A Holistic Approach: A Better Quality of Life for All (The Meaning of the Group or Region)

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The focus of this presentation is on concepts that are central to nursing, that are assumed to be inherent in nursing practice. A concern for quality of life, and a holistic approach to patient care, many in nursing would say, are what distinguish nursing from other health related disciplines. While commitment to these ideas is assumed and is repeated often, the practical implications of such a commitment are less clear and, I believe, much less often examined. It is generally true that the things we hold most sacred are the things least likely to be examined. While we are likely to scrutinize the things we are unsure about or opposed to. So it is important that we take opportunities, such as this conference, to reflect on what these concepts mean for nursing practice, research, and education. It is important to stop to reflect on questions such as: What is a holistic approach? What actually distinguishes a holistic approach to health care from one that is not. We assume that a holistic approach is more effective. Is that the case? How does a holistic approach, or does a holistic approach, improve quality of care or quality of life? Have we, as nurses, reached a place where we can claim to be holistic in our approach to nursing practice? Is that what we do? In order to answer these questions, we must be clear about what a holistic approach is.

One of our great challenges in nursing has been to document the impact of nursing care on

the health of individuals and groups. Research such as the work done by Linda Aiken has finally demonstrated that nurses do have a significant impact on the quality of care. For those of you unfamiliar with her work, Dr Aiken and a team of researchers showed a significant correlation between the level and number of nurses in hospital settings and patient outcomes. While we are increasingly examining the impact of nursing care, we have done very little, as a discipline to examine the impact of holistic care. In addition, we have done very little to examine what we mean by holistic care, how one practices holistically, what sort of research questions contribute to our understanding of holistic care, and how we educate future nurses to assume holistic approaches to wherever they work.

As the separate keynote addresses suggest, and has also made clear in the variety of papers presented at this conference, there are many ways to approach the topic of holistic care. One could take an individual, group, national or global perspective on the topic, each leading to different ways of defining holistic practice. There are physiological, spiritual, psychological, and sociological views at each of these levels. A truly holistic approach to care would necessarily include each of these views and the relationships among them. Therefore, carving out one piece or one perspective necessarily leads to a truncated, less than holistic per-

spective. One voice, one paper, one perspective must necessarily fall short of a holistic view. It is the diversity of responses, the dialogues among us that will allow us to reach a more holistic understanding of health and will hopefully lead to more effective approaches to care for all.

With that caveat in mind, I would like to carve out a path, to take a perspective on understanding a holistic approach to health that is often under-appreciated and I suggest is not well enough integrated into our practices, our research questions or our curricula. I will focus my comments on related-ness, our social relationships, on the relationship between the individual and the group, on being part of a group, and how this relatedness affects health.

To explore this issue, I will refer to work done by several authors on the determinants of health. (Evans, Kindig, Marmor) There are many others as well. These scholars were attempting to examine the question "Why are some people healthy and others Not?" This question takes us to a level beyond individual health outcomes. Each of these authors, as well as many others, reviewed research on several topics and populations in an attempt to identify the factors that contribute to a person's chances of being healthy or unhealthy. Their conclusions about what that research tells us, leads us directly to the importance of the group and how we are related to the groups we are part of and the larger social structure around us. The research they reviewed covers several decades, many countries, and examines a wide range of health outcomes. This is important that the studies cross national, ethnic, age and income groups. Strikingly consistent across all of these groups and health parameters and consistent over time (at least since the middle of the 19th century) is the conclusion that many researchers have come to about health and what contributes to being healthy or not being healthy. That conclusion

is.... that our social group membership, how we are related to those around, the meanings of our relatedness determines, possibly more than anything else, our chances of being healthy or unhealthy.

Stop and reflect - group membership, not individual habits or even genetic predisposition is the best predictor of our health status. Both genetic predisposition and individual health habits are strongly influenced by group membership. Now many of you may be thinking that you already knew that, I would like you to think about whether that understanding drives our approaches to practice, frames our research, or organizes our curricula. Do we look beyond the individual for the determinants of health or the solutions to health problems? Let me give you an example of how relatedness, or group membership is reflected in health outcomes.

One classic study done in the UK (the Whitehall Study) followed 10,000 British civil servants for two decades in an effort to identify the determinants of health. The researchers were attempting to discover what social and/or individual factors lead to differences in the health of individuals. The researchers enrolled hundreds of government workers and recorded individual health habits, environmental factors, use of health services, illness events. These factors and a range of health parameters were tracked over time for all the subjects. They found a consistent difference, by work group in morbidity and mortality. They found that even with same illnesses, the same diagnosis, the outcomes varied by group. Individual health habits, environment factors, and use of health services did not account for differences in health outcomes. Social group membership, however, explained health status differences consistently. In short, those on the top had significantly better chances for good health and longevity than did those in all other groups below them. As the level of the worker in the hierarchy increased or

decreased even slightly, so did the likely health outcomes or chance of being healthy. Each of these groups had equal access to health care services (universal access). It is important that access to health care was not a significant contributing factor. None of these workers could be classified as poor, and the differences in health outcomes could not be explained by the small pay gradients between or among the many levels of workers. There were 14 levels of workers, each consecutive group was paid a slightly higher wage than the next group. The magnitude of the pay differences did not add significant purchasing power. While it is generally accepted that large income differences have significant impact on health, this study found, and other subsequent studies have validated, that factors unrelated to income, and the things money can purchase, also significantly influence health outcomes. So increased resources was not the explanation. After eliminating exposure to a host of other unhealthy factors, the researchers concluded that the social group, specifically how the workers were related (socially) to those around them, was the primary determinant of health status. Now you may be thinking that this was many years ago and only looked at a group of government workers. However, this finding has been remarkably consistent over time and across populations. Many studies have demonstrated a similar relationship in other countries, with other groups, and in more recent times. This, I think raises important questions for nurses about where to focus our efforts to enhance health status. It tells us again that relatedness and social group membership are powerful determinants of health, probably even more powerful than the quality of health care available to a group.

The power of social relationships to determine health, in itself, has held up to intense scrutiny. Interestingly, this differential in health status across groups has increased or remained

constant, depending on the source, as access to health care and overall health status has increased.

Further validating the power of social relationship is the international work that has demonstrated the strong correlation between the health status of a group and the magnitude of social distance between the top and the bottom or the hierarchy that is found in the region. Even those on top of the hierarchy, it appears, can adversely affected by large status or income differentials among the social groups in a region. Although the effect is much more negative for those near the bottom of the social hierarchy. Those nations or provinces with the largest income and status differentials have to poorest health outcomes overall. Once again, this suggests that social relationships and the overall structure and group membership may be more powerful than the health mediating factors that are commonly accepted as the determinants of health.

The exact mechanisms by which social relationships operate to influence health are the subject of intense debate and significant research efforts. Much of this effort is focused on identifying and explaining the physiological mechanisms by which social relationships exert those effects. While this research is certainly important, a focus on the physiology of social differentials can divert our attention from the social determinants of health outcomes differentials, leaving these relationships unchallenged.

I think it is important for nursing (nurses) to consider whether our efforts effectively address these social determinants of health and illness. We know this to be true but do our practices reflect this understanding. Are we concerned with access to health care or are we concerned with the creation of health and illness. Do we address our practices to intervene in the creation of illness or do we come in late in the process, addressing only the outcomes. Simply

separating our understanding of health and illness from access issues is a new way of approaching the problem for many nurses. Providing even the best care to those who have become ill, does little or nothing to address the inequities that lead to illness. Providing excellent care for these groups is therefore a less than adequate response. Is there an opportunity, or even an obligation here for nurses? Is it an appropriate role for nurses and nursing then to address the social relationships that lead to illness? I am suggesting that nursing should consider a more direct focus on the social factors that lead, systematically, to inequities in the health status of groups.

This would certainly lead to a more radical role for nurses and for nursing. It would imply a shift in nursing practice to encompass activities that are not so often encouraged or contemplated. It would also have implications for nursing education and research as well as for practice. For example, taking such a perspective would require us to carefully reflect on nursing research so that our research programs could enlighten us and the community about systematically generated health outcome differences and how to better prevent them, rather than how to treat them after they have occurred. Thus, our research would inform us about preventing conditions social conditions, the relationships that lead to illness. On the other hand, research or education that focuses on assisting people to deal with that stress, while important, can have the effect of perpetuating the health inequities.

What would nursing look like if a holistic approach to practice routinely included such a sociological interpretation and intervention. Let me address the issue of nursing practice. What might the above insights say to us about our practice? Such a sociological approach might suggest, and is often interpreted as a commitment to caring for individuals and groups who have been adversely affected by the social

groups and relationships they find themselves in? This would result in nurses directing their energy to disadvantaged groups. This is socially responsible activity that acknowledges the inequities I have referred to. Certainly nursing is engaged in many such activities around the world. Indeed, we have a tradition of serving disadvantaged or at risk groups. Wherever there are groups or regions of people who have been affected by environmental or social disasters, or even by less dramatic disturbances, nurses can be found providing service. Clearly this is important work and to be supported and respected but is necessarily a limited approach to enhancing the health of groups.

However, focusing on the consequences of socially created disparities continues to leave the pathways to illness uninterrupted, once again, perpetuating the disparities. Such an approach does not prevent negative outcomes but only mutes their impact. This is what we refer to as a downstream approach. It is pulling people out of the river after they have fallen in rather than preventing them from falling in to the river in the first place. It is identifying and responding to the people who have already been harmed or who we know are likely to be harmed, rather than preventing the harm from occurring.

An additional challenge to this downstream approach is that it is increasingly difficult to provide care to disadvantaged groups as health care services are, throughout the world, increasingly rationalized and organized as a business rather than as an investment in the health of a group or nation, limiting access to services.

Recognizing the significance of social disparities, nursing has engaged in attempts to alter the impact or change the likelihood of harm. A strategy sometimes used by nursing to address such problems is to engage in public policy development and evaluation. Many public policy issues taken on by nurses and nursing organizations are quite explicitly and obviously related

to health. Some examples include: seat belt and helmet use, staffing requirements in hospitals and nursing homes, speed limit enforcement and organ procurement programs. These are important activities for nurses to engage in, and I would suggest, the sorts of things that nurses could be much more involved in. Each of these things is related to and would have an impact on many individuals. It is a strategy to enhance the health of groups or individuals. However, these strategies alone, once again, fall short of seriously altering the generation of poor health outcomes. This approach to public policy goes beyond individual impact, clearly influencing the health of groups but does little to address the sources of the problems. It is an appropriate, but I would suggest, inadequate approach. I am proposing that nursing practice be more conscious about, and more involved in altering, the social relationships, that affect health outcomes. The first challenge is to be more aware of these relationships. Only then can nursing activities be effectively and adequately directed at altering those relationships. This awareness is important in treating the individual more effectively as well as in helping the broader group. It will also illuminate how the group is reflected in the individual. Lets see what this might look like. For the individual it would involve asking the question "What social relationship, group membership or other social issue is reflected in the problem I see before me?" Asking this question shifts our perspective from an individual level, requiring an individual response, to a group level which requires a social intervention. Lets look at an example of the difference it would make whether the problem is understood as individual or social. An analysis of domestic violence, and how health care providers (as well as the rest of society) respond to the problem revealed that 'the problem of domestic violence' has been explained in several ways. Some see it as a psychological battle for control between

two people. Assuming the victim is female, this explanation often views the woman in the situation as 'too weak' to leave or as gaining something psychologically from being abused. Another explanation, a more sociological one, suggests that there are socially generated power imbalances between the genders that limit the woman's options and make it near impossible to leave. To many of us, this example sounds preposterous because our socially accepted explanations for domestic violence are currently more sociological. Although no doubt many in the audience will remember when the psychological explanation was much more widely accepted. Lets look at the first explanation of domestic violence, that the woman is too weak, psychologically, to leave. This understanding would lead to an individual intervention such as counseling. The goal might be to help the woman find the psychological strength to leave or to stop the violence. Interventions would be focused on the woman. Taking a more sociological view, understanding the situation as being about social relatedness, would lead to interventions aimed at increasing the woman's power in relation to the abuser, on diminishing the power of the batterer and altering the social relationships that maintain the imbalance of power. This might suggest legal and financial remedies rather than individual counseling. In addition, the batterer would be as much of a focus of intervention as the woman would be. This would alter their relationship rather than alter something about one of the people in the relationship.

What is important to realize is that there are many health problems that can be viewed through lenses such as these. Lead paint consumption by children from lower socioeconomic groups, obesity and asthma in low income children can also be examined from these different perspectives. What difference does this make? We could go through a similar exercise with

obesity, smoking, heart disease, and asthma. What is likely to be done if one sees these issues from an individual rather than a sociological perspective is that the goal would be to educate the parents about better control of their children, better diets, better compliance with health provider recommendations, completely bypassing the socially generated causes and undermining the chances of prevention. This would profoundly change the way many nurses think about their work. The ability take a sociological perspective, and the consequences of such a shift in perspective was described many years ago by a sociologist, C. Wright Mills. He described this as the ability to distinguish between 'Personal troubles and Public Issues.' Mills described the personal liberation and effectiveness in problem solving that comes from understanding personal troubles as systematically generated and therefore as very public issues. That is, seeing the social determinants of individual problems leads to better individual and group problem solving. I am suggesting that nursing could be similarly liberated, and probably much more effective by integrating a sociological understanding of health and illness and by acting in a way that is consistent with this understanding.

These are extremely important issues for nurses to engage in and will clearly have a positive impact on the health of the groups affected. I would like to suggest, however, that it is at least as important to step back and look upstream at issues not generally associated with our practices and not necessarily considered health issues. Those that are less obviously but just as directly implicated in the health of individuals and populations. These are the things that repeatedly show up as predictable differences on the way to poorer health outcomes for groups or regions. You might ask 'can nursing do about these issues?' Are they not outside the domain of nursing? Do these issues not require a different expertise? Is this not someone else's prob-

lem? And don't we have enough to do without getting involved in things that are not directly about health. I would suggest we might want to expand our notions about what is 'about health.' I would also suggest that our commitment to quality of life requires us to do so. The well-established relationships between health and social relationships and between each of these and quality of life, makes these issues the appropriate domain of nursing practice, research and education. If we focus narrowly on only those things that are directly and obviously related to health we will undermine our ability to improve health outcomes for individuals and groups. An explicit nursing involvement in public policy, in a way that goes beyond what is traditionally considered health will, significantly, make the link between these issues and health outcomes more obvious, making the link between social relatedness and health outcomes more transparent to the public in general and to nursing as well. Let me give you one example. A program called Head Start was implemented many years ago in the US, probably similar to programs in many other countries. Head Start is designed for preschool children who are considered disadvantaged. They are children who are considered 'at risk' for a range of poor social outcomes. The Head Start program supported children in several ways. It worked on basic skills needed to succeed in early school, enhancing the probabilities of success at an early age and often provided social support for parents as well. Several longitudinal studies have been done on the kids who completed Head Start programs. The studies found a long lasting, positive influence on health and social outcomes for Head Start kids. For example, Head Start kids had lower likelihood of being incarcerated, and lower incidence of divorce, unemployment and underemployment. These social outcomes are all positively correlated with better health outcomes. This is clearly a program that attempts to

decrease the social distance, and consequently the stress, that a targeted group experiences. In so doing, it is also likely to improve health and probably quality of life outcomes for the same group. The point here is that, as financial and emotional support for continuing Head Start programs began to falter, few nurses were in the vanguard, advocating for continued funding. It was not viewed fundamentally as a health issue. The obvious health outcomes would be experienced downstream, much later. I certainly can't say whether focused, deliberate nursing involvement would have made a difference or what difference it would have made. However I am suggesting several things. First, this is an issue that is appropriate to nursing and that deserves the attention of the nursing profession. It is about health. Any holistic definition of health and quality of life, would certainly include the outcomes related to Head Start, even though it is not explicitly a health care program. If we take seriously our commitment to a holistic approach

that includes a better quality of life, programs such as this, and many other social programs and policies, would clearly be within the domain of nursing. This suggests new partnerships, new coalitions, and new perspectives.

So now to return to the meaning of a holistic approach for the group or region, the evidence seems to tell us that social groups and individuals are one. That we must understand the group, and a person's relatedness to the group and to other groups, in order to understand health and illness and in order to address health problems effectively. Interestingly, this is much more consistent with an eastern philosophy than it is with the way most western nations think about the relationship between the individual and the group. Quality of life, cannot be usefully separated from quality of care since it is only in knowing about someone's life always including their relatedness to others, that we can understand their susceptibilities and how to help them achieve health.