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Editorial

Reorganizational Healing: A Health Change Model Whose Time Has Come

Robert H.I. Blanks, Ph.D.

On rare occasions, one can step back and say: "Wow, that is a really good idea." Now might be that time. The article on Reorganizational Healing (ROH) in this issue by Epstein et al. (pp. 475–487) presents a viable big-picture option for improving the health of individuals and addressing the current health care crisis in the United States and worldwide.

In their article (pp. 475–487), Drs. Epstein, Senzon, and Lemberger also present a radically new "big-picture" view of health and health care that challenges the dominant disease-care model of biomedicine. Currently, when people require care they receive diagnoses and treatments to return them to their former states of health. Cost reimbursement as well as diagnostic and treatment parameters are driven by this disease-based, "restorative healing" system by medical necessity. Prevention is also a growing part of the biomedical model and is practiced largely through patient education (primary prevention) and symptom management (secondary prevention). But preventive strategies are still disease-based and poorly reimbursed. Indeed, Julie Gerberding, M.D., M.P.H., former director of the Centers for Disease Control and Prevention (CDC), estimates that, of the annual medical budget in the United States (i.e., $2.4 trillion in 2008),[1] the overwhelming majority goes toward treatment of ill patients, and less than 5% goes toward keeping Americans healthy.[2] Recognizing the need for more emphasis on prevention, the CDC recently launched the "Healthiest Nation Campaign" to keep Americans healthy by promoting prevention and integrating health into social policies across all sectors of the economy (e.g., consider the broad-reaching implications of promoting health by providing better public transportation, assistance with health-related transportation, healthier environmental strategies, more bike and hiking trails, and facilities for child care that enable parents to attend regular health visits, etc.). The new acting director of the CDC, Richard Besser, M.D., has expanded the vision of the CDC as "Healthy People in a Healthy World—through Prevention" to stress the importance of preventive approaches, but this is still a disease-based model.[3]

So what is the novelty of the approach presented by Epstein and colleagues? In contrast to "Restorative Healing" (i.e., disease-based and preventive medicine), the new ROH paradigm is about helping people to be well and stay well. ROH reflects the highly complex and dynamic nature of health across all biologic psychologic, social, and spiritual domains. The intention of ROH is to bring about changes in individuals, helping them to develop new resources so that these individuals use the health challenge consciously to effect changes in their lives and bring about greater understanding and increased ability to thrive under most circumstances. ROH was inspired by, and can be practiced through, several interventions developed previously by Epstein, including a system of assessment and corrective body contacts called Network Spinal Analysis (NSA); an integrated 12-step healing program called The Twelve Stages of Healing; and a system of exercises that focuses attention, directs breathing, and creates energy awareness called Somato-Respiratory Integration (SRI). Basically, ROH is a metamodel that can include NSA and SRI, but ROH's greater power is the transcendence of any particular discipline. Success in ROH is not about symptom relief. Rather, success is the ability of the patient to apply the elements of ROH to effect lifestyle and health behavioral change (e.g., smoking cessation, etc.) and to take the novel perspective, first articulated by Jobst and colleagues,[4] that diseases can be viewed as indicators of what is going on in the individual's life and in society (i.e., "Diseases of Meaning" and "Diseases as a Manifestation of Health"), and thus be seen as a source of growth, understanding, and opportunity for greater awareness and as a catalyst for change.

Finally, ROH includes outcome assessments and clinical tools, including the Four Seasons of Wellbeing, the Triad of Change, and Energetic Intelligences (EIs). The Four Seasons of Wellbeing is an outcome measure used to assess an individual's readiness to change at any given moment in time. Practitioners trained in ROH learn to recognize these stages of readiness and direct interventions accordingly. The Triad of Change is a new and effective learning tool for teaching the

Department of Cell Biology and Anatomy, University of Miami Miller School of Medicine, Miami, FL.

fundamentals of health behavioral change. EIs are a means the ROH practitioner uses to assess the emotional reserves (resiliency), buffering, and willingness of patients to effect change in their lives. When applied in concert with NSA and SRI, these elements of ROH form a system of care that can be learned and applied by any health professional.

ROH is a model of health rather than a method. It is evidence-based, and it was slowly developed by Dr. Epstein during 25 years of clinical practice, research, and postgraduate teaching. Thousands of people have attended his transformational programs. A large cohort study by myself and colleagues, included analysis of 2818 patients under NSA care from 160 offices in the United States, Canada, Puerto Rico, and Australia.[5] Our results indicated that patients reported significant positive perceived change ($p < 0.000$) in all domains of health that were assessed. Effect sizes for these difference scores were all large (>0.9). These benefits of NSA are evident from as early as 1–3 months under care and appear to show continuing clinical improvements in the duration of care intervals studied, with no indication of a maximum clinical benefit.

Our research involved use of quality-of-life (QoL) surveys to assess NSA. There is an increasing trend in biomedical research to incorporate health-related QoL assessments.[6] Self-rated health (SRH), a formalized measure of subjective health, has been found to be an independent predictor of clinical outcome and mortality.[7] Even when numerous health status indicators are available, poor SRH is independently associated with increased mortality in different socioeconomic groups, in different age groups, in men and women, over time, and among persons with or without chronic illness.[8–12] Self-rated health also correlates with levels of circulating pro-inflammatory cytokines, which serve as biomarkers of general levels of stress (e.g., IL-1ß, IL-1ra, and TNFα). In a major study, poorer subjective health was associated with of higher levels of inflammatory cytokines in female subjects but not in males. Even when controlling for age, education, physical health, and diagnoses in multiple regression analyses, self-rated health was an independent and more robust predictor of cytokine levels than physician-rated health.[13]

A second series of papers on NSA by Schuster et al.[14,15] applied structural equation modeling to the data from our earlier[5] study to examine outcomes in relation to health-lifestyle practices and self-reported health and wellness. The final structural equation model indicated that individuals who underwent NSA successfully "reorganized" their self-reported health beliefs, practices, and behaviors along the lines of what is now the ROH Triad of Change. Namely, the benefits of care were distributed, meaning that health benefits of NSA were both direct and indirect. The direct effects of NSA on the health perception of the individual (perceptual) were significant and occurred across physical, mental/emotional, life-enjoyment and stress-related domains of health. There were also indirect effects of NSA care that led to positive changes in health behaviors (risk avoidance, healthy eating, food choice, and exercise). Although the direct effects of NSA on health belief were found to be the greatest, there was also a significant effect on patients who were making healthier lifestyle choices.[14,15] Across the population of 2818 subjects who underwent NSA care, self-reported changes in healthy lifestyle behavior included a 26% decrease in consumption of caffeine; an 8% reduction in smoking; and improvement in many healthy-lifestyle domains including a vegetarian diet (39% increase); consumption of vitamins (45% increase) and organic foods (46% increase); and use of regular exercise (40% increase); *t'ai chi*/yoga (20% increase), meditation (48% increase), and relaxation techniques (46% increase).[5]

Health lifestyle change must be part of health care reform. Nearly 1 in every 2 Americans has a chronic medical condition, defined as an illnesse that is prolonged, does not resolve spontaneously, and is rarely completely cured.[16] An estimated 90% of seniors have at least one chronic disease, and 77% of them have two or more chronic diseases.[17] Chronic diseases targeted by the CDC's National Center for Chronic Disease Prevention and Health Promotion are those illnesses that fit the broad definition of chronic disease and those that pose a significant burden in mortality, morbidity, and cost. Examples include chronic fatigue syndrome, rheumatoid arthritis, osteoarthritis, asthma, renal failure, diabetes, hepatitis, systemic lupus erythematosus, cardiovascular disease, some cancers, and osteoporosis. Although chronic diseases are among the most common and costly health problems (accounting for more than 60% of the nation's medical-care costs),[18] these diseases are also among the most preventable conditions. Adopting healthy behaviors, such as eating nutritious foods, being physically active, and avoiding tobacco use, can prevent or control the devastating effects of these diseases. The United States cannot address escalating health care costs effectively without addressing the prevention of chronic diseases. As indicated above, the NSA component of ROH has a significant influence on health lifestyle behavior and should be of help, if adopted broadly, in addressing the root causes and costs of treating chronic diseases.

Health Care Reform

Policymakers and other stakeholders agree that health care costs must be controlled, but these people disagree on the best way to address the cost issues while ensuring access, fairness, efficiency, and quality. To highlight the problem, the World Health Organization ranked the U.S. health care system as highest in cost and responsiveness throughout the world, but the U.S. health care system ranks 37th in overall performance and 72nd among the 191 member nations surveyed in terms of the overall health of its citizens.[19,20] The Association of American Medical Colleges (AAMC) serves and leads the academic medicine community of medical schools, hospitals and health professionals' organizations in the United States. Recently, the AAMC and 14 other health professional groups issued statements to guide health care reform. At the top on their list of recommendations are increased access to high-quality, cost-effective, and patient-centered care through existing or new public and private health insurance options; greater emphasis on prevention and wellness; and stable funding for a health educational infrastructure to ensure well-educated and trained health professionals.[21] Clearly, implementing these changes would be a major first step in serious health care reform.

A distinguished panel headed by James S. Gordon, M.D., founder and director of the Center for Mind-Body Medicine, in Washington, D.C., prepared a far more comprehensive series of ten recommendations[22] emphasizing the need for:

1. A coherent, rational system of national health care to meet the needs of all Americans.

2. A new model of universal care grounded in prevention valued as highly as diagnosis/treatment, and in which self-care and mutual help are fundamental.
3. Greater implementation and study of integrative approaches.
4. A reduction of the financial barriers for training of health professionals.
5. Transformation of the population by focusing on the health of children.
6. A sane alternative to the costly and destructive system of dealing with medical malpractice;
7. Removing the influence of the private sector (insurance companies, pharmaceutical companies, etc.).
8. A change in the balance of research focus to include basic and new clinical research to support a new health care agenda (multiple outcomes, nutrition, mind–body and exercise approaches).
9. Reinstatement of ancient perspectives of health as promoting personal, emotional, social, and spiritual fulfillment.
10. Creation of a White House Office of Health and Wellness to ensure the "ongoing active engagement of our population in their own care and in shaping the kind of care that will most effectively, humanely, and economically meet all our needs." If enacted, these recommendations would provide long-term financial stability to the health care infrastructure and provide advancement in the health of the population.

Impediments to Real Health Care Reform

Major health care reform has been considered in Canada but, in spite of strong evidence-based documentation and cost-effectiveness studies to the contrary, significant change and inclusion of complementary and alternative medicine (CAM) modalities such as chiropractic were never implemented into the Canadian single-payor system. Reports prepared in 1998 and 2000 by Ontario Health Economist Pran Manga, Ph.D., concluded that implementaing chiropractic could result in a potential savings to the Ontario health care system of as much as $380 million–$770 million per year; this extrapolated to a potential savings of $2 billion in Canadian dollars per year if implemented across all of Canada.[23,24] In a recent book written for the popular audience, *Squandering Billions: Health Care in Canada*, Bannerman and Nixdorf draw attention to the details the "Manga Report" and health-reform concepts of other prominent health economists.[25] We can learn a great deal from their recommendations. Accordingly, the 10 most common obstacles to overcome in implementing successful health care reform include the following concerns:

1. There is a need for patient awareness and accountability for maintaining a healthy lifestyle and balancing one's personal interests with those of society.
2. A reassessment of the basic reimbursement requirement only for "medically necessary services" is vital. Health is not the sole domain of the medical establishment, and health claims and access need to be integrated across all sectors of the economy.
3. When various services are being considered, governments need to understand the difference between "substitution" (shifting care from one sector to another, e.g., from primary care M.D.s to nurse–practitioners) and the typical bureaucratic interpretation of adding "additional" costs (i.e., services not now covered that would be covered over and above current costs).
4. Significant health care reform will require a "substation" of providers and services and not the "addition" of new services.
5. The bureaucracy and non–service-delivery-related infrastructure must be scrutinized and reduced at all levels. The noncompetitive environment must be improved. There is insufficient competition because of medical, dental, and pharmaceutical monopolies.
6. The modes of primary care delivery need to be vastly improved from the physician gatekeeper model to direct access to a variety of well-trained providers (e.g., chiropractors, nurse–practitioners, etc.).
7. Home care, convalescent hospitals, and small surgical centers should be dramatically expanded, each with the aim of providing adequate "substitution"[26] for more expensive acute care hospitals and trauma centers.
8. Pharmaceutical utilization and costs are out of control and need to be examined.
9. Dr. Manga stated that "good policies work if the leaders are prepared to be tough."[24] Frequently, this is not the case but will be an absolute requirement at all levels for health care reform to be successful.
10. "Progress gets lost in minutiae,"[24] said Dr. Manga. Searching for unanimous and even perfect solutions prevent any improvements from taking place. We need to get started now with a good (albeit not perfect) plan.

The benefits to society of systematically reorganizing the health care infrastructure are potentially enormous. I encourage all health care workers, policymakers, and citizens to read the Epstein, Senzon and Lemberger article in this issue (pp. 475–487) and consider the potential benefits that could be derived from a major shift in emphasis from the current restorative approach to a reorganizational healing perspective. I found that the best way to understand restorative healing was to review Table 2 of this article and then reflect on the triad of change model (shown in Fig. 2 of the article). Once I understood these principles, the potential for global world health offered by Reorganizational Healing became an exciting possibility.

Health economist Paul Zane Pilzer, author of *The Wellness Revolution*, summarized the situation well: "The sickness business is reactive. Despite its enormous size, people become customers only when they are stricken by and react to a specific condition or complaint. . . . the wellness business is proactive. People voluntarily become customers—to feel healthier, to reduce the effects of aging, and to avoid becoming customers of the sickness business. Everyone wants to be a customer of this earlier-stage approach to health."[27]

Moving forward, the real work begins once one makes the decision to shift focus from disease care to preventative care and, eventually, to reorganizational healing strategies. It seems clear that significant health care reform must focus on controlling the cost of health care while ensuring access, fairness, efficiency, and quality. The tools and techniques of ROH are not exclusive or restrictive and are being made available to all health professionals regardless of discipline. Research suggests

major changes in health lifestyle behavior are possible with the NSA component of ROH, and the additional ROH tools and outcome measures could benefit the massive re-educational task of teaching health behavioral change, patient awareness, and use of self-care and greater overall accountability of the citizens. A broadly tasked, fair and equitable system of health care delivery will better serve the health of all individuals, couples, families, communities, and nations.

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Address reprint requests to:
Robert H.I. Blanks, Ph.D.
Department of Cell Biology and Anatomy
University of Miami Miller School of Medicine
1600 NW 10th Avenue
Miami, FL 33136

E-mail: rblanks2@med.miami.edu