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Healing, Medical Care, and Health Service Organizations

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ABSTRACT

This paper reviews the reasons for disappointing health results from U.S. medical care, and prescribes values for health service organizations (HSOs) that will provide a foundation for better medicine. Although the United States spends more money that any other country in the world on medical care, it ranks twenty-sixth in major indicators of population health. One reason for this is inequality in income distribution and other issues relating to social justice. Lack of access to medical care and the poor quality of care that is often rendered may also damage population health. A key component in the movement for improved medical outcomes is the concept of healing care in contrast to curing disease. Patient-centered approaches such as those advocated by the Institute of Medicine to improve medical quality and reduce medical error may provide a bridge to a healing environment in HSOs. A research program on the optimal healing environment must study issues of cost, access, and quality to support successful, broad-based integration of such programs in HSOs. Key research questions on these topics are proposed.

INTRODUCTION

The United States has the most expensive health care system in the world, but the people of America are not as healthy as people in other countries who spend far less on medical care. This paper reviews the reasons for these disappointing results and prescribes values for health service organizations (HSOs) that provide a foundation for better medicine. A key component for this transition to improved medical outcomes is the concept of healing care in contrast to curing disease. Patient-centered approaches such as those advocated by the Institute of Medicine (IOM) to improve medical quality and reduce medical error may provide a bridge to a healing environment in HSOs. A research program on the optimal healing environment must study issues of cost, access, and quality to support successful, broad-based integration of such programs in HSOs.

Why would an HSO focus on healing instead of providing medical care? The status quo's disappointing results from medical intervention is reason enough to ask this question. HSOs have the primary objective to provide and finance medical care. The fundamental building blocks of these organizations are hospitals, provider offices, and specialized care facilities such as hospices, home care agencies and clinics. Although there are many secondary missions and stated priorities for these organizations, evaluation of how the health care dollar is spent supports the contention that providing medical care, curing disease and dispensing technology are the central foci of these organizations. At least 14% of the U.S. gross domestic product, or approximately $1.4 trillion dollars, was spent for health services in 2001, the vast majority for personal medical care.[1] In fact, by some estimates, 40–50 cents of the worldwide health care dollar is spent in the United States. Over 60% of this is spent on physicians and hospitals, although other elements such as pharmaceutical expenditures and payments for complementary and alternative medicine (CAM) have recently increased.[2,3]

Public opinion might assume the United States is the healthiest country in the world because we spend more per capita than any other country in the world on medical care. Only recently, has the concept that health equates with medical care been challenged.[4] The blatant failure of our investment in medical technology to create health is shown by spiraling rates of diseases resulting from lifestyle dysfunctions such as obesity. The health status of Americans lags behind other countries that spend far less on medical care. Life expectancy is an obvious

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example. The United states ranks twenty-sixth among the 166 countries that report these types of data,[5] yet we are the top world consumers of medical technology.

There are many reasons for these disappointing results. First, health and healing on a population level are more dependent on social determinants of health than medical care. Income, education, social support, personal safety, and lifestyle have far more to do with health than health services.[6] The best and most healing medical care in the world cannot compensate for poverty and poor living conditions. For example, a person is unlikely to adopt jogging if there is a good chance of being shot when they leave the house. Stress and overwork have become pernicious features of the American lifestyle, evidenced by the longer work week and fewer vacation days compared to our European counterparts. Recent increases of the number of Americans living in poverty do not bode well for improved population health.[7]

Second, even when medical care can produce health, it is unequally distributed. In a March 2003 Bureau of Labor Survey, only 45% of workers in private companies took advantage of employer-sponsored insurance.[8] Over 16.5% of the U.S. population under the age of 65 lacked health insurance in 2002, and the number of people without coverage is expected to increase further. These are the people more likely to die of treatable illness.[9]

Finally, health and healing have not been the goal of U.S. medical care. The organizational changes in health care during the past decade have been to control cost through the use of managed care. For-profit health maintenance organizations (HMOs) have proliferated.[10] The varied nature and confusing nomenclature for these organizations was reflected in the alphabet soup common in the 1990s (e.g., IPO, HMO, PSO, PPO). Subsequently, a managed care backlash followed, resulting in government regulation mandating certain aspects of consumer protection on a piecemeal basis that has little to do with improving comprehensive care. Intrusive regulations that take on specific issues such as length of stay postdelivery or mastectomy may be popular, but they do nothing to reform the industry values. From a systems point of view, the result is skyrocketing expenditures and increasing requirements for patient cost sharing. The pervasive focus on technology and cure of illness distracts from a more holistic approach that prevents illness and supports well-being. As a result, many opportunities to facilitate mental and physical wellness are missed.

A recent survey of Americans showed that 54% are dissatisfied with the overall quality of health care in the United States, and this has increased 10 points since polls were taken in the year 2000.[11] A new vision is desirable. What is the "optimal healing environment," and is it a useful conceptual model for an HSO to improve health care? The leaders of this symposium have defined a healing environment and the operational components that are necessary to realize this vision. For health services organizations, they include empowered patients, satisfying emotional interactions with patients and staff, excellent communication, a focus on lifestyle, and a choice for patients to integrate complementary providers into their routine care.

There are elements of this model that overlap with other efforts to improve the quality of medical care and reduce medical error. These movements seek to direct medical care back to a focus on the patient and their well-being. To achieve this redirection, specific values must be embraced by the HSO. As amplified below, these values include the ethical management of money, striving to put the patient first, recognizing the importance of community in health care, and a commitment to recognizing the importance of mental health in achieving physical healing.

FINANCIAL VALUES

Financial incentives can foster or hinder healing relationships in health care. Double-digit increases in insurance premiums will reinvigorate efforts for cost control.[12] Some for-profit companies have been shown to provide medical care with less patient satisfaction than nonprofit companies.[13] There are at least two ways the financial picture of the institution can damage healing. The first is over-use of harmful medical procedures because they are reimbursed fee-for-service. The allegations against Tenet Health present an extreme example of what may be the effect of financial incentives stimulating gross excesses in heart surgery and thus patient harm.[14] In the opposite scenario, some managed care companies have attempted to shorten provider visits and restrict benefits to the point that essential services are difficult to access. In these two extremes, HSOs focus on managing money instead of managing good medical care. Thus, the healing environment is secondary to other corporate priorities.

The vast majority of HSOs in the United States are dedicated to good patient care and responsible financial management. Because bankrupt organizations cannot provide care, financial incentives properly constructed will facilitate the healing environment. Financial incentives can improve the quality of care and install less toxic approaches to medical care by restricting or eliminating access to procedures and medications that may be harmful or excessive. The recent literature is replete with examples:

1. The extensive use of fetal monitoring may have increased morbidity in labor and delivery.[15]
2. Randomized controlled trials of arthroscopic knee surgery for osteoarthritis show that this expensive and widely used procedure is no better than a placebo.[16]
3. Long-term hormone replacement therapy for postmenopausal women has greater risks than benefits.[17]
4. A comparative evaluation of mammography in the United States and the United Kingdom showed that although cancer detection rates were roughly equal, the U.S. patients were more likely to be recalled for procedures such as

biopsy, ultrasound, and further diagnostic imaging.[18] More procedures did not lead to better care, and in fact the increased use of surgical procedures without improved cancer detection could be expected to produce medical harm.

5. Health services utilization for Medicare beneficiaries vary based on reimbursement and region, and have little correlation with quality and outcomes.[19] A business case can be made to shift resources from conventional care to unconventional approaches if these support natural healing with less toxicity. Healthy financial values within health services organizations will stimulate research that guides this process.

PATIENT-CENTERED LEADERSHIP

There is increasing awareness that the administrative leadership of HSOs are essential collaborators in the quest for good medical care. Early in the history of hospitals and clinics, the administrative arm was viewed by the clinical staff as a necessary evil for the purpose of billing and reimbursement. Recently, managers of HSOs have been assuming tasks that improve the patient's care experience. One of the best examples of this is the movement to reduce medical error and improve the function of U.S. health care. A truly healing environment cannot occur in an error-prone medical center because of the physical and psychologic harm that result from medical injury. Recent estimates suggest that at least 30,000 deaths occur each year with over $9 billion in costs because of medical injury.[20] Other estimates are higher.[21] Although some of this is unavoidable, health care providers alone cannot eliminate error because tools to report mistakes and reduce errors are dependent on organizational solutions. The first value the organization must adopt is to put the patient first. Initiatives to improve patient safety are the ground floor of this movement. Healing in the comprehensive sense may be the highest aspiration of patient-centered medicine.

COMMUNITY INVOLVEMENT

Healing is one road to health that can happen collectively at the level of society or at the level of the individual. In the ideal setting, HSOs operate at both levels. They must have substantial involvement with the community they serve for several reasons:

1. Nonprofit health centers are actually given tax advantages to stimulate community work.
2. Community health needs will determine some of the services that should be available in the HSO.
3. Needs assessment can determine if behavioral problems such as alcoholism, tobacco addiction, and obesity are prevalent in the communities served.
4. Psychologic barriers to health and healing often can affect whole communities. Dealing with violence and disaster are extreme examples when hospitals and clinics may be asked to provide comfort and psychologic support to help communities heal from acute trauma.

On the other hand, HSOs will not have every resource their patients need for all aspects of health promotion. Community-based support groups, minority counseling services, senior service organizations, transportation, and spiritual resources are only a few of the community resources that HSOs should identify for the purpose of patient referral.

THE MIND–BODY CONNECTION

Mind–body medicine may be one of the most neglected aspects of medical practice. In an effort to correct this, the National Institutes of Health are attempting to stimulate research in this arena. A recent request for applications (RFA) states, "The Public Health Service has documented that many of the leading causes of morbidity and mortality in the U.S. are attributable to social, behavioral, and lifestyle factors (e.g., tobacco use, lack of exercise, poor diet, and drug and alcohol abuse). Numerous studies have also documented that psychological stress is linked to a variety of health outcomes, and researchers and public health officials are becoming increasingly interested in understanding the nature of this relationship. Research has shown, for example, that psychological stress can contribute to increased heart disease and decreased immune system functioning. Other research has demonstrated that cognitions (attitudes, beliefs, values), social support, prayer, and meditation can reduce psychologic stress and contribute to positive health outcomes."[22]

In support of the above perspective, a recent evaluation of depression management in the context of arthritis found that an intervention to manage depression improved pain and function.[23] Mind–body practices as well as conventional mental health efforts can also support lifestyle changes separate from their potential direct health benefits. Counseling concerning weight loss and smoking cessation are two examples. The paradox of this renewed interest in the mind's influence on physical health is that conventional psychiatric services have been progressively defunded over the past decade. As a result, there have been closures of private outpatient clinics, reduction of private inpatient beds, and loss of public psychiatric hospitals.[24]

Among the conventional models for the integration of healing into HSOs are the IOM Model for A New Health Care System described in *Crossing the Quality Chasm,* and the MacColl Institute for Health Care Innovation's model for Chronic Illness Care. Both embody many of the concepts of the OHE. In *Crossing the Quality Chasm*, the IOM[25] formulates new rules to redesign and improve care. These rules recognize the importance of healing relationships in the

overall quality of health care. Implementation of these rules will require teamwork between administrative systems, caregivers, and patients (Table 1).

The IOM vision of patient-centered care is enhanced by effective communication outside the patient visit. This is innovative in that the health care provider no longer is cast in the role of the ultimate authority. An organizational framework is created in HSOs that supports healing by the continuous opportunity for communication, transparency of interaction, and collaborative plans to improve patient care. Thus, motivated administrators support care givers to create a continuous healing relationship with their patients. These institutes and models of care are based on creating a "system" of support with the goal of creating an informed and activated patient who has productive interactions with prepared practice teams.

At the core of these efforts is a "continuous healing relationship" between provider and patient. The qualities that are emphasized by the more conventional models are patient education, varied methods of communication outside of the provider visit and organized provider teams. In the OHE model, more emphasis is placed on compassion, listening, empathy and understanding. Some of the OHE values may be too subjective for some conventional care organizations. Yet, most would aspire to the ideal of healing if a tangible way to teach these qualities were developed.

THE MODEL OF INTEGRATED DELIVERY

Vertically integrated delivery systems incorporate all levels of care from primary to tertiary care, and the facilities and staff necessary to provide this care, under one organizational roof.[26] Thus, whatever a patient needs from cradle to grave will be covered by readily available services. In theory, this gives maximal opportunity for quality control and effective resource utilization because system-wide changes are possible to make through the network of a central administration and a global budget. Such an approach often limits choice to a defined network of providers and services. This fact may explain why less than 5% of the country is covered by staff or group model HMOs that offer fully integrated services. The opportunities for organized care delivery systems to create new models of care are substantial. In fact, group-model HMOs have been industry leaders in providing a variety of preventive services such as smoking cessation, mammography, screening for sexually transmitted diseases, and diabetes counseling. The presence of data systems, a wide spectrum of services, clear organizational values, and a commitment to preventive care make these institutions reasonable choices to both study and implement new models of healing care.

TABLE 1. INSTITUTE OF MEDICINE'S SIMPLE RULES FOR THE TWENTY-FIRST CENTURY HEALTH CARE SYSTEM

Current approach	*New rule*
Care based primarily on visits	Care is based on continuous healing relationships
Professional autonomy drives variability	Care is customized according to patient needs and values
Professionals control care	The patient is the source of control
Information is a record	Knowledge is shared and information flows freely
Decision making is based on training and experience	Decision making is evidence-based
Do no harm is an individual responsibility	Safety is a system property
The system reacts to needs	Needs are anticipated
Cost reduction is sought	Waste is continuously decreased
Preference is given to professional roles over the system	Cooperation among clinicians is a priority

THE INTEGRATIVE MEDICINE MODEL

The term "integrative medicine" usually refers to a blend of conventional and unconventional medical practices with a goal of providing a broader array of desirable services. The National Center for Complementary and Alternative Medicine defines CAM as a group of diverse medical and health care systems, practices, and products not presently considered to be part of conventional medicine. Kaptchuk and Eisenberg[27] further note that these are healing practices used by the general public as well as practices used by specific ethnic or religious groups. A number of studies demonstrate that the use of unconventional medicine is common in the United States. The study by Eisenburg et al.[3] indicated more than 40% of the population had used CAM during the previous year. At the very minimum, a conventional health services organization must open its awareness of unconventional medical practice because CAM therapies may interfere or interact with conventional treatment.[28]

People use CAM in search for healing, and recent studies have validated some of this use. The need for symptom relief and the presence of a poor health status have been shown to correlate with CAM use.[29] Inclusion of some of these services supports patient choice in how to pursue healing for specific medical conditions. Patient receptivity may be correlated with improved results.[30] For example, recent trials and recommendations support the use of massage for symptomatic relief of pain. Acupuncture helps with nausea and vomiting postchemotherapy.

HSOs must integrate services on a case-by-case basis in a fashion that is consistent with their organizational values and emerging efficacy data. In Washington State, CAM insurance coverage is mandated by state law for licensed providers, resulting in CAM providers achieving a legitimacy that has heretofore eluded many CAM practitioners.

The most common practitioners to be licensed include chiropractors, acupuncturists, naturopathic physicians, and massage therapists. High levels of patient satisfaction with CAM providers[31] indicates that, at minimum, patients feel well treated by the provider interactions. However, many CAM treatments have too few efficacy data published to make sweeping generalizations about the benefits of use. The same may be said about many conventional treatments, some of which are expensive and toxic. At the very least, if CAM substitutes for more toxic treatments, improved care results.

The distinction of the OHE is its attempt to create a system that merges invisible values such as empathy with more concrete delivery issues such as data systems. Research is necessary to determine if an OHE can be valuable to an HSO. Health services research is the study of cost, access, and quality of health care delivery, and is applicable to this imperative. A few of the health services research questions follow:

1. Is it possible to create healers, providers, and administrators through specific training programs? An operational model for OHE provider training could be developed that allows evaluation. It could combine a variety of methods to increase empathy, listening skills, and intention. Such a model could draw on a variety of disciplines. Mind–body medicine holds promise to implement certain aspects of the OHE in HSOs. Meditation, visualization, and integration of spiritual practices could improve intention awareness and wholeness for providers and patients. Many conventional disciplines stressing leadership training, stress reduction and patient education could also be explored. The "OHE-trained or -certified" provider could be a key ingredient to many efforts to improved care. They could also be useful in a variety of nonclinical positions such as patient advocates.
2. Is the OHE an important foundation to patient centered efforts to improve medical care? Fundamental to efforts to improve quality and reduce error is the ability to improve the provider–patient interaction. Measures for improvement start with patient counseling materials and other tools used by organized delivery systems. Although these may be one step behind the ideal process, patient care teams may benefit from training that creates listening skills, empathy and a genuine compassion toward the patient and their issues.
3. Is there a business case for implementing the OHE? Weaning patients and providers alike from harmful and expensive treatments is possible. Recent data on the use of three-tier drug benefits where brand-name products are charged a substantial copay suggest that some patients will stop medications rather than switch to generic drugs. Although financial incentives can steer patients in a particular direction, it is not clear if the addition of patient-centered education and mind–body techniques in the quest to produce a less toxic medical environment would help reduce costs through harm reduction and a change to less-expensive products.
4. Could the OHE model be useful for integrated delivery systems? Fully integrated delivery systems such as Kaiser Permanente and Group Health Cooperative of Puget Sound have many advantages. These organizations highly value clinical practice guidelines, preventive services and appropriate medical care. Unfortunately, these systems of care are the least prevalent forms of health care delivery in the United States. Part of the reason for this is that some patients worry that choices in these networks will be too limited and that poor care will result.
5. Can an OHE-trained staff add to the effective response in the cases of natural and manmade disaster? The OHE-trained provider may have special skills that are useful to the community in the event of a catastrophe. Patient counseling skills, teamwork, and organizational response might all be improved. Testing the utility of these skills in these circumstances could create new resources for disaster preparedness.

There are additional questions that lend themselves to research. They include: collecting data to answer whether integration of the OHE would help both the image of organized care and the practice of rational medicine; whether OHE training would reduce medical error and improve chronic disease treatment; and would a replicable model of the OHE based on client satisfaction find a place in commercial medical markets? All of the above questions are deserving of health services research funding if we are to move forward with data and factual conclusions in our continuing quest to improve the health care of our society and country.

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