

Chapter 6: Implications for Medical Professionals and Other Helping Relationships

(Last Updated – December, 2002)

**This Chapter Is Still Under Construction
Awaiting Community Input
Please Read Below**

The concepts and ideas revealed in this text about the characteristics associated with the healing relationship are not meant only for a professional audience of professionals in the mental health field. It is information that is meant for anyone seeking to help another toward feeling better – physically, psychologically, or spiritually. It is information that can be used by any practitioner in the business of human service.

This chapter should be considered *under construction* as professionals, from various human service domains, will hopefully make additions to this chapter. Any practitioner who wishes to write a description of how the healing relationship applies to their specific practice should compose a 2 to 10 page, single spaced paper (with references) and send for consideration via the web site – www.SacredHealingNow.com If accepted it will be added to this on line chapter with the author's name, and then added to the next printed publication.

Implications for the Medical Community

Is their compatibility between the Western culture of health care and the healing relationship? Can our system of providing high

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quality technical care make room for developing high quality healing relationships? In the continual pressure to make office visits shorter and to have more of them in a day is their time for the healing relationship? With all that there is for medical practitioners to learn how can take the time to learn about the healing relationship? These are the questions facing anyone seeking to introduce the idea of the healing relationship into the medical community.

The starting point of introduction is the concept of empathy. Can the medical community, can practitioners, agree that empathy is important to medical practice? As I have discussed previously the search for this agreement will depend on one's empathy definition, and empathy development. This is related not only to the person's history with empathy but also to the environment of training to become a healer practitioner. Our medical training of practitioners often focuses on the technique, although some nursing programs have managed to stay with the founding concepts laid down by Florence Nightingale.¹ If we are to continue to train medical technologists who pursue the cure through technique without understanding the importance of the relationship then healing will not be facilitated by practitioners but instead by people outside the medical profession.

It is unfortunate that the management of health care has forsaken the importance of the healing relationship in the pursuit of cost cutting. In doing so it has created a culture of medical technology void of soul and starving from the inside. Professionals seeking to offer the healing relationship are leaving the profession as we face a national shortage of caring people in the medical field. This shortage places greater demands on those remaining and further inhibits the delivery of the healing relationship. People seeking help from the medical community are experiencing this lack of compassion, this terse and mechanical bedside manner, and are seeking solace with alternative medicine practitioners. But it is possible to change, to keep our technology and the healing effects of halopathy.

Improving Bedside Manner

Exactly what is “bedside manner” and what is its purpose? The process of providing medical care incorporates the interview with diagnosis and treatment. A good bedside manner is understood to aid this process. It is proposed here that empathy is part of a good bedside manner and that advanced levels of empathy could facilitate healing as part of bedside manner and the treatment-cure model.

The characteristics of the healing relationship can be directly applied to improving bedside manner. The characteristics of the healing relationship, if it is to occur between medical practitioner and patient are as follows:

1. Proper Intent: both participants come willing to discover a path toward well being.
2. Healing Conditions: an environment is created where the practitioner is centered and demonstrates safety, compassion, genuineness, advanced empathy, and no judgment. The medical practitioner brings this to the “bedside” prior to speaking the first words of the interview.
3. The Sense of Empathic Oneness: the practitioner has a sense of being connected to the wholeness of the moment (including the client), not doing but just being, and the client has a sense of the practitioner being connected to him/her. In this space all aspects of the presenting condition can be understood, a more complete understanding of the diagnosis.
4. Catharsis: there is a process of experiencing suffering followed by a sense of “letting-go” (their sense of suffering changes) which is often described as if one had taken a journey, this can be accompanied by the

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administration of medical technology – a form of placebo enhancement. Patients are more receptive to, and compliant with, treatment.

5. Dramatic Shift into Well-Being: the patient leaves feeling better and has some sense of what needs to be done to continue to feel better.
6. Translation Loss: there are parts of this experience that transcend the technical, there is a way hearing and communicating with the person's suffering, and relief of suffering, that is difficult to describe for both practitioner and participant, a mystery to the process of healing.

There are many obstacles in our medical community that can prevent these characteristics from occurring. First, and foremost, we do not promote such a process as an important part of how we deliver medicine – we offer the technical relationship. This also means that patients do not expect to enter into the healing relationship, as they have also become indoctrinated into the technical relationship. Second, there is little training provided to medical practitioners on the nature of the healing relationship and how they would incorporate it into their own practice.

Understanding the importance of empathy in medical practice

As has been stated throughout this document the first step in learning to become a facilitator of the healing relationship in understanding the nature of empathy and its importance in your own practice. Another important point is to understand the difference between healing and curing, as this difference relates to the definition of empathy and ultimately its practice as part of bedside manner.

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Empathy, as part of medical practice, need not be seen as trying to do mental health therapy. Rather, in keeping with providing quality medical care, it can be seen as creating a relationship that will support the technical treatment. Empathy can add the healing processes to the curing processes. Empathy can help the whole person to be known in the interview, and to become a willing participant in treatment and their own healing. Empathy in medical practice, and the healing relationship, is something that can be learned by all practitioners in the medical field.

Pain is not the same as suffering and relief from pain is not the same as healing.² Pain is a physical response. Suffering includes all the thoughts, emotions, habits and relationship changes connected to our perception of the pain. Relief from pain is like Novocain. Healing is relief from suffering. We can learn to shift our mindset in relation to both pain and suffering, but often we need to learn how to do this. We need teachers. Whenever a medical practitioner is addressing a person's pain there is also the opportunity to address the persons suffering. The medical practitioner has the opportunity to help the person understand suffering with just a bit more clarity. In this way the healing process is promoted. But in order to provide clarity to the individual the practitioner must enter into a relationship where the person's suffering can be known with some clarity and where a small step toward well being can be offered. This is the role of empathy in medical practice.

In seeking to know the patient's suffering we need to join the patient's understanding of their condition, join with their intuitions, temporarily suspending judgment and in doing so we may also decrease error.³ Decreased error contributes to increased quality of care and an increase in trust. An increase in trust can lead to more openness to empathy and thus establishing a better relationship with the practitioner. This improved relationship can foster the process of healing and lead to the characteristics of the healing relationship. "Clinical decisions cannot be formulaic but must fit a person's beliefs,

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background and desires. The risks we are willing to take, and what we are willing to give up to try to live, differ for each individual.”⁴

It is important to attend to the suffering of the patient and to allow time to know this suffering. Time can be spent to form a relationship that contains empathy, and offers the healing relationship as a possibility. An alliance, or agreement, to do the necessary work toward healing begins the process.

“Attention to the quality of the relationship is ‘cost effective’ when the total consequences of not forming effective relationships are considered: misdiagnosis, doctor – shopping, downward spiral [of suffering], poor compliance, [and] litigation... Sound clinical practice involves building a sound relationship with the patient.”⁵

Advancing the practitioner’s bedside manner to include empathy and eventually advanced empathy could be the first significant steps toward offering health care in this country that is not only the best technologically, but also compassionately. “The major complaint people have about their doctors is that they don’t listen.”⁶

There are many doctors and nurses who are writing about the importance of a compassionate, empathic, bedside manner.⁷ Given the definition of empathy, and the characteristics of the healing relationship, it would seem that medical practitioners would want to know about advanced empathy, and learn how to incorporate it into their practice. It would also seem that the administrative systems that support practitioners would also support training in the healing relationship. But, as I pointed out earlier, people are going to have their own understanding of empathy and the healing relationship. Sometimes this understanding includes not understanding how it could be incorporated into the practice of Western medicine. There are many obstacle on will face in offering healing relationship training to medical practitioners.

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“We have come to believe that more doctors and more technology will solve our health problems... Physicians are trained to practice a technological medicine in which disease is their sole concern and in which technology is their only weapon... The balancing force to technology in medicine must be restored. That balance will be found, I believe, by a return to a much wider of the doctor’s job. A view that restores healing to its place along side curing as a trained and disciplined part of the physician’s role.”⁸

Training practitioners to become facilitators of the healing relationship

The key training points presented in Table 8 are applicable to the training of medical practitioners. These points can be utilized within the training programs of both nurses and doctors to improve the awareness, to awaken them to the possibility, of an empathic relationship can promote healing.

“Empathy is a concept deeply rooted in and central to professional nursing.”⁹ But, as with the mental health field, there is some question regarding its definition and thus its application.¹⁰ It is proposed here that nursing practitioners could adopt the definition offered in this document as it might help to clarify the construct ambiguity inhibiting practitioner training. Professor Alligood’s describing two types of empathy in nursing, trained and basic,¹¹ is similar to portions of the empathy developmental scheme presented earlier (Table 1). Empathy is considered something basic to entering the profession of nursing, and something that can be enhanced through training that is appropriate to practice. As stated earlier, misinterpretation of empathy can lead to misapplication, particularly if practitioner trainers foster the misinterpretation. It may also be plausible that some nurses could demonstrate more empathy

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development than others, and that these nurses may benefit from advanced empathy training – and possibly training in the art of facilitating the healing relationship.

Since the days of Florence Nightingale nursing programs have incorporated compassion, and relationship into their training of human service practitioners. But the same cannot be said of doctor training programs. Because we have prided ourselves in our technology we also expect our doctors to be technology experts. The selection of medical school candidates, and the training they receive, is often geared to yield these experts. If there is innate empathy in the trainee it often becomes buried. “In the empathy – objectivity battle within the physician, we all expect – even demand that his judgments be based on rational processes.”¹² The pressure to present as the distant scientist who has a rational view of the path to health often takes precedence over the compassionate physician who shares a persons suffering in order to know more about their path to health.

“In order to bring about the reunification of person [in suffering] and body [in pain] in medicine, physicians will have to be trained or retrained to consider the essentially moral problems of the sick person as an important part of their professional concern... The medical student must be taught to honor subjective information from the patients as he presently honors objective data.”¹³

Additional suggestions regarding empathy and the training of doctors include modifying the medical school entrance criteria to reflect evaluation of empathy¹⁴ and “continuing discussions about doctor-patient relationships, and about human relationships in general, throughout medical school (especially in the final two skill-sharpening years) and during residency.”¹⁵ It has been proposed that medical school training actually prevents the practice of empathy (see Robin William’s in the movie “Patch”) and that what is needed is some code of medical ethics, with empathy strongly rooted in its foundation.¹⁶

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Dr. Michael Bennett, of Harvard Medical school, published a book titled “The empathic healer: An endangered species?”¹⁷ He writes that our technologically superior health care system has lost its heart and that we need to re-introduce the importance of empathy. He also states that the “capacity for empathy is universal, and that this capacity can be both blunted and enhanced; therefore in its potential for enhancement it is teachable.”¹⁸ He suggests that doctors in training uses videotapes of their “bedside manner”, and that they solicit feedback on these tapes from not only peers, but also the participant.

In addition to the training suggestions proposed above for doctors, I propose that they become familiar with the points presented within Table 8 and then seek to expand their understanding of these points through continued training.

Applications to Other Human Service Professions

Hopefully readers will come to understand the healing relationship characteristics and understand how they impact practice within a given domain. Each domain of practice will have its own point of view on implementation. Contributions could address each of the following domains:

Case Management	Direct Service
Psychology	Psychiatry
Internal Medicine	Family Practice
Social Work	Family Therapy
Pastoral Counseling	Substance Abuse
Rehabilitation Counseling	Nursing

Any practitioner can submit a 3 to 20 page, single spaced, paper, that includes reference citations, discussing the application of empathy and the healing relationship within their domain.

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References Cited in Chapter Six

To find a reference locate the appropriate numbered footnote, remember the author's name and the year, then locate the author in the reference list at the end of this document.

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- ¹ Tschirch, 1997.
 - ² Tatelbaum, 1989.
 - ³ Cowley, 2000/2001.
 - ⁴ *ibid*, p. 5.
 - ⁵ Sabo & Havens, 2000, pgs.3 & 8.
 - ⁶ Cassell, 1976, p. 94.
 - ⁷ Ornish, 1998 speaks of Dr. Harvey Zarren at Tufts University. Papers in Kritek, 1997 including papers by Fenton, 1997, and Tschirch, 1997. Also Watson, 1985; Cassell, 1976; Spiro, et.al., 1993; Gallop, et.al., 1990.
 - ⁸ Cassell, 1776, pgs. 18 & 23.
 - ⁹ Walker & Aliligood, 2001, p. 140.
 - ¹⁰ *ibid*.
 - ¹¹ Evans, et.al., 1998.
 - ¹² Cassell, 1976, p. 110.
 - ¹³ *ibid*, p. 120.
 - ¹⁴ Morowitz, 1993.
 - ¹⁵ Spiro, 1993, p. 13.
 - ¹⁶ Reiser, 1993.
 - ¹⁷ Bennett, 2001.
 - ¹⁸ *ibid*, p. 8.