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AN ANALYSIS OF INNOVATIONS IN
THE HEALTH CARE DELIVERY SYSTEM
THROUGH A STUDY OF WHOLISTIC
HEALTH CENTRES IN HINSDALE,
ILLINOIS AND WINDSOR, ONTARIO

by

W. KENNETH JAGGS, B.A., L. Th.

A Thesis
Submitted to the Faculty
of Graduate Studies
through the Faculty of
Sociology and Anthropology
in partial fulfilment
of the requirements for the
Degree of Master of Arts
at the University of Windsor

Windsor, Ontario, Canada

1985

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ABSTRACT

The thesis is a descriptive case study of the wholistic health movement in contemporary North America. Some of the reasons that have contributed to this phenomenon are outlined. A detailed description is made of two wholistic health clinics located in Hinsdale, Illinois and Windsor, Ontario.

An in-depth analysis of what makes a wholistic centre different from traditional medical practices is made including a detailed interpretation of the spiritual component of wholistic healing. Wholism is an integrated approach to the body, mind and spirit of the human person. It assumes that all three must be taken into account in any healing process.

The thesis includes a description of what happens to a patient when he/she attends such a facility. The description identifies the key role played by the patient when interacting, on a peer basis, with the health care team. The appendices identify some of the forms used to facilitate patient involvement in the diagnosis, treatment and rehabilitation phases as well as the prevention of diseases.

The thesis identifies that while there is a large body of knowledge in the literature that pertains to the subject of wholistic health theory there is a real dearth of material relating to the pragmatic application side of operating a clinic. There is also a shortage of empirical evidence to support the claims of the proponents of wholism as a medical concept.

Finally, the author suggests that the advocates of wholism are attempting to make inroads into the health care field. The author further suggests that wholism is attempting to be integrated into the medical care system despite opposition from the medical establishment. The author makes several recommendations for future research that could assist in establishing wholistic health centres as a bone fide branch of medicine.

DEDICATION

To my wife Leda, sons David and Andrew, and daughters Leda A. and Elizabeth, who waited patiently for me to complete this added task to an already full life.

Pax Christi

ACKNOWLEDGEMENTS

I would like to express sincere appreciation to each of my committee members, Professors John Hoffman and Robert Whitehurst for their advice and counsel throughout the preparation of the thesis.

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CHAPTER I

INTRODUCTION

A. Preamble

The pursuit of good health represents a prime preoccupation of most people. To that end society is prepared to spend billions upon billions of dollars in trying to meet this common human need. Approximately one third of the budget of the Province of Ontario is spent on financing health care with the major share providing acute care for sick individuals. Only about five percent is spent on the prevention of disease.

Entrepreneurs of many products and techniques claiming to promise people a life free of anxiety and pain come on the market from time to time. Purveyors of distilled, brewed and fermented products make a fortune from the consumers of their products. Manufacturers of a myriad of medications make equal profits. Fortune tellers, faith healers, palmists, among others, garner their share of the spoils. This thesis is about a specific method called wholistic health care

(sometimes spelled holistic). It is designed to assist people to maintain a healthy life without resorting to synthetic crutches through utilizing their own inner resources.

Wholistic approaches to health care have been growing in popularity over the last decade. In response to a variety of factors such as the increasing cost of medicine, the renewed attention to dis-ease etiologies with functional components (stress and lifestyle related illness) and the impact of the consumer revolution, wholistic models of care emphasize the promotion of wellness through education and preventive medicine.

The thesis represents a descriptive analysis of this innovative health care concept in the U.S.A. and Canada. While innovative, the concept is really an old/new version of approaching the healing of disease and promoting health standards from a perspective of wholeness or completeness. The methodological approach to diagnosis, prognosis and treatment perceives the patient as a total entity adopting the comprehensive view of Man most common to Western society. Each person is seen as possessing three components - body, mind and spirit. In order for a person to have good health there must be a nourishment of the whole person. This includes taking each component into consideration in the

diagnosis, treatment and rehabilitation phases of sickness and health maintenance.

From the earliest of times Mankind has tried to keep this view of the human person as an integral part of society. Somewhere in the latter part of the 18th or early 19th century a bifurcation between the sciences of theology and physical medicine took place. With the pragmatism of Kant and Descartes rational Man began to view humanity and health solely in terms of empirically proven evidence which translates into seeing all disease as germ or virus induced. Other human ailments such as broken limbs or cuts and lesions had an explainable cause. Advocates for wholistic medical theory recognize the existence of these causes but go further and say, that the cause and effect of human illness is greatly influenced by the attitude people hold about life in all its dimensions.

Commencing in the late 1960's pioneers within the medical profession developed a desire to practice medicine in a different way. It seemed that with the coming of specialization the old concept of the family physician was doomed to disappear. Partly out of a reaction to that, and partly because these pioneers saw a need to treat the whole person, including the spiritual side, groups of health care

practitioners developed the idea of a wholistic clinic. Against this background Granger Westberg developed his idea of having a medical clinic associated with the institutional church.

At first the idea had difficulty catching on - physicians were sceptical, potential patients were hard to come by - but a breakthrough occurred in Springfield, Ohio. It was from this beginning that twelve clinics serving approximately 16,000 people were opened under Westberg's parent organization and with about one hundred and fifty more in various planning stages at this time.

The uniqueness of these clinics is the fact that they are located in church buildings. The staff function as a totally integrated team with a pastoral counsellor acting as the executive director thus symbolizing the bringing together of faith and science. The patient/client is also an integral part of this team in the development of a Personal Health Plan. Part of this plan is for the patient to assume a greater degree of personal responsibility for his/her own health due to the fact that many illnesses are directly related to poor living habits such as lack of exercise and inadequate nutrition. Personal attitudes play a major part in this process as well.

The clinics studied in this thesis are operated by Wholistic Health Centres, Incorporated, Hinsdale, Illinois. A similar project has been undertaken in Windsor, Ontario and is known as the Phoenix Wholistic Health Centre, Incorporated.

The original clinic from which the model has come was located in an economically deprived area in Springfield, Ohio. Following upon the success of the initial clinic Westberg was challenged to see if the concept could work in a highly affluent area. He chose an opulent suburb of Chicago. The model has been refined with the opening of each new clinic. The Phoenix clinic has been adapted to the Canadian medical and social scene.

All clinics are located in a church building or are visibly associated with a religious institution in order to symbolize the fact that religious institutions are concerned about the health of people. It also ensures that the spiritual health of the patient is taken into account as well as concerns about the health of the mind and body and the interrelationship of the mind, body and spirit. It is also seen as an attempt at healing the bifurcation that has taken place between faith and science.

Clientele

The clients of each clinic represent a microcosm of society and are representative of many social conditions including levels of income, education, religious background and degrees of commitment to a belief system. Attendance at each clinic is quite varied. Some clients are referred by health care professionals including medical doctors, some are self-referred and others are referred by family, friends and former clients. Each presenting person comes with a diverse level of health problem similar to other medical clinics. Expectations of the clients range from a sense of hopelessness at previous therapies that have failed, through to people who want an integrated approach to their health problem. The clinical methodology utilized in these centres is inclusive thus allowing for a more intimate relationship to evolve between client and centre staff. The average client is more likely to be female, over 25 years, better educated and with a higher family income average although this should not imply that others are excluded for lack of money or other considerations. All people are accepted and receive individualized levels of service.

Structure

The staff of the Hinsdale Clinics are all salaried and include physicians, nurses, pastoral counsellors and ancillary

staff. The director is usually a pastoral counsellor. Some volunteers serve on the staff complement as well. The Windsor Centre is currently staffed by volunteer nurses and pastoral counsellors and a paid administrative person. Other volunteers serve in non-professional capacities from time to time. Each clinic has its own board of directors and in the case of Hinsdale there is a corporate board that manages the parent body. There are also advisory groups that offer professional consultation when required. The respective boards of management recruit members from the fields of business, labour and the professions.

Prefacing the Study

This study is a descriptive analysis of wholistic health care through case history research of two geographically separated but similar clinical approaches. Two personal visits have been made to the Illinois-based clinics as well as a scrutiny of the printed reports of the project. Personal involvement in the development of the Ontario-based clinic is quite extensive, ranging from planning the original seminar in 1980 that acted as a catalyst in the formation of the Phoenix Centre, to personal involvement as a clinical volunteer and member of the board. At the onset of this study literature was not readily available, especially in empirical evaluation or investigation of this type of medical clinic. At the time

of finalization of the study more literature was coming on line, however there is still a dearth of purely objective studies.

Initial Visits

When a patient attends the clinic for the initial visit he/she is seen by an ancillary staff member or volunteer. The purpose of the initial visit is to explain the philosophy of an wholistic approach to health care and for familiarization with the clinic staff and surroundings. At this time the patient signs a contract with the clinic by which a commitment is made by the clinic and the patient as to conditions of payment and attendance at the clinic. Release of information forms for designated people are also signed. Patients who have not had a recent medical examination are required to do so. If the client agrees to a comprehensive inventory of the present state of health a Health Inventory Form is required to be filled out prior to the next visit to the clinic. This personal inventory serves as the basis of discussion with the staff nurse and counsellor.

Personal Health Plan

A personal Health Plan is developed collaboratively by the staff and the patient. The patient implements the plan with the assistance of the staff. The plan is modified from

time to time. Attendance at health care seminars is optional and these are offered periodically by the respective clinics. Among the unique aspects of the clinics are intimacy, in-depth visits with physician and personal involvement in the choosing of therapy. The use of medications and radical surgery are kept to a minimum although not precluded.

Contribution of the Study

This topic has been chosen due to the personal interest in the concept by the investigator. The concept identifies the relationship between science and faith in the treatment and prevention of disease. The study will contribute to the body of knowledge about wholistic health especially during this early phase in their evolution into the health system. It also identifies the level of public interest and demand that currently exists in North America.

The study represents an in-depth investigation into the current practice of wholistic health care as found in two distinctly different but similar wholistic centres. It focuses on a qualitative description with limited quantitative data from the Hinsdale group as determined by a recent study commissioned by the parent body. The relationship of the two centres is shown and a simple comparison is made on some of the major differences of the two medical approaches. Early

reports on this innovative concept indicate that wholism is already significantly altering some traditional medical practices.

B. Delimitations

The study is limited in scope due to lack of clinical evidence which identifies the efficacy of wholistic clinics. There is also a major shortage of material that presents the opposite point of view relative to wholism vs the traditional medical model. The study is also limited due to the different stages of development found in the two geographically separated centres. Personal involvement in the Phoenix project represents a potential bias on the part of this investigator and is stated if an obvious conflict emerges. This limitation has presented the author with a great deal of difficulty in defining the term 'spiritual' as this term is personally seen in religious dimensions as the ultimate meaning. Lack of evaluative research data especially on the Phoenix Centre and accompanying lack of funds to undertake a careful scrutiny contributed to the limitations. Access to specific client information as to demographics, client profiles and types of health problems was not possible. It was not possible to interview people from the Hinsdale project

after the study was commenced due to distance and time.

C. Definitions of Terms

Because of the uniqueness of the special terminology which tends to evolve in specialized fields it is important to include some rubrical words. At present, there are a wide range of definitions for each of the terms listed below. The author has chosen those which appear to be the most reputable and suitable for this study.

.Sickness - is a relative term relating to process. The continuum includes risk behaviour, signs of illness, symptoms of illness, disease process and disability. It signals a state of not being whole. Its cause is from a germ or virus or a repressive environment or sick values and patterns of living. (1).

.Health - is the process of adapting to change (physical, social, intellectual, and spiritual) which leads to adjustment and wholeness. It involves a series of growth enhancing transactions between people and their environments. It is not the opposite of sickness. Maximum health involves people being able to take care of themselves in the flux of life - being response-able beings. (2).

.Healing - is a movement towards wholeness and occurs when the divisions which separate people from their own resources and from others are resolved (or partly resolved) and they again live in harmony with themselves and others. This process is universal, stimulated by every resource for health and every health care provider. (3).

.Wholistic Health - in some ways is a catchall term for alternative approaches to health. But there

is an applied, if not specific, direction. This direction, might be reflected by the term 'integration of mind, body and spirit,' or by redefining health in the sense of including consciousness raising or growth. In a more ethical sense it addresses the human energy crisis, the energy sapping lifestyle problems or critical life events less amenable to a technologic approach to medicine. It redirects us to the importance of exploring our inner space or consciousness, as well as outer space, through emphasis on health education and responsibility for self. (4).

.Stress - is the common, nonspecific response to the demands and the wear and tear of whatever happens to a living being. (5).

.Spirit - the human spirit is the place where faith, hope and laughter are born and nurtured. Within the Biblical tradition this place can ultimately be found in the Imago Dei. (6).

.Religion (i) - Man's conscious link with God (or the gods) and his response thereto. (7).

.Religion (ii) - The Christian religion is that form of religion, distinguished by a new way of life, which is the response of the entire individual - mind, feeling and will - to the impact which the living Christ makes upon him. (8).

It should be pointed out that the terms client and patient are used interchangeably as this is the way they appear in the literature. Both terms designate a person in need or 'at risk'. The trend in some recent literature seems to prefer the term client thus demonstrating the downplaying of pathology although this is by no means universal.

SUMMARY

Chapter I has shown that wholistic health care is an old/new approach to providing health care and which is having a significant impact on traditional medical practices in both negative and positive terms. We have seen that wholistic treatment places strong emphasis on the three elements of the human person - body, mind and spirit.

Chapter II outlines the research methodology utilized in this study.

2

CHAPTER II

RESEARCH METHODOLOGY

A. Selection of Subjects

The two clinical areas for this descriptive case study are chosen due to proximity, similarity of purpose and personal familiarity with the projects by the investigator.

The American clinical setting has been established since the early 1970's while the Canadian clinic is just getting underway. The American clinics have a fairly firm financial footing while the Canadian clinic has extremely limited funding and relies heavily on volunteer professional help. The two settings function in entirely different political funding systems for comprehensive medical health care. The American system does not have the extensive senior government funding at the federal and provincial (state) level that the Canadian system currently enjoys. Canadian health services are more rigidly controlled by senior government policy as a result of being primarily funded by them.

Both clinics function from a similar operational

philosophy but are at different stages of development. This presents a unique opportunity for comparison. There is a scarcity of literature pertaining to actual clinics, their description and preliminary evaluation. There is ample literature on the philosophy and theoretical basis of wholistic medicine therefore making the descriptive analysis more viable.

Personal interest and involvement of the investigator is also a major factor in the selection of the subjects.

B. Research Data Needed

Since the study method is to be a descriptive analysis of two geographically separated health centres information pertaining to the internal operations of the centres is necessary. In order to fully understand the operational style of each centre, information is required which captures the essence of wholistic philosophy and theory. Information is also required as to the practical application of wholistic theory in the clinical setting. Statistical information concerning the demographics of the patient population helps the reader to identify the service rendered by the clinics.

C. Collection of Data

An extensive literature search has been undertaken to identify the evolution of wholism as a method and the historical development of the clinics under investigation. The search also assisted in the identification of wholism as it has evolved in the medical and religious systems of North America. As in any examination of new approaches and techniques in providing health care, it is necessary to discover some historical background material in order to at least partially address the questions:

- (a) Why is the wholistic health service important, and
- (b) How can wholistic health care become formalized as a discipline within the medical system?

Two on-site visits have been made to the Hinsdale location. The visits were not made for the sole purpose of this study. The information obtained was for the purpose of helping to establish a wholistic clinic in the City of Windsor. A secondary use of this information has been a valuable contribution to this case study. The first visit lasted three days with the first two being devoted to extensive personal interviews with all staff of the parent body at the corporate headquarters of the Hinsdale project including the founder. Other interviews were arranged with

professional, ancillary and volunteer staff of three separate clinics - an affluent area, middle income area and an economically deprived area. (The operations are very similar hence no distinction has been made throughout this document). A unique part of the visit was being a participant observer at a case consultation with the patient present. The third day was spent in attending the Second Annual Conference of the parent body.

The second visit to Hinsdale was with five other representatives of the Phoenix project and lasted one day. The morning was devoted to meeting with key personnel from the parent body who outlined the philosophy and theory of their operation. The afternoon was spent in visiting two clinics. As in the previous visit, little distinction in operational methods was made.

Access to internal documents such as minutes, correspondence, position papers and patient records during the Hinsdale visits was not possible however full access to the Phoenix documents has been possible and some of this data appears in this study. Access to patient documents at the Phoenix Centre has not been sought due to the sensitiveness of the release of confidential information since the implementation of the new Canadian Constitution. Since the

Phoenix Centre is attempting to acquire funding from the Ministry of Health it seemed advisable to stay away from sensitive issues such as confidential patient information. Patient profiles have been established by the Hinsdale group however no such data has been developed by the Phoenix group to date. For purposes of background material personal interviews have been held with staff and board members of the Ontario group.

D. Analysis of Data

Data analysis takes the form of providing a full description of wholistic health care theory with a succinct comparison with the traditional biomedical approach. Some historical roots are described. Detailed information is provided concerning the two centres with limited references to statistical information. As in any descriptive case study detail is provided to identify similarities and dissimilarities of the centres and the respective operational methods.

A detailed interpretation of the term 'spiritual' is made drawing from the literature and from the author's personal experience.

Next Chapter

The following chapter shows a short anthology on the subject of wholism dating from ca1926 to the present. In this short review various positions taken by the researchers and observers of this unique method of medical care are shown.

CHAPTER III

REVIEW OF LITERATURE

A. Historical Perspective of Wholistic Medicine

An editorial comment by John P. Callan, which appeared in the Journal of the American Medical Association on March 16, 1979, clearly indicates the degree of scepticism and cautiousness that is commonly felt by many towards wholism as a medical concept.

(W)holistic health, a term increasingly bandied about with reserve or reverence based on one's perspective, is an uncharted or at least fuzzy area for many physicians. Its proponents, a curious axis of faith healers, chiropractors, clergymen, and Ph. D's, along with MD's, RN's, DO's, and others without visible signs of qualifications preach a message as old as the Bible and as American as apple pie: personal growth through self-actualization and maximum functioning of mind, body and spirit. Their methods of achieving such laudable goals run the full gamut from laying-on-of-hands and kinesiology through to purging or external application of castor oil, to meditation, unusual diets, and some of the most recent scientific developments including biofeedback. (9).

It is not clear if Callan intends the reader to view his comments in a literal sense, however his editorial comments do catch the perspective from which many people regard wholistic

health care. As a group, medical doctors, in particular, are generally suspicious regarding any innovations in health care especially when developed outside the profession. Wholism, as a modality, certainly includes many people from outside the medical profession. In the same editorial Callan alerts the medical community to the fact that the concept of wholistic medicine is not likely to disappear and that detailed investigations by medical researchers are to be perceived seriously. It seems that the Ontario Medical Association (OMA) is taking more of a journalistic interest in the broad area of wholistic medicine than heretofore has been the case. According to Ontario Medicine, the OMA Committee on General Practitioners is currently engaged in writing a report for the Association. (10).

Need for Alternative Health Care

There are at least five reasons behind the current interest in wholistic medicine, or total person health care as some prefer to call it. (i) According to Norman Cousins, the broad support of the concept of wholistic medicine is largely a consequence of a growing lack of satisfaction on the part of the consuming public with traditional biomedical treatment modalities. (11). Indicators of this are found in letters to the editor of public newspapers. Even doctors in the syndicated columns, such as W. Gifford-Jones, mention this

dissatisfaction. The strongest critic of the system from within appears to be Robert S. Mendelsohn in his critical work about contemporary professional medicine and institutional care. He starts off the critique of his profession by declaring that he doesn't believe in modern medicine and that he has become a heretic. (12). (ii) The gist of these criticisms seems to be that people are better educated and therefore more aware of such important factors in health care as nutrition. They have gained greater insight into the power of the mind in coping with sickness and its potential in the prevention of disease. Medical doctors have chosen to ignore this societal change. (13). (iii) The contemporary practice of specialization has largely replaced the traditional family physician approach to people and their health problems. (iv) The high cost of medicine, hospitalization and medical technology has become prohibitive. And finally, (v) The spiritual dimension of the patient is not always taken into consideration.

Major Omission

The Age of Specialization, with its reliance on the use of high technology and sophisticated medications, has neglected to take into account that intangible and actual element in human lives known as spirituality. Mental, physical, emotional and spiritual factors are all of vital

significance in determining an individual's state of well being. Treating the whole person is the root meaning of the term 'wholistic' in the field of medicine.

Changes Needed

What all this means is that the health care professional needs to change his/her attitude by taking the time to listen to what clients are trying to say. The client, on the other hand, must become more assertive when attending a clinical setting. The client must also take the time to listen to what his/her own body is trying to tell about the state of his/her health. This is called Behavioural Kinesiology. (14). If personal attention cannot be accomplished by the medical practitioner then other health care professionals must fill this unnecessary gap in patient care. Clergy, trained as pastoral counsellors appear to be prepared to assist in filling this gap. Clients, on their part, must assume substantially more responsibility for their own health by re-examining their total environment and lifestyle. All play a part in obviating the disease process.

Source of Disease

The acknowledged expert in the field of wholistic medicine, Kenneth Pelletier, maintains that physical disease is caused by a variety of factors - psychological,

psychosocial, environmental and spiritual - and all these components of human beings have to be considered in totality if the patient is to be healed or 'made whole'. Such an approach is, of course, an anathema to those health professionals who subscribe to the reductionist theory of investigation and who focus on unconscious conflicts or aberrant molecular structures as the sole cause of illness. Pelletier, by contrast, reasons that despite its more comprehensive orientation, the wholistic method is still within the parameters of scientific medicine. (15). Robert James of the OMA supports this view and identifies wholistic medicine as the art of being well. "It's surgery where necessary, medicine where indicated, acupuncture, psychotherapy, attention to diet and more exercise where appropriate." (16). William Francombe, associate dean for academic affairs at the University of Toronto Medical School is not quite so definitive in his statements about the concepts of wholism being part of the medical process when he says, 'it's difficult to define let alone react to it.' (17). Thus far this statement seems to sum up what the critics of wholistic medicine say and a great deal of research needs to be undertaken on both sides of the ~~issue~~ before any conclusive results can be stated.

Inclusion of the Spiritual Dimension

Some of the authors, Diamond (18), Anderson (19), Szasz (20), Murray and Zentner (21), Bresler (22) and Simonton, Matthews-Simonton and Creighton (23) make no specific reference to the term spiritual. They define wholism strictly in terms of an integration of mind and body. In contrast, the term spiritual appears frequently in the literature with a wide variety of interpretation ranging from the description of an inner force that somehow motivates people in an animated, creative way, through to a more dogmatic or doctrinaire interpretation unique to each of the recognized World Religions. The literature seems to imply that all human beings possess some abstract, almost undefineable dimension that requires regular and systematic nourishment.

All religions say in one way or another that man does not, and cannot, stand alone. He is vitally related with and even dependent on powers external to himself. Dimly or clearly, he knows that he is not an independent centre of force in the world, a creature divorced from Nature or the Force or forces producing it. (24).


The chart on the following page graphically and succinctly illustrates a sample of these concepts as they relate to health and health care. (25).

CHART SHOWING WORLD RELIGION REFERENCES TO HEALTH AND HEALING.


Health & Healing in the World's Great Religions

 CHRISTIANITY :


"The prayer of faith shall heal the sick, and the Lord shall raise him up."

 CONFUCIANISM :


"High mysterious Heaven hath fullest power to heal and bind."

 BUDDHISM :

"To keep the body in good health is a duty . . . otherwise we shall not be able to keep our mind strong and clear."

 HINDUISM :


"Enricher, Healer of disease, be a good friend to us!"

 ISLAM :

"The Lord of the worlds created me . . . and when I am sick, He healeth me."

 TAOISM :


"Pursue a middle course. Thus will you keep a healthy body and a healthy mind."

 SIKHISM :

"God is Creator of all, the remover of sickness, the giver of health."

 JUDAISM :

"O Lord, my God, I cried to Thee for help and Thou hast healed me."

 JAINISM :


"All living beings owe their present state of health to their own Karma."

 ZORASTRIANISM :

"Lore endows the sick body of man with firmness and health."

 BAHAI :

"All healing comes from God."

 SHINTO :

"Foster a spirit that regards both good and evil as blessings, and the body spontaneously becomes healthy."

An in-depth discussion of spirit and spirituality appears in Section C of this chapter.

The Term Wholistic

A review of the literature identifies the confusion that has been picked up by those who approach wholism from a cautious perspective. One of the most confusing issues facing those who wish to investigate wholistic health care is that of definition. The words 'holistic' and 'health' are both derived from the same Anglo-Saxon root word, 'hal' meaning 'whole,' 'to heal,' or 'sound'. The word, as used in this study, is also spelt 'wholistic,' (coming from the Middle English), which accounts for the word being used interchangeably throughout the literature. (26).

The Greek word 'holos' meaning whole also comes into play in defining 'wholism'.

It is difficult to clearly identify the origin of wholism as a contemporary phenomenon, however Barbara Blattner has discovered that Jan Christian Smuts, drawing upon the theories of Hegel, Darwin and others, developed the first identifiable theory of wholism in 1926. Smuts had two intense interests - philosophy and biology. He disagreed with the analytical method employed by the life sciences to study

organisms. He thought there was more to learn about the human body than could be gained from taking each part (cell, system, etc.) and studying it in isolation. He felt there was something more that pulled everything together in harmony and caused the organism to maintain itself in a fluctuating environment. (27).

Others have picked up on the theory of wholism developed by Smuts. D.C. Phillips has developed five points which have become incorporated into wholistic thought:

- .The analytic approach as typified by the physicochemical sciences proves inadequate when applied to certain cases, for example, to a biological organism, to society, or even to reality as a whole.
- .The whole is more than the sum of its parts.
- .The whole determines the nature of its parts.
- .The parts cannot be understood if considered in isolation from the whole.
- .The parts are dynamically interrelated or independent. (28).

Health Defined

In recent years the definition of health has undergone some significant changes. In 1947 the World Health Organization defined health as, "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." (29). Other definitions have evolved showing the uniqueness and adaptability of the human species. Authors such as Halpert Dunn (30), Rene Dubos (31), George Sheehan (32) and Ivan Illich (33) have all made attempts at

describing the preciseness of health describing the conditions, internal and external, that must exist if people are to have optimum health. The Canadian Government in 1974 described health in an inclusive way indicating that people must assume greater personal responsibility for their own health. The report on health by the Ministry of Health and Welfare indicated that people must learn to control those forces, internal and external that contribute to health deterioration. (34). Attitude and personal lifestyles prove to be important factors in disease prevention and health promotion. Wholism has developed simultaneously with the evolution of health as a political and social reality. Wholism has come into prominence amidst this background of major changes in the health field due to altered perceptions by health care professionals, giant leaps in technology and sophistication of synthetic medications. Most authors indicate that wholism, as a medical entity, started in the early 70's. It could be stated that wholism as it evolves in North America is a new/old concept dating from Hippocrates, the Father of Western Medicine. Hippocrates saw medical care in terms of the total person. There does not appear to be any universally accepted definition of health. While no one definition prevails as a classic all seem agreed upon seeing the human person in its totality. The World Health Organization definition still prevails as a bench mark for all

others.

Wholistic Branches

Wholistic medicine seems to be branching off onto two distinctly different directions. One branch prefers to be seen as an alternate form of medicine and incorporates ALL techniques designed to alter human behaviour including use of the occult, phrenology, irridology, astrology, tarot, and palmistry. Major leadership for this branch seems to be centred in California. Evert Loomis and John Travis appear to be the acknowledged leaders in this all inclusive field. (35). The other branch, and which is reflected upon in greater depth in this study, is more closely connected to traditional medicine and merely attempts to alter some of the practices that create a distance between the patient and the practitioner as well as the role of the patient from passive to active involvement in the healing process. One leader here is Granger Westberg, a man who has shaped the clinics under investigation in this study. (36).

The common element between the two streams of wholism is summed up in the work of Kenneth Pelletier:

- .The whole person is treated through an integrated approach.
- .Each individual is unique and represents a complex interaction of body, mind and spirit.
- .The patient and the health practitioner share the

responsibility for the healing process. The patient's responsibility is to become an active participant, exercising his volition in regard to his own health, lifestyle, and further development.

.Health care is not exclusively the province or responsibility of orthodox medicine. Diagnosis and treatment of pathology is a medical concern. The creation of a lifestyle conducive to health maintenance and personal fulfilment is beyond the limited scope of pathology correction. Included in this idea is a multidisciplinary approach requiring mutual interaction and enrichment among many professions oriented towards helping clients achieve their own level of wellness.

.Illness is seen as a creative opportunity for the patient to learn more about himself and his fundamental values.

.The practitioner must come to know himself as a human being. (37).

B. Wholism as a Medical Theory

Traditional medicine has relied upon the treatment of symptoms utilizing a variety of medical techniques which usually involve the use of medication and surgery and other invasive probing. The medical team is hierarchical in composition with the tertiary specialist at the apex and the patient playing a submissive role at the bottom. All other health professions play a subordinate role to the tertiary specialist including the primary and secondary care physicians. Health institutions are also lower in status and scope than Health Science Centres, which are hospitals that perform a teaching and research function for Schools of

Medicine.

By-products of Hierarchical System

Empirical investigation is extremely important and the medical team must be purely objective at all times in approaching the patient and significant others. This expresses itself in obvious ways, such as, when a non-physician enquires as to the condition of a sick person an innocuous response such as 'as well as can be expected' is often given by the attending staff.

Disease has its origin in a germ and must be approached by treating the symptom. The mind, body and spirit are seen as separate and any physicians who identify psychosomatic illnesses refer the patient to a professional counsellor, the discipline of which varies but who is usually a psychiatrist. Such professionals may or may not function at a collaborative level with the referral source. As an alternative to referral or the use of psychotropic drugs the placebo is periodically used as a form of suggestion and which has the potential for a curative effect. Prevention of disease is seen purely in terms of geographical cures, rest, vitamins on occasion, physical exercise and control of tobacco use, food and alcohol intake.

Wholistic Approach Differs

Wholistic medicine takes a substantially different approach without losing the positive benefits of traditional medicine. Medication, surgery and other invasive techniques are used but alternatives are sought before utilizing such radical interventions. The medical team function as peers and the client is included as a full partner in the treatment process. Empirical investigation still plays an important role however intuitive processes are also considered as efficacious methods of treatment and diagnosis. The mind and spirit play an important role in treatment and prevention. All professionals involved in the care of human persons are utilized, each performing a specific function in a fully integrated way. Disease can originate from a pathogen but can also be self-induced from the mental and spiritual disharmony that can act as a 'poison' in the body. Assuming personal control over ones' lifestyle and attitude toward life are extremely important. External sources of spiritual energy are also considered and religious faith can become an integral part of the treatment process. Appendix # 1 shows a simple comparison of the two models of health care.

Interestingly enough, the leadership for the spiritual renewal within the practice of the healing arts is coming from medical practitioners, some of whom are quite prominent and

credible within medical circles such as Malcolm Todd, former president of the American Medical Society, and the official representative of the Government of the United States at the World Health Organization. (38). It is also interesting to note that many of the concepts of wholism are being introduced into medical schools and at least one medical school grounded in wholistic concepts is in the process of being founded in the U.S.A. (39). The clergy may have a strong vested interest in promoting wholism to offset their diminished role in the health field although there does not appear to be any evidence to support this premise. There is no question that medical science as a health discipline is evolving in a significantly modified direction. There seems little doubt that the concept of spirituality will become more important although it has not been determined what parameters will prevail on a concept which is so abstract and open to so many interpretations. Perhaps this is the uniqueness of wholistic medicine in that the client has the final say as to which interpretation, if any, he/she wishes to hold.

Inclusiveness Needed

Drawing upon governmental and clinical studies and statistics, Pelletier argues for a more inclusive form of medicine. He argues that patients must assume greater responsibility for their health particularly in that aspect

called lifestyle. He defines lucidly the major diseases which should be treated by a more effective and inclusive health system. He lists among the most pressing the incidence of cardiovascular disease and cancer. Based on research findings, Pelletier estimates that up to 80% of deaths due to cardiovascular disease are premature since they occur in relatively young persons and are clearly related to modes of living which are inimical to good health. Similar conclusions are made concerning the high incidence of premature deaths related to cancer. (40). Simonton et al agree and point this out to the consuming public in their, GETTING WELL AGAIN. The authors maintain that the patient has the capacity to prevent and/or cure carcinomas. (41).

Role of Stress

Stress and its manifestations in psychosomatic disorders is the single most evident factor contributing to the afflictions of civilization. Hans Selye has pioneered in defining these stress-related afflictions. (42). Inclusive preventive measures, by which individuals can recognize and alleviate excessive stress-related activity, appear to be top priority of the proponents of wholistic medicine. These preventive skills are a basic part of the educational and counselling services offered by wholistic clinics. The patient is encouraged to participate in these adjunct services

in addition to standard medical diagnosis and treatment. By examining the stresses that occur in the process of daily living the patient is able to identify these stresses over which he/she is able to exert some degree of control or at least, to accept the reality of those over which no control can be gained. The following represent some of the expressions of stress factors utilized by David Bresler at the University of California and Los Angeles Pain Control Unit:

- .I feel tense.
- .I feel angry or irritable.
- .I feel depressed or helpless.
- .I find it difficult to relax.
- .I find it hard to concentrate on one thing.
- .I find it hard to meet deadlines or quotas.
- .People at work make me feel tense.
- .People at home make me feel tense.
- .I have indigestion.
- .I have headaches.
- .I have high blood pressure.
- .I have rashes or other skin problems.
- .I have tension-related neck or shoulder pain.
- .My hands tend to be cool or perspiring.
- .I have difficulty falling asleep.
- .I wake up early in the morning.
- .I eat when I feel tense.
- .I smoke when I feel tense.
- .I drink alcoholic beverages when I feel tense.
- .I take drugs when I feel tense.
- .I chew my nails when I feel tense.
- .I worry about the future. (43).

The questionnaire represents some of the types of personal inventories that can enable a patient to gain insight into these daily stresses and their relationship to health problems. Donald and Nancy Tubesing, originally involved with Westberg, have developed several such questionnaires an example of which appears in Appendix # 2. (44).

As has already been indicated, wholistic clinics, as they are evolving, place a major emphasis on assisting the client to understand and learn to change or accept events that contribute, directly or indirectly, to the development of life style illnesses and diseases. Alcohol abuse, excessive food intake, excessive use of tobacco, and needless worry are all factors over which the client has some control. Other factors include fluorescent lighting, overheating of indoors, and environmental factors affecting air/water/food pollution. In a recent letter from the President of the Michigan Holistic Health Association the following point is made:

The mission of promoting natural forms of healing has barely made a dent in public consciousness. Let's not be fooled by the ultra-commercializing of 'healthy foods', 'natural' products and 'wellness' programs. Much of this is very misleading and can actually serve as a smoke screen for what the real problems are. For example, the important causes of employee stress and illness may not at all be that THEY (blaming the victim) don't know how to 'relax'. Instead, it might well be that ANYBODY asked to perform such a meaningless and unrewarding job in an environment full of toxins and other hazards

would be just as apt to get sick. The so-called wellness program or 'employee's assistance program' is often a tightly wrapped bandage around a festering and unsightly malignancy. (45)

Perhaps the foregoing represents a valid reason why the Hinsdale model adheres so closely to standard medical practice. The empirical evidence for the source of human illness must never be overlooked for the sake of an ideal methodology.

Wholistic Clinic Procedures

To facilitate the process, the patient is given an informal document which, after due explanation, is to be signed and returned to the clinic. (Appendix # 3). This document is not, of course, a legally binding contract, but it does serve the function of a symbolic reminder of the acceptance of personal responsibility. This procedure encourages and enhances the possibility for the patient to accept a greater degree of intention to alter personal lifestyle in order to reduce stress and the hazardous consequences of stressful living. This level of stress will differ with each human being. The onus for 'wellness' is thus placed upon the patient; the clinic staff are part of the process and assist the patient in the difficult undertaking of assessing and altering lifestyle and any other factors contributing to the besetting medical problem. The signing of

the agreement form is primarily a symbolic act. The staff are enablers and facilitators.

The assessment procedure also takes into account the spiritual dimension from a religious as well as a humanistic and psychological perspective. Once again, this will differ considerably with each presenting person. It is at the spiritual level that this type of medical clinic becomes vulnerable especially to programme evaluators and funding bodies. The abstractness of the spiritual dimension has difficulty blending empirically into the purely scientific approach taken by traditional medicine. Advocates for wholistic medicine are assisted in overcoming this difficulty in finding scientific acceptance by the general support of many recognized scientists such as Hans Selye, Linus Pauling, Malcolm Todd, Teilhard de Chardin and others.

Difficulties in Including Spirituality

It is argued that inclusion of the spiritual dimension is important in the healing process but not without difficulty. Sally Guttmacher, in her paper, WHOLE IN BODY, MIND AND SPIRIT: WHOLISTIC HEALTH AND THE LIMITATIONS OF MEDICINE, cites Robert Crawford in pointing out this difficulty. "Wholistic ideology promotes broadening of medicine into areas of life that have been considered

inappropriate for medical intervention." (46). To include spiritual abstractions from a religious perspective as part of the resources of a medical clinic and the healing process is difficult to assess and evaluate. However, to exclude the totality of the spiritual symbol system of the patient would be to ignore an important component of that person. Such exclusion, the writers argue, may well impede the progress of the patient in the rehabilitation phase after the implementation of sophisticated medical intervention. At this point in time there is a dearth of material in the literature that empirically supports or negates such a position. Initial evaluations made by the Hinsdale group point out the need for indepth research. The literature does identify, for example, that not all patients who attend the clinics are interested in or see the relationship between physical health problems and the spiritual dimension. Clinic staff see its importance but respect the right of the patient in this regard. (47). Non-wholistic centres also point out this research need. Marilyn Marai, past president of the Chaplain's Section of the Ontario Hospital Association, strongly exhorts her hospital chaplain colleagues to undertake some empirical investigation of what they are doing with their patients in the hospital setting. She says: "The fact is, if we (hospital chaplains) wish to make inroads in the health care field, we must begin to research projects in a very significant way." (48).

C. Theoretical Framework of Spirituality

The authors of wholistic literature speculate extensively about the role of spirituality in the healing and preventive process. In order to put a synopsis of this material into perspective some regular dictionaries and specialized dictionaries have been consulted Webster(49), Oxford(50), Cross(51), and Random House(52). Spirituality is defined in several ways of which four are mentioned as a starting off point:

- a. That dimension of the human person that pertains to intelligent and immaterial functions and possessing the higher qualities of the mind. Spirituality relates to conscious thoughts or emotions and which involve the use of intelligence and intellectual thought.
- b. That dimension of human life that cannot be totally explained and not limited by time, space, and bodily function; the term soul is related to this explanation. Spirituality identifies the spirit as the seat of moral or religious nature. The soul or spirit is distinguished from the physical nature of the human person.
- c. That aspect of being that represents something supernatural, whether good or evil, such as angels and demons.
- d. That aspect of life that pertains to sacred things or matters called religion and involving devotion in its many forms such as prayer, worship and meditation.

Each of these four different but related interpretations appear in various forms throughout the wholistic literature. Often the word 'spiritual' is used in an undefined way and the interpretation is left to the individual reader. Other authors define the term before proceeding to develop their thesis relative to the practice of wholistic medical care. Some authors referred to in this thesis attempt to define the spiritual dimension of humanity as it relates to health and healing. In some cases it can be the root cause leading to disease and illness.

Personal Perception of Spirituality

At this point it is appropriate to amplify the functional definition of spirituality from which this thesis is written and which represents the personal operational definition of the author. It represents a base from which the literature on spirituality is discussed.

Spirituality is a universal feature of human culture and social systems. It is universal because all human beings attempt to identify the source of human life, of meaning, of feelings, of emotions, of a beginning and an end. Spirituality involves such qualities as love, honesty, understanding, patience, compassion and humility. When an individual begins a personal search to find these qualities this involves conscious or unconscious movement from the inner self to the environment and beyond and into eternity. This personal movement is evolutionary finding its ultimate expression in religious thought. The spiritual movement, journey or pilgrimage is individualized even when membership is

acknowledged in a formalized religion.

Spirituality, then, involves the pursuit of these eternal qualities of human existence and which contribute to a sense of wholeness. This may, or may not, involve religious actuality in doctrinal terms. Spirituality involves the mind; it also moves beyond into the intangible, the abstract.

Further explanation needed

The practice of spirituality within the context of wholistic medicine involves intuitive thought as well as cognition. Some psychologists refer to this as right brain/left brain activity respectively.

To further assist the reader the following represents a summary of the literature in defining spirituality.

(i) Rational, Cognitive Thought

Rational, cognitive thought means that spirituality is purely a function of the mind and external stimuli in religious terms are less important. Scott Peck draws no distinction between the mind and the spirit, and therefore no distinction in the process of achieving mental and spiritual growth. They are one and the same. Recovery from illness involves spiritual growth so that the body and the mind are blended together. By integrating the body and the mind

spirituality depends upon conscious thought and involves the process of decision making. Peck goes so far as to say that this integration and consequent expression of spirituality relates to religion as a functional component in human growth. He rejects any doctrinally defined approach to religious expression or theology and in doing so joins forces with contemporary liberal theologians.

All People Religious

From his vantage point of healing the mental and emotional hurts of his psychiatric patients, Peck argues that all people are religious (and therefore spiritual) beings:

As human beings grow in discipline and love and life experience, their understanding of the world and their place in it naturally grows apace. Conversely, as people fail to grow in discipline, love and life experience, so does their understanding fail to grow. Consequently, among members of the human race there exists an extraordinary variability in the breadth and sophistication of our understanding of what life is all about.

This understanding is our religion. Since everyone has some understanding - some world view, no matter how limited or primitive, or inaccurate - everyone has a religion. This fact, not widely recognized, is of the utmost importance: everyone has a religion. (53).

Peck further argues that since all people are religious and all people have some sense of a world view that is realistic - that is, conforms to the reality of the cosmos and our role in it, as best we can know that reality - we must

constantly revise and extend our understanding to include new knowledge of the larger world. (54). This is called spiritual growth grounded in humanistic thought and not necessarily aligned, but not contrary to, any formalized expression of religion. Peck would refer to this universal phenomenon as a "journey out of the microcosm into an even greater macrocosm." (55). He calls this "the religion of science". (56).

O. Carl Simonton, his wife, Stephanie Matthews-Simonton, and associate, James Creighton pursue a similar approach as Peck but without specifically identifying any religious expression. They emphasize the importance of mental attitude and the images which the mind envisions relative to the disease being treated. These authors say that clients who are able to focus on immaterial concepts are able to have greater control of disease, even the dreaded disease of cancer. They make reference to the use of mental imagery, a form of meditation, which involves the use of an "Inner Guide":

For many people, the Inner Guide takes the form of a respected authority figure - a wise old man or woman, a doctor, a religious figure - with whom the patient is able to carry on an internal conversation, asking questions and hearing answers that seem to be wise beyond the individual's conscious capacities. (57).

Impact of the Mind

David E. Bresler writes: "In pre-Cartesian times,

Agrippa (ca 1510 A.D.) proclaimed 'so great a power is there of the soul upon the body, that which ever way the soul imagines and dreams that it goes, thither doth it lead the body'....in the post-Cartesian era (after Descartes divorced the body from mind and spirit) medicine began to emphasize a more mechanistic, physiologic approach to disease. No longer were medical students taught the role that the mind can play in disease." (58). Robert James, a Canadian wholistic physician from Toronto, Ontario, endorses this position when he states, "the mind has been left outside of science because it can't be tidily measured." (59).

Humanistic Interpretation

The Roman Catholic theologian, Matthew Fox, reports that "the term spirituality is experiencing a comeback". (60). Fox goes into great detail in differentiating between the Greek and Hebraic meanings of spirituality. Appendix # 4 represents a chart outlining his main points. (61). The approach taken seems to be fairly liberal for a Roman Catholic, who are usually more theologically conservative.

Not all of his theological colleagues would agree with his attempts to contemporize and contrast the meanings of spirituality solely in humanistic and liberal terms. However, his definition makes a valuable contribution toward an

understanding of an wholistic approach to spirituality within medicine. Reviewer, Rabbi Sholam A. Singer, says the contribution made by Fox is particularly significant in the rediscovery of a spiritual dimension in contemporary society. (62).

Spirituality Within

Basically, what Fox is saying is that spirituality comes from within and that this is unlike Greek spiritual thought wherein humankind's relationship to God is primarily vertical; God is up, humankind is below. Hebraic thought believes that humankind's relationship to God is horizontal and concentric in its meeting places. God is all and all is in God. God is more or less pantheistic. (63). The natural outcome of the approach taken by Fox is a humanistic interpretation of the Imago Dei and it is with this that the more theologically conservative would argue.

(ii) Contemplative, Reflective Thought

Inclusion of Eastern Spirituality

Contemplative, reflective thought involves the inner being or spirit or soul coming into union with or contact with an external source of energy usually found in personified

Nature or an expression of some form of Cosmic Consciousness. In a search for a sense of awareness in this realm of spirituality some practitioners of wholistic health care have turned to the mysticism of Eastern religious thought as an expression of spirituality that can benefit the patient. The relationship between the forces of nature and the inner consciousness are extremely important in Eastern religion particularly those having their origin in India. Consider the following by the Swami Rama, an Indian mystic practicing in California:

With the body of nature outside and the centre of consciousness within, one should be living in health and harmony, but having built boundaries, both externally and internally, the direct contact with these forces is lost. All human beings have the inner potential and skill to be healthy, but in today's world, because of the social and economic pressures, human beings have forgotten that all things happen deep within before they appear on the physical and mental levels. One must understand his inner skills and resources, use them as much as possible in order to insure perfect health. (64).

To achieve this state of wellness the individual is expected to get in touch with his/her personal level of consciousness, the essence of his/her very being. Devotees of this method practice any one of a number of ways of Eastern meditation or contemplation with the centre of concentration being on the inner self or psyche. This usually involves getting in touch with the body rhythm as expressed by

breathing and the beating of the heart while repeating a personal mantra (a word, phrase or sound) or focusing on a mandala (a visible symbol) or engaging in mudra (body movements) or a variation of all three. (65).

Rediscovery of Western Spirituality

There seems to be a serious attempt on the part of Christian spiritual writers at understanding spirituality in what some term a post-Christian era. Abbot Gabriel Braso, a French Benedictine monk, writes:

For some it (spirituality) is the equivalent to the life of Christian perfection, while others use it to designate the entirety of the activities of the human spirit. Some express by it a natural tendency to mysticism; for others it is synonymous with spiritual life. Others again indicate by the term 'spirituality' that part of theology which some call ascetical and mystical. The followers of the existentialist philosophy of the new theology use it to describe that indefinable 'spiritual climate' in which our interior activity takes place." (66).

The Trappist monk, Thomas Merton, wrote extensively on spirituality for modern man. The following lengthy but applicable quotation illustrates how society, and individuals, can transcend the mundane and move from a microcosm into a macrocosm:

Society....must be made up not of numbers, or mechanical units, but of persons. To be a person implies responsibility and freedom, and both these imply a certain interior solitude....

When men are merely submerged in a mass of impersonal human beings pushed around by automatic forces, they lose their true humanity, their integrity, their ability to love, their capacity for self-determination. When society is made up of men who know no interior solitude it can no longer be held together by love: and consequently it is held together by a violent and abusive authority. But when men are violently deprived of the solitude and freedom which are their due, the society in which they live becomes putrid, it festers with servility, resentment and hate.

No amount of technological progress will cure the hatred that eats away the vitals of materialistic society like a spiritual cancer. The only cure is, and must always be, spiritual. There is not much use talking to men about God and love if they are not able to listen....

Since faith is a matter of freedom and self-determination - the free receiving of a freely given gift of grace - man cannot assent to a spiritual message as long as his mind and his heart are enslaved by automatism. He will always remain so enslaved as long as he is submerged in a mass of automatons, without individuality and without their rightful integrity as persons. (67).

What Merton is telling the world is that people live in a spiritual vacuum often created by the environment in which they live. Like Scott Peck, he agrees that people get locked into a specific level of growth, victims of factors often unrealized and unable to escape so that spiritual and mental growth can occur. To move people to increase their level of spiritual reality is a difficult chore and hence the eventual devotion to God. "There is no greater disaster in the spiritual life than to be immersed in unreality, for life is maintained and nourished in us by our vital relation with realities outside and beyond us." (68).

Adopting States of Reality

To move people from a state of unreality to reality, or reality to another level of reality, is one of the roles of the healing professions - medical, psychological and pastoral.

Consider the case of a young epileptic woman who, in her opinion, has never received any love from her parents. She carries a photograph of them which she gazes forlornly at several times a day. She is locked into a level of unreality that cannot change unless she changes her sense of reality. With each passing month the epilepsy seems to grow worse as the external and internal forces press in on her. Her unreality is creating a destructive reality.

The role of the clinician is to assist in freeing her from her present state of unreality by helping her to understand that she can still love her parents while accepting the reality as it currently exists. She has to move on and grow spiritually and mentally in the all-embracing way intended by Merton and Peck so that she can live more as an individual thereby attaining her potential level of integrity and capability. She has to become her own person thereby creating a new and more healthy sense of reality - "To accept the things she cannot change, courage to change the things she

can and wisdom to know the difference", (to paraphrase a prayer used at all meetings of Alcoholics Anonymous).

Further Explanation of Contemplative, Reflective Thought

Some authors see spirituality in terms of 'intimacy love and expressions of love' Woollams and Brown (69), 'transcending' Tournier (70) and 'actualization' Shostram and Montgomery (71). All agree that relationships are extremely important. Spirituality involves developing a deepened relationship and this means moving beyond the self into community.

Energy Beyond

Francis MacNutt looks upon contemplative thought in a different way. He sees the source of healing energy beyond the inner self. Within Christianity, especially Roman Catholics and Pentecostals there is a movement known as the Charismatic or Spiritual Renewal Movement. The central focus of this movement as it relates to healing can be seen in light of the Gospel of St. Luke: "The spirit of the Lord has been given me. He has sent me to bring the good news to the poor, to heal the broken hearted, give sight to the blind, and freedom to the downtrodden." (72). This message has been taken literally by the leaders and followers of the Christian Renewal Movement. There is a strong desire for miracles in

the healing process.

Perhaps the leading authority on this approach to healing in the Christian Church is Agnes Sanford, closely followed by her son and disciple, John Sanford, who carries on her work but from a more academically oriented perspective. In fact, Sanford rarely mentions the work of his mother. The now-laicized, former Roman Catholic priest, Francis MacNutt, who was greatly influenced by the Sanfords, has written extensively on spiritual healing through the medium of prayer. His book, HEALING, is the first comprehensive Roman Catholic book on healing prayer. What the Sanfords and MacNutt have in common is the fact that spirituality in the healing process is seen in terms of prayer. This approach causes anxiety in many health care professionals but needlessly, they say. MacNutt hastens to assure the critics of this form of healing that there is no negation of medical science. "In no way do I conceive prayer for healing as a negation of the need for doctors, nurses, counsellors, psychiatrists, or pharmacists. God works in all these ways to get the sick well through every possible means." (73).

MacNutt perceives this form of ministry as credible even though many would disagree:

As a Harvard graduate with a Ph.D. in

theology I am as aware as anyone of problems of credibility and of a prevailing theological climate which questions whether God 'intervenes' or 'interferes' in the universe. But my own experience leads me to the conclusion that healing is the most convincing demonstration to most people that God is WITH US - that he is not 'out there' beyond the reach of human compassion. (74).

Not all theologians are as convinced as MacNutt that spirituality expressed in prayer and reflective thought is significantly involved in the healing of sickness. Morton Kelsey points out that in the most comprehensive survey of theology, John Macquarries' TWENTIETH CENTURY RELIGIOUS THOUGHT, not one of 150 theologians surveyed discusses the effect of man's religious life on his mental or physical health. (75).

(iii) Symbiotic, Religious/Scientific Thought

Much of the wholistic literature represents a plea for the reunion, or at least a converging, of religion and science. Leslie Weatherhead promoted the symbiotic relationship of religion and science. He saw a distinct relationship between body, mind and spirit, identifying the three as separate but interactive components of human life. (76).

Weatherhead believed that the 'whole man' must be the

aim of all three branches of the art of healing (medicine, psychology, religion) and they must act in closest cooperation. He quotes from Lord Horder's address to the Philosophical Institute of Edinburgh in October, 1928: "For the whole of man and not merely part of him is concerned, or may be, in Medicine, whether this be preventive or curative, and this 'whole' includes his spiritual or religious temperament". (77)..

While Weatherhead saw health and healing in terms of a religious expression of spirituality he was quick to add that sectarian religion has no place in healing a troubled person. While his language is characteristically typical of the era in which he wrote, he saw great promise for the spiritual dimensions (from a religious sense of emanance - God within) in healing broken minds and bodies:

I believe that healing, by non-material methods, has an immense and honourable future. I believe that the scope of such healing will gradually extend from what we now call, or miscall, the functional to the organic, I prophesy the dawn of a day when certain kinds of modern surgery, for internal growth for instance, will seem a clumsy carpentry which will make future generations open their eyes with dismay that there were such days when men were so limited in their knowledge of the ways of healing. And in such a day there will be a small space for the use of drugs.

I say this not in any spirit of depreciation of modern surgery and medicine, for I have an immense admiration for both, but because I have had a glimpse of immense energies, some of them

resident in personality itself, and others able, under certain conditions, to sweep through the personality itself from some source outside it which can cure not only functional disorders, but even those disorders deemed organic which may turn out to be but the concomitants of a psychological or even spiritual disharmony. (78).

Having said this he also made a strong appeal for spiritual approaches to healing to be scientifically investigated and become an art based as much on science as present medical methods are based on science. (79).

Synthesis of Science and Religious Faith

Pierre Teilhard de Chardin, is a seminal figure in the development of the philosophy of wholistic medicine although he did not call it as such. In his trenchant, sinuously argued publications, he sounded a clarion call for science and religion to join forces. Professor Julian Huxley, in his introduction to de Chardin's THE PHENOMENON OF MAN (the author's most forcefully reasoned argument for the synthesis of science and religion), predicted that the book would have a profound impact on world thought. He stated that de Chardin had succeeded through a blend of vast scientific learning, intensely felt religious faith, and a well-balanced sense of values), in convincing theologians to perceive theology from the perspective of scientific evolution. And scientists for their part to recognize the spiritual implications of their hypotheses. (80).

While de Chardin would not lay claim to current development in wholistic theory he has made a valuable contribution to bringing about a potential convergence of science and faith.

De Chardin also explains his concept of a fully developed human being by utilising the disciplines of both science and religion. He defined a fully developed human being as a more highly individualized person who has moved beyond the threshold of self-consciousness to a new level of thought, and thus, has attained a degree of conscious integration of the self with the outer world of Man and Nature. In other words, there is a potential for the reunification of Man in terms of body, mind and spirit in terms of science and religious faith.

Isolationism Negates

De Chardin believed it was no longer possible for science and religion to operate in isolation from one another, since both are germane to the wholeness of human existence. Those of religious persuasion cannot ignore the environment of the natural world, or misuse religion to focus all attention on 'the next life'. Likewise materialists and pragmatists can no longer rationally reject out of hand the powerful factors

of mind and spirit in human life. (81).

Further Arguments for a Synthesis

A more contemporary authority in 'sybiotic' thought is sociologist, Robert Bellah. Bellah has turned his pen to writing about the role of religion in health care. His views on an active partnership between science and religious faith agree basically with those of de Chardin, Tournier and Weatherhead. He acknowledges a lifelong preoccupation with the concepts of fragmentation and wholeness, from which religion has become an abiding concern for him. (82). In an interview in PSYCHOLOGY TODAY with Sam Keen, Bellah says:

Religion is as central to a culture's self-definition as speech or tool-making...the cosmos, the movement of history, or the purpose of God, provides a nation with its reason for being. Society is never merely a social contract, an association of individuals who band together out of mutual self-interest. It transcends the social and finds its meaning in the sacred. (83).

Throughout his long and sometimes controversial career, Bellah constantly searched for the meaning of wholeness as it relates to human life and existence. He travelled many academic paths in search of answers that could foster a sense of society and self-esteem in terms of wholeness. He said that wholeness could only be achieved through a process of "multi-layered inclusion". (84).

Like many writers in his field, Bellah believed that through religion and its symbiotic implications, Man was better equipped to adapt to the mysticism of science and the ultimate facts or reality of pain, aging and death. Bellah draws upon Weber and his observation of the necessary role of religious values in society in identifying two major concerns:

- (i) the centrality of, and,
- (ii) the irreducibility of, non-rational elements in human life. (85).

These concerns helped to identify the unfathomable mystery of evil, suffering and death, which science has grappled with since Man began to think in empirical terms. Weber argued that, if science was not equipped to unravel the deeper mysteries of these common human problems which perplexed humanity, religion was the logical alternative. Religion is able to offer two unique services:

- (i) it is able to profoundly affect motivation by 'the explosive force of a new affection' and,
- (ii) it has an influence upon social development. (86).

Religious Interpretation of Life Important

In developing his cybernetic model of religion, Bellah clearly identifies the need for systems, social and individual, to discover 'an identity':

A religion is the most general mechanism for integrating meaning and motivation in action, not

only to whole societies or groups of them. Many smaller units (individual personalities and groups) appropriate the religious symbols of their social and cultural environment in dealing with their own religious problems though always with some degree of individual variation. Moreover, even where prevailing symbol systems are rejected the idiosyncratic solutions of individuals and groups to fundamental problems of orientation and identity may be viewed in terms of this scheme as religious. Of course, the degree to which religious problems will be salient for any individual or group is quite variable. (87)..

Impasse Reached

One final author that should be considered as a person dedicated to furthering the aims of a symbiotic relationship is Swiss psychiatrist, Paul Tournier. Tournier, like Bellah, believes that medical science has reached an impasse in explaining the mysteries of disease and death. He believes there is a transcendence over the mundane:

There is, then, alongside immediate scientific causality, and independent of it because it is on a different scale, a transcendental causality. That is to say, there is an over-all plan governing the relationship of individual phenomena, and imparting to each of them a significance within the evolutionary process, so that they all move together toward the fulfilment of the destiny of the world. To say 'destiny' and 'over-all plan' is to say 'Spirit', the reality that transcends and governs visible reality. (88).

SUMMARY

In this discussion on the spiritual nature inherent in the wholistic model we have seen how some authors (ie. Fox, Peck, (Simonton and Bresler) describe spirituality in terms of sources of energy within each individual. When put to use the results can be extremely beneficial to the patient (client). This involves gaining control over the mind which in turn gains control over the body - sort of mind over matter which some call self-hypnosis. If the patient has any concept of God it means that the God concept is 'within' (immanence). Others (ie. Swami Rama, Orstein, Braso, MacNutt, Merton) perceive spirituality as that state whereby an individual allows the source of energy within to become 'at one' with the source of energy beyond. For the Eastern mind this is a pantheistic expression, for the Western this is an existentialist phenomenon. Still others draw from both concepts seeking to rationalize and integrate the disciplines of science and religion. This does not involve the eclectic approach of those who fit into the category called RATIONAL, COGNITIVE THOUGHT but rather allows the integrity of each discipline to remain intact.

Secular humanistic thinkers define spirituality in one way, Eastern mystics another, the Orthodox Jew another, the

Christian contemplative another, and the Christian fundamentalist yet another. Each person must decide for him/herself the optimum level of spirituality to which he/she wishes to aspire. This level can change from time to time and can be influenced in positive or negative terms by life events and environmental factors. The personal interpretation of this author identifies a religious perspective of spirituality as being of utmost importance. Having said this it is incumbent to point out that the interpretation of those who hold other views has to be seriously considered if there is to be any effective communication and understanding. This will be considered further in the discussion of the two clinics.

Chapter IV deals primarily with the Hinsdale and Windsor centres and represents an analysis of the data collected from the various sources as outlined in the methods section.

CHAPTER IV

DESCRIPTIVE ANALYSIS

Preamble

In many respects, a Wholistic Health Centre is similar to other Family Practice physicians' offices. Examining rooms and centre facilities are furnished with equipment identical to that found in primary care doctors' offices. Office-based medical services are available on a fee-for-service basis that is comparable to prevailing rates for medical services in the community. In addition, counselling services are available. Rooms are furnished to encourage in-depth discussion rather than hurried efficiency. One of the most noticeable differences, however, is its location in a church building (in some cases located elsewhere but sponsored by a church group).

Although these centres occasionally utilize techniques such as biofeedback, nutritional regimens, relaxation exercises, etc. the common thread that weaves through the centres is attention to the client/health professional relationship. The patient is encouraged and expected to participate in an integrated healing process. The following description of two centres identifies how these approaches are

integrated into their respective modalities.

A. The Hinsdale Model

The founder of the Hinsdale Wholistic Health Centres, Incorporated is Granger E. Westberg. In the early 1970's Westberg was a professor of practical theology and director of continuing education at the Hamma School of Theology, Wittenberg University, Springfield, Ohio. It was there, while providing pastoral care and counselling to the physically ill as a hospital chaplain, he underwent a kind of 'consciousness raising'. He became aware of the real problem that lay at the heart of many of the more seriously ill patients.

At the core of their being Westberg observed - and what ultimately led to the patient's alarmingly poor state of physical health - was a deep-rooted moral, psychological or spiritual trauma. Hence, an easily treatable physical ailment had, when combined with a singular absence of emotional well-being, deteriorated to the critical stage. (89).

In light of this startling and depressing observation, Westberg conceived the idea of an institute or clinic whose express purpose would be to cater to the 'whole person'; that

is, treatment would encompass the physical, psychological and spiritual aspects of the patient. It was out of this that his use of the term 'wholism' as it pertains to medical care, emerged. (Westberg prefers to use this spelling as it conveys that this approach to medicine does not mean pietistically 'holy', but rather 'whole'). The patient is seen as a total or complete person.

Influenced by Selye

Westberg was greatly influenced by the work of Hans Selye particularly in his investigation of the body's response to a wide variety of stimuli. Selye contended that when certain emotional and psychological defects such as angst, anomie and depression are present, they combine to have a deleterious effect on the body; conversely when these defects are absent one will generally find a healthy body. This includes having a healthy attitude about life and the self. (90).

A Challenge

These thoughts generated a challenge to Westberg. This challenge can be summed up in the following statements:

.Could the local churches together reach out in healing ministry to the neighbourhood? It was a perfect opportunity to experiment with an alternative health care delivery system, and at the same time train seminarians in ministry to

whole persons.

- .Why not utilize the church meeting rooms presently standing empty 85% of the week.
- .Why not offer sound health care to the neighbours as an outreach of human concern for them?
- .Why not offer a unique broad range of person-oriented healing services for family, work, and lifestyle stresses - services not usually connected with medical clinics..
- .Why not attempt to establish an 'Early Detection Health Centre' focussed on preventive as well as corrective medicine so people wouldn't have to get critically ill before they get care?
- .Why not call on the services of numerous professional and paraprofessional volunteers to staff the clinic? (91).

Following a 'needs survey' Westberg approached the Executive Committee of the County Medical Society however they could see no need and subsequently rejected the idea. Three physicians, however, privately urged the planning committee to go ahead. The administrators of the Community Hospital were encouraging and agreed to furnish the clinic with used equipment and some medical supplies. (92). Westberg and the committee then went to work in establishing a medical clinic. He hoped this unique clinic would create a synthesis between medical science and religion, with the emphasis on pastoral counselling and health education. (93).

A Dream Comes True

Westberg witnessed the realization of his dream in 1970, when, in the Parish House of the Good Shepherd Lutheran Church, Springfield, Ohio, the Neighbourhood Clinic opened its

doors under the sponsorship of the host church, Clifton Avenue Methodist, St. Joseph Roman Catholic Church and Trinity African Methodist. From the onset Westberg felt very strongly that wholistic clinics of this type should be sponsored by church-related groups and where possible, located in the church building or parish house. He maintained that there are many reasons for the institutional church to, as he states, get back into the health field. In a recent publication he outlined ten reasons why he feels so strongly about this:

- .Health is intimately related to how a person 'thinketh in his heart'.
- .Health is not to be 'our chief end in this life' - only a possible by-product of loving God and one's neighbour as oneself.
- .Health is closely tied to goals, meanings, and purposeful living - it is a religious quest.
- .Illness is often present in a life that is empty, bored, without purpose or aims.
- .Our present disease-oriented medical care system must be revised to encourage modeling and teaching wellness.
- .Our present separation of body and spirit must go, and an integrated, wholistic approach must be put in its place.
- .There is a difference between mere existence and a life lived under God, responsive to the promptings of his spirit.
- .The body functions at its best when a person, who is the body, exhibits attitudes of hope, love, faith and gratitude.
- .True health is closely associated with creativity, by which we as people of God participate with him in the ongoing process of creation.
- .The self-preservation instincts of a person can be happily blended with the innate longing to love and to help others. (94).

Obviously Westberg was sold on the concept of utilizing

the human and material resources of organized religion in providing health care. He was not concerned about the position held by some who maintain that the religious institution has an image of being rather 'stuffy' places where pompous people go to act righteous and 'holy'. Nor did he agree that churches are often known by some to contain moralistic persons who would rather preach at you than recognize where you are in your own 'spiritual journey'. There is little doubt that this image has some basis of validity however Westberg was promoting the 'ideal' to which most religious institutions appear to aspire. In fact Westberg added the prefix 'w' to the term 'holistic' to convey these concerns. Evidence for his concern is to be found in the respectful and individualized manner in which 'non-religious' or 'areligious' clientele are treated in the Hinsdale clinics.

As the first year progressed clinic services expanded from their half day per week and changed in response to patient needs:

- .Twenty paraprofessional volunteers were taught listening skills in a course entitled, HOW TO TALK TO PEOPLE WITHOUT DOING TOO MUCH HARM.
- .The juvenile court officials requested youth counselling services.
- .Local student nurses were doing on-site training at the clinic.
- .Home visits were increasing.
- .The pastoral counsellors and seminarians began to

- make the major decisions in over 50% of the cases.
- .A dental chair was installed and two dentists ready to volunteer services.
- .A Board of Directors was organized. (95).

Approach to Patients

In order to ensure that attending patients had the opportunity to incorporate his logic into the medical care they received he developed a method for seeing and dealing with patients in the early days of his first clinic. This method, although it has been subsequently refined and systematized, has been implemented successfully in other wholistic clinics under the aegis of the parent body.

The people of the Phoenix project (to be discussed in the next section) have responded to this innovation in a modified way while safeguarding the basic premises of Westberg as an integral part of the evolving programme.

Patients, sometimes accompanied with a spouse, or other family member, are received by trained volunteers who inform them there will be an introductory visit with a physician or nurse for the purposes of ascertaining a medical history. At this time, it will be suggested that a health planning conference take place involving, concurrently, the patient and the professional staff of the clinic - usually a physician, nurse and pastoral counsellor. The patient is instructed that

he/she is responsible for the final decision as to treatment and lifestyle alterations after all alternatives have been considered.

At some point in this early phase of treatment, the patient describes in his/her own terms, the physical symptoms, feelings or emotions, goals in life, personal strengths, and the nature of the help needed. This is accomplished through careful and deliberate completion of a Personal Health Inventory Form. (Appendix # 5). Knowing this information is of great importance and assistance to the clinical staff in aiding the patient to embark on the path to recovery. This approach is supported by Simonton, who points to Elmer Green, (another figure in the field of wholism and who specializes in biofeedback techniques) to illustrate that when people are trying to influence their health, it is necessary for them to learn what thoughts, attitudes and behaviours they are engaged in when they become sick as it is when they are well. Green concludes that when individuals possess information, regarding both illness and wellness, they are much better equipped to take part in their recovery. (96). Thus the questionnaire completed by the patient for the Hinsdale Clinic is a useful tool in getting patients to seriously analyze their state of mind during a period of ill health. It is a means to creatively confront a patient about the problems of lifestyle

and stress factors as they relate to illness and to potential 'wellness'. Frequently patients are requested to fill out the form again as the staff feel that not enough time has been spent on it. Patients often find the self-analysis to be extremely psychologically painful. One of the best ways to catch the flavour of a service is to see it through the eyes of the people who have used the service. Appendix # 6 relates three distinctly different case histories served by the clinics.

Inviolable Right

Counsellors at the Hinsdale Clinic found it gratifying, and even a bit amusing, that the majority of patients were nothing if not loquacious when discussing their personal problems; indeed, it was an effort to get them to be more succinct. Although it is the principle aim of the staff to achieve a condition of wholeness in health, they must also take care to ensure that the patient's values, sense of biorythms and timing, are not violated. (A practice which is an article of faith among the staff at the Hinsdale clinics - a sort of 'bill of rights' for the patient). In some cases, a patient may wish to keep some aspects of his/her life hidden or separate from physical treatment; it is mandatory that each staff member respect this right to absolute privacy. (97).

When the rights of the patient become a reality in terms of therapeutic modalities the patient plays a key role in what treatment is recommended. The patient is able to accept or reject such recommendations. With some exceptions, the current medical practice is to prescribe some form of treatment and the patient is expected to follow what 'the doctor orders!'. Not all patients are comfortable with the wholistic approach that emphasizes so much independence and interdependence. Neither are many members of the medical profession. Early results show that for many people the Hinsdale experiment is a viable alternative to the 'top/down' approach. Further, many patients are looking for a direct relationship between their religious faith system and standard medical procedures in the management of their illnesses and their prevention.

Rights of the Patient

All this leads inevitably to an issue that has long been a bone of contention in medical circles - the rights of the patient. It is here that the wholistic model in all of its forms, differs from the traditional biomedical model in the manner in which patient/health professional relate. It is also here that the wholistic model makes a valuable contribution to modern medicine. The role of the patient in health delivery is of ultimate importance in that society

takes the rights of the consumer very seriously.

Pertinent to this aspect of wholism is the work of psychiatrist, Thomas Szasz, and his theories on the relationship between a patient and the helping service, be it a clinic or individual health professional. Both the clinic and patient should be regarded as independent parties between whom a contract, either formal or informal, is made. Patients should be denied the power to coerce the counsellors; by the same token, the counsellors should be precluded from coercing patients. The power of both parties should be limited by law to persuasion. In the event that persuasion fails, each should be permitted to act autonomously of the other. (98). Both the Hinsdale and Phoenix Clinics take great pains to ensure the complete right of freedom, fostering instead a highly collaborative partnership between clinician and patient. This is symbolized in the signing of a contract.

Importance of Confidential Partnership

The importance of this partnership and the individual rights of the patient cannot be overemphasized. Henry and Joyce Thompson are particularly strong on this point in their book, ETHICS IN NURSING (99), as is Lorne Rozovsky in his THE CANADIAN PATIENT'S BOOK OF RIGHTS (100). (Appendix # 7). The patient has the right to complete privacy and confidentiality

concerning his/her own medical programme. Case discussion, consultation, examination, and treatment are private affairs and should be conducted discreetly. Those not directly involved in his/her care must have the patient's permission to be present; the patient also has the right to know the name of the person involved in any medical procedures to be undertaken. Moreover, the patient has the right to expect that all communications and records pertaining to his/her case should be treated as confidential in every way possible. As previously stated, the Hinsdale and Phoenix models attempt to undertake the implementation of the points covered in this section on the rights of the patient. Even in the methodology of treatment the patient is not required or coerced into participating in any of the educational or group programmes or patient health plan consultations.

Role of Parent Body

There are safeguards built into the administration of the clinics under study. In addition to an executive director, the clinic staff are responsible to an independent Board of Directors comprised of community people which usually includes representatives from the religious institution in which the clinic is located. In the case of Hinsdale group, each separate clinic has its own Board of Directors. There is a professional Advisory Board which assists the Board of

Directors in the setting of programme policy. This group includes representatives from the University of Illinois College of Medicine. All clinics have accountability to the parent body which is physically located in Hinsdale, Illinois and in the same church building as the Hinsdale medical clinic. The chairman of the parent board until recently, was Granger Westberg, however this has been assumed by a former subordinate to Westberg.

There is a central office staff who act as resource persons to the established clinics as well as potential clinics who are either incorporated formally with the parent organization or who become informally affiliated with them. The parent body also performs a public relations function for the clinics associated with them. Periodically the parent body undertake fund raising activities in order to sustain their own operation. This money is also used to develop printed resource material to be used by all the affiliated clinics. They also sell memberships to users of service and others who wish to give moral support.

When all of this activity is taken into account it can be reasonably assumed that serious steps as to accountability are adhered to by the respective parties.

Survey Research

As in any new service enthusiasm carries the day. In order to ensure that this enthusiasm was being directed in the right direction some evaluation research was required. In 1980 the parent corporation of Wholistic Health Centres commissioned a research project under a grant from the Joyce Foundation of Chicago. They were assisted in carrying out the research by The Department of Preventive Medicine and Community Health of Abraham Lincoln School of Medicine, and the Office for Community Health Research of the University of Illinois College of Medicine. The main finding of the study showed that "people attracted to this style of care are interested in becoming an equal partner on their own health team. Of the 42% who had a Health Planning Conference, eight in ten were satisfied with the Personal Health Plan developed, and nearly half followed through with the plan COMPLETELY", and the study underscores the word completely. (101). The importance of this finding is that it corroborates one of the main focuses of the clinical method of patient involvement in the therapy process.

In compiling an Executive Summary of the evaluation research information the Hinsdale board report the following results as are contained in the Research Monograph. (Appendix # 8).

Three centres were selected for the study and all were in the Chicago area. The centre patients reflected the characteristics of the communities of Hinsdale, Woodridge, and Oak Park, Illinois. The Wholistic Health Centre of Hinsdale, Incorporated is the model emulated by other such centres in the Hinsdale system. It is located in an area whose affluence is almost taken for granted. The Woodridge Centre is located ten miles southwest of Hinsdale in an area whose population is young, mobile and middle income. The Oak Park Centre is located in Chicago's west side and is one of the Nation's first intentional 'suburbs', and consists of a middle class population mix of young and aging residents.

The patients studied reflect the characteristics of the two counties in which the Centres are located in that they are:

.Well educated	72%	some college or college degree
	33%	graduate training or degree
.Married	70%	are married
.Family oriented	3.2%	members in the household
.Affluent	47%	with a family income of \$28,000.
		or more
.Middle aged	61%	between 25 - 44 years old
		Mean age is 41. (102)

The educational level among respondents is high. Over

two thirds had some college or a college degree and almost one-third had some graduate training or degree. It is difficult to accurately compare median years of education with the general population because of the dissimilarity in data collection methods. A study done by the area Suburban Health Systems Agency (similar in function to the Ontario District Health Councils) found that the median years of education was 13.3 for those 25 years of age or older. The wholistic data indicates that users 17 years and older have a median of 15.8 years of education. Thus, because of the age differences, the differences in medians is actually greater. (103). These statistics compare favourably with a survey of Hinsdale and Woodridge Centres undertaken in 1975. Some college or college degree is identical while the 1980 study shows an increase of 3% in those reporting some graduate training. (104)

It is impossible to compare general population statistics with the wholistic survey due to methodological difficulties. The 1980 Federal Bureau of Statistics was not available to the Hinsdale researchers in time to make any comparisons. The following comparisons of data with the general population are included but have not been verified by the Hinsdale group.

The average household size of the Hinsdale patient

population is 3.2 as compared with an Illinois average of 2.76 per household. (105). Cook and Du Page Counties report 2.8 per household. (106).

The socio-economic status of patients is classified as affluent. In 1980 the median family income was \$24,566. for wholistic centre users, as compared with \$18,876. for the total planning area of Suburban Cook and Du Page Counties (\$19,999. for Du Page alone) in 1975. (107). The personal income reported in 1981 by the Federal Bureau of Statistics was \$12,570. for Cook County and \$13,487. for Du Page, for a combined total of \$13,029. (108). These figures probably reflect increases in the cost of living as well as the increase in the number of women joining the labour force. There is no information available to substantiate this assumption.

The majority (61%) of users are between the ages of 25 and 44. (109). Statistics for this categorization are not available in the Census Tract. The census figures reveal that the median age for Cook and Du Page Counties is 29.9 years. There were 59.6% of the population of these two counties between the ages of 18 to 64 years. Illinois reported 60.6 % in the same category. (110).

Patients came to the centres primarily for two reasons: because the centre was recommended by a friend or provider (28.2%), or because they preferred the wholistic approach (26.1%). (111).

The average number of visits to the centres was 3.6 per year with the median being 2.1. Women patients (3.5) were slightly ahead of the men (3.1). (112).

The most major medical problem for which people sought care at the centres was a general check-up (27.7%) or an acute illness (22.4%). Comparing these figures with a previous study of two centres in 1975 only 12% of patients came for general check-ups. Concurrently, in 1980 only 12% came for chronic problems, whereas 29% did so in 1975. (113). This would seem to indicate that users saw the clinic as practicing preventive medicine. It may also indicate that the clinic treatment methods with chronic patients involved too much self-motivation on the part of the patient. It may reflect a lack of success with chronic situations.

The following table indicates the types of medical problems of the patient population. The most common presenting problem consisted of physical examinations without illness and which involved psycho-social consultation (32.7%).

(114). Appendix # 9 shows a comparison chart of primary diagnosis between wholistic health centres and other general and family practitioners. The most common presenting problem in the latter category involved problems in the respiratory system (18.5%), whereas only 12.9% appeared for physical examinations and which did not involve illness. (115). This comparison may demonstrate that patients' perceptions of traditional medical offices is illness oriented rather than preventive. It may also indicate that patients do not perceive general and family practitioners as being involved in psycho-social counselling.

Medical Conditions Experienced Over the Past Year
by Center for 1980

Condition	Composite	A	B	C
Arthritis	14.7%	9.7%	15.6%	16.8%
Cancer	1.4	1.3	1.8	0.9
Dental problems	26.7	31.4	25.5	25.6
Diabetes	1.9	3.1	0.4	3.1
Glaucoma	0.3	-	-	0.9
Hardening of the arteries	1.2	0.4	1.2	1.7
Heart condition	4.1	7.1	3.0	3.7
High blood pressure	17.4	21.2	17.6	14.8
Stomach conditions	15.7	14.6	15.6	16.8
Stress	34.2	33.6	33.3	35.8
Stroke	0.3	-	0.2	0.6
Ulcers	2.7	4.4	2.6	1.7
Upper respiratory illness	19.1	20.4	19.0	18.5
Other	25.7	24.8	26.9	24.7
	n=1,075	n=226	n=495	n=352
Mean number of conditions per person	1.7	1.7	1.6	1.7

Religious affiliation is considered in wholistic health centres. The study identified over half were Protestant, one-quarter were Roman Catholic and a little over one-tenth Jewish or other religions, and only one out of ten said they had no preference. (116).

Almost half (49.1%) of the users are either moderately or extremely involved in religious activities, while almost a third (31.7%) reported no involvement at all. (117). It must be said that this kind of information is very hard to evaluate. The types of questions asked in the survey did not really address the spiritual dimension of the respondents in any great detail. There were no categories for the identification of religious activities. This weakness in the questionnaire is rather strange given the obvious importance of religious spiritual values in treatment philosophy.

Summary of Survey Research

In summary, the author of this thesis has drawn an initial conclusion based on the evidence presented in the research report of the Hinsdale board. It is possible to assume that the patients are middle-class, above average intelligence, and religiously oriented - that these people would, for the most part, be well-adjusted and reasonably

happy. However, statistics, as well as rendering salient and useful information, can also be misinterpreted; for example, although these patients may be employed at a relatively well-paying vocation, it might not provide sufficient intellectual stimulus or they might be asked to perform duties which they consider unnecessary; it might even be a job in which they have to engage in unattractive compromises, or downright unethical practices - all of these factors are potential catalysts for anxiety, trauma, and depression. Most important to this study is that the individual factors may well be affected by a deep-seated spiritual malaise.. He/she may admit to having some religious faith, and may even be a regular church-goer, but, as is often the case, this is merely an accepted routine - a form of lukewarmness and non-committed service.

What is especially gratifying to proponents of wholism is that the patients are attempting to find an alternative to their present situation. While the research is still inconclusive the concept seems to have general acceptance as an alternative among those who avail themselves of the service. How general this acceptance will become to the larger population using medical services is yet to be shown.

B. The Phoenix Model

The Phoenix Wholistic Health Centre, Incorporated, located in the Cencourse Complex, 660 Ouellette Avenue, Windsor, Ontario, follows a modified version of the Hinsdale model. Initially, the clinic operated out of the offices of Central United Church, which generously provided rent-free office space and other facilities including secretarial and receptionist services. Recently, the clinic moved into separate quarters in an attempt to gain a separate identity and higher community visibility. The professional staff consists entirely of unpaid volunteers with the exception of the administrative assistant. The physician consultant is paid by the Ontario Health Insurance Plan.

Initial Activity

In the late spring of 1979 the Programme Committee of Iona College (the United Church of Canada College affiliated with the University of Windsor) appointed a sub-committee of health care professionals and others to investigate the possibility of holding a seminar on wholistic health care. The sub-committee consisted of physicians, priests, ministers, nurses, educators and business people. This diversity of membership ensured community support and representation. The sub-committee, after due deliberation, attempted to find a

credible Canadian medical authority grounded in wholistic theory. When this proved to be impossible, the sub-committee agreed to retain the services of the founder of the Illinois-based Wholistic Health Centres, Incorporated, Granger E. Westberg. On March 5, 1980, Iona College sponsored three separate seminars.

Community Seminars Held

The first seminar, by invitation only, was held at Iona College. Of some fifty invitations approximately thirty-seven health care and social service personnel (nurses, psychologists, social workers and clergy) attended. All people present were senior representatives of the agencies invited. The second seminar was for physicians and department heads of the five Essex County hospitals and was co-sponsored by Windsor Western Hospital Centre. No one tallied the total attendance but nine physicians were among those present. (The Phoenix sponsors thought this to be not an unreasonable number considering physicians are notorious for non-attendance at such events. They were aware that internationally acclaimed hand surgeon and consultant to the World Health Organization, Paul Brand, only drew four physicians at a recently held seminar at Grace Salvation Army Hospital. A similarly low number attended a seminar on alcoholism by a well known internist from Michigan sponsored by the Essex County Medical

Society). The presentation was held at Windsor Western Hospital Centre. The third and final presentation, under the chairmanship of Walter Wren, Director of Medical Services at the University of Windsor, Past Chairman of the Board of Iona College and Past Chairman of the Essex County Medical Society, was for the general public. Approximately one hundred and twenty-five people attended the event held at the Moot Court Auditorium in the Faculty of Law. Considerable interest in the concept was expressed during the discussion period which followed the formal address by Granger Westberg. The media gave extensive coverage as well.

Steering Committee Formed.

Following the persuasive presentations at the respective seminars, an ad hoc 'Steering Committee' was struck combining members of an interested group from Central United Church and some of the Iona College sub-committee. Others were added following the initial meetings of the Steering Committee. This Steering Committee later formalized themselves as the founding Board of Directors of the Phoenix Wholistic Health Centre. Other people were invited to become part of the twelve member founding board. The Phoenix Centre was incorporated as a non-profit organization in May, 1981 by application to the Ministry of Consumer and Corporate Affairs of the Government of Ontario. (Appendix # 10). They also

applied for and received a charitable donation number from the Internal Revenue Department of the Federal Government on May 19, 1981. (118). The Board is interdenominational and interfaith in its constituency in order to emphasize the inclusiveness of the project. It has recently been reconstituted with a new chairman and three new members. Two board members resigned due to an inability to maintain the time commitment required for such an innovative project. One person relocated to another city. All resignees agreed to remain in an advisory capacity.

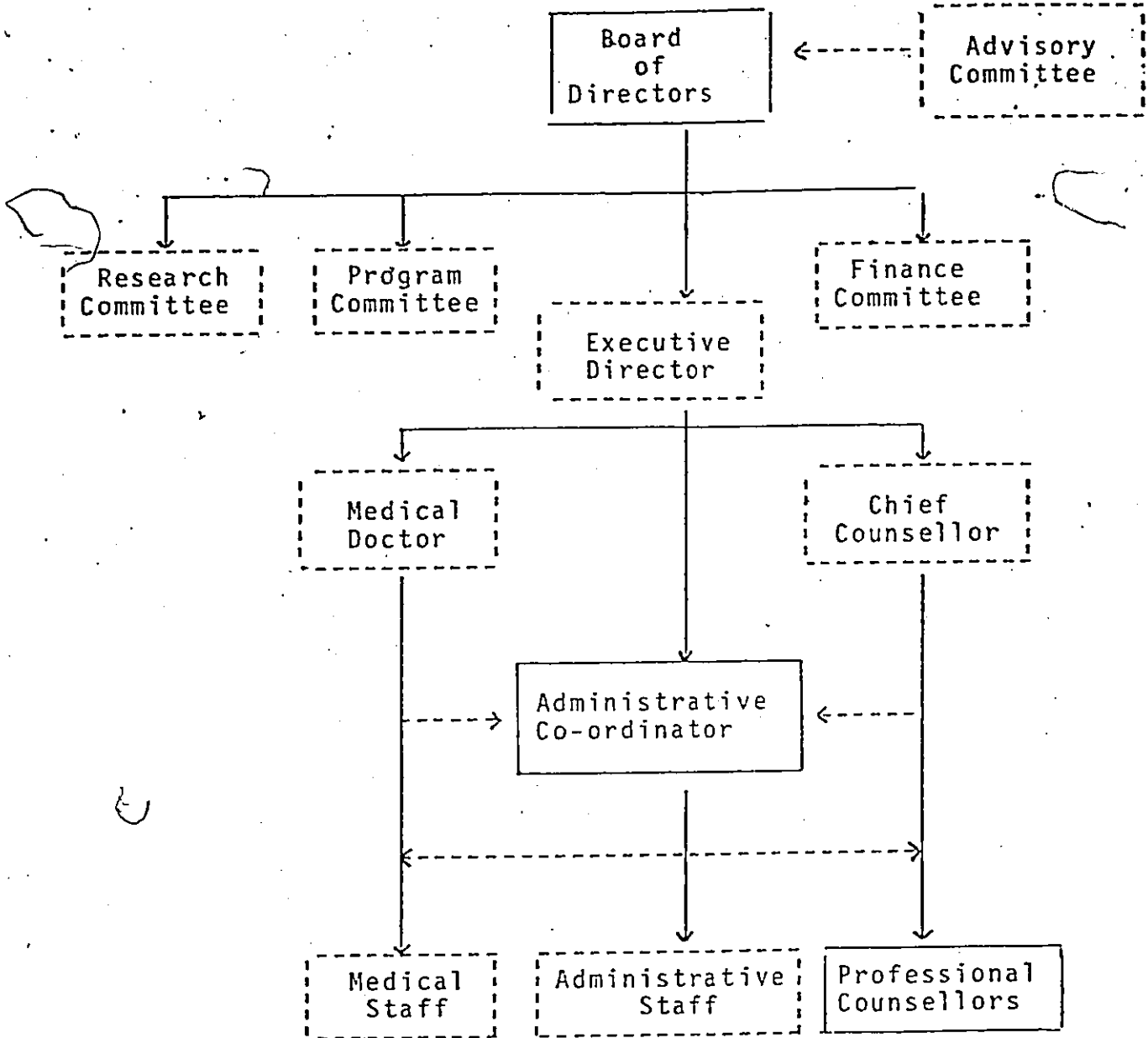
Organizational Structure

The organizational structure of the Phoenix Centre consists of board members representing the legal (1), medical (2), dental (1), religious(3), business(4), nursing education (1) communities. (119). Three staff members serve on the board in addition to their volunteer professional involvement with the programme. Chief among the board members, and whose function it is to oversee the daily operation of the clinic, is the executive director. This director is presently a retired member of the clergy. It is the intent of the centre to continue the practice of appointing a pastoral counsellor as director. The policy of the board indicates that the executive director possess a solid background in counselling combined with broad-based experience in programme

administration.

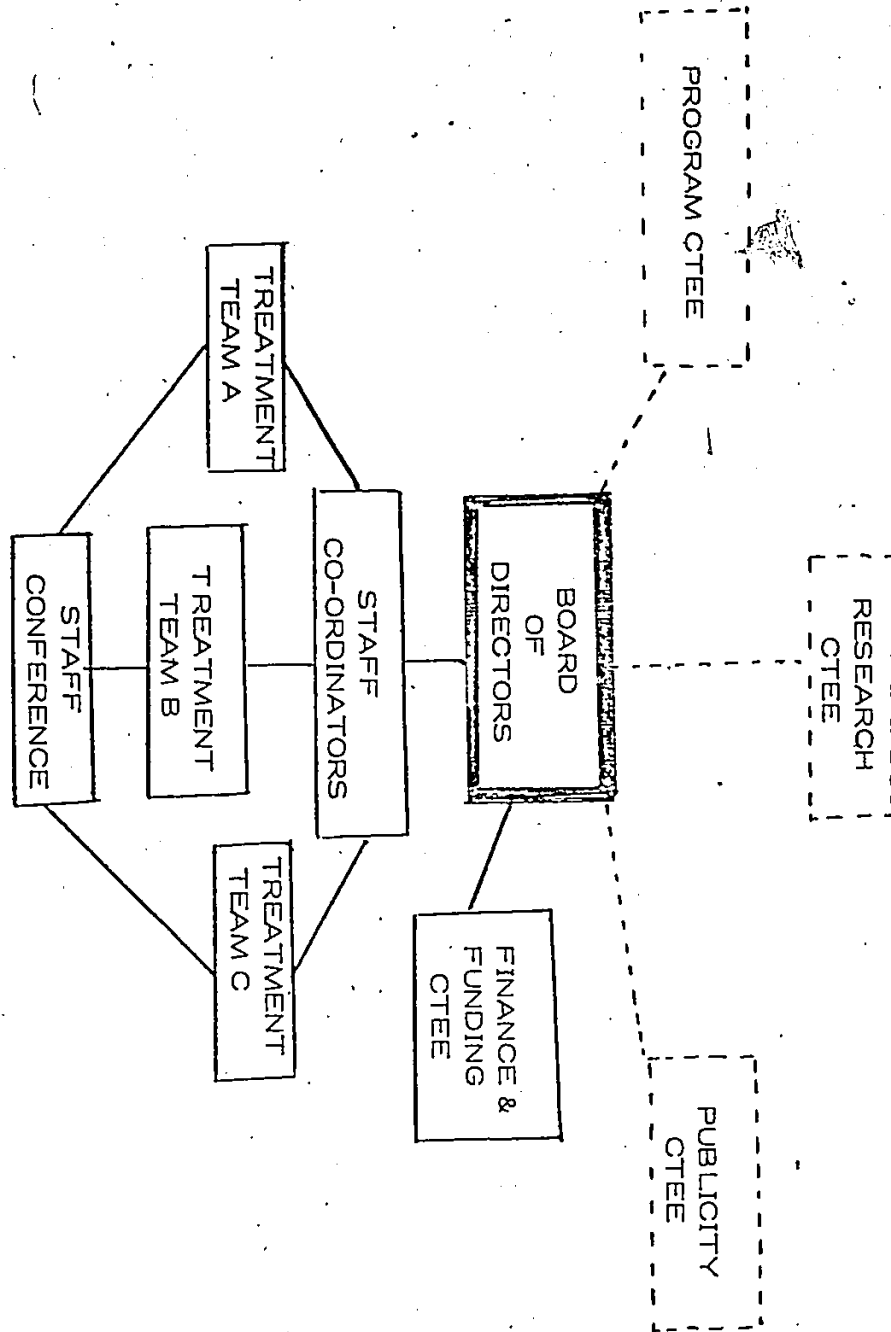
Fully qualified nurses are an important part of the clinic staff. Ideally, one or more physicians should be part of the regular team however, at present, the Phoenix Centre is unable to have a physician. Further, pastoral counsellors are an integral part of the staff. The secretary-receptionist of the clinic transcends the standard secretarial role in that she is the first person with whom the patient comes in contact in more than a routine way. In order to emphasize the extended role the position title has been changed to administrative coordinator. The final group represented on the personnel complement are volunteers who carry out a myriad of non-patient related functions. The total staff complement of the Phoenix Centre currently stands at one consulting physician, one administrative assistant, six registered nurses, and six pastoral counsellors. All volunteers comply with the requirement that the principles of wholistic health is sine qua non. Other medical, psychiatric, and other therapeutic consultants are involved on an as-needed basis in providing patient consultation. The following Organization Charts indicate that all authority is vested in the board of directors: (120).

WINDSOR WHOLISTIC HEALTH CENTRE ORGANIZATIONAL CHART



Existing
 Proposed

ORIGINAL ORGANIZATION CHART



ORGANIZATION CHART

= now operating
 = to be organized

Staff Activity

Since the staff are expected to work together as a closely-knit unit on a peer basis, the acting executive director is ex officio Chairman of the Personnel Committee responsible to the board of directors for the appointment of staff. He conducts the monthly staff meetings.

Each staff member currently volunteers a minimum of three hours per week in providing service to patients. Staff meetings are over and above this time commitment. Not all staff work the three weekly hours if no patients are scheduled for interviews. At first, the nurse and the pastoral counsellor would attend the clinic for the three hour period even if no patients were scheduled. The rationale for such attendance was for the purpose of team building and maintaining a symbolic presence on the premises. This procedure gradually fell off largely by default rather than design. It has not been necessary to reinstate the procedure as the level of programme activity has been increased substantially since moving into the new quarters. In fact, most volunteers are giving more than three hours. Communication between staff members is maintained through monthly staff meetings where some staff training is undertaken. Case consultation is a regular feature in order to improve on recommendations made to patients and for

assistance with sorting out difficult patient problems.

Patient Consultation Method

The consultation method of Hinsdale is part of the clinic procedure. The physician, pastoral counsellor and nurse function as a team with the initial orientation interviews being undertaken by a secretary-receptionist.

In the Phoenix situation, the physician is not present for the case consultations but is available for comment. Most clinic visits involve the administrative-coordinator. She acts as a trouble-shooter for helping the patient sort out logistical problems or just as a friendly face to ensure patient comfort prior to the interview. Following the initial intake procedures a complete medical is obtained although this has presented some difficulties for patients who have their own physicians. To date, patients who attend physicians other than the consulting clinic doctor, simply submit a self-report of medical problems. It is difficult at this point in time to obtain clinical data from the physician. This presents considerable difficulty for the staff, however the consultant does provide assistance in some of these cases. Careful attention is accorded the report of the medical consultant as well as any possible recommendations. (121). The clinic staff and board are still endeavouring to involve the family

physician in a more intimate way. There is evidence of some slight improvement as another family physician has agreed to be on the board. He has also agreed to do medicals and case consultations. An internist and a psychiatrist have agreed to serve on the advisory board.

A minimum of three more consultations with the patient are conducted by the nurse and pastoral counsellor. During this process the consulting team confers with the patient in order to design an individualized health plan similar to the techniques used in the Hinsdale Health Planning Conference. Appendix # 11 represents a sample plan. Advice regarding nutrition, physical exercise, relaxation techniques, small group training, meditation, etc., is provided by the professional team. Upon being advised of this, the patient chooses a Personal Health Plan that will best suit his/her particular needs. A well-designed, personalized Health Plan allows the patient to become self-sufficient and personally responsible for his/her own wholistic programme.(122). Follow-up programmes have been afforded the patients since the late autumn of 1983 through the use of seminars and work-shops. (123).

Community Need

The board claim there is a widespread need for services

provided by this type of clinic as reported in the following excerpt from a promotional brochure published in the winter of 1983:

We discover the following needs: .

- .A multiplicity of services with no central coordination.
- .Overworked medical specialists with no time left over to discern life situations of patients.
- .Frequent statement heard that 'no one has time to listen to me'.
- .Health education a prime need.
- .Reported over-use of medical facilities shows need for persons to take responsibility for their own health.
- .Stressful lifestyles largely neglected as prime factor in health and sickness.
- .Widespread positive response to wholistic seminars whenever offered, e.g. at St. Mary's Anglican Church, Walkerville, through the winter of 1981-82.(124).

These claims have not been substantiated in any empirical way however a telephone survey is underway to provide further evidence of the need.

Search for Funding and Credibility

Despite their statement that there is a community need for such a service the Phoenix project is experiencing similar difficulties as the initial Springfield, Ohio group. In March, 1984, the Phoenix board made a funding request in the amount of \$280,000. operating funds to the Essex County District Health Council under the Community Health Centre Programme of the Ministry of Health. (125). The District

Health Council decided to defer action until the Phoenix group had sorted out their difficulties in establishing credibility with the Essex County Medical Society. The Medical Society maintained that the Phoenix group have not definitively established a community need. On June 25, 1984, representatives from the Phoenix met with the Executive Committee of the Medical Society to discuss the contents of a letter sent to the Health Council. (126). (Appendix # 12). The outcome of the meeting was an agreement to hold another meeting in September, 1984. At that time the Phoenix would share the results of an independent 'marketing study' which had been commissioned with a large Public Relations Firm. The results of this survey are not available for inclusion in this study.

The Phoenix people maintain that if they could receive stable funding for a two year period under the Health Centre Programme they would attempt to substantiate the claims they make in their stated objectives. Current funding is through small private donations, limited fees-for-service, seminars, charitable bi-monthly bingos and the generosity of the volunteer staff. The United Church of Canada gave a small grant at the onset of the project. The results they hope to achieve are:

.Fewer visits by patients to their medical doctor.

- .Fewer medical prescriptions required.
- .An improvement in self-understanding.
- .Increased patient self-worth.
- .Improved patient attitude towards work.
- .Increased patient participation in social and community affairs.
- .Increased successful handling of stress-producing problems by patients.
- .Greater enjoyment of life by patients.
- .Decreased health care costs to patients and the Ontario Health Insurance Plan. (127).

Patient Information and Goals

There are doubtless manifold intangibles that exist when dealing with the complete person. To ensure that the finest care is administered to its patients, accurate patient information is supposed to be kept; this documentation contains information on the past and present health status of the patient, current health plans, together with anticipated and actual results. Recent investigation by the board of directors showed that not all staff were recording needed data and steps are being taken to improve this important area for purposes of patient/staff continuity and future programme evaluation and statistical gathering.

Ultimate Aim

Obviously, the ultimate aim of the programme is for the total well-being of its patients in all areas of life - personal and public - with a renewed sense of worth. Of assistance to achieving this end will be the ability of the patient to make a morally binding agreement with the centre. This moral agreement or statement of intent obligates the patient to participate in the aforementioned consultations, physical examinations and the devising of a suitable Health Plan when appropriate (signed copies of this plan are sent to the physician). However, should a patient not request such involvement they are still eligible to receive medical

attention. Entry into the full programme can occur at any time.

Generally, the patient attends three, one hour sessions in order to determine a personal Health Plan. In appropriate instances the time given to particular patients could be more or less than the allotted time. (128) Experience to date shows that the average patient spends more time than the three hours although it has not been determined if this is due to time availability given the initial small number of patients or other cause including staff inexperience at this method of health care. As further evidence of commitment, the patient is required to pay a fee based on ability to pay. The current payment scale identifies \$ 1.00 for every \$ 1,000.00 earned as the base mark. Even welfare patients are required to pay a symbolic amount. The latest census of patient population is approximately one hundred although there is no data available as to how many of these have actually paid. At least three patients are reported to have volunteered their services in lieu of fee payment.

Summary

The Phoenix project is a bold experiment in that there

does not appear to be a prototype on the Canadian scene. Obviously health services structures are substantially different from the U.S.A. This mitigates against using the Hinsdale model as a total prototype. A great deal of the Phoenix project is by trial and error which is not without its difficulties. Establishing community credibility at the professional level becomes harder, making the service known to the consuming public becomes a problem and acquiring stable funding is equally difficult.

The staff and board are extremely dedicated to the task at hand and expend a great deal of energy in adapting the Hinsdale model to the Canadian scene. To date, claims are made that patient satisfaction is high although this has not been empirically substantiated and is based solely on hearsay evidence. Steps are underway to clearly establish the marketability of such a service. The Phoenix board hope to acquire enough funding in order to be firmly established for a minimum of two years so that they can test out their hypotheses concerning the type and quality of health care.

Similarities between the American and Canadian model are based primarily on the issue of the rights and responsibilities of the patients. The attention paid to the whole person - mind, body and spirit - is an important

commonality.

The next chapter demonstrates some of the difficulties encountered by wholistic clinics in finding acceptance by other professional bodies, most notably the medical establishment.

CHAPTER V

PROBLEMS WITH CREDIBILITY

The precursor to wholistic medicine is psychosomatic medicine (diseases of 'psyche' and 'soma'; mind and body). Some physicians say that about half (some say more than half) of the patients coming to their offices come for reasons that are in part, or wholly, due to emotional or psychic disorders.

(129)

The Medical Establishment

The healing power of faith, of humour, of the need to survive, may one day be translated into scientifically understandable terms. Until this happens in a more concrete way than is the present 'state of the art' the medical establishment will continue to have serious reservations about supporting wholism as a medical concept. We have seen the difficulty encountered by the Phoenix group in finding acceptance by the Essex County Medical Society. The Hinsdale group experienced the same difficulty in developing the first clinic in Springfield, Ohio. Tubesing reports that "The Executive Committee of the County Medical Society were opposed

to the idea because there was no need." (130) This was interpreted as a stalling tactic and it proved to be the same criticism aimed at the Phoenix clinic by medical officialdom. Three physicians from Springfield "privately urged the planning committee to go ahead, without waiting for encouragement from the Medical Society." (131) The Phoenix group received similar private advice from several physicians, some of whom offered to become affiliated with the project in an advisory capacity.

Westberg experienced similar difficulty in trying to find medical school support. Individuals often responded favourably only to have administrative bureaucracies cause delays and other blocking tactics. (132) He persevered and finally did get the acceptance of the Department of Preventive Medicine and Community Health Center, Abraham Lincoln School of Medicine at the Medical Center, Chicago, Illinois. (133) This seemed to be an indicator that the medical establishment could be won over.

Part of the reluctance on the part of some physicians to be more accepting of wholism is a direct result of the socialization process operative in most medical schools. The educational process socializes doctors "to view themselves as solely responsible, both legally and morally, for their

patient's care." (134) This means that they have been taught to develop and nurture responsibility and to carry the burden of responsibility alone.

The status ascribed to medical doctors in contemporary North America is one of high social and economic standing. To share treatment goals with other health care professionals and with the client would be tantamount to diminishing that status. Peer acceptance would result in a loss of power in the community.

One staff member of the Phoenix project reports a conversation she had with a medical doctor about why he thought the Phoenix project was having a hard time getting acceptance from the medical community. His reply was simply 'a matter of pure economics'. If physicians are not in total control of medical treatment, (eg. diagnosis, treatment modalities, laboratory work, diagnostic imaging and specialized consultation, etc.) they stand to lose considerable income.

By maintaining total control of patient care the medical profession is able to clearly differentiate between medical science and the science of other modalities. This is especially true where spirituality is translated into

religious terms.

Physicians Not Alone

Physicians are not alone in being somewhat less than enthusiastic about religious institutions being directly involved in including the spiritual dimension of humanity in diagnosis and treatment of health problems and their prevention. Kelsey reports that in a conference on the subject of spiritual healing in one of the large eastern states the physicians who attended were deeply involved in the proceedings while the clergy present hardly treated the subject as a serious one. (135) At about the same time as this conference a large western hospital held a seminar on religion and health. All but one of the medical doctors responded to the invitation and eighty percent of the the respondents attended. Of the clergy who received the invitation only fifty percent attended the meeting. (136) No reason was given for this apparent lack of enthusiasm.

Other Problem Areas

Another area where wholistic practitioners encounter difficulty is the matter of funding. This is especially true in the Canadian system of funding health care. The private enterprise system in the United States makes it a little easier for wholistic clinics to obtain funding. The Canadian

system depends almost totally on government financial support. This fact makes it mandatory that all medical programmes requiring funding from the Ministry of Health meet the legislative requirements of the government bureaucracies. Wholistic terminology differs substantially from traditional terminology used by advocates of the biomedical model. Different nomenclature is required by government bureaucrats and this presents a difficulty in the use of such abstract and esoteric terms as spirit and spiritual.

It seems the more academically oriented an individual is the more scepticism or reluctance there is in accepting wholism as a viable method of medical care. This is largely due to the abstract and esoteric dimensions associated with the spiritual dimensions of life and the fact that so many aspects of religious practice are accepted by faith rather than through empirical validation. Certainly this is what prompted Whitehead and Buskirk to comment on the possible translation of spiritual inclusion into scientific terminology.. Wholistic practitioners believe this is what they are attempting to accomplish.

Most authors are optimistic about the future of wholism and many see it as only a matter of time before a symbiotic relationship between these two branches of medicine will

exist. Only time will decide whether the optimism is grounded.

The final chapter draws some conclusions based on the data presented in the body of this study. Some recommendations for further action are also made.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

A. CONCLUSIONS

The impressive and rapidly growing body of knowledge pertaining to wholistic health care introduces an innovative and potentially viable alternative model within the current health care delivery system that meets the individualized needs of the 'whole person'. The thesis identifies practical applications of wholistic theory as operationalized by the clinics sponsored by the Wholistic Health Centres, Incorporated, Hinsdale, Illinois and to a decidedly lesser degree by the fledgling clinic sponsored by the Phoenic Wholistic Health Centre, Incorporated, Windsor, Ontario. The study has attempted to describe and analyze these clinical expressions of wholism in order to show:

- (a) Why the wholistic service is important, and
- (b) How wholistic health care can become formalized as a discipline in the medical system.

It has been difficult to identify any definitive answers to these questions. The evolutionary stage of wholistic clinics is not far enough advanced nor is the research.

complete enough to be more specific than outlined in this study.

The study has identified some of the evolutionary trends in medical care with particular emphasis on treating the whole person from a physical, mental and spiritual perspective. While some clinics interpret the word spiritual in terms of humanistic psychology the study focuses primarily on those clinics which see spirituality in religious terms as well as psychological. It is difficult to pinpoint the origin of wholistic medicine as defined in this study except relative to the works of such men and women as cited in the body of the study. A number of authors such as Leslie Weatherhead, Teilhard de Chardin, Thomas Szasz, Kenneth Pelletier, and Carl Simonton are dedicated to exploring deeper methods of healing. They have pioneered the fundamental concepts of the wholistic approach from multifarious positions. The modus operandi of many health care workers has been greatly affected by these and other prominent figures. With the practical implementation of this innovative approach to the practice of western medicine Granger Westberg became a seminal figure in promoting and developing medical clinics (currently twelve in number with another one hundred and fifty in various stages of planning).

The study identifies how the clinics have operationalized the religious basis of the wholistic movement - that a reawakening of religious faith, or at the very least, a stronger and more thorough commitment, can create a new state of wholeness, a feeling of unity with an ultimate being, family and other human beings, an ability to confront the frustrations and fears of life and occasionally tragic vicissitudes. Where patients have not expressed any desire to explore religious beliefs the staff of the clinics respect this inviolable right of a free human being. The individualized Health Plan reflects the value system of each individual.

The thesis has shown that the innovators of the Phoenix and Hinsdale projects believe that science and religion can exist in symbiotic relationship and that a synthesis is necessary and practicable given the extensive role of religious faith in the lives of people in North America. The success of the Hinsdale pioneer project has demonstrated a pragmatic example of this possibility. The literature and general experience shows incontrovertibly the havoc wrought by an uncontrolled use of all types of drugs, including alcohol. Where religious faith and spiritual values are present wholism maintains that the probability of recovery and achievement of wholeness is greatly increased.

The study has shown how some medical professionals are giving leadership in confronting the reluctance of that honourable profession called medical science, to allow the introduction of non-empirically validated treatment methodologies, such as mental imagery, relaxation exercises, meditation, reflection and nutritional regimens as adjunct services to standardized medical procedures. Some medical scientists are actively encouraging and promoting a reconciliation between the technical and spiritual approaches to health care and disease prevention however much painstaking research is needed to ensure the integrity and credibility of each discipline. Such a revolution in health concepts in contemporary medical circles affirms and supports the wholistic health care movement as outlined in this thesis.

In summary, the study concludes that:

.Wholistic health care is workable with a diverse patient population.

.Wholistic clinics can be staffed by volunteer professionals.

.Wholistic concepts are difficult to explain to the uninitiated, however once the concept is grasped enthusiasm evolves.

.In depth counselling can be effectively integrated into a primary care medical centre with over 50% of the patients responding.

.Efficiency in the management of a clinic is crucial especially in the area of record keeping.

.The clinics studied have been able to offer an alternative form of health care.

Finally, the literature clearly suggests that the practice of wholistic health care, in its many forms, is attempting to be integrated into the medical system. The study has detailed the wholistic approach as adopted by the Hinsdale group and which has sparked the development of a similar project in Windsor. Whether the current methodology in the application of wholistic theory will remain the same in these clinics, only passage of time will tell. The basic concepts will undergo many changes in the years ahead. How the integration into traditional medical medical practice will occur no one can clearly tell. Victor Hugo once said: "Nothing is more powerful than an idea whose time has come." Perhaps the dawn of the new age of medicine to which Weatherhead made reference as long ago as 1933 is emerging with these progressive innovations. The people of the Hinsdale and Windsor clinics think they are contributing to this new age of medicine.

Many believe that the disease oriented medical model has outlived its usefulness. It needs to be modified. The emerging trends toward the wholistic model point to a consumer search for an alternate model. The 'whole' person concept takes into account the physical, mental and spiritual being. Unless there is a sense of balance and harmony between these components of Man there is a serious chance of debilitating

illness. Wholistic health is one means whereby medical science working hand-in-hand with faith systems can enhance the opportunities for the maintenance of a high standard of personal health. The task facing health care planners is monumental in that medical service represents personal income and community status. Part of the task will be to convince current practitioners that inclusion of wholism is not a major threat to medical solidarity.

Wholistic clinics are still very much in their infancy, and are not yet defined well in terms of their potential in communities. They experience both internal and external problems of some magnitude which may in the long run endanger their survival.

The basic power struggles of communities tends to favour continuation of the older medical model; the problematic here lies in the future definitions and flexibilities the medical profession may choose to exercise (or not to exercise). If continuing rigidities persist within conventional medicine, the future of wholistic medicine may be either delayed or reacted to in such a way as to make their future difficult or worse.

Although there is a general sense of acceptance by those

who have familiarity with wholistic health centres as they operate, there is widespread lack of concern and knowledge on the part of the masses about their advantages. In part this is due to what may be termed 'brainwashing' or propaganda by the conventional medical community, it is also in part due to the tradition of failure to accept (or want to assume) responsibility for one's own total health and wellness. Thus, a great task remains before wholistic health will become widely practiced, if indeed this ever happens. Some minor trends relating to better health habits could be interpreted as a beginning and positive sign of such a turn of events.

RECOMMENDATIONS

The opportunity exists for advocates of wholistic health to make inroads into altering the present biomedical system of health care. Before this can happen the champions of this untested model must consider many research questions and evaluation of their claims. The scope of this study is too limited to be able to more than 'beg the following questions'.

.Is the medical establishment ready to support wholistic medicine as a viable method of practicing preventive medicine?

.How do wholistic clinics compare to traditional group medical practices?

.Can the Personal Health Inventory serve to identify patients 'at high risk'. If so, to what

dimension should health care providers intervene?

.Can the Personal Health Plan prevent people from developing serious illness?

.To what extent should other family members and friends become involved in the treatment plan?

.What is the effect of specific spiritual interventions? Do prayer, meditation, relaxation, ritual, worship, or participation in a spiritual community improve health?

.Are the centres really practicing preventive medicine? Are people willing to pay for preventive medicine?

.Is there a more time efficient way to achieve the same results?

.What would an inventory and analysis of the spiritual dimension in diagnosis, treatment and rehabilitation show?

.So controversial in some quarters have the terms 'wholistic' and 'holistic' become that some proponents of the theory say the term(s) should be dropped. What is the reason behind this turn of events?

THE END

FOOTNOTES

CHAPTER 1

1. N. L. Tubesing, PHILOSOPHICAL ASSUMPTIONS (Hinsdale, Illinois: Society for Wholistic Medicine, 1977), p. 18.
2. Ibid., p. 19.
3. Ibid., p. 20.
4. Malcolm Todd, "The Challenge to Medicine: Prevention of Illness." In E.M. Goldwag, ed., INNER BALANCE AND THE POWER OF INNER HEALING (New Jersey: Prentice-Hall, Inc., 1979), p. 5.
5. Hans Selye, THE STRESS OF LIFE, Revised Edition (New York: McGraw-Hill Book Co., 1976), p. 399.
6. Kenneth Vaux, "In Search of a Context and Concept of Wholistic Health" In G.E. Westberg, ed., THEOLOGICAL ROOTS OF WHOLISTIC HEALTH CARE (Hinsdale, Illinois: Wholistic Health Centres, Inc. 1979), p. 69.
7. Leslie D. Weatherhead, PSYCHOLOGY, RELIGION AND HEALING (London: Hodder and Stoughton, 1951), p. 412.
8. Ibid., p. 413.

CHAPTER III

9. J. P. Callan, "Holistic Health, Holistic Hoax" JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 24 (March 16, 1979): 11, p. 1156.
10. Pauline Anderson, "Holistic Medicine, A Closer Look," ONTARIO MEDICINE, 1 August 1983, p. 1.
11. Norman Cousins, ANATOMY OF AN ILLNESS (New York: W.W. Norton & Company, Inc., 1979), p. 22.
12. Robert S. Mendelsohn, CONFESSIONS OF A MEDICAL HERETIC (New York: Warner Books, Inc., 1979), p. 11.
13. Cousins, p. 19.

14. J. Diamond, YOUR BODY DOESN'T LIE (New York: Warner Books, Inc., 1979), p. 33.

15. Kenneth Pelletier, HOLISTIC MEDICINE: FROM STRESS TO OPTIMUM HEALTH (New York: Seymour Lawrence, 1974), pp. 13-15.

16. Anderson, p. 1.

17. Ibid., p. 1.

18. Diamond, p.33.

19. Anderson, p. 1.

20. Thomas S. Szasz, THE MANUFACTURE OF MADNESS: A COMPARATIVE STUDY OF THE INQUISITION AND MENTAL HEALTH MOVEMENT (New York: Harper & Row, Publishers, 1970), p. 227.

21. R. M. Murray and J. P. Zentner, NURSING ASSESSMENT AND PROMOTION THROUGH THE LIFE SPAN, 2nd Edition (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1979).

22. David E. Bresler, FREE YOURSELF FROM PAIN (New York: Simon and Schuster, 1979).

23. O. Carl Simonton, Stephanie Matthews-Simonton, and J. Creighton, GETTING WELL AGAIN (Los Angeles: J.P. Tarcher, Inc., 1978).

24. John B. Noss, MAN'S RELIGIONS (New York: The MacMillan Company, 1949), p. 3.

25. Marcus Bach, "Spiritual Power in Holistic Healing," In E.M. Goldwag, ed., INNER BALANCE AND THE POWER OF INNER HEALING (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1979), p. 208.

26. "Haelan", HAELAN, (Spring, 1984), p. 1.

27. Barbara Blattner, HOLISTIC NURSING (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1981), p. 3.

28. D. C. Phillips, HOLISTIC THOUGHT IN SOCIAL SCIENCE (Stanford, California: Stanford University Press, 1976), p. 6.

29. World Health Organization, Constitution of the World Health Organization. CHRONICLES OF THE WORLD HEALTH ORGANIZATION, 1, 1947, pp. 1-2.

30. H. L. Dunn, HIGH LEVEL WELLNESS (Arlington, Virginia: R.W. Beatty Company, 1961), pp. 5-6.

31. Rene Dubos, MAN ADAPTING (New Haven, Connecticut: University Press, 1965), p. 351.

32. George Sheehan, ON RUNNING (Mountain View, California: World Publications, 1975), p. 91.

33. Ivan Illich, MEDICAL NEMESIS (New York: Bantam Books, 1977), pp. 271-272.

34. Marc Lalonde, A NEW PERSPECTIVE ON THE HEALTH OF CANADIANS (Ottawa: Ministry of National Health and Welfare, 1974), p. 66.

35. Blattner, p. 19.

36. William M. Peterson, Donald A. Tubesing and Nancy L. Tubesing, THE PROCESS OF ENGAGEMENT (Hinsdale, Illinois: Society for Wholistic Medicine, 1976), p. i.

37. Kenneth R. Pelletier, MIND AS HEALER, MIND AS SLAYER (New York: Dell Publishing Co., 1977), p. 318-321.

38. Elliott Goldwag, ed., INNER BALANCE AND THE POWER OF INNER HEALING (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1979), p. xix.

39. R. A. Liebelt and Valory Murray, "Role of Medical Education: Global Aspects of Health", In E.M. Goldwag, ed., INNER BALANCE AND THE POWER OF INNER HEALING (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1979), p. 266.

40. Pelletier, p. 234.

41. Simonton, et al, pp. 43-51.

42. Selye, THE STRESS.

43. Bresler, pp. 254-255.

44. Donald A. Tubesing and Nancy L. Tubesing, THE CARING QUESTION (Minneapolis: Augsburg Publishing House, 1983), pp. 35-37.
45. Letter from the President. Michigan Holistic Health Association Newsletter, March, 1985.
46. Sally Guttmacher, "Whole in Body, Mind and Spirit: Wholistic Health and the Limitations of Medicine", HASTINGS CENTRE REPORT, (April 1979), p. 16.
47. Peterson, et al.
48. Marilyn Marai, "The Hospital Chaplain", ONTARIO HOSPITAL ASSOCIATION NEWSLETTER, 1980, p.11.
49. D. B. Guralnik and J. H. Friend, ed., WEBSTER'S NEW WORLD DICTIONARY (New York: The World Publishing Company, 1963).
50. J. B. Sykes, ed., THE CONCISE OXFORD DICTIONARY (Oxford: Oxford University Press, 1976).
51. F. L. Cross, ed., THE OXFORD DICTIONARY OF THE CHRISTIAN CHURCH (Oxford: Oxford University Press, 1957).
52. C. O. S. Mawson and K. A. Whiting, ed., ROGET'S POCKET THESAURUS (Montreal: Pocket Books of Canada, Ltd., 1962).
53. M. Scott Peck, THE ROAD LESS TRAVELED (New York: Simon and Schuster, 1978), p. 185.
54. Ibid., p. 191.
55. Ibid., p. 193.
56. Ibid., p. 193.
57. Simonton, et al, p.187.
58. Bresler, p.358.
59. Anderson, p. 1.
60. Matthew Fox, ON BEING A MUSICAL MYSTICAL BEAR (New York: Paulist Press/Deus Book, 1972), p. xi.
61. Ibid., p. xviii-xx.
62. Ibid., frontispiece.

63. Ibid., preface.
64. Swami Rama, A PRACTICAL GUIDE TO HOLISTIC HEALTH (Honesdale, Pennsylvania, The Himalayan International Institute, 1978), pp. 3-4.
65. R. E. Ornstein, THE PSYCHOLOGY OF CONSCIOUSNESS (San Francisco: Harcourt, Brace and Jovanovich, Inc., 1977), p. 164.
66. Gabriel M. Braso, Translated by L.J. Doyle, LITURGY AND SPIRITUALITY (Collegeville, Minnesota: The Liturgical Press, 1960), P. 218.
67. Thomas B. Merton, THOUGHTS IN SOLITUDE (New York: Dell Publishing Co., Inc., 1961), p. 112.
68. Ibid., p. 17.
69. Stan Woollams and Michael Brown, TRANSACTIONAL ANALYSIS (Dexter, Michigan: Huron Valley Institute, 1978).
70. Paul Tournier, THE PERSON REBORN (London: S.C.M. Press and William Heinemann Ltd., 1967).
71. E. L. Shostram and Dan Montgomery, HEALING LOVE (Nashville: Abingdon, 1978).
72. ST. LUKE 4:18.
73. Francis P. MacNutt, HEALING (Notre Dame, Indiana: Ave Maria Press, 1974), p. 14.
74. Ibid., p.24.
75. Morton T. Kelsey, HEALING AND CHRISTIANITY (New York: Harper and Row, Publishers, 1973,) p. 307.
76. Leslie D. Weatherhead, PSYCHOLOGY AND LIFE (London: Hodder and Stoughton, 1934), p. 28.
77. Weatherhead, PSYCHOLOGY, RELIGION, pp. 494-495.
78. Ibid., pp. 30-31.
79. Ibid., p. 33.

80. Pierre Teilhard de Chardin, THE PHENOMENON OF MAN, with an introduction by Sir Aldous Huxley (New York: Harper and Brothers, 1959), p. 12.

81. Ibid., p.108.

82. Robert N. Bellah, BEYOND BELIEF: ESSAYS ON RELIGION IN A POST-TRADITIONAL WORLD (New York: Harper and Row, 1970), p. 8.

83. Robert N. Bellah, Interview with Sam Keen, "The Sacred and the Political in American Life" PSYCHOLOGY TODAY, 9, 8, 1976.

84. Bellah, BEYOND BELIEF, p. xix.

85. Ibid., p. 7.

86. Ibid., p. 12.

87. Ibid., p. 12.

88. Tournier, p. 26.

CHAPTER IV

89. R. M. Cunningham, THE WHOLISTIC HEALTH CENTRES: A NEW DIRECTION IN HEALTH CARE (Battle Creek, Michigan: The W.K. Kellogg Foundation, 1977), p.9.

90. Selye, THE STRESS.

91. Donald A. Tubesing, AN IDEA IN EVOLUTION (Hinsdale, Illinois: Society for Wholistic Medicine, 1976), p. 4.

92. Ibid., p. 5.


93. Ibid., p. 14.

94. Peterson, William, ed., GRANGER WESTBERG VERBATIM (Hinsdale, Illinois: Wholistic Health Centres, Inc., 1982), p. 55.

95. Tubesing, AN IDEA, p. 7.

96. Simonton, p. 104.

97. Cunningham, p. 19.

98. Szasz, p. 227.
99. J. Thompson and H. Thompson, ETHICS IN NURSING (New York: The MacMillan Company, 1981), p. 212.
100. L. E. Rozovsky, THE CANADIAN PATIENT'S BOOK OF RIGHTS (Toronto: Doubleday Canada Limited, 1980), pp. 3-4.
101. Michael Glasser, L. Q. Kleppel, E. A. Lichter and John E. Riedel, INQUIRY INTO WHOLISTIC HEALTH CARE (Hinsdale, Illinois: Wholistic Health Centres, Inc., 1981), p. i.
102. Ibid., p. 2.2.
103. Ibid., p. 2.3.
104. U.S. Federal Bureau of Statistics, (Washington, D.C.: Government Printing Office, 1981), p. 107.
105. Glasser, p. i.
106. U.S. Federal Bureau of Statistics, (Washington, D.C.: The Government Printing Office, 1981), p. 131.
107. Glasser, p. 2.3.
108. U.S., Federal, p. 107.
109. Glasser, p. i.
110. U.S., Federal, p. 131.
111. Glasser, p. 3.6.
112. Ibid., p. 3.3.
113. Ibid., p. 3.4.
114. Ibid., 3.21.
115. Ibid., 3.24.
116. Ibid., 3.18.
117. Ibid., 3.19.
- 

118 PROGRAMME SUBMISSION FOR THE ESTABLISHMENT OF A WHOLISTIC HEALTH CENTRE, March, 1984, p. AC5.

119. Ibid., p. AC3.

120. Ibid., p. AC2.

121. MINUTES OF THE SPECIAL PROJECTS COMMITTEE OF THE PHOENIX WHOLISTIC HEALTH CENTRE, p. 6.

122. THE PHOENIX WHOLISTIC HEALTH CENTRE BROCHURE, 1981, p. 2.

123. MINUTES OF THE BOARD OF DIRECTORS' MEETING, June 26, 1983.

124. THE PHOENIX WHOLISTIC HEALTH CENTRE PROMOTIONAL BROCHURE, 1983, p. 5.

125. Programme Submission, p. CA1.

126. LETTER FROM THE ESSEX COUNTY MEDICAL SOCIETY, April 5, 1984.

127. Programme Submission, p. BC1.

128. Programme Submission, p. BC 1.

CHAPTER V

129. James D.V. Buskirk, RELIGION, HEALING & HEALTH (New York: The Macmillan Company, 1952), p. 2.

130. Tubesing, AN IDEA, p. 5.

131. Ibid., p. 5.

132. Ibid., p. 14.

133. Ibid., p. 14.

134. Reba Detornyay, "Doctor and Nurse-Retraining Forces in Teamwork." HOSPITAL FORUM 17(May 1974): 4-6.

135. Kelsey, p. 5.

136. Ibid., p. 6.

BIBLIOGRAPHY

- Anderson, Pauline. "Holistic Medicine, A Closer Look." ONTARIO MAGAZINE, 1 AUGUST 1983, P. 1.
- Bach, Marcus. "Spiritual Power in Holistic Healing". In E.M. Goldwag, ed. INNER BALANCE: THE POWER OF HOLISTIC HEALING. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1979.
- Bellah, Robert N. BEYOND BELIEF: ESSAYS ON RELIGION IN A POST-TRADITIONAL WORLD. New York: Harper and Row, 1970.
- Bellah, Robert N. Interview with Sam Keen, "The Sacred and the Political in American Life." PSYCHOLOGY TODAY. 9. (1976): 8.
- Blattner, Barbara. HOLISTIC NURSING. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1981.
- Braso, Gabriel. Translated by L.J. Doyle, LITURGY AND SPIRITUALITY. Collegeville, Minnesota: The Liturgical Press, 1960.
- Bresler, David E. FREE YOURSELF FROM PAIN. New York: Simon and Schuster, 1979.
- Buskirk, James D.V. RELIGION, HEALING & HEALTH. New York: The Macmillan Company, 1952.
- Callan, John P. "Holistic Health: Holistic Hoax." JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. 241 (1979): 11. p. 1156.
- Cousins, Norman. ANATOMY OF AN ILLNESS. New York: W.W. Norton and Company, Inc., 1979.
- Cross, F. L. OXFORD DICTIONARY OF THE CHRISTIAN CHURCH. London: Oxford University Press, 1957.
- Cunningham, R. M. THE WHOLISTIC HEALTH CENTRES: A NEW DIRECTION IN HEALTH CARE. Battle Creek, Michigan: W.K. Kellogg Foundation, 1979.
- Detornyay, Repa. "Doctor and Nurse-Retraining Forces in Teamwork." HOSPITAL FORUM 17(May 1974): 4-6.

- Diamond, J. YOUR BODY DOESN'T LIE. New York: Warner Books, Inc., 1979.
- Dubos, Rene. MAN ADAPTING. New Haven, Conn: Yale University Press, 1965.
- Dunn, H. L. HIGH LEVEL WELLNESS. Arlington, Va.: R.W. Beatty Company, 1961.
- Essex County Medical Society, LETTER, 5 April 1984.
- Fox, Matthew. ON BECOMING A MUSICAL MYSTICAL BEAR. New York: Paulist Press/Deus Book, 1972.
- Goldwag, E. M. ed. INNER BALANCE: THE POWER OF HOLISTIC HEALING. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1979.
- Glasser, Michael; Kleppel, L. Q.; Lichter, E. A.; and Riedel, John E. INQUIRY INTO WHOLISTIC HEALTH CARE. Hinsdale, Illinois: Wholistic Health Centres, Inc., 1981.
- Guralnik, D. B.; and Friend, J. H. WEBSTER'S NEW WORLD DICTIONARY. New York: The World Publishing Company, 1966.
- Guttmacher, Sally. "Whole in Body, Mind and Spirit: Wholistic Health and the Limitations of Medicine." HASTINGS CENTRE REPORT. April, 1979, p. 16.
- "Haelan." HAELAN. Spring, 1984.
- Illich, Ivan. MEDICAL NEMESIS. New York: Bantam Books, 1977.
- Kelsey, Morton T. HEALING AND CHRISTIANITY. New York: Harper and Row Publishers, 1973.
- Lalonde, Marc. NEW PERSPECTIVES ON THE HEALTH OF CANADIANS. Ottawa: Ministry of National Health and Welfare, 1974.
- Liebelt, R. A.; and Murray, Valory. "Role of Medical Education: Global Aspects of Health." In E.M. Goldwag, ed. INNER BALANCE: THE POWER OF HOLISTIC HEALING. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1979.
- Marai, Marilyn. "The Hospital Chaplain." ONTARIO HOSPITAL ASSOCIATION NEWSLETTER, 1980, p. 11.

- Mawson, C. O. S.; and Whiting, K. A. ROGET'S POCKET THESAURUS. Montreal: Pocket Books of Canada, Ltd., 1962.
- MacNutt, Francis P. HEALING. Notre Dame, Indiana: Ave Maria Press, 1974.
- Mendelsohn, Robert S. CONFESSIONS OF A MEDICAL HERETIC. New York: Warner Books, Inc., 1979.
- Merton, Thomas B. THOUGHTS IN SOLITUDE. New York: Dell Publishers Co., Inc., 1961.
- Michigan Holistic Health Association Newsletter. Letter from the President, March, 1985.
- Murray, R. M.; and Zentner, J. P. NURSING ASSESSMENT AND PROMOTION THROUGH THE LIFE SPAN, 2nd Edition. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1979.
- Noss, John B. MAN'S RELIGIONS. New York: The MacMillan Company, 1949.
- Ornstein, R. E. THE PSYCHOLOGY OF CONSCIOUSNESS. San Francisco: Harcourt, Brace and Jovanovich, Inc., 1977.
- Peck, M. Scott, THE ROAD LESS TRAVELED. New York: Simon and Schuster, 1978.
- Pelletier, Kenneth R. HOLISTIC MEDICINE: FROM STRESS TO OPTIMUM HEALTH. New York: Seymour Lawrence, 1974.
- Pelletier, Kenneth R. MIND AS HEALER, MIND AS SLAYER. New York: Dell Publishing Co., 1977.
- Peterson, William M., ed. GRANGER WESTBERG VERBATIM. Hinsdale, Illinois: Wholistic Health Centres, Inc.; 1982.
- Peterson, William M.; Tubesing, D. A.; and Tubesing, N. L. THE PROCESS OF ENGAGEMENT. Hinsdale, Illinois: Society for Wholistic Medicine, 1976.
- Phillips, D. C. HOLISTIC THOUGHT IN SOCIAL SCIENCE. Stanford, Ca.: Stanford University Press, 1976.
- Phoenix Wholistic Health Centre. PROGRAMME SUBMISSION FOR THE ESTABLISHMENT OF A WHOLISTIC HEALTH CENTRE. March, 1984, p. AC5.

- Phoenix Wholistic Health Centre. MINUTES OF THE SPECIAL PROJECTS COMMITTEE. p. 6.
- Phoenix Wholistic Health Centre. BROCHURE. 1981, p. 2.
- Phoenix Wholistic Health Centre. MINUTES OF THE BOARD OF DIRECTOR'S MEETING. June 1983.
- Phoenix Wholistic Health Centre. PROMOTIONAL BROCHURE. 1983, p. 5.
- Rozovsky, L. E. THE CANADIAN PATIENT'S BOOK OF RIGHTS. Toronto: Doubleday Canada Limited, 1980.
- ST. LUKE 4:18.
- Selye, Hans. "Stress: The Basis Of Illness." In E.M. Goldwag, ed., INNER BALANCE: THE POWER OF HOLISTIC HEALING. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1979.
- Selye, Hans. THE STRESS OF LIFE, Revised Edition. New York: McGraw-Hill Book Co, 1976.
- Sheehan, George. ON RUNNING. Mountain View, Ca.: World Publications, 1975.
- Shostram, E. L.; and Montgomery, D. HEALING LOVE. Nashville: Abingdon. 1978.
- Simonton, O. Carl.; Matthews-Simonton, S., and Creighton, J. GETTING WELL AGAIN. Los Angeles: J.P. Tarcher, Inc., 1978.
- Swami Rama. A PRACTICAL GUIDE TO HOLISTIC HEALTH. Honesdale, Pennsylvania: The Himalayan International Institute, 1978.
- Sykes, J. B. THE CONCISE OXFORD DICTIONARY. Oxford: Oxford University Press, 1976.
- Szasz, Thomas S. THE MANUFACTURE OF MADNESS: A COMPARATIVE STUDY OF THE INQUISITION AND MENTAL HEALTH MOVEMENT. New York: Harper and Row, Publishers, 1970.
- Teilhard de Chardin. THE PHENOMENON OF MAN, with an introduction by Sir Julian Huxley. New York: Harper and Brothers, 1959.

Thompson, J.; and Thompson, H. ETHICS IN NURSING. New York:
The MacMillan Company, 1981.

Todd, Malcolm. "The Challenge to Medicine: Prevention of
Illness". In E.M. Goldwag, ed. INNER BALANCE: THE POWER OF
HOLISTIC HEALING. Englewood Cliffs, New Jersey:
Prentice-Hall, Inc., 1979.

Tournier, Paul. THE PERSON REBORN. London: S.C.M. Press and
William Heinemann Ltd., 1967.

Tubesing, Donald A. AN IDEA IN EVOLUTION. Hinsdale, Illinois:
Society for Wholistic Medicine, 1976.

Tubesing, Donald A.; and Tubesing, N. L. THE CARING QUESTION.
Minneapolis: Augsburg Publishing House, 1983.

Tubesing, N. L. PHILOSOPHICAL ASSUMPTIONS, Hinsdale, Illinois:
Society for Wholistic Medicine, 1977.

U.S. Federal Bureau of Statistics. Washington, D.C.:
Government Printing Office, 1981.

Vaux, K. "In Search of a Context and Concept of Wholistic
Health." G. Westberg, ed. THEOLOGICAL ROOTS OF WHOLISTIC
HEALTH CARE. Hinsdale, Illinois: Wholistic Health Centres,
Inc., 1979.

Weatherhead, Leslie D. PSYCHOLOGY AND LIFE. London: Hodder and
Stoughton, 1934.

Weatherhead, Leslie D. PSYCHOLOGY. RELIGION AND HEALING.
London: Hodder and Stoughton, 1951.

Woollams, Stan; and Brown, Michael. TRANSACTIONAL ANALYSIS.
Dexter, Michigan: Huron Valley Institute, 1978.

World Health Organization. "Constitution of the World Health
Organization." CHRONICLES OF WORLD HEALTH ORGANIZATION. 1,
1947, pp. 1-2.

APPENDIX # 1

SCHEDULE 1.

TWO MODELS OF HEALTH CARETraditional Clinical/Medical Model

The doctor has primary responsibility for medical/health care.

The emphasis is on medical diagnosis, treatment and care.

The individual's entry point for health care is usually symptoms of illness.

The approach for utilizing other professionals is a support system including other doctors, nurses and members of other disciplines as needed. The decision-making around need is usually determined by the doctor.

Wholistic Health Care Model

The patient has primary responsibility for medical/health care.

The emphasis is on understanding the inter-relationship of all the components of the patient's life, recognizing that illness is commonly a feedback message that something is out of balance in one or more of the dimensions of the total person.

The individual's entry point for health care may be the same as the traditional clinical/medical model or may be for what the individual considers a non-medical concern.

The inter-disciplinary team (pastoral counsellor, doctor, nurse) plus the patient decide on the utilization of other professionals. The decision-making around need is collaborative.

EVALUATE YOUR HABITS

In the next chapters we'll outline specific self-care strategies for promoting physical, mental, relational, and spiritual health. But before you listen to what we have to say about these, please stop and reflect for a moment about your current self-care habits. How well do you take care of yourself in each of the dimensions of life?

The quiz on the next few pages will give you some idea of your current self-care patterns. You may be surprised by some of the questions. "What does laughter have to do with health?" you may ask. What about forgiveness? Seat belts? Or friendships? We'll get to all these issues in later chapters. For now, go ahead and answer the questions.

Mental

- I seldom experience periods of depression.
- I generally face up to problems and cope with change effectively.
- I worry very little about future possibilities or things I can't change.
- I laugh several times a day and usually fit "play" into my schedule.
- I am curious and always on the lookout for new learning.
- I maintain a realistic and basically positive self-image.
- I choose to feel confident and optimistic.

Relational

- I seek help and support when I need it.
- I have at least one friend with whom I can share almost anything.
- I have nourishing intimate relationships with family and/or friends.
- I experience and express a wide range of emotions and respond to others' feelings appropriately.
- Each day includes comfortable and stimulating interaction with others, frequently new acquaintances.
- I solicit and accept feedback from others.
- I stick up for myself when it's necessary and appropriate.

Spiritual

- I set aside 15-20 minutes each day for prayer or meditation.
- I participate in regular spiritual rituals with people who share my beliefs.
- I accept my limitations and inadequacies without embarrassment or apology.
- I keep the purpose of my life clearly in mind and let it guide my goal setting and decision making.
- I regularly offer my time and possessions in service to others.

Health Habit Inventory

- | Yes | No | <i>Physical</i> |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | I participate regularly (three times a week or more) in a vigorous physical-exercise program. |
| <input type="checkbox"/> | <input type="checkbox"/> | I eat a well-balanced diet. |
| <input type="checkbox"/> | <input type="checkbox"/> | My weight is within 10 lbs. of the ideal weight for my height. |
| <input type="checkbox"/> | <input type="checkbox"/> | My alcohol consumption is seven drinks (shot, beer, or glass of wine) or fewer per week. |
| <input type="checkbox"/> | <input type="checkbox"/> | I always wear my seat belt. |
| <input type="checkbox"/> | <input type="checkbox"/> | I do not smoke cigarettes, cigars, or a pipe. |
| <input type="checkbox"/> | <input type="checkbox"/> | I generally get adequate and satisfying sleep. |

35

- I am sensitive to ultimate truths and the spiritual dimension of life.
- I readily forgive myself and others.

Count up your yes responses for each category and record them below.

Physical	<input type="checkbox"/>	Yes responses
Mental	<input type="checkbox"/>	Yes responses
Relational	<input type="checkbox"/>	Yes responses
Spiritual	<input type="checkbox"/>	Yes responses
Total	<input type="checkbox"/>	Out of 28 questions

HOW TO INTERPRET YOUR SCORE

Your total of yes responses on the Health Habit Inventory provides a general idea of how well you take care of your health across all dimensions of life. Compare your total score to the Caring Question Standards:

- 24-28 **Excellent:** Your habits are enhancing your health.
- 16-23 **Average:** You're obviously trying, but there's room for improvement.
- Below 16 **Poor:** The quality of your health is probably diminished by your poor habits.

THE PHOENIX WHOLISTIC HEALTH CENTRE
660 Ouellette Avenue, Suite 100, Windsor, Ontario
Tel. (519) 253-4641

AGREEMENT

Between:

The Phoenix Wholistic Health Centre,
an Ontario non-share capital organization,
hereinafter referred to as P.W.H.C.

&

(name)

(address)

I, _____ hereby retain the services of
the P.W.H.C., which ^(name) agrees to provide such services, to help me with my personal
problems by counselling with me in preparation of a plan of action during three (3)
sessions of one hour each, for a fee of \$ _____ per session.

Dated at _____ Ontario
this _____ day of _____ 19 _____

Phoenix Wholistic Health Centre
per _____

Yesterday

Greek

Spiritual means immaterial

From Plato via Augustine and Denis the Pseudo-Aeropagite

Soul wars with both

Limit please, shun it.

Matter is sinful or at most tolerated

Private (God and me)

Centred around the theological theme of the Fall and humankind's need for redemption

Pride and lust are capital sins to be put to death by mortifications.

Negative toward the human person and human history

Artists must choose between sacred and secular subjects, between spiritual and material

Humankind's relationship to God is primarily vertical: God is up, humankind is below

Today

Hebraic

Spiritual means what is life-giving

From the Jews via the prophets and Jesus.

Person is at war with evil in its many forms.

Ecstasy is gift of Creator

Matter too is God-made and holy

Political (God and us)

Centred on the theological theme of creation and how it is good, how we may thank you by enjoying and sharing enjoyment of it.

Developing your talents is the Creator's desire (as in the parable of the talents). Any ascetic practices are strictly means, not ends.

Affirmation toward the person and human history not in a naive optimistic sense, but in the sense that humankind has dominion over creation provided it first receives the gifts and beauties of the Creator

Every experience of beauty is an experience of God and all artistic expression is a sharing in the image and likeness of the Creator

Humankind's relationship to God is horizontal and concentric in its meeting places. God is all in all and all is in God. God as pantheistic.

File No: _____

Your Name: _____

LIFE EVENT CHECKLIST

Check events which have occurred in the past few years and circle those that have been most important to you. Reflect on these changes before completing the remainder of the inventory.

THE SPIRITUAL DIMENSION

- _____ Change in relationship with God
- _____ Change in Church activity or prayer life
- _____ Significant spiritual experience
- _____ Spiritual emptiness
- _____ Constant feelings of guilt or anxiety
- Other: _____

PERSONAL EVENTS/CHANGES

- _____ Death of a close friend or family member
- _____ Personal injury, illness, or hospitalization
- _____ Pregnancy (or pregnancy of spouse)
- _____ Loss of self confidence
- _____ Outstanding achievement (graduation, promotion)
- _____ Change in eating habits
- _____ Change in sexual activity
- _____ Change in sleeping patterns
- _____ Change in energy level
- _____ Considered suicide
- _____ Change in religious belief or practice
- _____ Stress related to vocation
- _____ Change in relationship with parents
- _____ Change in recreational time/activity
- _____ Trouble with the law
- _____ Change in time schedule
- _____ Change in drinking _____ smoking _____ drug use _____
- Other: _____

MARITAL RELATIONSHIP

- Married _____ Divorced _____ Separated _____
- Widowed _____ Living Together _____
- Disagreements over money management _____
- Increased emotional distance _____
- Trouble with in-laws _____
- Spouse beginning or stopping work or school _____
- Other: _____

HOUSEHOLD EVENTS

- _____ Family member left home
- _____ Gain of a new member (birth, parents moving in, adoption, etc.)
- _____ Spouse at home more than before
- _____ Problems with children at home
- _____ Change in residence
- _____ Remodeling or building
- _____ Change in health/behavior/attitude of a member of the household
- _____ Change in neighbors or neighborhood
- Other: _____

VOCATIONAL EVENTS

- _____ New job, or new line of work
- Quit _____ Fired _____ Retired _____ Laid Off _____
- Less job security _____
- Promotion _____ Demotion _____
- Trouble with work associates _____
- Change in hours, conditions, travel, etc. _____
- Other: _____

FINANCIAL CHANGES

- _____ Changes in financial state (better or worse)
- _____ Major mortgage or loan taken out
- _____ Foreclosure of mortgage or loan
- Other: _____

1. Physical symptoms I'm concerned about:

2. Feelings/emotions I'm concerned about:

3. Goals toward which I'd like to begin moving:

4. My strong points and special abilities in moving toward my goals:

5. Kinds of help I need in moving toward my goals:

APPENDIX # 6

THREE CASE HISTORIES

(a) One of the first patients, a 14-year-old boy referred by the school nurse for stomach pains, was diagnosed as having the beginning of an ulcer. He said little, and appeared uneasy. Later when the seminarian accompanied him outside to shoot baskets, the story unfolded. The boy's father, 42, had ulcers and emphysema. Other boys said his dad was lazy. While defending his dad outwardly, sometimes he resented his feeble father for the pain he was causing. Saying little to anyone, the boy swallowed his pain day after day. As the friendship developed with the seminarian, the boy had a place to vent his feelings and his symptoms began to dissipate.

(b) Jane Doe, 22, mother of two boys, 4 and 2, and her husband, John, who normally would have sufficient income to pay fees, chose to come to the clinic rather than a private physician. "Tony, my baby, has cerebral palsy," the young mother said in a newspaper interview. "John works in Yellow Springs, and we took Tony there for treatments once or twice a week -- but it was \$30. each time. I bring him here now. The clinic is arranging for Children's Medical Centre in Dayton to see him." Jane has lost twenty pounds at the clinic's Weight Watcher chapter and had twenty-nine pounds to go. "There's times I don't know what I'll do," she admitted. "At first, I thought Tony's trouble was my fault. Maybe I wasn't talking to him right. But the counselling helps. They helped me see it wasn't my fault, but was something we all would have to learn to live with."

(c) A physician at Community Hospital who worked in the emergency room was asked what he thought of the church clinic. He told this story: "One day a little boy was brought to the emergency room of the hospital with a spider bite. I treated the spider bite, charged him \$17.50, and sent the boy home. Three days later, he received another spider bite and this time was taken to the church clinic. There he was treated for the spider bite, but then was immediately accompanied to his home where an investigation was made to learn the source of spiders. This was discovered in a dank old basement that was cluttered with debris. The seminarian tracked down the landlord of the house and with some gentle persuasion was able to get him to clean out the basement, spray it, and rid it of the spiders. This is real health care."

A Patient's Bill of Rights

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.
3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent, should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.
4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.
5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.
6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.
7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.
9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.
11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.
12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

SUMMARY OF CHARACTERISTICS OF WHOLISTIC HEALTH CENTRE PATIENTS
 OVERVIEW
 BASED ON SURVEY CONDUCTED IN 1980 BY
 WHOLISTIC HEALTH CENTRES INC.
 HINSDALE, ILLINOIS

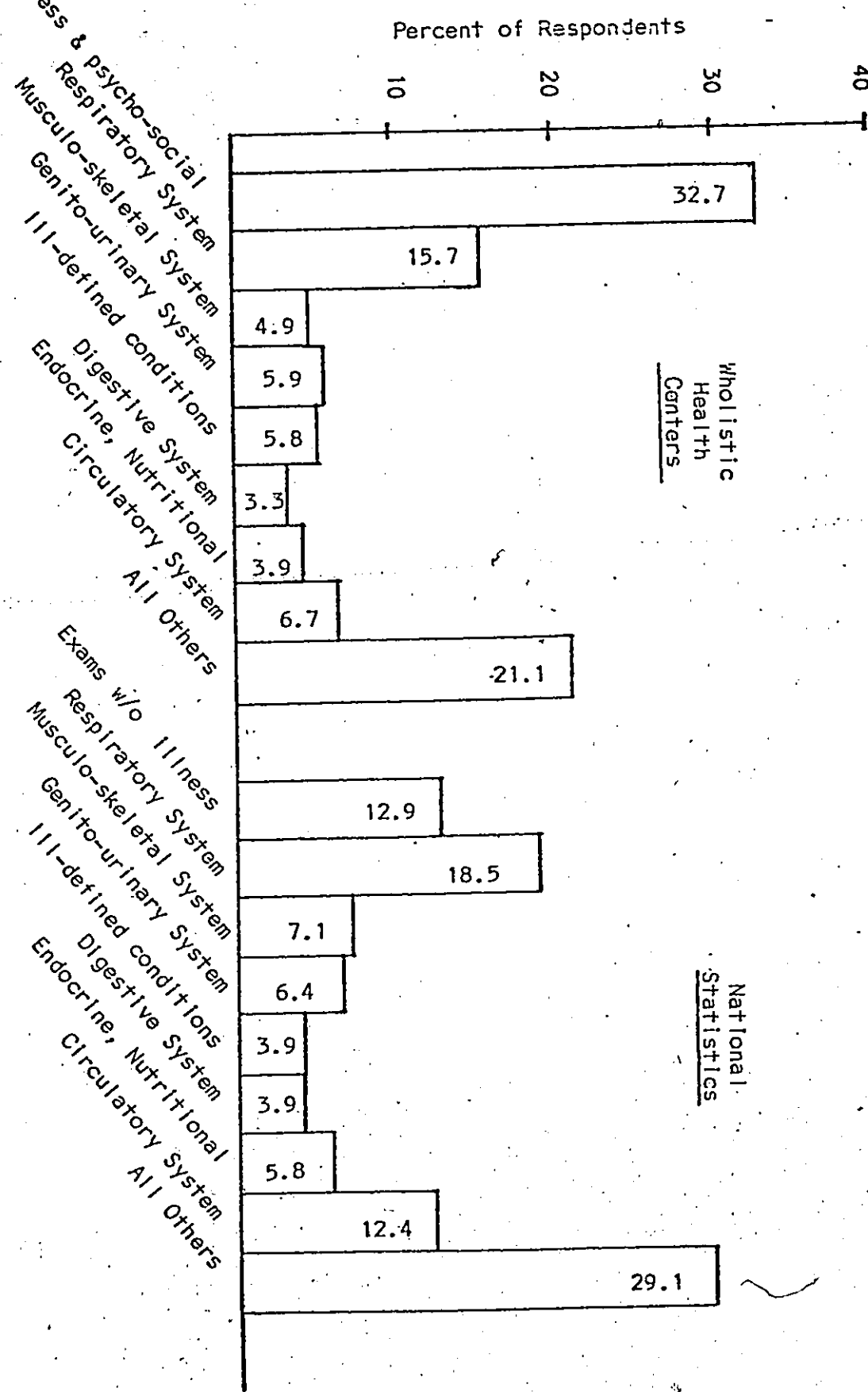
CHARACTERISTIC	SURVEY RESULT
1. Total respondents	1,182
2. Age	61% between ages 25 - 44 Mean age = 41
3. Sex	Female - 68% Male - 32%
4. Marital Status	Married - 70% Single - 14% Divorced/ Separated - 10% Widowed - 6%
5. Members in household	Mean = 3.2 per household
6. Education	72% had some college edu- cation or a college degree. 33% had graduate training or a graduate degree
7. Family income	\$18,000 - \$28,000/yr. - 27% Over \$28,000/yr. - 47%
8. Employment	85% Men employed full time 57% Woman employed full time
9. Religion	Protestant - 54% Roman Catholic - 25% Jewish - 2% Other - 9% No Preference - 10%

10. Mobility. 26% lived in present com-
 munity 2 - 5 years

3.24

Exams w/o Illness & psycho-social

Percentage of Office Visits to General and Family Practice Doctors by Principal Diagnosis: United States, National Ambulatory Medical Care Survey, 1975.



Comparison of Primary Diagnoses Between Wholistic Health Centers and Other General and Family Practitioners²

GRAPH 3 - 17

PHOENIX WHOLISTIC HEALTH CENTRE

NAME _____ FILE NO. _____

PERSONAL HEALTH PLAN

1. The use of a relaxation tape daily especially when feelings of anxiety or fear take over.
2. The use of a 'Thought for the Day' consonant with the teachings of the Roman Catholic Church.
3. The consideration of attending the Family Life Programme offered on Thursday mornings by St. Mary's Anglican Church, Walkerville - 252-9696.
4. The consideration of a relaxing type of hobby in addition to current hobbies.
5. Consultation with physician as to an exercise programme, including walking.

Signed: _____

witnessed: _____

date: _____

cc: physician, patient



ESSEX COUNTY
 DISTRICT HEALTH COUNCIL

APR 06 1984

RECEIVED

ESSEX COUNTY MEDICAL SOCIETY

1011 OUELLETTE AVENUE
 WINDSOR, ONTARIO N9A 4B9

PHONE (519) 256-4611

April 5, 1984

Dr. Andre Spekkens
 Executive Director
 Essex County District Health Council
 Suite 207 Bartlett Building
 76 University Avenue, West
 Windsor, Ontario
 N9A 5N7

Dear Doctor Spekkens:

The Executive of the Essex County Medical Society at a meeting on March 26, 1984 discussed the proposal of the Windsor Wholistic Health Centre to apply for approval for funding by the Community Health Centre Programme.

It was the unanimous feeling of the Executive that we have serious reservations regarding this proposal for the following reasons.

- 1) There is a failure to identify that the target group in this proposal has either a higher disease burden, or has impaired access to traditional medical services.
- 2) The budget, equipment, and staffing priorities as outlined on Pages CB2 and CC1 are completely inadequate to provide "Basic Primary Health Care" to the target population as identified on Pages BB2.
- 3) In spite of offering services since 1981, the fact that "upwards of 50 patients" has been recorded (reference Page BA1) suggests that the "Wholistic" approach has considerably less appeal in this community than we are led to believe by this optimistic presentation.
- 4) In times of fiscal restraint, when there is a crying need for funding of other services in the Essex County, a proposal to allocate \$324,000. to an unproven facility, appears to this group to be completely unwarranted at this time.
- 5) The average "Wholistic" patient, as identified on Page BA1 appears to be a member of a privileged rather than a disadvantaged group, and it

VITA AUCTORIS

NAME: WILLIAM KENNETH JAGGS

BIOGRAPHICAL DATA

PLACE AND DATE OF BIRTH: Port Credit, Ontario
January 2, 1929

MARITAL STATUS: Married
Four Children

EDUCATION: B.A.
University of Western Ontario, 1957
L.Th.
Huron College, 1958

EMPLOYMENT:

- a) Programme Consultant
Addiction Research Foundation
- b) Priest in Charge
St. Michael & All Angels Church
Anglican Church of Canada
Windsor, Ontario
- c) Religious Commentator
Canadian Broadcasting Corporation

Presently a doctoral candidate at the thesis stage at the Ecumenical Theological Centre, Detroit, Michigan.