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## *Chapter 6*

# **THE ROLE OF RELATIONSHIP AND CREATIVITY**

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## **ABSTRACT**

This chapter draws from both personal experience and studies in the role of relationship as it applies to creative expression. It will explore the effect of “power-over” based relationships in health care, which include interprofessional collaboration, gender context, provider-patient interaction, and cultural competence, all of which have direct effects on the delivery of health care. The collective shift to a healthier relationship model is critical for the creative process in rehabilitation in situations that range from research and innovation to patient care and adherence. That process involves moving from personal internal experience to the larger role of interprofessional collaboration and interfacing with our communities in creating health.

## **INTRODUCTION**

- Relationship in Health care
- Historical Hindrances
- Relationship Continuum
- Cultural Competence
- Relationship Layers
- Domination Pedagogies
- Relationship in Mindful Leadership
- Sustainable Partnership for the Future of Rehabilitation

## RELATIONSHIP IN HEALTH CARE

A very specific type of relationship, not just relationship in general, is critical for fostering creativity in rehabilitation. We have all had experiences where we felt belittled, marginalized, or outright ignored in the health care system. As rehabilitation professionals, these stories may sound familiar:

### Scenario 1:

A patient, “Deborah,” had this experience during a consult with a surgeon, “Dr. D.” from a well-known, elite teaching hospital. The interaction with Dr. D that left her feeling powerless and humiliated.

Dr. D came into the examination room where Deborah was waiting with her husband. The doctor did not introduce himself when he entered the room. After a casual exam, which she knew to be inadequate to diagnose a serious shoulder injury, Deborah tried to discuss her symptoms. Dr. D interrupted her and dismissed her inquiry as irrelevant. Dr. D did acknowledge Deborah’s presence, but when it came time to respond he turned to her husband to make eye contact with, and speak to him. Deborah’s final attempt to ask a question about evidence-based alternative treatments for pain management in order to avoid unnecessary prescription drugs received the following response: Dr. D. literally rolled his eyes, turned to her husband, gave him a “knowing” sarcastic smirk and condescendingly remarked, “No, that (alternative treatments) will not work.”

### Scenario 2:

“Emily,” confided that treatment she received from her ob/gyn practice was horrendously humiliating, as she was regularly belittled by her caregivers at the practice and her concerns marginalized. She felt it was because early in the doctor-patient relationship she questioned the evidence-base behind recommended “standard” procedures. She made it clear that she desired a natural pregnancy and birth if at all possible (i.e., asking why some of the testing, an ultrasound and repeated Doppler, was needed and also asking why less invasive forms of monitoring baby couldn’t be used.) The physician turned to Emily and her husband and, peeking out the door in mock-fashion as if to “look” outside said, “What? Did you ride in here on a horse and buggy?” Despite repeated requests to consider her birth plan, Emily went on to have two births with the same large ob/gyn practice. Both ended in “emergency” C-sections, which put her in dire straits as an uninsured, self-employed, new mother.

Deborah and Emily are real people with real stories. The relationship with their health care providers stunted their input and ignored their personal concerns. It labeled them as medical conditions first and people second, and left lasting scars of humiliation and dehumanization which they will associate with the health care system for years to come. Their stories are the unfortunate norm in not only orthopaedic and maternal care, but in health care today. But let’s also consider these relational scenarios that implicate patient care as well as policy. How might they impact creative potential through relationship?

- “My association says that we cannot discuss alternative therapies such as yoga with patients because they are not considered skilled therapeutic exercise.”
- “My doctor says therapy will not help for my back pain and that injections or surgery are the best route; but when I question him he cannot tell me why.”
- “My PT says he will only allow me to sit in this position so my disc does not bulge.”
- “Hospital policy mandates that external fetal monitoring must be carried out on all laboring mothers every hour, regardless of their pregnancy risk or health status.”
- “Organizational policy cannot consider integrating coursework from, or completing research, outside of our own department for completion of your allied health degree.”

All of these real life cases describe a single type of relationship. A relationship in which patients are disempowered by health care providers and where health care providers or students are disenfranchised by the health care system or its academic body. Everyone’s potential is radically diminished in this type of hierarchical relationship. Health care providers and patients alike are stuck in the antiquated cogs of a “my way or the highway” sick care system.

In the cases above, three observations can be made. The first is that relationship which is not well developed negatively impacts patients self-efficacy, stifles outcomes, suppresses leadership potential, and limits creativity. The second is that if the patient does not feel their story or experiences are heard or respected, they will be far less likely to engage the provider, participate in, or follow through with their health care plan. In a real way, patient outcomes are dependent upon the quality of relationship with the provider. The third is that collaboration with a patient should not kill evidence-based medicine. Rather, consideration of a patient’s input should expand the definition of evidence-based medicine, which would foster creativity via considering all possibilities for best care. In other words, evidence-based medicine and provider-patient collaboration are not mutually exclusive.

Given these three points, then the very nature of relationship must change in our current health care system. Fostering creativity in evidence-based rehabilitation, though, must be pursued in the name of sustainable innovation and equitable research that will establish trust, improve patient care, and reinforce caring relationship in the patient and public.

## **HISTORICAL HINDRANCES**

Relationship is often discussed as being an essential part of health care delivery, but what is its role in creative rehabilitation culture? In today’s biomedical paradigm, two distinct variables have prevented development of relationships that foster creativity and sustainable innovation. Those variables are ingrained socialization and cultural conditioning, which will be explored through the remainder of this chapter.

Ingrained socialization and cultural conditioning are perhaps most apparent in the “powerful and pervasive myth in biomedical health care systems that the domain of medicine belongs solely to physicians” (Eisler & Potter, 2014; position 522). This has perpetuated two myths. One is that patients should blindly follow “doctor’s orders” without question. This issue could be theorized as more of a generational gap issue, since younger generations are beginning to question the “power of the white coat.” The second is the myth that pits men

over women. Traits stereotypically assigned as feminine, including compassion, nurturing, and empathy, have historically been devalued and viewed as “soft or weak,” with their development particularly stigmatized, discouraged, and even overtly scorned. Masculine traits like competition, aggression, and assertiveness, however, have historically been lauded, considered stronger, and given more value. These cultural attitudes have impacted gender equity, which fundamentally stunts creativity for both men and women.

These patterns of social ingraining negatively impact relationship and effectively make relationship not only an individual, but a social phenomenon (Eisler & Montuori, 2007). Further, cultural conditioning related to gender inequity has created a “discourse on creativity which has been almost exclusively by and about one gender: the male.” (pg. 479). If relationship is part of a larger social phenomenon, then it is that relationship, more than individual effort alone, which will ultimately determine the creative potential in rehabilitation. Only when both men and women are respected for what they can contribute can we recognize our full potential in the field of rehabilitation.

For creativity to thrive in the rehabilitative field, two things are needed. The first is an ungendered definition of creativity (Eisler & Montuori, 2007). The second is an evolution of health care culture toward a new relationship paradigm free from the trappings of inequity and domination of one gender (literal and the traits associated with) over another. This paradigm shift would affect all levels of relationship, from physicians and health care providers to providers and patients. But first, we must deconstruct the continuum of relationship that defines creativity as a holistic pursuit that affects the larger social collective.

## **RELATIONSHIP CONTINUUM**

Cultural transformation theory (Eisler, 1987) posits that human relationships fall along a continuum from domination to partnership. While no society purely operates from one of the models, the degree to which society supports the development and vibrancy of all its members, not just the few at the top, depends on its alignment with partnership (Eisler, 2002; Eisler, 2007). Deconstruction of these relationships reveals two observations: 1) the dominator model limits creativity and, 2) the partnership model fosters creativity.

The dominator model is based on a hierarchy of rigid top-down rankings that is maintained through physical, psychological, and economic control. The dominator model, also viewed as a “power-over” relationship (Eisler, 1987; 2000), maintains its rigid hierarchy by historically favoring only one gender: male (Eisler, 1987). The shadow that the dominator model has long cast over health care has not been fully considered until recently (Eisler & Potter, 2014).

The biomedical model has traditionally been organized under a dominator relationship, historically pitting one profession over another and one gender over another. However each field or profession in health care brings its own medicine to support patient healing and wellness (Eisler & Potter, 2014). Eisler (2007) identifies four distinct characteristics about the dominator model. The dominator model favors:

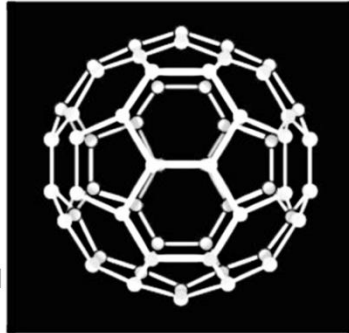
- 1) institutionalization of hierarchies that rank men over women,
- 2) an authoritarian and inequitable social and financial structure,

- 3) a high level of institutionalized social violence, from violence against women and children to violence in war, and
- 4) beliefs and stories that justify and idealize domination and violence.

### The Partnership System

Democratic and economically equitable structure

Equal valuing of males and females and high regard for stereotypical feminine values



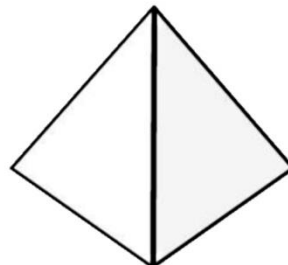
Mutual respect and trust with low degree of violence

Beliefs and stories that give high value to empathic and caring relations

### The Domination System

Authoritarian and inequitable social and economic structure

Subordination of women and “femininity” to men and “masculinity”



High degree of abuse and violence

Beliefs and stories that justify and idealize domination and violence

Figure 1. Dominator/Partnership Model.

In contrast, the partnership model is based on a democratic and economically equitable “power-with” structure that:

- 1) equally values both stereotypically male and female traits and work contributions,
- 2) has low levels of violence and functions in an atmosphere of mutual respect and trust,
- 3) demonstrates democratic and economically equitable structure, and
- 4) invests in beliefs that give high value to empathetic and caring relations (Eisler 2007).

## CULTURAL COMPETENCY

Our current definition of creativity is biased. Socialization practices designate creativity as an individual creator or “lone genius” treating the world as objects to be used in service of a creative vision rather than viewing creativity as an open-ended and evolving conversation between subjects with their own internal integrity and vision. The historical definition of creativity then, is skewed by dominator model socialization that perpetuates cultural beliefs and practices that devalue historically stigmatized “feminine” characteristics such as nurturing or compassion, thereby valuing masculine traits as more desirable or beneficial than feminine traits.

The patriarchy that institutionalized this definition of creativity is damaging for both men and women, since it limits relationship and creative expression with one another by only recognizing the contributions of half of humanity’s potential. Men and women alike are socialized to negate femininity in all areas of social construct, from “not running like a girl” in sports to “being more aggressive in the boardroom” in order to compete in the workplace. Even our everyday language perpetuates the dominator model with common phrases and clichés like “That’s above my pay grade.” or “My doctor said he will only allow me to \_\_\_\_\_.” continue to erode the partnership potential of our health care system.

The current domination model in health care creates barriers to receipt of health care services by identifying physicians as “gatekeepers,” with all other health care professionals ranked as subordinates. Their determining what services all other disciplines provide is a short-sighted approach. No checks and balances exist to ensure patients are getting services they need or that the decisions physicians make are based on best plan of care rather than what’s convenient or financially best for the physician or their employer. Communication is also stunted because the physician hands down directives rather than using a team approach that creates accountability for a patient’s best care. What results is disjointed continuity of care, which erects barriers to receipt of necessary rehabilitation services and erodes creative potential by not considering the input of rehabilitation professionals.

Insurance companies also have a “power-over” relationship with rehabilitation professionals. Use of the dominator model reduces utilization of needed non-invasive services by providing a distinct barrier: requiring orders from a physician who may know little or nothing about the highly specialized fields of rehabilitation. The ideals of capitalism are exploited by bringing gross financial profits at the expense of the society that needs health care. The cost of health care in the United States is the most expensive in the world, spending more of its GDP (17.7%) than any other developed nation; and yet performs the poorest, ranking last of 11 other wealthy nations studied (Davis et al., 2014), especially on measures of access, efficiency, and equity. Worse, the US has ranked last in previous reports as well, including 2010, 2007, 2006, and 2004 (Davis et al., 2010; Davis et al., 2007; Davis et al., 2006 & Davis et al., 2004).

Without an advocate experienced in negotiating the current dominator system of health care, a patient does not know what services are needed, what services to ask for, or that they even have a right or option for rehabilitative or preventive services. The patient is left feeling like they have very few options, very little voice, and therefore oftentimes feel their real

problems are left unaddressed. This scenario works against society's best health, quality of life, and economic prosperity, further illustrating why rehab needs rehabbing.

The patient has been left feeling dominated, marginalized, belittled, dismissed, or outright ignored as a patient. But how does the dominator model affect us, the providers? In "Transforming Healthcare Culture: Unlocking the Foundational Barrier to Improved Patient Safety, Quality, and Experience," a workshop offered through the Center for Partnership Studies, Julie Kennedy-Oehlert posits that the dominator model can create:

- Lack of validation in (health care) roles
- Patient and employee "policies and procedures" that are steeped in domination theory (urban legend-like outdated policies)
- Punitive-based policy
- Lack of common language and a name to call out things/relationships where they are on the continuum (domination/partnership)
- Culture that doesn't allow for partnership and interprofessional collaboration

Additionally, perpetuation of the dominator model in rehabilitation can take the form of:

- lack of health literacy in both health care professionals and patients that perpetuates the dominator view of MD at the top,"
- lack of direct access to rehabilitation services and providers in all states, and
- lack of public health policy and social policy to support individuals and families who care for the young or old.

Ultimately everyone loses in the domination model. Physicians lose because they cannot possibly supervise and carry a sufficient knowledge of all rehabilitation practitioners, nor do they have intimate knowledge of the skills and services each profession is able to provide. Rehabilitation professionals lose because another profession controls their expertise and contributions to patient healing. Most importantly, the patient doubly loses because they feel neglected and dehumanized by the system and their needs go unmet.

Partnership-based health care would maximize the healing potential of all therapies and forward creative problem solving in rehabilitation through several means. Use of a partnership model in health care:

- 1) views the patient as the leader in his or her health care, wherein the individual's feelings and stories are listened to and considered in mutually arriving at a best plan of care,
- 2) fully engages the patient and family members as active participants in their own health and well-being, and
- 3) empowers the patient to take responsibility for her or his own health.

Use of partnership-based model is also a more sustainable means for a solvent health care economy because it increases the likelihood of patient adherence through patient engagement and focus on relationship thus leading to better overall long-term all-health outcomes and a lower burden of cost for the individual and the system. Ideally, partnership should see a relationship where clinical doctors and health care professionals practice "shoulder-to-

shoulder” with one another. This approach was described at the First Physical Therapy Summit on Global Health as a horizontal, than the historical vertical, approach (Dean et al., 2011) to clinical practice, which is congruent with the definition of a partnership relationship between health care providers.

The partnership model is also based on the egalitarian principle that both male and female are capable of creativity and leadership, and that one gender or person does not need to be considered superior to another. Creativity then, must be redefined to include “both the female and male halves of humanity to be more congruent with research” (Eisler & Montuori, 2007 pg. 480). This egalitarian definition of creativity depends on shifting from the domination model to the partnership model. In other words, we do not have to disembodiment compassionate, nurturing, and the caring state of being from the self. We are both.

## The Domination/Partnership Continuum

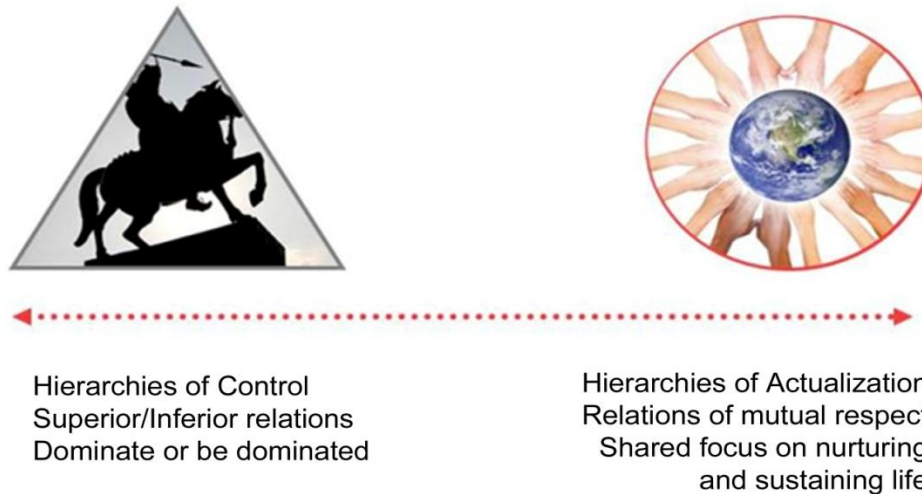


Figure 2. Domination\_partnership continuum.

Partnership-base health care depends on harnessing the power of “feminine” values, including empathy, compassion, and nurturing within a biomedical system that is largely driven by “masculine” values. Partnership also allows health care professionals to apply the same feminine values to relationships with patients, their coworkers, families, and ultimately, themselves (Eisler & Potter, 2014). Strengths on the feminine part of the continuum (again, seen in both women and men) include (Turner, 2012):

- Building relationships and establishing community in the workplace
- Structuring teams and groups in non-hierarchical, egalitarian networks that encourage involvement
- Collaborating (as well as competing)
- Making decisions by paying attention to process, gathering input and synthesizing perspectives (vs. driving to a goal)
- Influencing by persuading (vs. commanding)
- Sharing information, credit and power



Where on the relationship continuum does your organization or workplace fall? The remainder of this chapter will help identify where organizations may fall on the relational continuum through elaboration on the deeper layers of relationship, patterns of domination in health care culture, how relationship affects leadership, and how cultural competency affects the paradigm shift toward sustainable partnership in rehabilitation and health promotion.

## RELATIONSHIP LAYERS

When a patient goes in for a health care visit, how many layers of relationship are visible to the clinician? How many layers does the provider recognize e.g. self and patient, patient and family, patient and community, etc.? How do those layers of relationship, and their quality, affect the patient's prognosis or potential for well-being?

In Deborah and Emily's cases, how did their relationship with health care providers factor into their overall health outcomes? With their self-efficacy? With future relationships with health care providers? And how did the stunted relationship affect the caregiver's creative potential in determining the best plan of care? Did either Deborah or Emily's provider even consider their unique and creative abilities could contribute to the healing process?

What about interprofessional or educational interaction? How many layers of relationship are visible between a physician and therapist? Or between a therapist and student therapist? Instructor and student?

At the most basic level, there are two types of relationship in which the individual participates: 1) intrapersonal and 2) interpersonal. Intrapersonal relationship describes the depth and health of the relationship you have with yourself. Interpersonal relationship describes the way you relate to, and communicate with, others. As described in Chapter 3, healthy interpersonal relationships depend on an accurate sense of self-communication, or intrapersonal relationship.

But both types are equally important to the health of both the patient and the provider. Eisler's cultural transformation theory challenges health care providers to rethink all of their relationships including relationship with self, patients/ clients, colleagues, other professionals, and communities (Eisler & Potter, 2014, position 1051-1052). The layers of relationship should then be considered at the following levels:

- patient and provider,
- patient and clinic staff,
- provider with the self and environment (staff, family, community, and society)
- individual with the self and environment

These intersecting relationships must also be considered within the virtual plane of interaction via digital culture. Digital citizenship and engagement have drastically influenced how we receive and interpret information, permanently changing the collective social landscape and creative potential in healthcare. Whether a digital native or digital immigrant, digital citizenship - the idea that a person can be a multi-cultural member of society from their desktop - is a powerful method of communication that has given birth to vast creativity.

Seven dimensions of transcultural citizenship have been identified that can further affect creative potential via digital relationship, which include (Pathak-Shelat, 2014) an individual's:

- 1) Identities/Affinities
- 2) Values
- 3) Knowledge/Information
- 4) Connection/Communities/Networks
- 5) Expression/Voice
- 6) Dialogue/Deliberation
- 7) Action (which also describes the sense of one's efficacy)

Online or distance education is another forum through which the creative muse can be lost or found, and which affect all seven dimensions of transcultural citizenship. Both forums, digital citizenship and digital education, encourage us to develop a more critical outlook on relationship, perhaps viewing citizenship or belonging as something that happens with human beings, rather than occurring only in the context of one government or organization.

Relationship also happens on a larger scale at all seven dimensions, because citizenship includes not only relationships with people, but with the environment as well. In the partnership model, being in relationship appeals to an obligation to "respond to others with hospitality and the feminist theory of ethics of care" (Pathak-Shelat, 2014, pg. 62).

Even more complex is the degree of culture competence and sensitivity that exist in relationship. At a basic level, there is the quality and quantity of relationship that exists between rehabilitation professions and between those same professions and other health care providers, including medical doctors and nurses. For example, the struggle for autonomy and so-called "turf" wars has led to many battles between medicine and rehabilitation professions, as well as between rehabilitation professions ourselves. One discipline fights to have exclusive rights and privileges over another profession without considering how both professions can work together to dually provide aspects of service in order to increase access to, and efficacy of, care.

These layers of relationship must be considered, as well as their context, because of the complex template they provide to negotiate the creative path in rehabilitation. In addition to lack of literacy, access, and policy, there are also barriers to creation of health care literacy, direct access to rehabilitation services, and caring public health and social policies. In order to earn the trust of patients and public, those in health care fields would "likely need to develop radical new means of thinking and acting collaboratively" (IOM 2013 pg. 1-1). Statements like this reaffirm the need for adopting a partnership model in rehabilitation, in hopes that the shift to an egalitarian model would eliminate some of these age-old barriers.

## **DOMINATION PEDAGOGIES**

Another relational realm in rehabilitation culture that can affect creative potential is the way we teach and learn. The growing body on interprofessionality points toward a pedagogical model aligned with partnership. Transdisciplinary professionalism, "an approach

to creating and carrying out a shared social contract that ensures multiple health disciplines, working in concert, is worthy of the trust of patients and the public” (ABMS, 2013).

The way a teacher views and instructs a student is a reflection of the pedagogical relationship model the teacher has knowingly or unknowingly adopted. Use of a dominator model pedagogy, may take on the following characteristics:

- the “expert” teacher resides over the student and views the student as a blank sheet of paper waiting to be “filled” with the teacher’s knowledge, while
- the “underling” students operate only under the knowledge given to them by the “expert” teacher, excluding their own experiences and prior knowledge.

Teaching in this way limits and often disqualifies a student’s own experience, inherent knowledge, or inborn talent and genius, thereby limiting teacher-student interaction, the student’s ability to be creative, and as a result, subsequent innovation in the classroom. Dominator interaction during a student’s medical education, can exact negative consequences, such as an instructor belittling the student in front of colleagues, or creating an atmosphere of fear in a clinical residency or rotation where the students avoid asking questions for fear of being ridiculed. These negative experiences can affect the self-esteem of students across professions (Eisler & Potter, 2014). If students in medical training “cannot trust their own observations, how will they become full partners in health care if their self-esteem is weak?” (Eisler & Potter, 2014, position 2637). Overall, any system where rigid hierarchies reign supreme do so at the expense of proactive collaboration and true innovation, because they are built on competition and control or “power-over,” rather than on establishing relationship based on mutual respect, trust, and authenticity, or what Eisler & Montuori (2001) describe as “power-with”.

By contrast, a partnership model in health care exists within a framework that validates authentic experiences and unlocks people’s potential, says Sara Saltee of the Center for Partnership Studies. Frenk et al. (2010) calls for major education reform in health care in *The Lancet*, citing that breaking down professional silos through interprofessional education should occur alongside increasing “collaborative and non-hierarchical relationships in effective teams” (Frenk et al., 2010 p. 1924), which is congruent with the definition of the partnership model.

The Institute of Medicine (IOM) reports that transdisciplinary professionalism would facilitate improved interprofessional teamwork and may even synthesize and extend discipline-specific expertise to create new ways of thinking and acting” (IOM, 2013 pg. 1-1). The IOM (2010) also states that physicians should be educated with other health care professionals both as students and throughout their careers (and vice-versa) in lifelong learning opportunities, an approach well supported by the World Health Organization (WHO), the Centre for the Advancement of Interprofessional Education (CAIPE) in the United Kingdom, and the Canadian Interprofessional Health Collaborative (CIHC), to name a few (WHO, 2010; WHO, 1978).

Developing innovative thinkers in rehabilitation must consider cultivation of collaborative skills, behaviors, and values to students in health care programs, as well as developing leadership that can facilitate “ongoing research and innovation for transformative change” (IOM, pg. 1-1). This movement toward interprofessional education and collaborative practice (IPECP), in existence for decades, is finally receiving increased attention. Especially

in the face of the health care crisis in the United States today, there should exist an increased sense of urgency and deliberate effort to work together in partnership.

“Health systems research, which aims to capture such complexities, by necessity, needs to be multi-disciplinary and multi-method” (Swanson et al., 2012, pg. 58.; Mills, 2012).

## **RELATIONSHIP IN MINDFUL LEADERSHIP**

The new creativity discussion in rehabilitation recognizes the crumbling silos and tension between professional identity and integral understanding. But to shift the paradigm of practice in health care from a dominator to partnership model, effective leadership must also be addressed.

Leaders become so because of the quality of their relationship and interaction with others. If we learn who we are from others, then we become who we are because of the quality of interaction with others, says Daniel Siegel, clinical professor of psychiatry at the UCLA School of Medicine and Co-Director of the Mindful Awareness Research Center. Relationship, then, is the context for creativity, including creating our own sense of self and health.

Partnership-based health care in the community would look flatter and less rigid than the hierarchal organizations we are accustomed to seeing (Eisler & Montuori, 2001). Chapter 4 on evidence-based practice underscores that research and community-based inquiry are both affordable and efficacious. In evidence-based practice, hierarchies often rank quantitative evidence over qualitative (Potter & Eisler, 2014), placing randomized controlled trials (RCT’s) above all other types of research. “RCTs in isolation are inadequate to address complex challenges inherent in the context of health systems” (Swanson et al., 2012, pg.58, Mabry et al., 2010). Evidence-based medicine should not be ranked above the experience of the patient or practitioner.

International commentary on strengthening health care systems identify three themes as being most prominent or critical to systems-thinking approaches:

- 1) collaboration across disciplines, sectors, and organizations,
- 2) ongoing, iterative learning, and
- 3) transformational leadership (Swanson et al., 2012).

A global, partnership-based conversation is necessary as advocacy groups and global health leaders address the epidemic non-communicable disease rates, combined with achieving universal health care coverage and strengthening weak health care systems. The conversation shift, and success of achieving global health initiatives, depends on leaders’ “ability to collaborate with other key stakeholders around a shared vision...through creation of “learning organizations” that bridge across communities, sectors, and disciplines, continuously working together toward a common future” (Swanson et al., 2012).

Twentieth century medicine and rehabilitation were built around the necessity of dealing with acute disease and injury; however, 21st century health care must respond to the overarching social and behavioral determinants of health, chiefly chronic diseases caused by

lifestyle choices. Since medical intervention affects a person's lifelong health by an overall estimated 11%, while lifestyle and personal choices dictate 62% of a person's health (Kaufman, 2012; Kaufman & Pomeroy, 2012), health care of the future must focus on setting "common goals and targets with patients and relevant stakeholders, ensuring that each person is properly informed and engaged" (Swanson et al., 2012). This means that transformational leadership is not defined in terms of the traditional, patriarchally-defined hierarchy. Instead, transformational leaders will exist at all levels of an organization and will serve to challenge old ways of thinking and practice. Leadership representation will be found through the organization and will be built around a "shared vision of equity and efficiency...encouraging collaboration across disciplines...to break down traditional professional and disciplinary silos" (Swanson et al., 2012, pg. 58). Moving away from a dominator-style leadership in education would not require elimination of hierarchies, but instead encourage the development of leaders at all levels of an organization.

Leadership in health policy has also been linear and short-sighted in application. In the past, "Policy makers too often approach health systems from a mechanistic perspective, assuming that implementing a particular policy will lead to a predictable change in the behavior of local actors (such as providers, professionals and citizens), thereby ignoring the interactions between them. This line of thinking leads increasingly to detailed incentives and regulations from the top down, a so-called 'command and control' approach to policy" (Rouse, 2007). This approach leads to a loss of locus of control, self-efficacy, and dependence, which ultimately undermines leadership thinking at all levels by defaulting to punitive strategies and reward-type incentives. This type of approach also fails to consider that there are many determinants of health and a wide variety of efficacious interventions available.

From a neuroscience perspective, leadership must be considered according to brain-based thinking. The prefrontal cortex is "responsible for many competencies of good leaders," and is ironically dubbed the executive center (Siegel, 2014). Effective, mindful leaders must create an organization not through the old dominator mentality, but through helping those in the organization become their best self, described as helping the "latent self" in others to emerge (Siegel, 2014). Meaning, the potential for greatness lies in the individual already and a good leader will help the individual recognize the unrealized self. A truly visionary leader communicates in ways that motivate, instead of through old dominator patterns which would use intimidation, threats, or ultimatums.

## **SUSTAINABLE PARTNERSHIP IN REHABILITATION AND HEALTH PROMOTION**

"Much of what is happening today (in health care) is the conflict between the shift to partnership systems countered by domination/hierarchical resistance" (Eisler & Montuori, 2001). The organizational development and cultural transformation field is moving toward an overarching partnership model. For example, the University of Arizona's vision for academic medicine embraces partnership theory by focusing on unifying culture via (Kennedy-Oehlert, 2014):

- Service/patient experience
- Faculty and staff experience
- Diversity and inclusion
- Multi-dimensional communications
- Joint planning
- Interprofessional practice

Hospitals, clinics, and human resource departments in organizations and private practices can focus on partnership by addressing vestiges of dominator-relationship in (adapted in part from Kennedy-Oehlert, 2014):

- Patient policies (e.g. strict limitations on visitation/attendance at appointments that prevent patient inclusion and family engagement),
- Employee policies (e.g. staff bullying and interprofessional relationship; rigid work schedules that do not consider flextime, job-sharing, etc.)
- Procedures, Research, & Development (e.g. encouraging interprofessional collaboration and research through creating accountability policies that require interaction between professions and departments)
- Leadership development (e.g. Do leaders carry interprofessional goals and share responsibility? Are leaders responsible for engagement and who is included as a leader? Is there a team approach used? Is there lateral violence, high turnover, or discrimination in recruitment policies?)
- Patient-Provider Interaction (e.g. See the sample letter/conversational template that promotes collaborative person-provider interaction\*)
- Provider-Provider Interaction (e.g. Establishing healthy dialogue between providers at all levels of an organization or between practices)

\*Consider this sample letter used to encourage collaborative person-provider interaction encased in a partnership model:

It was a privilege to meet and work with you today. Thank you for sharing your story, your birth experience, and your fears and hopes with me today. I am glad you felt an environment of trust and respect to do that. This is how medicine should be and it is why I operate outside of the typical/conventional mode of practice. Healing is affected by our environment, the attitude and outlook of our health care providers, and as a result, I try to provide a welcoming, nurturing environment to each individual that becomes a patient. Your health care is very important and should warrant a team approach in every instance. That means your health care providers should always work together to provide a holistic, biopsychosocial plan of care. I am glad to hear that you have/are doing...Please see the attached program for your IHP (individualized home program).

Grace and Peace,  
Ginger Garner PT, ATC

## CONCLUSION

We are staged to use partnership in American health care, but we are not using it. Creativity in rehabilitation requires leadership that moves past the rhetoric of political and social conditioning and gender discrimination. Leadership development includes a balance of both feminine and masculine traits, encased in a partnership model. When both genders thrive, a country's economic system is stronger, which is a boon for potential health care, not to mention economic, reform. "Abandoning preoccupation with material wealth and profits and elevating ourselves to a more empathic worldview will require embracing feminine characteristics that foster peaceful communities and sustainable economies" (Perkins, 2011). A nation's quality of life is inextricably connected to the status and power of women. When their status is threatened, an entire nation's quality of life suffers (Eisler, 2007).

From boardroom to bedside and beyond, the partnership model can allow rehabilitation professions to pursue their vision more effectively, sustainably, and certainly, more creatively. We must press on toward cultural transformation in health care that fosters health literacy and collaborative education to truly see active partnership thrive and forward the creative agenda in rehabilitation.

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