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Healing Landscapes: Patients, Relationships, and Creating Optimal Healing Places

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ABSTRACT

Healing can be both an intensely personal and a social and community event that often surprises us when it emerges from the landscape of everyday life. This observation raises at least three questions that serve as the focus for this paper's reflections about creating optimal healing places. Who are patients? What relationships and features of those relationships help patients toward healing? How do we understand and facilitate the emergence of healing over time and place? Using existing literature and our own past and current studies of patients, clinical encounters, and primary care practices, we explore each of these questions. We identify four different aspects or faces of patients: patients as human animals, patients as persons, patients as techno-consumers, and patients as *patiens*. We highlight 10 lessons or observations about patients and their healing experiences. Key features of relational process are described, and nine interdependent relationship characteristics that appear to promote healing are discussed. The idea of healing landscapes as an emergent life space is introduced as a way of conceptualizing and further investigating these observations. A reflective action process for facilitating the emergence of healing landscapes and creating an ecology of hope is presented, and recommendations for future research are briefly shared.

"Landscapes can be deceptive. Sometimes a landscape seems to be less a setting for the life of its inhabitants than a curtain behind which their struggles, achievements and accidents take place."

—John Berger[1]

INTRODUCTION

Healing, the search for wholeness, often surprises when it emerges from the landscape of our everyday lives. How does it happen? How do we understand it? How is it facilitated? How do we recognize and study it? What is discovered when the curtain opens and healing is revealed?

Jorge Morales settled in a rapidly growing urban Mexican immigrant community in the United States when he was in his teens. Jorge took great pride in learning English and going to cosmetology school, believing that independence was important for assimilating into American society. He succeeded, becoming a hairdresser. As a gay male, Jorge was well aware of his risks for contracting HIV, but was nevertheless devastated when he discovered his partner had the disease and was dying. Feeling betrayed and depressed by his partner's infidelity, Jorge ignored his own symptoms until he needed hospitalization; he could no longer deny his own HIV status. As he lay desperately ill and alone in his hospital bed, a group

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of doctors came to his bedside, informed him that he had "full-blown AIDS," and walked away.

Although his body responded to the HIV medicines, his spirit did not. Dejected, Jorge returned home to his rural Mexican roots to live with his mother, but there was little solace to be found there. She understood neither his sexual orientation, nor his disease. She was terrified of catching AIDS and refused to touch him, even insisting that he eat on his own dinnerware and wash his clothes and linens separately. Disconnected and empty of hope, he planned a return to the United States to die. Before leaving, however, his 11-year-old sister tearfully pleaded with him to live for her. "I want you to give me away at my wedding," she said. Clinging to this lifeline of hope, he returned to the United States.

Now that he had something to live for, Jorge sought help in a small inner-city family medicine office near his apartment. Unlike the physicians at the hospital, this new doctor treated him as if he, Jorge, distinctly mattered. Over time, Jorge grew to trust his doctor. He felt this doctor was able to get into his head, particularly when he would say, "Don't you want to see your sister get married?" In return, Jorge worked hard to adhere to his medical regimen.

Meanwhile, Jorge carefully decorated his apartment, giving him a sense of pride and control. His hairdresser trade also provided a place of support and gave him needed self-respect. Over time, and with the persistent intercession of his sister, Jorge's mother gained a better understanding of his life with AIDS, and Jorge was able to arrange for her to move from Mexico into an apartment in his building. While he will never be "cured" from his disease, Jorge has experienced healing.

This story offers a glimpse into part of one person's healing landscape. The story reveals the complexity of being a patient and suggests that healing often involves many relationships and multiple places. Healing appears as a deeply personal experience that emerges from a suitably fertile, relational, social, biological, and cultural ecology, a *healing landscape*, and is not limited to particular clinical encounters and/or health care sites. In this paper, we explore the conceptual and research implications of relational process and healing landscapes for creating optimal healing environments in health care. We reflect on the following three questions: 1. Who are patients and what are their experiences of illness and healing? 2. What relationships and what features of those relationships help patients toward healing? 3. How do we understand and facilitate the *emergence of healing* over time and places? These questions are explored using existing literature, current studies in progress, and our own past work. We conclude with a brief review of the implications for research.

Patients and healing

Jorge Morales is a complex human being. He is an immigrant, gay hairdresser betrayed and infected by his lover, caught between worlds, and struggling within his own family. His healing is hindered by social status, a toxic hospital experience, and a shaming mother but then facilitated by the love of a younger sister, the sharing of his story with an affirming physician, and the satisfaction of being able to work. Jorge's story of healing is remarkably similar to those found in the pathography literature.[2] These self-told tales of healing highlight four different aspects or "faces" of a patient and trace out a distinct patient trajectory within a healing landscape. The four faces include the patient as human animal, as person, as techno-consumer, and as *patiens*. All four of these faces, often conflicted, present in need of healing. A brief look at each face reveals even more about what it means to be a patient.

We are all human animals and share a common heritage of species-specific traits.[3–7] We are storytelling, family-forming, brainy bipeds who are facile with language and symbols, share a long dependency requiring intimate emotional support, and gifted with ecological intelligence for navigating a complex food resource labyrinth and with social/emotional intelligence for navigating the complex political labyrinth of group living. As tool-making scavengers, we cherish technology and have tendencies toward being restless, aggressive, acquisitive, selfish, and easily aroused to anger. We are also tribalists seeking companionship and a sense of fairness and can behave with altruism and compassion, and we experience transcendental consciousness and a deep sense of spirituality. Nevertheless, we aren't a standard package. Each of us is also the result of a complex, locally coevolved biology, but most of us no longer live in the environments for which our physiology was adaptive. We are also cultural animals whose physical experiences of biology are powerfully shaped by social and symbolic force [see Agdal as example.[8] All of these factors influence the illness and healing process.

Each patient is also a unique person. Each of us represents a unique story, a relatively coherent repertoire of context-dependent, socially and self-constructed identities. These arise from a particular weaving of history, family, genetics, communities, cultures, and heroic (mythic) narratives. Somehow, healing must also have an acquaintance with these particulars.[9]

In this era of corporate globalization, there is also the face of the patient as techno-consumer who shops for care via cell phone in search of a satisfaction defined and framed by the marketplace. This face is characterized and energized by a growth fetish, an aggressive capitalist ethic that promotes individualism and is built upon the gap between satisfaction and fulfillment such that identity and happiness become defined by what we own and how we appear.[10–12] The consumer face is easily ruled by desire, prone to litigation, and

often feels entitled to be better than well.[13,14] Consumerism also leads to narrowing the discourses of normalcy such that more and more of us need some type of enhancement or change to feel "normal."[15] These techno-consumer forces also shape the healing process.

The human animal, the person, and the techno-consumer faces are active for both patients and nonpatients. What defines a patient is the fourth face of *patiens*, Latin for "reclined," one who is flattened by life with the experience of a broken body. Patients travel a typical trajectory similar to the hero's journey that moves from uncertainty, where change from "normal" begins to happen, to disruption or crisis and through striving to regain self or seeking help and hopefully ending with regaining wellness (see Fig. 1).[16,17] Patients also share some common dimensions. These include a disruption of the body-mind that threatens dissolution of the self, a loss of self-respect and change in life plans often associated with shame and humiliation, a loss of power, assumption of the sick role as prescribed by society,[18] and a special language of sickness with its associated core narratives.[19]

The four patient faces and common illness trajectory are evident in our depth interview studies of pain and diabetes and our observational study of encounter types. Patients talk about pain through stories and each has their own narrative identity. There is Ann, the "Everyday Heroine" telling "hero stories," tales of her constant heroic struggles with everyday conflicts and sufferings of life and how she keeps overcoming them, and Frank, the "Worker" telling "tough guy stories," tales emphasizing "macho" work ethic and the importance of dealing with what is current. Physicians, on the other hand, spend the first hour of their interviews about personal pain staying in the professional mode before remembering a personal experience of pain that is then described in terms identical to the patients. The professional cloak and routinization of work blocks their access to empathy.[20]

The dangers of routinization of the clinical encounter are highlighted again in a study that sought to understand what influences glucose control in patients with diabetes. An important factor turns out to be an epiphany. For example, a teacher with diabetes observes that one of her second grade students with diabetes abstains from sweets and birthday treats and then resolves to change her own eating habits. Unfortunately, patients are often unable to voice these changes to their physicians as both get trapped inside the routine scripts of their past encounters. These patients often move to new physicians.[21] This study also suggests that patients present with different degrees of readiness for healing transformation. This finding is consistent with that in an observational study of the different types of encounters in a family medicine office. Routines are where patients present with simple, single concerns for which they want restitution to life as it has been (e.g., most "colds," ankle sprain, and so forth). Dramas are where people have complicated concerns and deeper fears and are more open to a series of visits that

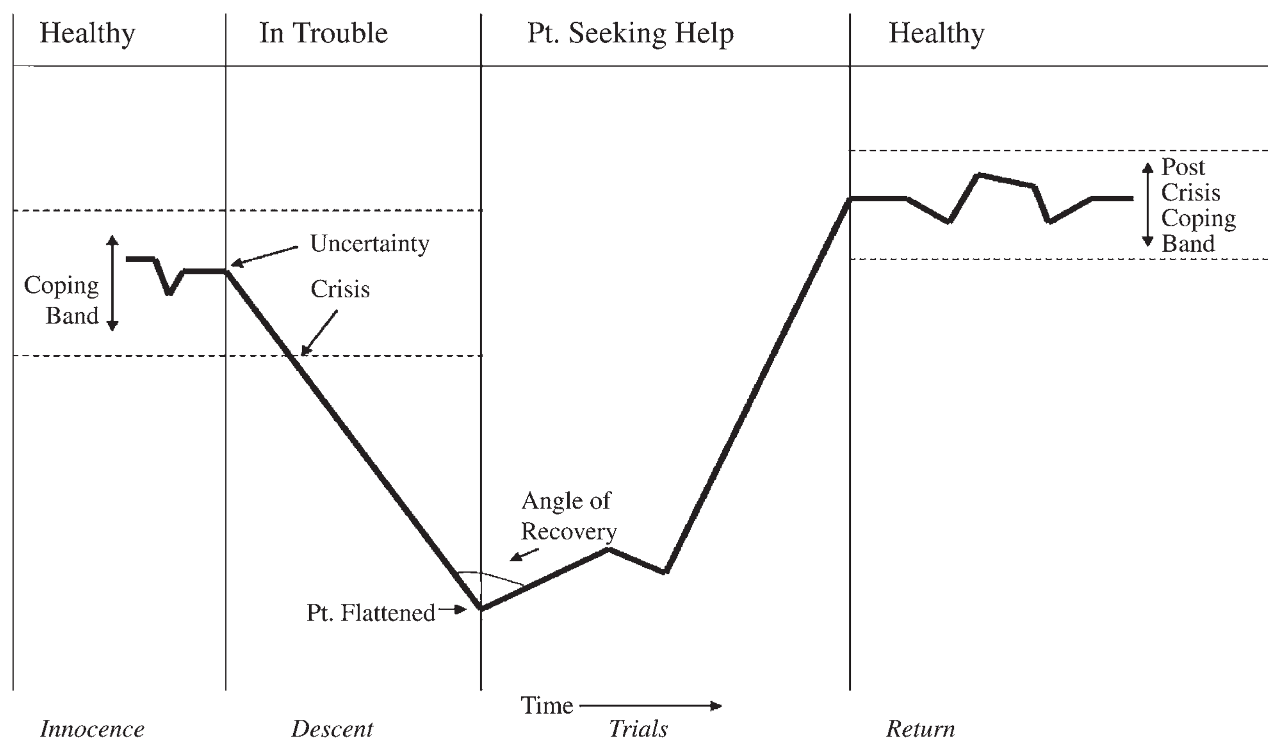

FIG. 1. Patient's illness trajectory.

move towards healing (e.g., new diagnosis of heart disease, change in perception of diabetes, chronic fatigue, and so forth). Maintenance ceremonies are highly scripted and include preventive visits, such as routine gynecology care, well child visits, and chronic care follow-up, where the condition is stable and less open to healing transformation.[22]

This brief exploration of who are patients and what are their experiences of healing lead to several summary observations. Much healing occurs outside the clinical encounter and even outside medical practice. Healing emerges from many different relationships. Because patients are flattened by life, there is, initially, an inherent power imbalance in clinical relationships. Epiphanies that arise from within a patient's life space as part of everyday occurrences often result in new expectations and behavior changes. There is a danger that routinization of self-care and clinical encounters can block empathy and attentiveness to new cues. On the other hand, a source of empathy is the inherent symmetry of clinician and patient; the clinician also has four faces, the fourth being that of *clinikos*, of "making upright." Thus, the clinician has an important but not determining role, suggesting that healing is more likely when the clinician is present at key moments. Stories and goals are at least as important to patients as diagnosis and treatment. It is helpful to address these life narratives and all four faces. We also note the importance of patient readiness for healing and how that influences the clinical encounter. Finally, all of the stories highlight that patients and healing are resistant to standardization. Table 1 summarizes these lessons.

Relationships and healing

At the heart of nearly every healing story is one or more critical relationships. In some cases, the relationships are problematic, as when Jorge encountered the physicians in the hospital. In others, the relationships are transforming as when Jorge's younger sister reaffirmed purpose and connection for Jorge. How can we better understand the relational process? What differentiates healing relationships from others? Some suggestions are emerging from our current research examining both practices and clinical encounters as complex adaptive systems.

Table 1. Summary of Lessons about Patients and Healing Experiences

Multiple Locations for Healing
Many Different Relationships Matter
Four Patient Faces
Patient as human animal
Patient as person
Patient as techno-consumer
Patient as *"patiens"*
Power Imbalance in Encounter
Epiphanies Are Common
Important Role of Clinician
Routinization Can Block Empathy
Clinicians Can Mirror Four Faces of Patient
Stories and Goals are Important
Patient Readiness for Healing and Different Encounter Types
Resistance to Standardization

Our encounter study uses audiotapes of doctor-patient encounters from a sample of family physicians previously identified as exemplars of preventive service delivery Institutional Review Board (IRB)-approved study currently being conducted). An example from this study illustrates what can block healing in a relationship. A middle-aged man with complicated kidney problems, significant work stress, and high blood pressure tells the nurse that he is here for a checkup. The doctor locks onto to that and never engages the patient's painful stories; the doctor just runs the checklist for check-up and preventive services. As the patient talks about his work stress and its possible blood pressure relationship, the doctor says, "Right. Right. Breathe deeply in now. Breathe normal. . . . Hold you breath. . . . Open up. Say, 'Ah.'"

Fortunately, there are also examples of emergent healing. A young woman presents with foot pain for which the physician quickly develops a treatment plan for mild tendonitis until the encounter is disrupted by a comment from the patient's young son who challenges his mother about how many shoes she has. New aspects of her problem emerge, and the treatment plan and follow-up dramatically changes.

The first example demonstrates a commonly observed tendency for clinicians to tightly control the content of encounters and thus cut off the voices of patient complexity and prevent an opportunity for healing. This study also raises the hypothesis that the imposition of technology, prevention technology in this case, can block the emergence of healing. On the other hand, the second example demonstrates how diversity (the addition of a young son) and openness to shared power by the clinician can facilitate the emergence of healing action.

The significance of diversity and openness are affirmed in studies of primary care practices. Able Family Medicine is a two-physician and one–nurse practitioner practice struggling to survive with especially poor communication around clinical operations. They enroll in a practice improvement study using complexity theory models and begin weekly reflection action process (RAP) team meetings. The staff pushes to focus on internal communications rather than patient care problems. Within several months, they all comment on how much better relationships are. They are a happier and more successful practice and able to move onto patient care issues.[23] This example, among many from our 10 years of studying practices and change, highlights that practices can become healthier places of joy and that this is facilitated by action/reflection cycles and focusing on improving relationships.

The relational processes that we have observed represent nonlinear, iterative, reciprocal, self-organizing patterns of

relating (the webs of relationships) and patterns of meaning (stories of change and continuity) that are enacted in the everyday living present of each practice and clinical encounter. The emergence of novelty seems to depend upon the degree of diversity and mindfulness present in the webs of relationships.[24–26] Several specific practical implications of this understanding of relational process are noteworthy. First is the importance of self-awareness, showing up mindfully so that one becomes aware of emergent clues and is able to shift out of routine, let go of control, hold intention lightly, and attend to the process.[27,28] This requires superb communication and relationship skills, such as active listening and positive criticism, as well as creating facilitative spaces where the above can occur. Facilitative spaces are places where defenses can be let down and emotions shared for deepening self-awareness and sensemaking.[29] This could be aided by better management of technology, including limiting technology in the encounter and creating systems external to the encounter that ensure the delivery of preventive services and other guideline-driven protocols of care. All of this, in turn, points to the need for formation of more collaborative teams within practices, across practices, and with the community. This latter could help practices become more heedful of critical healing moments occurring outside the practice.

Many relationships facilitate healing including those with friends, coworkers, family, fellow worshipers, practice staff, clinicians, strangers, and even pets, plants, and animals. It is not only who in relationships that matters but also what. From our studies of practices.[24,25,30,31] the interdependent relationship characteristics that appear to promote healing include mindfulness, respectful interaction, heedful inter-relating, a mix of rich and lean communication, diversity, a mix of social and task relatedness at the group level, and trust. Emotional engagement (empathy) and shared power are important at the dyad level. Mindfulness refers to openness to new ideas and different perspectives, the continuous creation of new categories. Respectful interaction represents honest, tactful, and mutually valuing interchange where each person brings meaning and value to the other. Heedful inter-relating is interaction where individuals are especially sensitive to the way their role and others fit into the larger group and its goals. There needs to be a mix of rich and lean communication. Rich communication refers to face-to-face relationships which are best when messages are highly uncertain or unclear or emotionally full. Lean communications are more impersonal (e.g., e-mail) and better suited for when messages are clear, unambiguous, and emotionally thin. Diversity includes differences in mental models (perspectives, thoughts, and views of world) and in age, gender, and ethnicity. A mix of social and task relatedness is also important. Social relatedness includes nonwork-related conversations and activities that are often based on family and friendships; whereas task relatedness consists of work-related conversations and activities. Finally, trust refers to believing that you can depend on the other and the associated willingness to be vulnerable to another.

Healing is a social and community event, a relational process, and includes family, friends, and workplace along with clinicians and their staffs. Conventional physician-centeredness and an encounter-focus may, unintentionally, act as barriers to healing by preventing team formation, impeding staff empowerment, impairing practice reflectivity, increasing competing demands, deflecting the importance of family and community, and building resentment in the physician, leading to an attitude where the patient becomes a burden or enemy. We see much evidence for this in our encounter and practice studies. Thus, it might be helpful to reframe the clinical encounter as a place to facilitate healing. The encounter may not necessarily be where healing occurs, but it can become an important catalyst for helping the patient move toward healing within their life space, for facilitating the emergence of hope and a healing landscape.

Healing landscapes

A healing landscape is defined as the potential emergent life space, the terrain and particular places and living beings wherein and with whom a patient coevolves, journeys, experiences, and particular relationships and medical care from which healing emerges. Healing is an emergent property significantly dependent upon the degree of healthy relationship-centeredness. The concept of healing landscape shifts the focus from healing in the encounter and/or practice to healing within each patient's life space. Facilitating the emergence of this healing landscape can occur from any entry point and not just the practice.

The healing landscape concept focuses our attention on the multiple relationships that participate in the emergence of healing. Figure 2 illustrates a healing landscape. The circles each represent a place in the patient's environment. The circle within the circle is the facilitative space within a primary care practice. The circles that are slightly overlapping are a hospital and an associated medical specialty office building. The other circles represent the patient's home, workplace, church, wildlife park, and shopping center. The notes and puzzle pieces denote different types of relationships, and more can be placed in all of the circles and along the dotted line "healing pathway." Much of this pathway corresponds to the patient trajectory (see Fig. 1). Thus, there are places, living beings, types of relationships, care activities, and paths that are the possible sources of healing.

Practices and encounters can change to facilitate being more heedful of the patient's four faces and of each patient's healing landscape and to facilitate the healing process throughout it. The healing landscape approach maintains the patient focus of practices while expanding their attention into the community. The practice becomes a personal healing home. The healing landscape becomes a way to accommodate the four faces of the patient. It highlights paths to

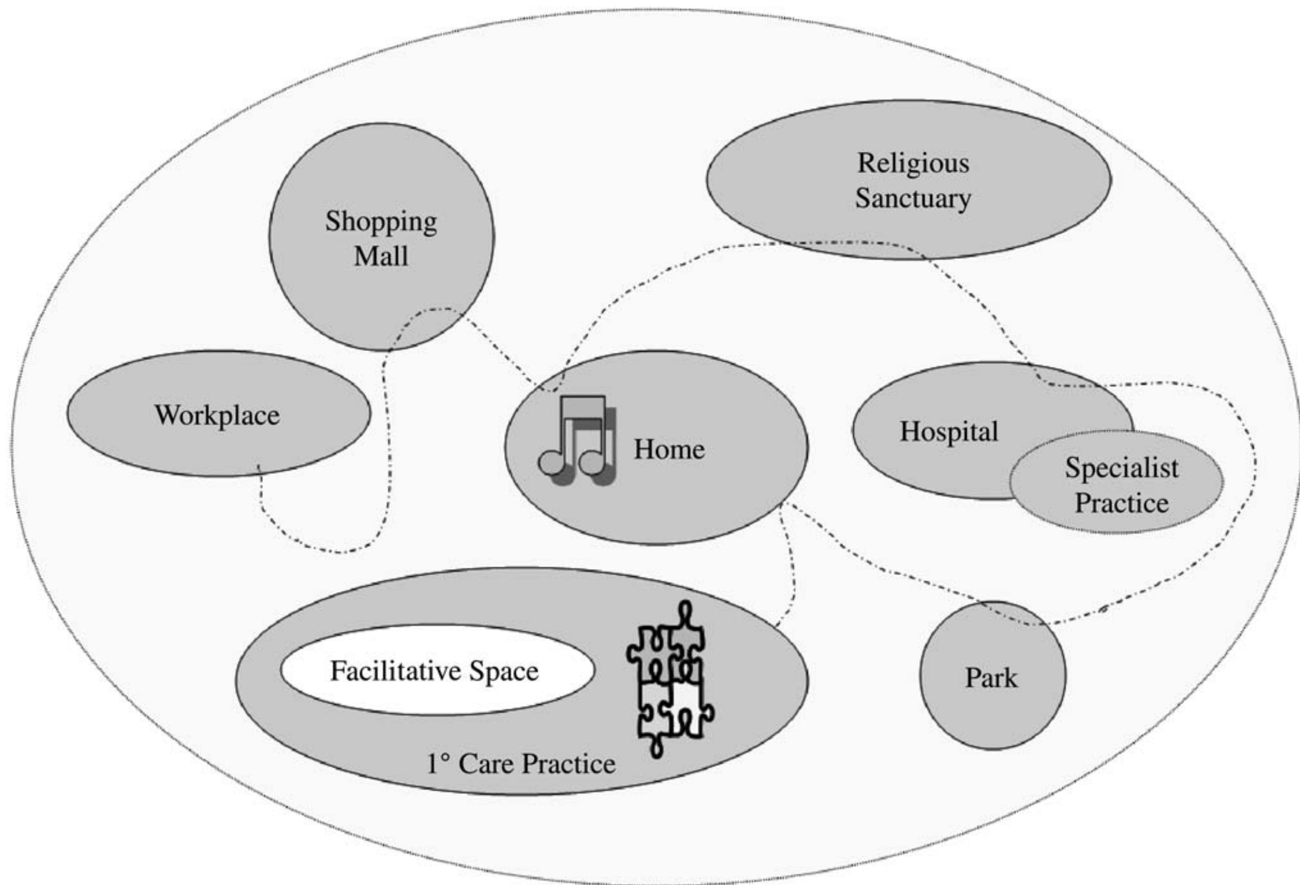

FIG. 2. Illustration of healing landscape.

wholeness, threads that bind together our fragmented selves becoming a way to bring animal, person, techno-consumer, and place together.

Facilitating landscape and practice change

There are many ways to facilitate the emergence of healing landscapes. Some focus on facilitating healthier, more learning-oriented and relationship-centered clinical encounters,[32] while others explore patient activation approaches, group visits,[33] and other ways to increase diversity in the practice and encounter, and information technology, such as Web portals. Our own research has focused on how to help individual primary care practices change toward becoming healthier, more learning-oriented, and relationship-centered environments. The healing landscape concept integrates these into a larger framework—an ecology of hope (see Feudtner for specific strategy suggestions on generating hope within this ecology[34]). We share what we have learned about an approach that centers on engaging practices and their participants in a process for creating the conditions within which the Chronic Care Model and relationship-centered care can be implemented [see Wagner et al.[35]] from which healing landscapes can emerge.

Creating relationship-centered healing places requires paying attention to at least three guiding principles: (1) acknowledge everyone's personhood, so each emerges as a cocreative participant within a landscape; (2) focus on improving relationships among all stakeholders; and (3) recognize that there are multiple ways for a place to become a healing environment. Activating these principles requires the development of supportive leadership and the motivation of key stakeholders to engage in processes that will initially seem very foreign and counter to socialized norms. That is, instead of having a vision that focuses on improved components and improved measurement, have a vision that focuses on increased capacity for learning, improved systems, and richer connections and relationships.[31]

The reflective action process or RAP is a way for implementing these principles by focusing on changing relationship patterns in a practice and stimulating participants to tell different stories that matter locally. The goal is to teach practice participants skills in active listening, mindfulness, emotional intelligence, and positive criticism. In

order to do so, it is essential that the practice create the time and space for learning and reflection. In our work, we have recommended that practices create RAP teams that include diverse representation from all stakeholder groups of the practice, including at least one patient. The RAP team meets weekly for an hour after setting ground rules for respectful interaction. The RAP team can focus on a wide range of topics, including how to balance finances, office operations, and clinical care. Over time, this face-to-face rich communication for group reflection enhances the seven relationship properties noted above, which, in turn, enriches the practice's capacity for change and reflection, its ability to anticipate and prioritize opportunities for change, and its capability of responding to external pressures.[23] Guidelines and more details for implementing RAP have recently been published.[23]

Challenges and research recommendations

To initiate research in this area, it will be necessary to overcome some powerful assumptions that have dominated the research community. Instead of believing that all behavior has a corresponding intention, it is necessary to understand that life is also a miracle, with mystery, gifts, and unintended consequences. Much of science is rooted in linear causation; however, we now know that instead of every effect having a discoverable cause, there is often interdependence and unpredictable, emergent surprise.[36,37] In addition to focusing on accurate transfer of information, we also need to understand the inherent subjectivity and social construction underlying communication.[38]

The characteristics of optimal healing relationships described in this article lead to some specific recommendations for future research designs. Research needs to have a goal of making things better by enabling more skillful and mindful participation in relational processes. That is, research needs to be participatory and collaborative. The recognition that healing emerges in multiple places implies that it will be necessary to create models of healing landscapes (optimal community healing environments) as learning laboratories outside current economic constraints. Research will need to adapt new methods, such as social network studies,[39,40] life space diagrams,[41,42] and borrow tools from other disciplines like ecology, which has experimented with mathematical language for describing the shapes of fitness landscapes or possibility spaces.[38,43,44]

Evaluating the four faces of patients, relationships, and emergent healing landscapes requires more systems-oriented research methodologies. Assessing context becomes as important as measuring effect. Future research needs more mixed methods, including the double helix design with multiple assessments for both process and outcome.[45–47] To study the four faces of the patient necessitates longitudinal studies of patients in practices and communities. Multiple outcome measures are needed for these studies. Measures of functional status, social engagement, and spirituality are examples relating to the human animal. Quality-of-life measures link to the unique person, and patient satisfaction helps to address the techno-consumer. The *patiens* face is measurable using indicators of patient enablement and shared decision making and disease outcome markers.

We need a research program that investigates the components and dynamics of healing landscapes. These include the coevolutionary landscape, the specific places involved in healing, the living beings who act as agents on the landscape, the many types of relationships and the characteristics of them associated with healing, and the context in which that is true, sources of hope, and the many possible paths across a healing landscape.

CONCLUSIONS

A healing landscape celebrates abundance, generosity, compassion, humility, and prudence. These are ancient virtues of good healing practice. The concept of healing landscape also reminds us that healing isn't just about a specific individual; healing concerns enhancement of life overall on the landscape. Healing is about making good ripples. A healing landscape is a learning landscape, a terrain where hope flourishes over time. How do we cocreate multiple optimal healing places such that a patient's landscape becomes an ecology of hope, like Jorge's, where healing can more easily emerge? How do we discover wholeness within the four faces of each patient? Maybe our most challenging question on the quest for optimal healing environments is how to have technology serve healing and the spiritual in a consumer-dominant world. Where, on healing landscapes, does one do the spiritual work and where the technological? How do we foster the development of more hopeful and healthier connections and relationships? We have searched for too long and broken too much on a narrow path of reductionism and perfection. Returning to wholeness calls forth an ecology of hope.

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