Samuelli definition of OHE, we initiated “conscious development of intention, awareness, expectation and belief in improvement and well-being” on enrollment and reinforced these themes throughout the relationship. Clients were reminded on a regular basis that health is hard work, and that there are no silver bullets in any health belief system.

Similar to other integrative clinics, the majority of patients seeking care at the Tzu Chi Institute was living with chronic illness and presented with complex health histories. Physical, emotional, and sexual abuse was common, as was disordered eating and chronic pain. Nearly 70% of our patients reported three or more health concerns for which they were seeking treatment.⁹ Readiness in this population was often related to the burden of illness the patient was experiencing (e.g., fatigue, economic hardship, feelings of hopelessness and helplessness), and the existence of a functioning social support system. Therefore, assessing readiness meant considering the broader determinants of health when facilitating goal setting with patients experiencing a high burden of illness, and also determining ways to support healing beyond direct clinical interventions. Creating access within the OHE to a social worker, employment counseling, spiritual counseling and mind–body programs that invite the participation of “significant others” are some of the ways we considered to expand the support.

RESEARCH AND LEARNING: ADDRESSING “GAPS” IN READINESS

The Tzu Chi Institute’s Integrated Care Program, as an example of a developing OHE, provides a useful overview of

what is required to define and operationalize a complex concept. Using our framework to assess readiness of OHE in our cocreators facilitated the identification of “gaps” and assisted in planning ways to address them. The main “gaps” in readiness we experienced at start-up were: cocreator agreement on mission and vision; stability of leadership and funding; undefined or poorly defined foundational concepts (transformation, therapeutic encounter, integrative, whole systems approach); research literacy/capacity among clinical team and an undefined patient population. These early gaps in readiness reflected underdeveloped understanding or lack of clarity about the philosophy and values and structure of the program.

These gaps were addressed at the decision-maker level by attracting strong administrative and research leadership, developing a feasible business plan and honing the vision and mission to focus on “the transformation of health care from an illness and technology-centered model into a wellness, patient-centered orientation that understands and empowers the integration of mind, body, spirit and community into health care.”¹⁰ Early external influences on this process included the mind–body literature and strong clinical leadership from a practitioner who attended training programs with James Gordon, M.D., and Jon Kabat-Zinn, Ph.D., and conversations with John Weeks about integrative health care as a principles-based industry. Networking with members of the Collaboration for Healthcare Renewal Foundation, many of whom were struggling with the same developmental issues, confirmed that we were not alone in our thinking. In terms of conceptualizing integration, Tracy Gaudet’s article on integrative medicine¹⁰ as an emerging field and Tataryn and Verhoef’s⁶ papers on levels of integration were relevant references and aligned with our vision.

As enrollment grew and the program developed, readiness gaps around processes and the measurement of outcomes became more apparent. How long should our relationship with patients last? Do we define our program as consultative or primary care? What is the best way to facilitate exchange of clinical knowledge and patient information between practitioners? Are our patients’ expectations being met? Are they realistic? Is there a cost benefit to the type of care we are providing? Are we making a difference?

These questions and many others were addressed by the creation of a “living laboratory” approach to knowledge generation and knowledge transfer.¹¹ The goal of the living laboratory approach was to create an in-house research/practice cycle that allowed for continual, evidence-based evolution of the Integrated Care Program with subsequent knowledge transfer and knowledge uptake. Over the time period the clinic was open, data were collected using a variety of methods and representing a number of cocreator perspectives. Analysis of those data addressed issues of relevance for patients and potential patients, clinical practitioners and administrative staff by providing ongoing direction for developing various aspects of the program. It also capitalized on the Institute’s onsite library and professional librarian services that formed the basis for a feasible, relevant research

agenda. Internal influences on this process included strong mentoring by a senior research associate in combined quantitative/qualitative approaches to research, and attention to the research questions that arose directly from practice at the Institute.

External influences in creating new knowledge specific to their gaps of understanding included the emergence of whole systems research methodology for the study of integrative health care, beginning with the article by Bell et al.¹² and complemented by an international workshop on the topic.¹¹ In addition, hosting two international conferences^{**} enhanced the Institute's opportunity for networking and sharing found wisdom with others engaged in similar OHE pursuits.

We believe the following list of hypotheses are cogent to our focus and are worthy of funding of research directed toward the collection of data:

1. The greater alignment a patient has with OHE philosophy and values, the more positive his or her health outcomes will be.
2. Burden of illness (e.g., economic hardship, fatigue, pain, mobility issues, and depression) is the most likely reason for people to abandon OHE care.
3. There is a positive correlation between a clinical practitioner's experiential understandings of integration and transformative, self-care practices and improved health outcomes among their patients.
4. Using a concept such as "readiness" to focus the assessment, planning, and implementation of OHE in clinical settings results in a more efficient use of resources and a shorter start-up phase than not having a focus.

CONCLUSION

Creation of an OHE in a clinical setting is a multifaceted undertaking and subject to a wide variety of developmental influences. While comprehensive definitions for OHE, such as the one proposed by the Samuelli Institute, might provide sufficient guidance for communicating philosophy and values and developing patient-practitioner processes for an OHE, direction for creating a supportive administrative structure or establishing an evaluation/research strategy is less obvious. Operationalizing the concept of OHE by breaking it down into components—values, structure, process and measurement of outcomes—proved to be a useful frame-

work for analyzing the evolution of the Integrated Care Program at the Tzu Chi Institute. Future OHE initiatives may benefit from using this type of framework to assess readiness among cocreators prior to development and implementation, as a guide for ongoing evaluation of OHEs postimplementation and as a basis for comparing OHEs across a variety of clinical settings.

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¹¹International workshop on Research Methods for the Investigation of Complementary and Alternative Medicine (CAM) Whole Systems, Vancouver, British Columbia, Canada: October 2002.

^{**}International conferences held by the Tzu Chi Institute. *Art and Science of Healing I* (1998) and *Art and Science of Healing II: Integration of Complementary and Conventional Medicine* (2001), Vancouver, British Columbia, Canada.