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A New Paradigm for Health Care delivery

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Introduction

My first essay [ ], explored the definition of wholeness, for healing involves attaining the experience of the whole. In psychotherapy it is defined as healing the psyche, psyche is defined and the relationship of psyche to the whole is discussed. Two paradigms are presented: the medical model which offers an inadequate model to explain how the psyche and the soma are interrelated, and an older system of healing defined in terms of the archetype of wounded healer. The meaning of wholeness within the archetype of the wounded healer is discussed in terms of the Aggada of the talmud, the shaman and modern therapists.

In part II, I reflected on the cerebral underlying networks that explain psychosomatic disorders then show how brain imaging revealed structural changes. Reviewing key contributions to our recent understanding of the blurring of neat distinctions between psyche and soma the ground has been set for my claim in this last essay.

This will then support my thesis below, that intangible interactions found in the therapeutic encounter described in holistic sources may also apply to somatic hard core medical diseases.
With much gratitude to the work of Christopher Alexander in a field far removed from medicine (architecture), the concept of the nature of order and structure and the need for contentment, wholeness and beauty as fundamental core needs central to the design of a project made me aware of the possibility for such intangible values to be possible in the therapeutic encounter as well.

His work describes a revolutionary vision of the human environment: one which will, in coming eras, be conceived, designed, built, made, and widely understood as a necessity of emotional and social life. This will inevitably change the way we conduct ourselves in all the arts of building.

From the very beginning of the building project described in this book, we intended to show that architecture can bring life to a community — indeed, that it is necessary in order to help the community come to life. Thus, we mean to show how the physical fabric of the buildings plays a necessary and unavoidable role in the success of a community. ...

The purpose of all architecture, the purpose of its spatial-geometric organization, is to provide opportunities for life-giving situations. The central issue of architecture, and its central purpose, is to create those configurations and social situations, which provide encouragement and support for life-giving comfort and profound satisfaction — sometimes excitement — so that one experiences life as worth living. When this purpose is forgotten or abandoned, then indeed, there is no architecture to speak of.
From his inspiration I was able to apply similar values and like him critique the very field of science that supported his profession.

In light of the last century's advances in science and medicine we have access to health and cures never before dreamed of however along with these advances came a dark age of industrialized war and genocide. After the loss of over 100 million fellow humans in the last hundred years the inner landscape of the collective soul has been depleted. We have yet to recover for such massive loss as each successive decade has brought its own new genocidal fever.

The entire project of modernity has thus been called into question both in the social sciences as well as theology. Since the darkness has affected postmodern man reflected in a vapid culture and a breakdown of political norms that reflect a good society, it is no wonder that the soul sickness afflicting mankind is represented in disease both organic and psychosomatic.

Syndromes from anxiety, depression, chronic fatigue to stress induced diseases make up easily a third of presenting symptoms to the doctor's office.

Yet few ever discuss these underlying social maladies when faced with a patient in the examining room. We are quick to rule out serious illness that might present with these symptoms yet, ce ruled out we have little to offer other than symptomatic relief that masks the underlying pathology.

I am the tip of a spear representing the medical industrial pharmaceutical complex, a multi-billion dollar industry who sole purpose is to perpetuate itself and make profit as a conglomerate.

Forces bearing down upon the practitioner includes FDA DEA Government Agencies OIG Medicare CDC state agencies Professional Licensing boards Hospital medical committees specialty boards and ethics committees Fraud Inspectors, Patient grievances, malpractice attorneys etc…

Forces bearing up on the practitioner include socio-economic status, personal ethnicity and racial biases, gender, religion, past trauma, past experiences with similar problem patients, past fears of suits, language barriers, accent biases, etc.

This powerful matrix imposes itself on all therapeutic encounters in the following way:

Medicare has relativized every act of medical interaction by a taxonomy known as RBV's whether performing an ingrown toenail or brain surgery the intervention is subject to a numerical ratio.

Medical Device companies compete for the attention of surgeons with consultant fees and junket trips. This affects the cost of the procedures as well as fees passed onto the insurers.

Testing companies promote expensive blood analyses to rule out new genetic diseases that have little effect on the treatment yet cost thousands of dollars.

The insurance companies are no less complicit with the entire prior authorization outsourced industry that makes percentages of tests they are able to deny. The very cost of these third parties add to the cost of care in the overt motive to cut costs.

Doctors routinely practice defensive medicine in the fear of malpractice suits that have radically changed the way we practice. In a prior generation a test was ordered to confirm a clinical impression or diagnose. Today tests are ordered to rule out exotic diagnoses to prevent the possibility of "mis-diagnosis" even though the yield is negligible.

This fear of the DEA precipitates urine toxicology screening on patients with no real risk of abuse causing thousands of dollars in cost to the patient and insurer in order to comply with the DEA that does not differentiate between opiate users. On the contrary the fear of losing the DEA license prompts testing without thinking clinically.

The opiate pharma industry is only recently being indicted for causing millions of deaths due to the unbridled seduction of primary care doctors who overprescribed causing huge medical costs for overdoses.

Hospital grievance committees are complicit in forcing physicians to behave in a streamlined therapeutic model with no room to allow for clinical judgement since the hospital lawyers now demand standards fo clinic practice rather than good evidenced based medicine.

Unnecessary operations such as open heart surgery and spinal surgery have been well documented and the cost to the medical industry has been staggering.

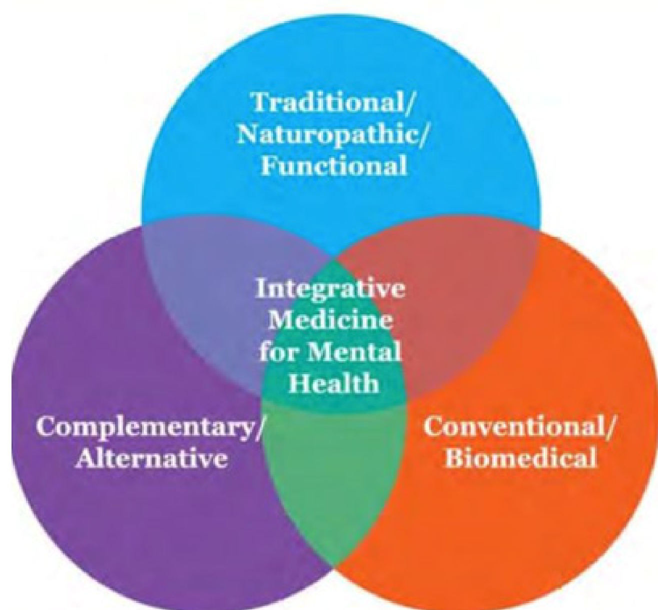
The collusion between big pharma and the hospital industry all pressure government and its various sectors such as the FDA, Medicare, DEA and NIH as well as those who vote in congress to protect their interests such as prescription drug costs.

All this adds to the GNP devoted to healthcare compared with European or Canadian is a factor of tens. All this only reduces the power of the individual patient to make choices as the forces impacting the physician and mid-level practitioners are so great they rarely provide intelligent choices based on the patients individual needs.

This only adds to the anxiety experienced by my patients due to the expensive hitech tests they are being subjected to. The fear of this or that ominous diagnosis (because of the referral with the "rule out diagnosis" often exaggerated to pass muster with the insurance prior auth departments) causes days if not weeks of anxiety for fear of the ominous vs the trivial.
As practitioners, due to these massive societal forces we have inadvertently become lazy, relying on technology and sloppy causing iatrogenic disease because of our over testing over diagnosing and over treatments all the while hiding behind the veil of compassion and academic precision.

During the interview (average 12 minutes) most of the time is taken up hiding behind a computer screen in order to worship the electronic health record originally meant to serve the patients but rapidly devolving into a method of big brother watching the practitioner for time management and whether he or she has fulfilled the RBV criteria to bill the insurers.

The avoidance of eye contact the avoidance of a hug or any other human contact, the absence of listening intently to the patient as opposed to filtering out the medically significant complaints from the trivial as one is transcribing into the EMR, all has the effect of dehumanizing the encounter.



Using the above model for allopathic medicine.

A Different Approach

Were we to allow ourselves the luxury of listening to our patients, were we to allow ourselves the emotional capital to enter into their pain suffering and anguish, and feel and understand their symptoms, the way I described in the psychotherapeutic references in my prior paper, the following would happen.

Our hearts would be broken, we would suddenly become aware of the human dimension of anguish behind the physical symptoms, the social dimension and lack of support during the chronic illness, the psychological trauma going back years of abuse and neglect form family, the absent social systems in place for those in poverty as opposed the resources available to the wealthier patients, and this awareness would affect our interaction with our patients in a profound way.

We will feel shame, for the privilege we represent and the education and socio-economic privilege that allows for assumptions and prejudices we brought to the therapeutic encounter. Our hearts would bleed for the single mom with 3 kids (with spectrum disorders) who lives on food stamps and relies on the monthly Medicaid cab to get to one physician, who medicates her broken life with opiates and benzodiazepines. What chance does shave for managing her migraines fibromyalgia, chronic back pain and anxiety and depression.

We would then dis-cover our complicity in this encounter, how we represent in our bleached white coats, the tip of the spear where all the government agencies, big pharma, medical device companies and lab testing organizations not to mention the fraud infested medical supply companies, all these come to a sharp point in the persona of the care giver who dispenses, who orders tests, who demands urine toxicology screens to weed out those who medicate illegally, who makes the wheels of the entire medical industrial complex grind.

Like other "professionals" my fragmented specialized world of my subspecialty is a way of the larger system can control the fragments yet impose its holographic image reincarnated in every practitioner and my local examining room lab and testing facility becomes the crucible by which the violence of the state sponsored healthcare agencies imposes itself.

A Proposal

A new model of care would make the focus the therapeutic encounter and the primary goal that of caregiver and patient interaction to be the most meaningful human encounter. This interaction must produce a deep sense of trust as both doctor and patient remove the masks of their respective roles and lay bare their souls in an act of vulnerability.

A new type of training that enables a physician to open up to his own wounds and the care he needs to undertake to take care of his own soul would be a prerequisite.

All members of his team from the from the front desk, the mid-level practitioner down to the lab tech and x ray technician: all will need training as well, in a new type of healing attitude of compassion, despite the technical aspects of their interaction. The new philosophy of care must come down from the top level management through the practitioners to even the billing and collection departments. The goal is the welfare of our patient and the healing can only occur in a compassionate environment at all levels.

The basis for this new healing philosophy is one of WHOLENESS and LIFE AFFIRMING.

The physical plant of the office will no longer be anonymous cubicles where patients are sequestered and wait for the nurse to enter, the waiting room will reflect the humanistic side of all the encounters. The architecture of space must reflect the softness and vulnerability of those who work there imparting a healing feel to those in waiting. Sight sound and smell is affected and must be paid attention to.

The design will lift the spirits of those in the clinic both helpers and patients. The music the odor the colors and the shape of the space will foster beauty serenity peace calm and a sense of healing. Plant life and fish add to this sense of belonging to one ecosystem.

Strategies and goals

Transformative strategies will include the following:

Promoting mutual vulnerability

A leveling of hierarchies with rank only for the outside world but all participants in the organic plant have a voice from the janitor to the techs and lab personnel.

The holistic approach to care affects all participants in the plant with no

divide between care giver and care receiver. Self-care for all physical psychological as well as spiritual. All signing on to the goal of healing self and others.

Attention of staff to past trauma abuse PTSD… and manage them so that judgments are not projected onto the patients.

Recognize old patterns of mis-behavior and resisting corporate influences and bring to the light old tendencies such as succumbing to the powerful if not conscious corporate practice of medicine for profit.

Intuitive care development through techniques to develop deep listening attention compassion and empathy.

Sharing with other members of the unit both medical and technical all insights and values in an educational arm of the plant in a fellowship of values.

Enhance beauty serenity esthetics sound and smell in the plant.

My model is based on the work of the visionary architect Christopher Alexander [2], who is described by Salingaros as follows:

"beauty connects us viscerally to the material universe. Life forms evolved to experience biological connectedness as an absolute necessity for survival. Starting one century ago, however, dominant culture deliberately reversed the mechanism responsible for visceral connection.

The resulting disconnection from the material world will continue to have long-lasting negative consequences for human well-being. Christopher Alexander describes how to revive the visceral connecting process, creating conditions for human-centered design in our times. Biological connectedness arises from an organic projection of the designer's "self" onto the material reality of the object being designed, and to its physical context.

Exploring multiple scenarios using informational feedback avoids letting the designer's ego or imposed images exert a controlling influence. Implementing Alexander's connecting method could revolutionize design, with the potential to produce a new, nourishing art and architecture.
Recent developments in biophilia and neuro-design help to better understand Alexander's ideas, using results not available at the time he was developing his theory"[3].

Alexander identified nine operational principles that are elements in designing living spaces.

1. Fundamentally, architecture is and must be an art of making. The impetus for wholeness guides everything, and is the driving force of all construction activity. Adaptation is a necessary aspect of design. The entire production of buildings must be an ongoing, dynamic process, alive to the circumstances that emerge day by day, and able to develop opportunities and events that come to light.

2. In support of this new production system, there will need to be sweeping changes in human organization. These changes of organization will provide for involvement and coordination among the interested people and skilled workers, and thus give a level of deep involvement in decision-making by all concerned. Together, they will act on adaptation.

3. A new approach to the management of money will do away with the mercenary and profit-driven foundations of the building industry. Money management will need to be controlled via non-profit organizations.

4. A major focus on the fragility of human beings and whatever enhances their well-being will be respected. This will be treated as a major emphasis, and will always be considered as a source of feedback and evaluation.

5. So, too, care must be given to all animals, insects, and plants, meadows, forests, ice-floes and other natural habitats. This intense care for all living beings and systems will be a priority.

6. The land (urban or rural) — its shape, its character — will provide the context for every building project in a way that is conscious and careful. Land configurations and old buildings will provide the primary origin of buildings and new construction.

7. The shaping of buildings and parts of buildings will always be through works of craft, made by human hands (though it may include many small prefabricated components). As a whole, every effort is to be understood to be a full-fledged work of art.

8. A generative process (something like a pattern language) will always be seen as the key dynamic framework that gives generic instructions for all planning, design, and construction.

9. Something we may loosely call "spirit" will be the underlying foundation of the work of building. This "spirit" will be held in common, and because of this, the buildings we produce will be endowed with spirit themselves.

The spiritual element making up the ninth is critical for our model.

These techniques also depend on the spiritual or religious underpinning of daily building practice. Of course, the present-day secularized forms of religion are (by now) far from such a goal. Nevertheless, I choose to focus attention on the word religion, and its very interesting origin and purpose, because it does have tremendous relevance to our idea, and to our practice of architecture. The word "religious" comes from the Latin *re-ligare*, or re-binding.[2] Making a new world *which binds things together well* is the underlying essence of all profound techniques of architecture.

The "spiritual" aspect of healing flows seamlessly into the spiritual aspect of the new model affecting all aspects of care as well as the interpersonal interactions between healthcare givers, the space the plant and the machinery.

In the next essay I will outline the difficulties in transforming the model from the current system of medical care delivery to the proposed visionary approach.

More to follow….

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