The Interface of Medicine, Spirituality, and Ethics

A Case Study of the McGill Programs in Whole Person Care

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October 2008

A thesis submitted to McGill University
in partial fulfillment of the requirements of the degree
of Master of Arts

Your file Votre référence
ISBN: 978-0-494-67006-4
Our file Notre référence
ISBN: 978-0-494-67006-4

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Abstract

Academic and medical institutions are responding to rising critiques of mainstream, scientific medicine (biomedicine). One response is the establishment of centers and programs devoted to whole person care. I assess the response of the McGill Programs in Whole Person Care (WPC) to these critiques, particularly its incorporation of spirituality into medicine. Through textual hermeneutics, participant observation, and semi-structured interviews with faculty members, I argue that WPC is constructing its own worldview and normative framework. It does this by selectively drawing from the religious traditions of ancient Greece, Buddhism, and Christianity, interpreting these selections in terms of Jungian psychology, and sometimes secularizing them. My aim is to better understand the theory and praxis of whole person care in McGill University's Faculty of Medicine as a case study but also the ethical issues it raises. I conclude by providing points of reflection for institutions wishing to incorporate these health ideas and practices into conventional medicine.

Résumé

Les institutions académiques et médicales réagissent aux critiques de plus en plus fréquentes visant la médecine scientifique traditionnelle (biomédecine), d'où l'établissement de centres et de programmes voués au "soins holistiques" ("whole person care"). J'évalue la réaction des McGill Programs in Whole Person Care (WPC) à ces critiques, plus spécifiquement son intégration de la spiritualité en médecine. Par le biais d'herméneutique textuelle, d'observation de participants et d'entrevues semi-structurées avec des membres de la faculté, je suggère que le WPC est en train d'établir une vision du monde et une structure normative qui lui sont propres. Il fait ceci en s'inspirant d'aspects particuliers des traditions religieuses de la Grèce antique, du bouddhisme et du christianisme et en interprétant ces aspects selon la psychologie jungienne ainsi qu'en les laïcisant dans certains cas. Je vise à mieux comprendre la théorie et la pratique du "soins holistiques" dans la Faculté de Médecine de l'Université McGill en tant qu'étude de cas, mais aussi de mieux comprendre les problèmes éthiques qu'elles posent. Je conclus en offrant des points de réflection pour d'autres institutions qui souhaiteraient incorporer ces idées et pratiques ayant trait à la santé dans la médecine conventionnelle.

Dedication

I would like to dedicate this thesis to my loving parents, Lorne and Maureen Prokopy, as well as my partner and best friend, Matthew Killi, who never ceases to inspire me.

Acknowledgments

I would like to extend my deepest gratitude to Dr. Katherine Young of the Faculty of Religious Studies for her insight, guidance, and support throughout my graduate studies and the thesis writing process in particular. Her interests, especially in cross-disciplinary research, enthusiasm, and continual encouragement have been inspiring and altogether afforded me the opportunity to explore my own diverse research interests. I am, furthermore, indebted to the faculty members at the McGill Programs in Whole Person Care, both past and present. They have been so accommodating in my requests, openly receptive of my ideas, and volunteered so much of their time. I only hope that my work will impart to them what they have so graciously and genuinely given me. I would also like to thank my fellow graduate students particularly the biomedical ethics group, Kassy Wayne, Veronique Bergeron, Hayden Bernstein, and William Affleck, for their ever-engaging ideas and support. And last but never least, I am grateful for the unabating love and support of my family and friends. Without them, none of this would have been possible.

Abbreviations

A.F.M. = Anonymous Faculty Member

BMJ = British Medical Journal

CAM = Complementary and Alternative Medicine

CMAJ = Canadian Medical Association Journal

CW = Collected Works

ESRD = End Stage Renal Disease

HHM = Holistic Health Movement

MBSR = Mindfulness Based Stress Reduction

MQOL = McGill Quality of Life

MUHC = McGill University Health Centre

NAM = New Age Movement

NCCAM = National Centre for Complementary and Alternative Medicine

NIH = National Institute of Health

NKJV = New King James Version

OED = Oxford English Dictionary

QOL = Quality of Life

SW = Selected Writings

UMass = University of Massachusetts

WHO = World Health Organization

WPC = McGill Programs in Whole Person Care

ZHP = Zen Hospice Project

INTRODUCTION

The current overarching system of medicine in North America, namely biomedicine[1], has accrued unprecedented success and effectiveness in the understanding, curing, and treatment of disease particularly within the realm of acute disorders and conditions (Ventegodt, Morad, and Merrick 282). Nevertheless, it has been the subject of much debate ranging from commentary and criticism to outright condemnation. The focus of this debate resides in the professed inadequacies of the current Western medical paradigm with its predominant emphasis on such principles as reductionism, mechanism, objectivism, positivism and the anatomical, physiological, and biochemical designation of disease (Engel 132). The professed deficiency of biomedicine's health care has been most conspicuous within the arena of chronic and life-threatening illness, where disease diagnosis, prognosis, and etiology remain relatively nebulous and ineffectual within current biomedical methodology. Rising critiques of biomedicine have resulted in a significant increase in health care developments both within and outside biomedicine. These developments include the increasing use of complementary and alternative medicine[2] such as homeopathic medicine[3], naturopathic medicine[4], Ayurvedic medicine[5], and

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[1] Biomedicine refers to the predominant disease model in the West with molecular biology as its primary discipline. It is based on the rigors of the scientific method, such as reductionism and mind-body dualism, and explains phenomena through the language of chemistry and physics (Engel 130). According to Kristin Barker,

> [It] is a term that captures the nature of important changes that emerged in Western medical practice between the late 1800s and early 1900s. This period marked the coming together of medicine and the laboratory-based biological sciences ... Even as the practice of medicine at the dawn of the twenty-first century differs greatly from that of a century ago, the term 'biomedicine' represents the historical thread that unites the practice of medicine in two otherwise different eras. In brief, biomedicine is a medical practice based on the principles, methods, and technologies of the biological life sciences, and it has tremendous cultural authority in matters of illness. (10)

[2] According to the National Centre for Complementary and Alternative Medicine (NCCAM), a component of the National Institute of Health (NIH) in the United States, complementary and alternative medicine (CAM) is "a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine" (NCCAM).

[3] Homeopathic medicine refers to "A whole medical system that originated in Europe. [It] seeks to stimulate the body's ability to heal itself by giving very small doses of highly diluted substances that in larger doses would produce illness or symptoms (an approach called 'like cures like')" (NCCAM).

[4] Naturopathic medicine is "A whole medical system that originated in Europe. [It] aims to support the body's ability to heal itself through the use of dietary and lifestyle changes together with CAM therapies such as herbs, massage, and joint manipulation" (NCCAM).

[5] According to the NCCAM website,

traditional Chinese medicine[6], which is occurring largely outside of biomedicine's purview. These also include the development of the bio-psycho-social model, patient-centered medicine, narrative medicine, integrative medicine, and the hospice/palliative care movement, which are developing predominantly within biomedicine. As critiques focus on biomedicine's strict adherence to a separation of mind and body, many of these developments redress this through appealing to the wholeness of persons in mind, body, and spirit in general and incorporating spirituality into medicine in particular. One recent reform to this effect (occurring on the margins of biomedicine) is that of "whole person care," a model considered by Edmund Pellegrino to define the new epoch of medical care (qtd. in Mount, "WPC" 28). Although such people as Dame Cicely Saunders[7] and Sir William Osler[8] have advocated whole person care in the past, its formal institutionalization is occurring currently in some university medical faculties including that of McGill University.

In February 1999, Balfour Mount and the Dean of Medicine at McGill University Abraham Fuks initiated the McGill Programs in Whole Person Care, henceforth referred to as WPC. The initial proposal submitted by Mount, Patricia

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> Ayurvedic medicine (also called Ayurveda) is one of the world's oldest medical systems. It originated in India and has evolved there over thousands of years. In the United States, Ayurvedic medicine is considered complementary and alternative medicine (CAM) – more specifically, a CAM whole medical system. Many therapies used in Ayurvedic medicine are also used on their own as CAM – for example, herbs, massage, and specialized diets. The aim of Ayurvedic medicine is to integrate and balance the body, mind, and spirit. This is believed to help prevent illness and promote wellness. [It] uses a variety of products and techniques to cleanse the body and restore balance.

[6] Traditional Chinese medicine is "a whole medical system that originated in China. It is based on the concept that disease results from the disruption in the flow of qi and imbalance in the forces of yin and yang. Practices such as herbs, meditation, massage, and acupuncture seek to aid healing by restoring the yin-yang balance and the flow of qi" (NCCAM).

[7] Dame Cicely Saunders is known as the foremost founder of the modern hospice movement through the creation of St. Christopher's Hospice in London in 1967. "Because the founder of St. Christopher's, Dr. Cicely Saunders, thoroughly articulated a philosophy of hospice and diligently worked to share this vision among medical and religious professionals, St. Christopher's became the founding model for the hospice movement (Garces-Foley 342).

[8] Born in Canada in the mid 1800's, Sir William Osler has been remembered as one of the most renowned physicians in North America. He is ubiquitously avowed as the quintessential embodiment of the ideal physician for his prudent integration of the science and art of medicine. And this is no different for his legacy at McGill where he is considered by many to be the McGill Faculty of Medicine's most eminent medical graduate and faculty member ("Sir William Osler"). The medical community both within and outside of McGill has created a tradition of medical practice modeled on Osler's medical insights, approaches, and developments, nominally known as the Oslerian tradition (Bryan 682, 683). Because Osler's legacy both began and ended at McGill (before his death, he donated the greater part of his book and manuscript collection to McGill), McGill University has appropriated this tradition into its Faculty of Medicine's history, teaching, and practice ("Sir William Osler").

Boston and Robin Cohen described its aim as the following: to address the current need for education and research programs devoted to the subjective experience of illness so as to specifically incorporate the existential and spiritual dimensions of personhood ("Newsletter 1" 4).

Much of the impetus for the creation of WPC derived from Mount's pioneering work in palliative care. This work began after an adult education meeting at a local church where he was encouraged to undertake research at the Royal Victoria Hospital in Montreal, Canada, on attitudes to life-threatening illness and a series of case studies investigating the experiences of terminally ill patients. The results of this research indicated that there were not only unmet psychosocial, existential, and spiritual needs but also poor control of pain and other symptoms (Mount, Interview). "And what was equally significant for me was that we just weren't aware of it as a problem at all. These were good people – competent, concerned, caring people – who were involved in delivering inadequate care without any idea that it was inadequate" (Mount, Interview). This led Mount during the year of 1973 to visit St. Christopher's Hospice in London, England, where Dame Cicely Saunders founded the modern hospice movement and "was advocating whole person care approaches in the tradition of William Oslet and the Swiss physician Paul Tournier" (Mount, "WPC" 28). Subsequent to this visit, Mount spearheaded the development of palliative medicine by bringing the work of the United Kingdom hospice movement to North America in the mid-seventies through the creation of the first in-hospital palliative care unit at the Royal Victoria Hospital (Seely 2, 3).

It was specifically, and quite appropriately, Mount's experiences in palliative care, particularly those with his patients, that testified to the significance, complexity, and multidimensionality of the subjective quality of life in illness as well as the potential to create a space for healing even in the event where treatment was no longer able to effect disease outcome ("Newsletter 1" 4). Mount cites a number of his patients who made a contribution to such professional and personal insights, often referring to them as his "teachers about suffering" (Mount, "WPC" 29). Their experiences, he says, contribute to the great wisdom traditions of the ages (Mount, "Existential" 95). But, it was particularly a patient by the name of Chip (often cited as C.D.) who demonstrated to Mount some major problems in current medical delivery. "I was impressed that we were missing what Chip was talking about in measuring

quality of life and that the inner life, existential, spiritual domain was a major contributor to subjective wellbeing" (Mount, Interview). This led Mount to pursue further inquiry into the following questions. What determines quality of life? What is healing? What is the significance of the inner life and its subsequent impact on illness (Mount, "Music" 37)? More specifically, does the spiritual/existential domain exist? Does it modify our experience of health, illness, suffering, and quality of life? Is the spiritual domain a determinant of the healing that can occur in dying? And are these issues essential to our understanding of health and health care (Mount, Foreword viii)? In response to these inquiries Mount asserts that the spiritual, existential, and inner life dimensions of personhood are a recognizable reality and have been throughout human existence. Alienation from these dimensions gives rise to "spiritual pain" and thus can impact the overall health and wellbeing of an individual irrespective of personal health status (Mount, Boston, and Cohen, "Proposal" 6).

These foundational questions and subsequent conclusions formed the basis not only for Mount's work in palliative care but also for the development of WPC. And as Mount so asserts, particularly at the outset of WPC's development, palliative care and WPC are engaged in a mutually beneficial relationship and alliance. Both are concerned with acknowledging the mind-body-spirit complex in illness, the patient's subjective experience, and the inherent limitations of the current disease-oriented biomedical model in addressing these dimensions (Mount, Boston, and Cohen, "Proposal" 3,4). Both represent a Kuhnian paradigm shift in medicine where the reductionist biomedical model is extended to include a broader perspective: that of whole person care. However, the "main thrust" of WPC is its wider development and application not only within the domain of chronic and terminally advanced illness, such as in palliative care but also within the arena of acute disease and even the arena of health (Mount and Hutchinson 4, 7; Mount and Kearney 658). "Clearly, the need for whole person care wasn't just confined to people who were dying; it was [needed for] everybody. So, we started Programs in Whole Person Care" (Mount, Interview).

These recent developments in biomedicine create an interesting area for cross-disciplinary research in the interface of medicine, religious studies, and ethics. My thesis explores this interface through a case study of WPC. I examine the following questions in particular: how is whole person care at McGill integrating spirituality into medicine both theoretically and practically; what are some of the challenges and

ethics associated with this integration; and what might this suggest for the ethical delivery of health care? For instance, can its approach provide a sound basis for acceptable and appropriate standards of practice in biomedicine?

I explored these issues by, first, analyzing the primary and secondary sources of the WPC literature. Second, I observationally participated in those programs I was permitted to attend. These included undergraduate medical lectures and simulation activities, seminar series, film series, and book club. Lastly, I conducted one hour, semi-structured interviews with WPC faculty members and one of its affiliates. Thus, my method involved textual hermeneutics and qualitative research methodologies.

In providing an overview of WPC's theories in chapter one – particularly its conceptions of illness, suffering, healing, and whole person care – I delineate the pivotal importance of spirituality to these concepts and the respective influence of Carl Jung, Eric Cassell, Michael Kearney, Viktor Frankl, and Martin Buber. WPC dynamically applies these theories to its major programmatic initiatives, which I describe and outline in chapter two. As the spiritual dimension is so pivotal to WPC's theoretical formulation, I investigate its perspective on spirituality and religion in chapter three primarily through describing 1) its definitions of pertinent terms such as spirit, inner life, and religion, and 2) the sources it draws from to construct its perspective. This exposition provides evidence that WPC is selectively drawing from various traditions, particularly the religious and psychoanalytic, and is also appealing to secular interpretations. To this effect, WPC is constructing its own worldview. The last chapter examines the major challenges and ethical issues confronting WPC in its attempt to integrate this worldview into the broader institution of health care education, research, and delivery. In short, this thesis examines and assesses the problems that arise when the divergent spheres of biomedicine and spirituality converge in a secular medical context, and what this convergence might suggest in terms of the ethical delivery of health care. Such issues are important because they ultimately have an effect on the quality and standard of care for patients in the health care sector.

CHAPTER 1: General Concepts and Theories

In general, the goal of WPC is to "create a focus for healing and whole person care" ("Newsletter 1.1" 1). The interpretation and theories associated with these two concepts are pivotal to its mandate, initiatives, and practices. This chapter explores the influence on the concepts by authors such as Eric Cassell, Michael Kearney, Viktor Frankl, Martin Buber, and Carl Jung (Mount and Hutchinson 17). I begin by examining definitions and distinctions of WPC's core concepts. Following this, I focus on the principles of the healing process. Throughout this chapter, I argue that the theories of WPC are unequivocally rooted in spirituality, which is consistent with its major aim to redress the paucity of concern for the spiritual dimension in medicine.

Definitions

Central to the theory of WPC are the following concepts: whole person care, disease, illness, curing, healing, wounding, suffering, and wholeness. Below, I delineate WPC's definitions and descriptions of these terms particularly highlighting important distinctions among them.

Whole Person Care

According to the initial core faculty members consisting of Mount, Boston, and Cohen,[9] "whole person care" refers to the following:

> The active total care of patients ... [c]ontrol of pain, of other symptoms, and of psychological, social, and spiritual problems, is paramount. (Mount, Boston, and Cohen, "Proposal" 15)

> An approach to care that considers the patient and family, taken together, as the unit of care and involves the total care of patients, through the control of pain and other symptoms, and attention to psychological, social, and spiritual problems. It replaces the preoccupation with disease that is characteristic of the biomedical model with a broader perspective, that of experienced illness, suffering, and quality of life. (Mount, Boston, and Cohen, "Appendix V")

[9] See Appendix 1 for short biographies of the WPC faculty members in general and the initial cohort in particular.

> Care encompassing all aspects of the human being. (Mount, Boston, and Cohen, "Appendix I" 6)[10]

These definitions suggest a system of care that takes into consideration all domains relevant to human suffering, illness, and quality of life including the patients' and their respective families' particular context. They draw particular attention to incorporating the spiritual dimension into medicine in addition to explicitly maintaining – and at no point intending to forsake – medicine's current preoccupation with the control of pain and other related physical symptoms. As such, WPC seeks to redress the balance of health care education, research, and delivery by bringing subjective experience and the determinants of quality of life to the fore. In this aim, its primary concerns follow other trends such as the holistic path paved by hospice/palliative care, the need for qualitative research methods (at times in conjunction with quantitative modes of inquiry) in assessing quality of life and the determinants of suffering (Mount, Boston, and Cohen, "Proposal" 1, 3, 5, 12), and the general societal trend toward spirituality.

Disease/Illness and Curing/Healing

WPC makes two important distinctions – that between disease and illness and that between curing and healing. The medical literature often refers to the disease/illness distinction as it was originally put forth by A. Reading.[11] In this context, disease specifically refers to the various medically defined abnormalities in the structure, functioning, or physiology of the human body extending from the

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[10] These definitions indicate WPC's origins within the hospice and palliative care movement. In particular, the first definition of "whole person care" is a direct excerpt from the World Health Organization's (WHO) definition of palliative care that was proffered by a WHO Expert Committee in its Technical Report Series (no. 804) (Mount, Boston, and Cohen, "Proposal" 15). WPC appropriated the WHO definition of palliative care and used it verbatim to define what it intends by "whole person care." Even further, this description as well as the second definition correlates significantly with the concept of "total pain" as coined by Dame Cicely Saunders. According to Saunders, "Care, matched with an increasingly sound evidence base, was by then underpinned by the concept of 'total pain' – defined in 1964 as including not only physical symptoms but also mental distress and social or spiritual problems ("Palliative Care" 430). Again, it becomes evident that whole person care and palliative/hospice care are inextricably related. The inception and development of WPC has been greatly influenced by palliative medicine, at least as indicated by Mount's history in the palliative care movement and in the initial proposal of the Programs (Mount, Boston, and Cohen, "Proposal" 1-5).

[11] For instance, the textbook Public Health and Preventive Medicine in Canada by Shah refers to this distinction between disease and illness (4) as well as Aronowitz in Making Sense of Illness: Science, Society, and Disease (191). The social scientist Kleinman also draws this distinction in The Illness Narratives (3, 5) in addition to The Nature of Suffering and the Goals of Medicine written by Cassell (47).

molecular and cellular levels to tissues, organs, and systems. On the other hand, illness is an individual's personal experience and perceptions of disease, ill health, and inability to function normally in society. WPC applies this disease/illness differentiation to explain two divergent approaches to medical care and treatment – that of curing and healing. Curing refers to medical care that focuses primarily on disease (disease as an object or entity) where the respective treatment seeks to eradicate the physical disease entity and emend pathophysiology in hopes of prolonging patients' lives. Conversely, healing involves consideration of all domains relevant to patients' subjective experience of disease and poor health status. In other words, healing fundamentally focuses on the subject of disease (the person who has the disease). The aim of healing is to improve quality rather than quantity of life (Mount and Hutchinson 13); however, increased life span could be a corollary benefit of an illness-oriented medical model.

These two distinctions are particularly important for WPC. Whereas standard biomedical practice largely considers illness as best treated by dealing with the underlying disease (Mount, Boston, and Cohen, "Proposal" 8), for Mount and Tom Hutchinson "disease is neither necessary nor sufficient to explain illness" (8). In numerous cases patients suffer from chronic illnesses in the alleged absence of a physical disease entity and experience the persistence or even exacerbation of this suffering following the implementation of curative treatment protocols (Cassell, Nature 29, 47). The paucity of concern for the subjective experience of ill health in medicine in turn leads to inadequate patient care and unexplainable ill health in spite of the fact that it is illness and not disease per se that prompts patients to seek the care of health care professionals in the first place (Mount and Hutchinson 8). Therefore, the healing/curing distinction and the respectively related differentiation between illness and disease serve to highlight the current medical model's preoccupation with treating merely the disease.

The call for WPC necessitates a medical mandate with greater breadth. It demands that not only disease be treated but that suffering (the subjective experience of pain and anguish) be alleviated. "The requirement for whole person care arises out of our mandate to do more than simply treat the disease; that is, to adopt instead a broader perspective: the alleviation of suffering" (Mount, "WPC" 28). Cassell asserts that,

> The test of a system of medicine should be its adequacy in the face of suffering; ... modern medicine fails that test. In fact, the central assumptions on which twentieth-century medicine is founded provide no basis for an understanding of suffering. For pain, difficulty in breathing, or other afflictions of the body, superbly yes; for suffering, no. (Nature v)

And in fact, Mount and Hutchinson specifically argue that in order to understand this paradigm shift in medicine from

> ... the reductionist biomedical model to the more inclusive perspective of whole-person care, to move beyond an exclusive focus on disease, pathophysiology, curing, and quantity of life to include consideration of experienced illness, suffering, the art of caring, and quality of life ... we need to distinguish between disease and illness. (7)

As useful as these distinctions are for medicine in general and WPC in particular, they are not accepted as wholly accurate even by those originally championing and perpetuating them. Cassell and his co-investigator Donald Boudreau submit that healing is inclusive of all medical care, even that which is disease oriented or curative. In a personal interview, Cassell states the following:

> Don Boudreau: he was the one who wrote that all medical care is healing. The illness/disease distinction is mine (among other people). I wrote about it a lot before anyone else did: it's wrong. I mean it was useful, but it's wrong. It's all of healing, all of it – the physical, the emotional, the social, the spiritual. It's all part of healing. Why? Because if you don't understand that the person won't get back to functioning. (Interview)

According to this understanding, the term healing incorporates *both* disease and illness – both the physical disease object and the subjects' experience of it. Mount and Hutchinson too submit that although there are distinctions between curing and healing, they are also inextricably related. "Because healing and curing are so intimately linked ... healing may potentially occur in the course of a routine visit for a blood pressure check, or in the process of a dialysis treatment for renal failure" (Mount and Hutchinson 2). Therefore, they argue that healing and curing are both radically different and that they are complementary. However, those qualities that physicians require for curing and for healing are not the same and at times even contradictory (Hutchinson, "Book Review").

Healing and Wounding

In an interview, Dawn Allen, a research fellow of WPC, states that, "when I began my work here two words that Tom [Hutchinson, the current director of the Programs] strongly associated with the work that I would be doing were *suffering* and *healing*. So my understanding was that [WPC], as Tom described it, is all about promoting healing in the context of medicine" (Interview, emphasis added). The primary mechanism by which WPC defines this concept is through what it calls the quality of life continuum, which is also known as the healing dialectic.

For WPC, quality of life is defined as an individual's personal assessment of subjective wellbeing. As depicted in Figure 1, the quality of life continuum moves between two endpoints: individuals personal experience of suffering and anguish on the one hand and their experience of wholeness and integrity on the other. Healing is a response shift or a movement away from an experience of suffering, anguish, or "total pain"[12] towards an experience of integration, wholeness, integrity, homeostasis, or inner peace (Hutchinson, "Transitions" 273). Alternatively, wounding is a shift towards an experience of suffering and anguish and away from an experience of wholeness and integrity (Mount, Boston, and Cohen, "Connections" 373). These definitions are notably not only applicable and relevant to those who are ill but also to the physically healthy (Mount and Hutchinson 1).

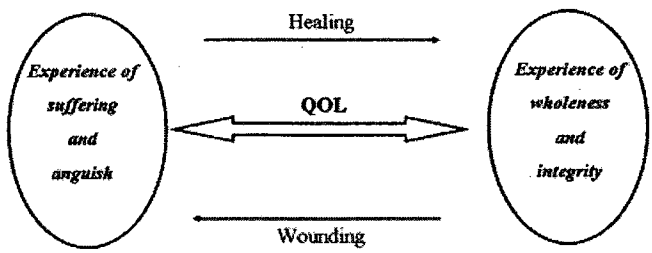

Figure 1. The WPC Quality of Life Continuum (a.k.a. the healing dialectic)
(Mount, Boston, and Cohen, "Connections" 373)

[12] Dame Cicely Saunders coined the term "total pain" and defines it as pain or suffering that involves not only the physical dimensions of illness but also that of the emotional, social, and spiritual. Saunders derives this concept from the following insight, which she received through her work with the dying: "It soon became clear that each death was as individual as the life that preceded it and that the whole experience of that life was reflected in a patient's dying" (Saunders, "Shadow of Death").

Suffering and Wholeness

According to Cassell, suffering arises out of a perceived threat to one's personal integrity and continues until the impending threat is abated, eradicated, or a sense of integrity is otherwise reconstituted (Nature 32).[13] In other words, a personal perception or experience of an impending threat to individuals' sense of wholeness and integrity creates a shift towards a sense of suffering and anguish. And for Cassell, not only can the affliction of disease engender a threat to personhood and hence result in suffering but so too can its corresponding treatment (Nature 29). Therefore, suffering can result out of a threat to any aspect of individuals' sense of self, meaning, or integrity (Hutchinson, "Transitions" 273). This threat may arise, for instance, when individuals perceive a discrepancy between their personal expectations for themselves and that of bona fide reality (Mount, Lawlor, and Cassell 305).

Now although WPC defines the term suffering in considerable detail, particularly through Cassell's interpretation, a definition of wholeness remains elusive. This is quite surprising since 1) the concept of wholeness constitutes the foundation on which WPC defines healing and wounding, 2) WPC provides explicit definitions of all other terms constitutive of the healing dialectic, 3) Mount argues for the need to understand the concept of wholeness in order to understand patient suffering (Mount, "WPC" 29) and 4) WPC insists upon the importance of developing a shared language and vocabulary for the spiritual and inner life dimensions so as to facilitate communication in health care (Mount, Lawlor, and Cassell 304). Nevertheless, the authors of WPC offer a few comments.

In general, Mount regards wholeness as a state inclusive of all domains of personhood that constitute a body-mind-spirit complex: "Body, mind, and spirit: three components contributing to our sense of wholeness, functionally intertwined yet independent" (Mount, "WPC" 30). For Mount, concepts of wholeness include the so-called Eastern understanding where individuals represent a microcosm of, and participate in the harmonious and balanced maintenance of, the cosmos. It is this

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[13] WPC refers to Cassell's definition of suffering in a number of articles such as in Mount, Boston, and Cohen's "Healing Connections," Mount's "Existential Suffering and the Determinants of Health," as well as Hutchinson's article "Transitions in the lives of patients with End Stage Renal Disease." WPC furthermore incorporates it into its operational definition of suffering as Mount, Lawlor, and Cassell describe in the article "Spirituality and Health: Developing a Shared Vocabulary."

wholeness or harmony that maintains the personal or universal potential for peace ("WPC" 30). Wholeness, then, is not a static state but constantly in flux. And in the context of healing, wholeness fluctuates with respect to its diametric opposite – suffering. But we are also told that wholeness is an end to be reached, a condition to aspire to, rather than a normative state of being. Kearney equates it with the individuation of Carl Jung[14] and "Jung saw psychological work as having both short-term and long-term goals ... the long-term goal was the achievement of the state of psychological wholeness which he called *individuation*" (Kearney, Healing 115). This is another interpretation WPC intends in its quality of life continuum, as wholeness constitutes not just one of the spectrum's extremities but the end that is the ultimate aim of healing. It is a state of equanimity, integration (Mount, "Path"), homeostasis, integrity, inner peace (Hutchinson, "Transitions" 273), and becoming "a bit more Real" (Mount, "WPC" 37). But Mount contends that wholeness (the ultimate goal of healing) is not a state that is in fact attainable: "Progression toward healing is slow. Indeed, the goal is never reached" (Mount, "Commandments" 50). Taking all of these interpretations into consideration, the authors of WPC perplexingly describe wholeness as an unattainable, yet normative state of being as well as both a dynamic process and a stationary end to reach. Allen recognizes that this theory is rather tenuous.

> Now healing [as a shift towards an experience of wholeness] was a fuzzy term for me and is still. Nonetheless, I read Eric Cassell's work and I read Bal Mount's work. And I tried to read around in these concepts. But I didn't find the notion of healing well theorized. Suffering was pretty well theorized. Healing was not very well theorized and it tends more towards spirituality. (Allen, Interview)

As Kearney indicates, the WPC concept of wholeness is largely based on a Jungian interpretation. Mount too defines wholeness in terms of individuation. "I see wholeness as the degree to which individuals are able to realize their potential ... the degree to which, as Carl Jung said, there was individuation" (Mount, Interview). Examining what Jung means by the terms individuation and wholeness demonstrates how they were the inspiration for WPC's understandings of wholeness.

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[14] See below pp. 19-21: *Healing Connections: Connections with the Self* for a description of Jungian individuation.

To understand what Jung means by wholeness, it is worth noting that he conceives of the psyche as engaging in a dynamic balancing process between the conscious and unconscious. In other words, it operates according to the principle of *enantiodromia*, the constant oscillation between opposing poles. Jung conceives of the psyche as a closed system whereby expression of one extreme, such as passiveness, in the conscious realm will necessitate compensation for this excess through expressing its opposite, assertiveness, in the unconscious realm, or vice versa. And similarly, any psychic changes in the conscious realm (which Jung calls progression) will halt psychic changes in the unconscious realm. Conversely, any impediments to this progression will create psychic changes in the unconscious realm (which Jung calls regression). As Michael Palmer explains, "A regression represents an attempt to activate in the unconscious that which has been excluded from the conscious attitude, to redress the balance of the psyche ... and thus reveals the possibilities of renewal and regeneration that lie within them" (106, 107). This parallels WPC's conception of wholeness as constantly fluctuating and dynamically operative. For Jung, disturbances in this equilibrium give rise to neurosis or illness (Palmer 103, 120). As such, healing involves balancing or integrating these disparate elements into a unified whole. This process, according to Jung, is called individuation and constitutes a task to which all people ought to devote themselves (Jung, CW 9:275; Palmer 121). Therefore, much like WPC's conception, wholeness is teleological – a goal to aspire to.

Jung also describes wholeness or psychic integration, the goal of individuation, in terms of the self. "Individuation means becoming a single, homogenous being, and, in so far as 'individuality' embraces our innermost, last, and incomparable uniqueness, it also implies becoming one's own self. We should therefore translate individuation as 'coming to selfhood' or self-realization'" (CW 7:171). Thus, individuation involves realizing the self and coming to know its true potential, as Mount describes above.

For Jung, wholeness is also archetypal; "the central archetype; the archetype of order; the totality of the personality" (Memories 385). The archetype of the self, then, is precisely the archetype of wholeness (Palmer 121). However, what does Jung mean by the term archetype?

> Archetypes are those pre-existent forms or primordial types that have existed since the remotest times of humanity. This does not, however, mean that they are forms or types consigned merely to the past. For the archetypal images, precisely because they are images emanating from the depths of the collective unconscious, are manifestations *of the structural nature of the psyche itself*, and thus expressive of a universal and common substratum which is present in all human beings and constantly and dynamically operative. (Palmer 115)

According to this understanding, then, wholeness or the realization of the true, essential self is both an intrinsic tendency of the psyche and a prospective, teleological goal. Jung summarizes this as follows:

> The self [or conversely, the archetype of wholeness] has somewhat the character of a result, of a goal attained, something that has come to pass very gradually and is experienced with much travail. So too the self is our life's goal, for it is the completest expression of that fateful combination we call individuality, the full flowering not only of the single individual, but of the group, in which each adds his portion of the whole. (CW 7: 239-240)

From this, it is clear that WPC's understanding of human wholeness is greatly influenced by the Jungian interpretation of wholeness, particularly its dynamic, intrinsic, and teleological aspects.

The Healing Process

WPC, particularly Mount, bases the quality of life continuum – and the corresponding definitions of healing and wounding – on the notion that healing is not necessarily contingent upon a return to physical health or wellbeing. Mount argues that it is possible to experience terrible suffering in the absence of physical symptoms and conversely, to experience a sense of wholeness in the event of devastating physical decline (Mount, "Suffering" 40).[15] In other words, the ability to transcend suffering in the midst of illness is indeed possible, and Thomas Egnew's research study on healing corroborates this claim.[16] Based on interview data and qualitative

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[15] Mount bases this argument on a number of case examples that include those from his personal experiences in palliative care as well as some additional insights, from Cassell's Nature of Suffering and the Goals of Medicine for instance, and research studies, such as Kagawa-Singer's investigation into terminally ill patients' perspectives on their own sense of health and wellness (Mount, Boston, Cohen, "Proposal" 9).

[16] The Programs often refer to Egnew's research article "The Meaning of Healing: Transcending Suffering" as it clearly substantiates the conception of healing WPC promotes. In particular, Mount,

analysis, he says, "Healing is the personal experience of the transcendence of suffering" (256). Mount, Lawlor, and Cassell too argue that, "It is possible to die 'healed,' in the sense of having moved towards a previously unattained sense of wholeness" (305).

This definition links the dimension of healing with transcendence and spirituality. Mount and Kearney render this even more explicit. For Kearney, healing entails a "process of becoming psychologically and spiritually more integrated and whole; a phenomenon which enables persons to become more completely themselves and more fully alive" (Healing xix). Mount adds that healing involves wholeness, integration, and transcendence in body, mind, and spirit – a process that allows for the realization and expression of one's truly unique essence at the core of personhood and that which precisely constitutes Jung's individuation (Mount, "WPC" 35; Mount, Lessons).

For WPC, there are two main ways to encourage and attain healing. First, it is engendered through a sense of enriched personal meaning and second, via a sense of connectedness (Mount, "Music" 37). And although WPC's authors accord these two approaches distinct importance, they also demonstrate their inextricable relation and mutual dependence.

Creating Meaning[17]

WPC points out that the capacity to create meaning strongly impacts the subjective experience of suffering, wholeness, and quality of life (Mount, Lessons; Cassell, Nature 36). For instance, the meaning patients assign to illness can be a decisive factor in the occurrence and magnitude of their suffering, and likewise, the meaning caregivers attribute to their own working experiences can significantly impact the care they provide. To substantiate these assertions, the WPC literature refers to its own research. For instance, in a study exploring patients' experiences and relevance of spirituality to suffering, healing, and quality of life, Mount, Boston, and Cohen demonstrate an association between meaninglessness and increased

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Hutchinson, and McNamara discuss this article in the context of its undergraduate medical school lectures. They require that this article be read in their course and they include it in the respective course reader (McNamara and Hutchinson 49).

[17] Meaning in this context refers to those beliefs and values that provide significance to concepts, objects, and life experiences.

experiences of suffering and anguish. Concomitantly, they reveal a correlation between experiences of wholeness and a sense of meaning and purpose ("Connections" 376). In a similar study, but directed towards the experiences of caregivers in palliative care, Boston and Mount elucidate some of the difficult experiences people face in caring for palliative care patients. The case of one research volunteer demonstrates how reframing a difficult experience might allow the caregiver to discover enhanced meaning in the situation and also experience a sense of relief, for instance, from caregiver guilt (22). WPC refers to the research study Bower et al. conducted to elucidate the profound impact that creating meaning can impart to patients and their health status. Specifically, this study discovers through the combination of both quantitative and qualitative research methods that HIV-seropositive men[18] who engage in cognitive processing are more likely not only to discover meaning from the loss of a loved one but also demonstrate less rapid declines in CD4 T cell[19] counts and thus, a decreased rate of AIDS-related mortality. These results were independent of baseline health status, health behaviours, and other anticipated confounding variables (Bower et al. 982-984). For WPC, these studies provide remarkable evidence for the often overlooked association among healing, mortality, and circumstantial meaning discovery (Mount, Boston, and Cohen, "Connections" 373).

These studies demonstrate, for instance, that meaning associations might apply not only to the transcendent, spiritual, and inner life dimensions of illness but also to the body and mind. To further this point, Cassell describes a number of instances in which patients' emotions are manifest physically, for example, when patients become physically nauseous through the mere thought of cancer radiation treatment (Nature 36, 236). Cassell says that, "The meaning is the medium through which the experience is translated into emotions or sensations that are associated with changes in the body" (Nature 236). Thus, for some patients, the most effective treatment protocol may just be to investigate, discuss, and modify the meaning they associate with their illness (Cassell, Nature 256). Using the above examples as evidence, WPC substantiates its claim that meaning and healing are highly

[18] Participants in this study were composed of HIV-seropositive men who recently lost a close friend or partner to AIDS (Bower et al. 980).

[19] CD4 T cells are immune "booster" cells that are implicated in HIV; higher levels of these particular cells correlate with decreased HIV disease progression (Bower et al. 980).

correlative. However, the theoretical foundation for this assertion is drawn mainly from the work of Victor Frankl.

Frankl notes that "Nietzsche's words, 'He who has a *why* to live can bear with almost any *how*,' could be the guiding motto" (97). In particular, his experience demonstrated to him that meaning can be found through 1) creative accomplishments and achieved tasks, 2) personal experiences and encounters with goodness, truth, love, or beauty – whether it be in nature or culture and 3) the experience of suffering itself (Frankl 133).[20] According to WPC, these sources of personal meaning can engender in a patient feelings of engagement, identification, purpose, and involvement (Mount, "WPC" 36). Moreover, Mount argues that they "may lead to transcendence of suffering through identification with something greater and more enduring than the self" (Mount, "Suffering" 40). As such, the existential anguish produced from a fear of meaninglessness and isolation can be transcended through the creation of meaning by Frankl's five sources. Thus, Frankl proposes that the foundational basis for quality of life is the creation of a context full of personal meaning (Mount, Boston, and Cohen, "Connections" 383).

Frankl observes that how one bears suffering or "takes up his cross" (88) makes one able to discover deeper meaning and purpose in life irrespective of the difficulty or circumstance. Referring to Dostoevsky, he submits that when people actively choose to attain the highest spiritual and moral values in the bleakest circumstances is when they discover a profound sense of meaningfulness and are worthy of the sufferings they bear (87, 88). "Everything can be taken from a man but one thing: the last of the human freedoms – to choose one's attitude in any given set of circumstances, to choose one's own way" (Frankl 86). And this human freedom Frankl clearly describes as foundationally spiritual: "Man can preserve a vestige of spiritual freedom, of independence of mind, even in such terrible conditions of psychic and physical stress ... It is this spiritual freedom – which cannot be taken away – that makes life meaningful and purposeful ... and add[s] a deeper meaning to his life" (86-88).

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[20] Based on these findings, Frankl developed Logotherapy, a psychotherapeutic approach devoted to enhancing quality of life through fostering personal meaning in patients' lives (Mount, Boston, and Cohen, "Connections" 383).

This ultimate quest in life (the search for meaning) is within the confines of personal choice and will, according to Frankl. He proclaims that, "Ultimately, man should not ask what the meaning of his life is, but rather he must recognize that it is *he* who is asked. In a word, each man is questioned by life; and he can only answer to life by *answering for* his own life; to life he can only respond by being responsible" (131). Frankl quite simply "sees in responsibleness the very essence of human existence" (131).

This capacity to discover meaning in the most deplorable situations and unimaginable suffering is but one way, says Frankl, that people can exercise their spiritual freedom and, subsequently, create a sense of meaningfulness in life. However, for WPC just as much as Frankl, it constitutes one of the – if not the – most profound means ("Commandments" 51). For Mount, Boston, and Cohen, the spiritual freedom of Frankl provides substantive support for the discovery that patients' experiences of wholeness in the midst of illness and dying are dependent on their ability to establish profound purpose in their life. In fact, it constitutes one of five common themes across patients' experience of integrity and wholeness: "a sense of meaning in the context of suffering" (Mount, Boston, and Cohen, "Connections" 382, 383). As they say, "life, even now, can be meaningful" (Mount, "WPC" 36).

Although WPC makes no explicit mention of this, Jung too argues for not only the integral importance of meaning in the process of healing but also its spiritual nature.

> A suitable explanation or a comforting word to the patient may have something like a healing effect which may even influence the glandular secretions ... The words are effective only in so far as they convey a meaning or have significance. It is their meaning which is effective. But "meaning" is something mental or spiritual. Call it fiction if you like. None the less it enables us to influence the course of the disease in a far more effective way than with chemical preparations ... Among my patients from many countries, all of them educated persons, there is considerable number who came to see me, not because they were suffering from neurosis, but because they could find no meaning in life or were torturing themselves with questions which neither present-day philosophy nor religion could answer. (Jung, Modern Man 231)

Healing Connections[21]

The second means by which healing can be achieved is through creating and establishing an experience of connectedness or what WPC terms "healing connections." These are experienced at four levels: through connection with the self, others, nature and the phenomenal world, and Ultimate Meaning or the Divine however personally conceived (Mount, "Music" 37). WPC partly derives its concept of healing connections – much like the concept of creating meaning – from Mount, Boston, and Cohen's qualitative study examining patients' experiences of wholeness and integrity in the face of illness ("Connections" 374, 383). However, Mount also argues that knowledge of these healing connections has long been 1) suggested by all wisdom traditions (various religious, mystical, and knowledge-based traditions dating back to antiquity) and 2) gained through personal experiences of illness, end-of-life, and caring for those in such circumstances ("Existential" 95; Mount and Kearney 657).[22] The concepts underlying each of these healing connections require further elucidation.

Connection with the Self. This level of relating that initiates the healing process involves a connection with the individual self at – what Mount, Boston, and Cohen describe as – "the level of most profound contact" ("Proposal" 15). It refers specifically to "the 'individuation' of Jung – an experience of realized personal potential" (Mount, Boston, and Cohen, "Connections" 383). Mount describes it as involving a relationship with Jung's "Self" or "the essential self" at an innermost level and provides a "model of the psyche" in order to explain this relationship ("Music" 37).

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[21] WPC uses the term "healing connections" to refer to the capacity to form bonds of connection and its respective potential to impart healing (Mount, Boston, and Cohen, "Connections" 376).

[22] Mount mentions that the new physics as well acknowledges this sense of connectedness, specifically through the notion of "wave-particle duality." In very general terms, the concept refers to the notion that matter is, at the same time, a wave and a particle – both continuous and discrete. However, matter is not observed in both states but rather takes on wave-like *or* particle-like characteristics. And it is precisely through observation (via a participant or measuring apparatus) that results in matter exhibiting this either/or classification. This inextricably binds the observer with the observed in a state of mutual influence and connectedness (Kearney, Healing 21-23). Using this as evidence, Mount argues for the underlying connectedness and essential co-dependence of all things (Mount and Kearney 657; Mount, "Music" 37; Mount, "Suffering" 41). Kearney also discusses the "wave-particle" duality in a similar manner but more specific to its metaphorical implications for an inclusively holistic, integrative, and relational healing model (Healing 23-24).

Mount derives this model of the psyche ultimately from the work of Jung but refers to Kearney's interpretation. This model is composed of two dimensions – the surface mind and the deep mind (See Figure 2). The former refers to the aspect of the psyche associated with waking consciousness and rational, literal, and logical thought patterns (Mount, "Suffering" 41). The surface mind is the repository of the ego – the aspect of the mind that one consciously recognizes as the self and that keeps the mind functioning in its usual and predictable capacity and that Westerners spontaneously identify – and even confuse – with the self. In particular, the ego maintains the normal functioning of the mind and seeks to control and eradicate the unknown (Kearney, Healing 16). Any perceived threat that the ego senses, particularly from the unknown dimension of the deep mind, necessitates denial and closure to the foreign and mysterious (Mount, "Suffering" 41).

The deep mind, on the other hand, is associated with the intuitive and unconscious aspect of the mind that is intimately connected to the emotions, imagination, metaphoric thought, and collective unconscious. Its interpretive language consists of image, symbol, myth, and narrative. It is the residence of dreams, waking fantasy, creativity, and what Jung termed the "Self" (with a capital "S")[23] or, as P.W. Martin describes it, the "Deep Center." Specifically, it is the "Deep Centre," according to Mount, that possesses the personal potential for wholeness and thus is inextricably involved in healing ("Suffering" 41).

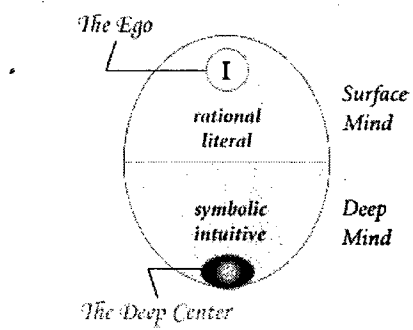

Figure 2. Kearney's Model of the Psyche (Dagan)

[23] I, henceforth, use the term self with a capital "S" to denote this concept that is specific to Jung's model of the psyche and individuation. I will also employ it interchangeably with the terms the "essential self" and the "Deep Centre."

As described above, the means by which the Self is implicated in healing is through the process of individuation. This requires working with, confronting, getting to know, and allowing freedom of expression and subsequently analysis of the unconscious or deep mind (Stevens 14, 24, 38). Furthermore, coalescence of both conscious and unconscious thought and experience is integral to the individuation process and the attainment of wholeness. As Jung describes, "Conscious wholeness consists in a successful union of ego and [S]elf" (CW 225). One Jungian analyst, Andrew Samuels, describes the process of individuation as "A movement towards wholeness by means of an integration of conscious and unconscious personality" (qtd. in Kearney, Healing 115).

Precisely the connection with the Self characterizes the first level of connection according to WPC. Specifically, it is the establishing of a relationship with the essential self that enables individuals to move towards an experience of wholeness and engage in the process of healing.

Connection with Others. Secondly, individuals can achieve healing through establishing a connection with others individually and in community at a level of deep attachment. For WPC, this level of attachment is quintessentially the "I-Thou" relating of Martin Buber (Mount, Boston, and Cohen, "Connections" 384). It involves, specifically, recognizing and relating to other people not as objects (as in the "I-It" relating according to Buber) but rather as human beings in their own right and uniqueness. Furthermore, connection at the level of Buber's "I and Thou" entails an authentic, intimate, caring, and mutual relationship. At its essence, this requires identification and acceptance of others for who they are, which includes respect and awareness not only of their uniqueness but also their indivisible unity for which they are considered to be normatively "whole," and hence irreducible (Charme 162, 165). "Buber wants to emphasize that a person treated as a whole, as a unity, and as unique is more than the sum of all that can be scientifically determined about him or her" (Charme 171). And as the substantive aim of WPC is to promote care of whole persons that recognizes people in all their dimensions, uniqueness, and indivisibility (Mount, Boston, and Cohen, "Proposal" 15), it is no surprise, then, that the "I-Thou" relating of Buber is suggestive of the relating with others that WPC intends.

This level of connection is particularly pertinent within medicine as it provides a theoretical framework for relating to others in this context. Relationship

complications among patients, families, physicians, and allied health care professionals lead to a decrease in patient therapeutic and follow-up compliance and an increase in public distrust of health care professionals as well as a growth in patient litigation ("Report Faculty Working Group" 3). WPC's "I-Thou" model encourages physicians and other health care professionals to "focus[...] on the otherness of the person cared for and on the wholeness of her personhood" (Mount, "WPC" 35). It draws particular attention to such relationship complications as physician detachment and perpetuations of the medical hierarchy.[24] The "I-Thou" resolves the dilemma of negotiating the extremes of physician detachment and identification: "I cannot be subjective and stumble into the trap of identification when I am focused on the patient's otherness, and, at the other extreme, I can't depersonalize when I focus on the wholeness of her personhood" (Mount, "WPC" 35). Cassell reiterates the potential for healing at this level of connection: "Our intactness as persons, our coherence and integrity, come not from intactness of the body, but from the wholeness of the web of relationships with self and others" (Nature 38).

Connection with the Phenomenal World. WPC's third form of healing connection involves an experience of connectedness with the phenomenal world as perceived through the five senses (Mount, Boston, and Cohen, "Connections" 384). These healing experiences can be generated through music, art, poetry, literature, film, the natural world, and even sports. Rather than creating a generic response, these experiences are specific to individuals' particular preferences and circumstances. However, for Mount, this form of healing connection – much like all the others – generally induces a moment of meaningfulness or connectedness to something larger and more enduring than the ordinary self (Mount, "WPC" 35).

Connection with Ultimate Meaning. The fourth and final healing connection for WPC involves an experience of connectedness with Ultimate Meaning and the

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[24] This is most evident in the WPC's "Physicianship 3: Physician as Healer" course with third year undergraduate medical students and its corresponding medical simulation activities. Here, specifically, is where WPC focuses on relationship issues in the medical context. For instance, there are five major themes, three of which are the following: 1) relating to the patient; 2) relating to other team members; and 3) the patient-physician relationship (McNamara and Hutchinson 3). There are a number of articles in its respective course reader addressing physician detachment and perpetuations of medical hierarchies in particular (McNamara and Hutchinson 19, 21-44, 77-79, 81-88, 93-99, 123-129, 131-136).

Divine however particularly realized. Mount describes the relationship with the divine in various ways: it involves the Other, the Ultimate Reality (Boston and Mount 21), and the More (i.e. "that which is nameless, yet the ground of existence" ("Suffering" 41)). It entails a personal experience of God and a powerful awareness of unity with the universe (Mount, "Connections" 380). Moreover, it involves an experience of transcendence sometimes in connection with a sense of immanence ("Suffering" 41). It is particularly this transcendence that allows individuals to adapt, cope, and endure the challenges of illness or immanent death, for instance, and helps one to experience a deeper and more profound awareness of and insight into life. Therefore, an experience of transcendence through connectedness with the Other – with something beyond the self – begets healing, a movement towards an experience of wholeness and integrity.

Although WPC does not state this explicitly, all levels of its healing connections are rooted in the last one – an experience of connectedness with the spiritual or transcendent. With regards to the first healing connection, Mount posits that the Self is that essential and archetypal aspect of the mind that is connected to the transcendent and inseparable from the divine ("Suffering" 41). Pertaining to the second healing connection, the experience of connectedness with others is characteristically spiritual as, according to Buber, the "I-Thou" relating amongst humans is of the same fundamental nature as that between humans and God (Charme 161). WPC implies this healing connection in the term "spiritual care":

> Spiritual care refers to an interaction that has a capacity to "heal" by virtue of its impact on the sufferer's total lived experience ... The quality of presence the caregiver brings may transform the simplest act into spiritual care, whether or not that was the intended outcome. Such an interaction supports a sense of integrity and personal meaning. (Mount, Lawlor, and Cassell 305)

This "quality of presence" in spiritual care is precisely the authentic, caring, and mutual relating characteristic of Buber's "I-Thou." Thus, spiritual care is care in the spirit of Buber's "I-Thou" relating. And lastly, the healing potential of the divine is connected to that of nature. Mount specifically draws attention to the ability of nature and the phenomenal world to evoke a sense of meaningfulness or connectedness to something larger and more enduring than the self. Specifically, experiences of

connection with the phenomenal world can encourage a deep-reaching and heightened awareness of transcendence. Focusing much of his attention on music in particular, Mount suggests that healing at this level "opens us to a greater appreciation of our essential connectedness to the cosmos, our oneness with all that is" ("Music" 37).

Therefore, these healing connections are not mutually exclusive. Based on Mount, Boston, and Cohen's qualitative research study, healing in one domain necessitates healing at another. "An experience of connectedness at one of these levels frequently appeared to be associated with openness to connecting at the other levels" (Mount, Boston, and Cohen, "Connections" 384). And what's more, each of these levels of healing connection are specifically rooted in a sense of connectedness with Ultimate Meaning, the Divine, and an awareness of the unity of all that is.

In chapter three, I examine the spiritual facets of WPC's theoretical framework in greater detail. But because McGill WPC does not exist solely in theory, the following chapter explores the ways in which it applies these principles practically to its major programmatic initiatives.

CHAPTER 2: Theories in Practice

In 1999, Mount, Boston, and Cohen proposed a mandate for what was then called the Education and Research Programs in Integrated Whole Person Care[25] to 1) explore the nature of healing, 2) delineate and record its foundation in health care, 3) integrate those concepts into health care by developing multidisciplinary undergraduate and graduate teachings program, 4) determine teaching requirements for healing in the health profession, 5) explore the determinants of healing in particular patient groups, and 6) determine the correlations between specific healing interactions and molecular biological events (Mount, Boston, and Cohen, "Proposal" 2). Although this preliminary mandate has undergone slight alterations in its implementation through the years, WPC continues to enact it in three major programs. These include 1) an educational initiative to both McGill medical undergraduate students through the Physicianship Program and to the general public and wider academic community in the form of a seminar, film, and book series; 2) a Mindfulness-Based Meditation Wellness Program based on Jon Kabat-Zinn's prototype and directed to breast cancer patients as well as health care professionals respectively; and lastly 3) a research initiative that emphasizes qualitative methods of inquiry. Since healing and whole person care is a central focus of not only WPC's mandate but also its theoretical foundation, the breadth and application of these concepts are evident throughout its programmatic initiatives.

In this chapter, I discuss each of WPC's initiatives with regards to the theories discussed in the previous chapter. In addition, I analyze some new principles of WPC, particularly that of patients' innate healing potential and the importance of tacit, experiential learning. Once again, the work of Jung, Kearney, and Cassell are central to the discussion.

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[25] The McGill Programs in Whole Person Care has been associated with many titles over the years. In addition to this 1999 name that Mount, Boston, and Cohen introduce, the reviewer for a site report visit terms it the McGill Programs in Integrated Whole Person Care (Seely 2). Mount and Hutchinson called it the McGill Centre for Integrated Whole Person Care in their 2003 proposal document. It was not until 2005 that the faculty of WPC introduced its current name, the McGill Programs in Whole Person Care ("Progress Report 2005" 1).

Education Initiative

McGill Undergraduate Medical Education

In June 2001, the McGill Faculty of Medicine established the "Faculty Working Group on Healing and Healthcare," a group of sixteen physicians who would develop over three years teaching strategies for the medical school curriculum on the topic of healing ("Progress Report 2003" 2; "Report Faculty Working Group" 1). It would also explore the "perceived need to better understand and implement healing in health care" (Mount and Kearney 657), especially the value added by integrating "healing" as a primary objective for the McGill medical curriculum ("Report Faculty Working Group" 1). It sought to address three fundamental questions: what is healing; is healing part of the medical mandate; and if so, what are the implications for education, research, and clinical practice (Mount and Kearney 657)? Of significant importance is the fact that Mount and Kearney[26], the founding director and a visiting professor of WPC respectively, led the Working Group in 2002 and 2003 ("Progress Report 2003" 2; Mount and Kearney 657). Those individuals who constitute a central position in the theoretical formulation of WPC in general and its conception of healing in particular are also individuals who spearheaded the discussions and subsequent findings of the Faculty Working Group on Healing and Healthcare.

Based on the investigations and findings of this Working Group, the McGill Faculty of Medicine instituted "healing" as a primary objective and subsequently developed curricular changes incorporating this concept. But it was not only the objective of healing that McGill Medicine instituted into its medical curriculum, it was also that of professionalism. Taken together, physician as both healer and professional is called the Physicianship Program. According to Helen McNamara and Hutchinson, Physicianship specifically "refers to the dual roles of the physician: that of the Professional and the Healer, which are enacted primarily through the Clinical Method and in particular, Communication Skills" (McNamara and Hutchinson 5).

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[26]As discussed in chapter one, Kearney's work has been foundational in the inception and development of WPC's theories of healing and whole person care. But, he has additionally been pivotal in the formulation of WPC's programmatic initiatives. In 2002 and 2003, WPC hosted Dr. Kearney in the capacity of a two-year, part-time visiting professorship (Mount and Kearney 657). It was during this time that Kearney was able to apply his theoretical contributions to the practical undertakings and endeavours of WPC.

The Faculty Working Group Report on Professionalism puts it this way: "the desirable professional and healing behaviours demonstrated by the ideal physician in practice" (Cruess et al. 2). Even though separate Faculty Working Groups developed the "Physician as Healer" and "Physician as Professional" components of Physicianship, McGill Medicine considers them intertwined. Sylvia Cruess explains this as follows: "Healing is the mandate of medicine, and professionalism is how it is organized" (qtd. in "Report Faculty Working Group" 4). Nevertheless, WPC's contribution to the Physicianship Program rests almost exclusively within the domain of the physician's role as healer, although some WPC faculty members, such as McNamara, are currently attempting to explore further the relationship between and integration of these dual mandates (McNamara, Interview).

The Physicianship Program constitutes one of the four major components in McGill's medical school curriculum alongside that of the Basis of Medicine, Introduction to Clinical Medicine, and Clerkship. It introduces Physicianship throughout all four years of medical students' undergraduate education, particularly through course lectures and a mentorship program called the Physician Apprenticeship. This assigns a physician-mentor to a small group of students. McGill Medicine nominally refers to these mentors as Osler Fellows (in keeping with the tradition of William Osler at McGill)[8] and charges them with the task of accompanying these students throughout their four years in their transition to Physicianship (i.e. in becoming physicians) (Osler Fellow Orientation). Specifically, the medical faculty mandates them with the task of not only teaching students how to take a clinical history but also guiding and showing them by example the morality of medicine and the concepts of Physicianship such as the desirable behaviours and skills of empathy, caring, insight, presence, and teamwork (Fuks; Cruess et al. 8).

During a student's third year at McGill, the Faculty directly addresses the "Physician as Healer" component through a required course specifically devoted to this topic. WPC primarily directs this course. Led by Hutchinson and McNamara, it involves six sessions on the following themes: relating to the patient, relating to other team members, relief of suffering and promotion of healing, patient's perspective and physician's perspective, the patient-physician relationship, and integration of all these

concepts and themes (McNamara and Hutchinson 3). Each of these sessions involves a variety of pedagogical techniques. For instance, the course uses patient interactions with students, panel discussions with clinical leaders, experiential discussions among students and professors, and interactive scenarios at the McGill Medical Simulation Center that involve self assessment, peer assessment, debriefing, and feedback. It also includes small group teaching sessions in the Physician Apprenticeship Program with students assigned an Osler Fellow for guidance (McNamara and Hutchinson 3, 6, 20).

The concept of whole person care is clearly evident in this McGill medical education initiative. According to McNamara and Hutchinson, the primary aim of the "Physician as Healer" course component is to teach students about the physician's role as healer, which consists of two fundamental obligations – the relief of patient suffering and the promotion of patient healing. Mount and Cassell also discuss this twin obligation; it involves physicians alleviating patient suffering as well as treating disease (Mount, "WPC" 28; Cassell, Nature v). McNamara and Hutchinson further assert that the primary means by which to achieve these twin obligations is through the creation of a healing patient-physician relationship whereby the physician facilitates the patient's movement from a state of suffering to a state of healing (2, 5). The instructors of this course integrate Mount's quality of life continuum (or healing dialectic) in general and his definition of healing in particular. In fact, the course reader directly quotes Cassell's and Mount's definitions of suffering and healing respectively. McNamara and Hutchinson additionally emphasize throughout each session the uniqueness, subjectivity, and context-specificities of the patient, physician, and resulting relationship (thereby promoting Mount and Cassell's interpretations of healing and suffering as characteristically subjective and individualistic)(5, 45, 59). They argue that the healing of a patient "is an experience occurring within the patient and may be very different and have different timelines or trajectories for individual patients with the same illness, depending on the individual patient's perspective" (45). As Cassell puts it: "same disease, different patient – different illness, pain and suffering" (qtd. in Mount, Boston, and Cohen, "Proposal" 8).

The course too explores the interactions among health care team members and even the physicians' inner relationship with the self, for "[r]elating to patients who are suffering on a daily basis may have a negative impact on the wellbeing of

physicians and their relationships with other team members" (McNamara and Hutchinson 19). It is "particularly important when these team relationships involve a power differential, such as that experienced by medical students in the clinical setting" (McNamara and Hutchinson 19). According to Adolph Guggenbuhl-Craig – one of the authors whom McNamara and Hutchinson feature in their course reader – this can negatively affect the care patients receive and subsequently their healing process (39). Medicine, says Cassell, gives increasing attention to not only the individuality and subjectivity of the physician but also the inner development of physicians and the subsequent impact this can have on the care of patients (Nature 70). As such, the "Physician as Healer" course emphasizes the role of self-care and self-reflection for physicians in their role as healers and explores how this may, in turn, influence patient care (McNamara and Hutchinson 59).

WPC's emphasis on teaching physician self-care is to a significant degree rooted in its theory of healing connections, particularly at the first level – an experience of connectedness with the individual self and as it relates to Jungian individuation (Boston and Mount 383; Mount, "Commandments" 50) and thus conceive of healing as involving a process of introspection and connection with the essential self in the endeavour to achieve self-transformation, growth, and/or wholeness. As we will see in further detail in chapter three, WPC, Kearney, and Guggenbuhl-Craig, for that matter, all derive their emphasis on physician self-care from Jung because for him the *sine qua non* of any medical treatment is the "analysis of the analyst," – that is, physicians learning to examine their own psyche and cope with their own problems in order to teach their patients to do the same. As Mount says, "We are more likely to be effective as healers if we are consciously on the spiritual path and seeking self-knowledge, thus making our own inner life needs a priority" ("Suffering" 42).

Students explore who they are and how they behave as physicians by focusing on caring, compassion, insight, openness, presence, a capacity for empathetic listening, and involvement (Cruess et al. 8). The Physicianship Program places a particular emphasis on communication skills.

> Communication that fosters healing is at the core of the healer's skills and is occurring all the time in a medical interaction, not just by what is said, but by how it is said and by everything that the physician does and how he does it – from how he shows interest in the patient as a

> person, listens to the story, takes a blood-pressure reading or does a rectal exam. (Mount and Hutchinson 14)

It associates any one of these "healing" attributes with how they are executed rather than their mere occurrence; they are an expression of the subjectivity of the individual physician (Mount, Orientation). Kearney adds that mentors and members of the health care profession should validate this subjectivity through medical school curricula (Kearney, Orientation). The Physicianship Program instituted journaling/portfolios and small group discussions to develop this subjective dimension in physicians (McNamara and Hutchinson 90, 137; Mount and Kearney 657; Mount and Hutchinson 7).

Unsurprisingly, this initiative directly applies the many concepts that WPC promotes, particularly that of healing (especially in terms of connectedness with the essential self through physician self-development and self-awareness), whole person care, and the importance of the subjective dimension. According to McNamara, the McGill medical school initiative is one of the most important if not the most important component of WPC ("Seminar").

Education to the Academic Community and General Public

WPC provides education to the overall academic community, both at McGill and elsewhere, and to the general public through a seminar series, film series, and book club. A wide range of individuals attend these events and include WPC colleagues from the Faculty of Medicine, Nursing, and Pastoral Care ("Newsletter 1" 3) as well as patients, students – particularly in medicine – palliative care volunteers, health care professionals, cardiologists, community members such as retired teachers in theology, and of course, WPC faculty and affiliates.[27] The themes of this academic and public education initiative generally focus on healing and whole person care in keeping with the theoretical foundation of WPC. It intends not only to discuss these topics but to also encourage self-reflection and dialogue. Films, written narratives, and academic lectures are specifically chosen for their poignant ability to foster personal transformative healing and growth. For instance, "Leisure reading allows the luxury of personal reflection prompted by the stories of others. We can share these

[27] This information comes from a personal survey of participants at the book club for Caroline Knapp's Drinking a Love Story hosted by Dr. Saleem Razack in the fall of 2007.

reflections ... it offers a rich curriculum for the study of what we do and how we do it. There is also a bit of the why" ("Newsletter 3" 2).

Seminar Series

In January 2005, Hutchinson, the current director of WPC, initiated the McGill Seminars on Healing. These consist of approximately ten to twelve presentations by featured speakers in the fall and winter semesters each year. Presenters generally involve McGill and McGill University Health Centre (MUHC) colleagues as well as visiting professors from other Universities ("Newsletter 1" 3). Topics include 1) mindfulness meditation,[28] 2) practicing whole person care in medicine,[29] 3) religious and spiritual perspectives in medicine,[30] 4) healing through art, nature, and humour,[31] and 5) holistic health and healing (in terms of human wholeness – the connectedness of body, mind, and spirit with the external environment).[32,33] On many occasions, WPC faculty members will present their own research. For instance, McNamara presented her and Hutchinson's work with the Physicianship Program titled "Teaching Physicians the Healer Role: the McGill Experience" [34]; Patricia Dobkin introduced her work on "Fostering Healing Through

[28] Seminar speakers on mindfulness meditation include Saki Santorelli ("Medicine, Mindfulness and the Relief of Suffering") and Patricia Dobkin ("Fostering Healing Through Mindfulness Meditation").

[29] WPC directed a number of lectures on practicing whole person care in medicine. Such seminars include Anna Gamsa's "Listening to Chronic Pain Stories: What are we treating? Who are we treating?", Balfour Mount's "Our Silent Dancing Partner: Attitudes toward death and how they got to be that way," Thomas Moore's "The Spirit and the Soul of Medicine," and lastly David Kuhl's "Physician Self-Care."

[30] WPC has featured two particular speakers discussing religious and spiritual perspectives on healing, suffering, and health care. These include Ellen Aitken's lecture on "Words and the Body: Ancient Spiritual Perspectives on Suffering and Healing" as well as Faith Wallis' presentation "God's House: Religious Dimensions of Sickness and Care in the Medieval Hospital."

[31] Manuel Borod presented at the McGill seminar series on "Humour in Medicine," the filmmaker Gary Beitel on "Healing and the Artistic Process," and Marc Laporta with a lecture entitled "Emotions and Empathy: Music as a Vehicle."

[32] Seminars on the topic of holistic health and healing, particularly those that take into consideration the interconnectedness of persons within (i.e. the body-mind-spirit complex) as well as without (i.e. living within a specific and unique context that includes for instance social, environmental, and cultural influences) include Gabor Mate's "The Mind-Body Connection," Saleem Razack's "Culture, Healing, and Medicine," Michael Kearney's "Soul Pain, Fear, and Healing at the End of Life," Steve Sims' "Whole Health: Making the Connections," and Craig Webb's "The Healing and Spiritual Potential of Dreams."

[33] I derive these five overarching themes from an analysis of the seminar series speakers and their respective topics between the fall semester of 2005 and the winter semester of 2008.

[34] This was presented on the18th of April 2008.

Mindfulness Meditation"[35]; Allen and Hutchinson presented their research entitled "Healing, Transformation, and Identity,"[36] as well as their research on patients and caregivers dealing with end-stage renal disease.[37]

Unsurprisingly, many of WPC's underlying theories are incorporated into the seminar series such as its theory of healing connections. Mindfulness meditation, for instance, is affiliated with an experience of connectedness with self and thus involves WPC's first level of healing connection, particularly as it is a practice of self-reflection and self- (or "mindful"-) awareness. Moreover, seminars on healing through art, nature, or humour directly correlate with the second and third levels of healing connection – healing through an experience of connectedness with others (as can be the case with humour) and the phenomenal world as perceived through the senses (such as with art or the natural world). In addition, seminars deal with the normative wholeness of persons in general (the connection of mind, body, and spirit) and their spiritual dimension in particular (Mount, Boston, and Cohen, "Proposal" 15).

This initiative is an academic, lecture-based pedagogy but occasionally incorporates opportunities for subjective experiences. For instance, Dobkin's seminar "Fostering Healing Through Mindfulness Meditation" introduced the conceptual basis of mindfulness meditation not only through reviewing its theories but also by guiding audience members in a mindfulness meditative exercise.

Film Series

In 2005, WPC initiated a film series entitled "Films That Transform: In Dialogue with Others on the Journey." These are stories of personal transformation such as coping with an incurable condition or the process of dying. According to one participant, they demonstrate remarkable experiences of healing in varying contexts and concentrate on "themes such as making choices, forming community, or

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[35] This was presented on the 14th of March 2008.

[36] This was presented on the 9th of December 2005.

[37] Moreover, on September 5th, in 2006 Kearney spoke on "Soul Pain, Fear and Healing at the End of Life" as well as presented a lecture entitled "The Interconnectedness is *Already* there" on May 2nd, 2006. The current director of WPC, Hutchinson, lectured on Virginia Satir, "Longing for Virginia: Satir's Genius for Healing" and the founding director Mount spoke on "Our Silent Dancing Partner: Attitudes Toward Death and How They Got to be that Way" on the 27th of April, 2007 and the 31st of March, 2006 respectively.

appreciating the beauty of the natural world" (Koessler). Even more, some of these films' themes involve experiences of increasing individual awareness, consciousness, and connectedness within the wider universe (Koessler). Because the power of film maintains "the capacity to promote positive transformation and healing" ("Films"), this particular media was aptly chosen. After each film, there is a panel discussion with members directing discussion of the films' implications for personal healing and wellness in everyday life ("Films").

WPC ultimately aims to encourage self-reflection and integration of the film's story into the individual's own life journey. One participant writes, "A common thread throughout is the aspect of a story unfolding and expanding to develop greater wholeness and integrity of the individual, of the surrounding community or of the universe" and "triggers the sparks within our human psyche that can lead to healing and integration of our body, mind, and spirit" (Koessler; "Films"). Consider the film "The Man Who Learned to Fall".[38] This film was produced in collaboration with WPC, directed by Garry Beital, and featured Phil Simmons' tumultuous journey with Lou Gehrig's disease (ALS). Mount considers Simmons "a fellow traveler of incomparable grace and lightness, a teacher of great wisdom" where the sixteen months of filming with him leading up to his death in July 2002 "was an intoxicating dance, a privilege, a gift" (DVD). Simmon's notion of "learning to fall" or embracing life fully while simultaneously learning to let it go has served as an integral theoretical underpinning to WPC's message (Mount, DVD). Notably, this film won in 2005 a Freddie Award, two awards at the International Health and Medical Awards in New York City in the category of Coping, and a Michael E. DeBakey Award for Outstanding Educational Entry ("Newsletter 2" 3).[39]

Book Club

Beginning in 2007, WPC instituted a book club that reviews non-fiction and fiction literature on the themes of healing and whole person care ("Newsletter 3" 2). Similar to the film series, it does not exclusively address issues surrounding end-of-

[38] This was presented on the 10th of January 2005.

[39] Other films WPC featured at the series include Braindamadj'd (dir. Paul Nadler, 2006), At My Mother's Breast (dir. Heather Watson-Burgess, 2005), Doing Time, Doing Vipassana (dir. Eilona Ariel and Ayelet Menahemi, 1997), Born into Brothels (dir. Ross Kaufman and Zana Briski, 2004), and 39 Pounds of Love (dir. Dani Menkin, 2005).

life or living with a life-threatening or chronic condition but features a diversity of stories that demonstrate transformative experiences. For instance, it featured a memoir detailing an author's battle with alcoholism and her growth and personal transformation (Caroline Knapp's Drinking: A Love Story).[40]

Wellness Initiative: Mindfulness-Based Meditation and Stress Reduction Programs

Prior to the establishment of the Wellness Programs, WPC was interested in meditation and stress-reduction initiatives. Since January of 2003, it has led a number of meditation groups specifically for first year medical students and eventually made them available to medical students throughout their undergraduate years. In addition, Mount, Dobkin, and Hutchinson attended a one-week training program in Mind-Body Stress Reduction and a nine-day professional development workshop at the Omega Institute for Holistic Studies with colleagues such as Kabat-Zinn and Saki Santorelli from the University of Massachusetts Medical School in 2006 ("Progress Report 2003" 3; "Progress Report 2004" 3; "Progress Report 2005" 5; "Progress Report 2006" 1, 3). It was particularly these training programs that led to the implementation of the WPC Wellness Programs, also known as the Mindfulness-Based Meditation and Stress Reduction Initiative. Instituted at McGill in 2007 and led by Drs. Hutchinson and Dobkin, the Mindfulness-Based Meditation and Stress Reduction Programs consists of two programmatic arms – that of "Mindfulness-Based Medical Practice" and "Mindfulness-Based Whole Person Care," which they tailor to specific audiences (Dobkin, "Wellness Project" 3). What follows is a brief description of both of these programs. But because they are central to the following chapter's discussion, its theories and practices are therein described in fuller detail

Mindfulness-Based Medical Practice

WPC offers the "Mindfulness-Based Medical Practice" program in eight-week increments in addition to a required five-hour silent retreat. WPC initially provided it exclusively to physicians but eventually expanded it so as to include any individual in

[40] Some additional books and respective authors WPC features for discussion at its book club include the following: Mountains Beyond Mountains (2003) by Tracy Kidder (led by Dr. Joyce Pickering), Everyman (2006) by Philip Roth (led by Dr. Maureen Rappaport), and Vincent Lam's Bloodletting and Miraculous Cures (2006) (led by Dr. Gordon Crelinsten).

the medical profession. Currently the program enrolls a wide-range of participants from the health care field such as general practitioners, pediatricians, psychiatrists, geneticists, and palliative care providers ("Newsletter 3" 1).

In addition, WPC offers a one-day workshop entitled "Practicing Medicine Mindfully: Cultivating Imperturbability and Equanimity" to introduce physicians and other health care professionals to the extended eight-week program on mindfulness medicine ("Newsletter 3" 1). This program appeals to the deeply rooted Oslerian tradition at McGill. According to James Shedlock, Osler is "already canonized by the medical profession as its most current saint and the epitome of the ideal physician for the twentieth century" (351); he provides the quintessential embodiment of "Mindfulness-Based Medical Practice" through his promotion of imperturbability and equanimity in health care education and practice. And according to Hutchinson, Osler exemplified on numerous occasions mindfulness and an ability to bridge the ostensibly contradictory roles of curing and healing in medicine. "Clearly Osler was fully present and awake as a committed, caring, and creative human being; that is, he was "mindful" in [his] healing encounter[s]" (Hutchinson, "Atrium" 391).

Mindfulness-Based Whole Person Care

WPC specifically devotes the "Mindfulness-Based Whole Person Care" to women who have completed breast cancer treatment in, at least, the past three months. A pilot project in September to December of 2006 gave rise to its full implementation in 2007 ("Progress Report" 1). As with the "Mindfulness-Based Medical Practice," this patient-specific wellness program lasts eight weeks and involves experiential introductions to imagery, walking, standing, formal sitting meditation, body scanning, and hatha yoga.[41] After this introduction, participants select the most appropriate method for their particular circumstance and preferences. Participants engage in group discussions, approximately forty-five minutes of

[41] Tacon et al. describe body scanning, sitting meditation, and hatha yoga in the following way:

> Body scan involve[s] a gradual thorough sweeping of attention through the entire body from feet to head, focusing noncritically on any sensations or feelings in body regions with periodic suggestions of breath awareness and relaxation. Sitting meditation involve[s] mindful attention of the breath and other perceptions and a heightened state of observational yet nonjudging awareness of cognitions and the stream of thoughts and distractions that constantly flow through the mind. Hatha yoga involve[s] simple stretches and postures designed to strengthen and relax the musculoskeletal system and the development of mindfulness during movement of the body, or meditation in motion. (28, 29)

homework per night, which is later discussed with the group, and a five-hour silent retreat on the sixth day, which Dobkin and Hutchinson consider an essential component of the intervention. Moreover, participants undergo both a pre- and post-intervention interview. In the pre-interview, the program's instructors inquire into patients' understanding of the participatory requirements as well as determine whether they satisfy the inclusion criteria. In the post-interview, the participant and the program leader discuss how to integrate and maintain the newly developed skills in daily practice (Dobkin, Interview).

Research Initiative

The major research objectives for WPC aim at 1) developing a shared vocabulary with which to discuss the spiritual, existential, and inner life dimensions of illness that transcend varying religious and cultural worldviews, and is thus appropriate for use in a multicultural context; 2) undertaking a systematic survey and review of existing literature relating to the topic of spirituality and health; and 3) advancing our understandings of suffering and quality of life determinants, particularly those related to spirituality and the inner life, by applying both quantitative and qualitative research strategies (Mount, Boston, and Cohen 15). Through a number of research projects, WPC has been able to fulfill each of these programmatic objectives and continues to do so (See Appendix 2).

> Its methodology emphasizes qualitative research.
>
> Questions relating to life experience in a changing environment, which are concerned with meaning, patterns or relationships, call for a form of research inquiry that is able to uncover subjective experience in a dynamic and complex social situation. "These questions weave the concerns of body, life and power into a holistic narrative and call for the designs and methods of the qualitative clinical researcher." (Mount, Boston, and Cohen, "Proposal" 12)

And as we have seen, all of these "whole person care" considerations are important constituents to WPC's theoretical framework. Nevertheless, this call for qualitative research to address the subjective experience of illness and quality of life at no point intends to override the admissibility of quantitative methodologies or undermine its successes and advantages.

> The methodology used in assessing the determinants of such varied experiences should be chosen on appropriateness for the study at hand.

> Whether quantitative, qualitative, or a combination of the two, the research design must be rigorous and the researchers able to retain a broad perspective that can integrate both qualitative and quantitative evidence. (Mount, Boston, and Cohen, "Proposal" 11)

Thus far, I have examined the theories of WPC as well as their practical implementation in health care education, research, and delivery. Now I turn to an exploration of WPC's position on religion and spirituality particularly as it selectively draws from various traditions in the attempt to negotiate spirituality into a secular, medical institution.

CHAPTER 3: Perspectives on Religion and Spirituality

According to WPC, the spiritual dimension is a significant determinant of subjective quality of life not only in the setting of palliative care but throughout a disease trajectory (Mount, Boston, and Cohen, "Connections" 373). One of WPC's fundamental aims is to incorporate the spiritual dimension of personhood into the broader sphere of medicine. In the initial proposal, Mount, Boston, and Cohen describe the first and perhaps foremost objective for WPC as follows: "To develop a language with which to discuss the "inner life" that transcends traditional, cultural, and religious world views and is thus appropriate for use in a pluralistic society" ("Proposal" 3, 15). I begin this discussion by defining those terms that constitute WPC's shared vocabulary. I then explore the diversity of traditions that WPC appeals to in formulating its perspective on religion and spirituality. Specifically, I delineate the influence of Jungian psychology, Buddhism, and Christianity on the theories and practices of WPC through examining its promotion of Asklepian healing, Mindfulness-Based Meditation, and the Wounded Healer Archetype.

Definitions

What follows are WPC's definitions and descriptions of the following terms: spirit, inner life, spiritual, spirituality, transcendence, and religion. I highlight in particular the stark differentiation between spirituality and religion.

Spirit (or Soul)[42]

In introducing the concept of the spirit, WPC begins by describing its etymology from the Latin word *spiritus* meaning breath, air, life, soul, pride, and courage (Mount, Boston, and Cohen, "Proposals" 6; Mount and Hutchinson 10). Mount, Lawlor, and Cassell in their shared vocabulary initiative (See Appendix 2B) equate the term spirit with "God," "the Sacred" (305), and the "animating or vital

[42] Throughout its literature, WPC equates the term spirit with the soul. "While some draw a sharp distinction between 'spirit' and 'soul,' for the purpose of this discussion 'spirit' will be used as inclusive of both terms" (Mount, Boston, and Cohen, "Proposal" 6; Mount and Hutchinson 10). And WPC similarly describes that, "Soul is often used as a synonym for spirit" (Mount, Lawlor, and Cassell 305).

principle in humans" (Mount, Lawlor, and Cassell 305).[43] WPC further defines spirit according to this interpretation while adding some additional points to consider. "'Spirit' has been defined 'as the animating or vital principle in humans; the soul of a person, as commended to God, or passing out of the body, in the moment of death'" (Mount, Boston, and Cohen, "Proposals" 6; Mount and Hutchinson 10).[44] Thus, the authors of WPC emphasize the portability of the spirit beyond corporeal existence and the fabric of space and time but also its existence within the confines of human life, mind, and body giving rise to "matter incandescent" (Mount, Boston, and Cohen, "Proposal" 6). In other words, the spirit is both immanent and transcendent (Mount, Lawlor, and Cassell 305).

This paradoxical but particular union of opposites significantly parallels Jung's concept of the Self. As the archetype of wholeness (Dion 32; Palmer 121), the Self is essentially the transcendent God rendered immanent within individuals. He describes it thus: "The extraordinary difficulty in this experience [of the Self] is that the Self can be distinguished only conceptually from what has always been referred to as 'God,' but not practically. Both concepts apparently rest on an identical numinous factor which is a condition of reality" (Jung, CW 14: 546).[45] And this numinous factor is, for Jung, both immanent and transcendent because 1) it is an "experience ... connected to the psychic processes of the experiencing subject," and 2) "is an effect produced by the experienced object, by the numen or archetype itself which impacts upon individuals through the medium of symbols (Palmer 139, 151, 153). The Jungian analyst Jane Wheelwright notes that, "Jung has referred to the [S]elf as 'the God within us'" (qtd. in Kearney, Place of Healing 16). And Palmer argues that "the immanent-transcendent, 'God within us'" is precisely the essence of religious experience for Jung (150). Thus, the Self refers to the experience of divinity within

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[43] According to The Barnhart Dictionary of Etymology, the term *spiritus* acquires the association the "animating or vital principle, breath of life" in 1250 A.D. from Genesis and Exodus (1047).

[44] WPC derives this definition from the Oxford English Dictionary.

[45] For Jung, this numinous factor refers to the empirical, universal reality that the symbols of divinity and the self are one in the same; in other words, the experiences of God and the self are both experiences of unity and, therefore, of psychic wholeness (Palmer 139, 151, 153). Palmer precedes this discussion with Jung's interpretation of the word symbol particularly in the context of religion. He argues, "For no matter what individual or social experiences may contribute to the formation of the images of God, they are all necessarily expressions of that which cannot be expressed directly, and for that reason alone the archetypal God-contents *can only be expressed symbolically* ... Symbolic language thus becomes *the language of religion*, the only language appropriate for the expression of the individual's immediate and absolutely certain psychic experience of God within" (129).

one's being. WPC makes the association between the spirit and the essential self of Jung explicit. "From the earliest recorded time persons have thought themselves to be something more than body and mind. That 'something more' is spirit. It is, in this conception, the essential self" (Mount, Boston, and Cohen, "Proposal" 6).

More generally, though, Mount associates the term spirit with a variety of WPC's core concepts: "The soul and spirit ... are variously conceived as having to do with healing, wholeness, immortality, connectedness, purpose, meaning, inner journey that involves the depth of our being and the potential for inner peace" (Foreword vii). And as "Jung saw the soul as a *psychological fact*, irrespective of scientific proof of its existence" (Salman 60), so too WPC deems it a dimension that is imperceptible to the observations and inquiries of science directly; however, in its capacity to impact the mind and body, it can be indirectly evidenced throughout them (Mount, Boston, and Cohen, "Proposal" 6).

Inner Life

WPC authors continually refer to the term "inner life" interchangeably with the words psychological, existential, spiritual, or subjective depending on the context of discussion or research. For instance, in Mount, Boston, and Cohen's research aiming to "achieve an in-depth description of the *existential* and *spiritual* experience of patients with life-threatening illness" ("Connections" 374; emphasis added), the researchers intentionally reference the term "inner life" more so than any other. Mount, Boston, and Cohen explain: "As suggested during preliminary trial interviews, the term *inner life* was frequently used to avoid the ambiguity and sensitivity associated with the words *psychological*, *existential*, and *spiritual* in discussing the overlapping domains indicated by these terms" ("Connections" 374). Allen describes a similar situation in her research work with Hutchinson that investigates the experiences of patients and caregivers dealing with end-stage renal disease. She was unable to use the terms healing and suffering in soliciting potential participants because of their spiritual connotations.

> I went into the dialysis context and I said that I'm doing a study on various people's perspectives on suffering and healing on dialysis and at least one patient – I think maybe a couple of patients – very early on said, "Well, if you're talking about spirituality I don't want to have anything to do with it." So I stopped using suffering and healing as words for describing the work that I was doing. So, instead I said that

> that I'm doing a study on quality of life. And people were very open to that. (Interview)

Thus, WPC appears to be appositely drawing upon terms such as inner life and quality of life in order to evade what some people perceive to be negative associations with the terms spiritual or existential. However, WPC generally does not explicitly define inner life in either its literature or its initiative to develop a shared vocabulary. An exception, though, is the following working definition that Mount, Boston, and Cohen offer: "'Inner life': having to do with meaning and purpose, the essence of the individual, the essential self, the 'Self,' the 'Deep,' psyche, the soul; the relational self at the level of most profound contact" ("Proposal" 15). Although Mount, Boston, and Cohen say they will refine this definition through dialogue with other faculty members and colleagues ("Proposal" 15), WPC has yet to do so.

Spiritual

Drawing from the Oxford English Dictionary (OED), WPC defines the term "spiritual" as "of, or pertaining to, affecting or concerning the spirit or higher moral questions" (Mount, Boston, and Cohen, "Proposals" 6; Mount and Hutchinson 10). Although WPC always precedes or follows this definition with an explanation of the term spirit as I describe it above, it essentially defines "spiritual" using terms that require defining or further elaboration themselves. WPC, for instance, offers no elucidation on what it intends by "higher moral questions." Such a definition, thus, remains elusive particularly as it is the only definition WPC offers. However, Mount, Lawlor, and Cassell in their shared vocabulary initiative quote Kabat-Zinn's inclusive conception of the term:

> Perhaps ultimately, spiritual simply means experiencing wholeness and interconnectedness directly, a seeing that individuality and the totality are interwoven, that nothing is separate or extraneous. If you see in this way, then everything becomes spiritual in its deepest sense. Doing science is spiritual. So is washing the dishes. It is the inner experience that counts. And you have to be there for it. All else is mere thinking. (qtd. in Mount, Lawlor, and Cassell 306)

This definition is clearly inspired by the Zen tradition of Buddhism. According to Walpola Rahula,

> To live in the present moment, to live in the present action ... This is the Zen way ... You haven't got to perform any particular action in

> order to develop mindfulness, but you have only to be mindful and aware of whatever you may do ... you have only to cultivate mindfulness and awareness always, day and night, with regard to all activities in your usual daily life. (72, 73)

Drawing from the Zen tradition, Kabat-Zinn's definition implicates the spiritual dimension in every possible experience and activity and thus, in the medical care of patients. McNamara explains:

> ... And I think that in my experience of being a patient I was cared for in a very *spiritual* way by my caregiver. Not in any religious way whatsoever, but in a way that there was a connection that was way beyond the ordinary doctor-patient relationship: you know, let me fill in your form and send you home. It was caring that I perceived as a patient that put everything on a different level, and I think that this spirituality and my experience of being a patient may have changed significantly how I am as a doctor and a teacher and why I think it's so important to teach students explicitly how to aspire to treat patients the way I was treated. (Interview; emphasis added)

It is precisely the spiritual dimension that Hutchinson and McNamara seek to harness not only in their own medical care but also in teaching medical students the healing role at McGill (Hutchinson, Interview; McNamara, Interview).

Spirituality

Similar to the term inner life, Mount, Boston, and Cohen propose a preliminary definition of spirituality in their initial proposal for the implementation and development of WPC; they describe it as relating to the following three dimensions of persons: the transcendent, intuitive, and existential (15). Mount, Lawlor, and Cassell expand upon this definition in their shared vocabulary initiative. "Spirituality refers to the spirit, and the human capacity to respond to the sacred in the search for meaning in life" where the "Sacred refers to that which is deemed holy, consecrated, esteemed, or special by virtue of an association with ultimate reality, ultimate meaning or God, however perceived by the individual" (305). Thus, WPC defines the terms inner life, spiritual, and spirituality by their relationship to the spirit (or soul). Again, this demonstrates the ambiguity of the definitions WPC is providing.

In qualitative interviews, I asked the WPC faculty members a number of questions with regards to their spirituality and religion. Many of them view spirituality as an experience with something greater, deeper, and more profound than

the ordinary self. Hutchinson states the following: "what's actually happening is a sense of something deeper, more important, more rewarding going on and that's my experience of spirituality" (Interview). McNamara sees spirituality as "something that is bigger than me" (Interview). "Spirituality is in a broader way ... a connectedness with a higher power" according to A.F.M. (Anonymous Faculty Member)[46]. More vaguely though, Dobkin considers spirituality "more about being connected and connected to other people, to what's alive, to what's out there." And lastly, Mount describes it as "yearn[ing] for something greater and more enduring than the self" (Interview). Although this is WPC faculty members' description of spirituality, it more precisely constitutes the substantive basis for the term "transcendence" according to the WPC literature in general and in Cassell's interpretation in particular (see below).

Nevertheless, WPC describes spirituality in terms of its theory of healing connections, especially connectedness with the Divine. For Mount,

> Spirituality is relational in its expression.[47] It is expressed in one's relationships at three levels – to the self (in the individuation of Jung); to others (at a *quantum level* we are one with the cosmos in a state of undivided wholeness; at a *psychic level* we share with others the collective unconscious; at the *transpersonal level* a potential for 'I-thou' relating); and to ultimate meaning however conceived – God, the More, and the cosmos. ("Existential" 41)

Two faculty members respond in a consistent manner with Mount's above description. For A.F.M., "Spirituality is your connectedness with a higher power, with God. To me it is God. But it is as well connectedness with nature, with other people." Similarly, Dobkin says, "Well, the word that comes to mind is connectedness, so connectedness in lots of ways and lots of levels. Connected to other people, connected to nature, connected towards what's alive and connected to what's not alive. So, for me the word just resonates. When I walk in the woods I feel connected to what's there" (Interview). Moreover, Hutchinson and McNamara both associate spirituality with an experience of connectedness with others, particularly with their patients. Hutchinson says the following:

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[46] In order to preserve the desired anonymity of one participant and the informed consent agreement, I refer to this person as A.F.M. (Anonymous Faculty Member).

[47] In response to my interview question "how do you define spirituality," this is precisely and verbatim how Mount responded (Interview).

> So I would say my most clear-cut experience of spirituality is talking to people who are dying. Something happens when you are talking to people for whom this is it and you realize that someday this will be it for you too and talking to them without running away from that and being present to that, that's a really precious moment and something happens – time slows down, triviality disappears and you are right there with them. That to me is a spiritual experience. (Interview)

And for McNamara,

> The spiritual thing for me is be good and do good ... to put other people's needs before my own, because I feel like there is something supporting me in doing that. There's something out there that cares about me or puts me in the right place at the right time or smoothes the way. And that fills me up to be able to pay it forward or pass it on whether it's a patient care situation or a friendship situation. You know what I mean? (Interview)

Also, McNamara associates spirituality with relating to God. "As I see spirituality for me, it's God. I don't know what it is for other people, but [for me it is] something that is bigger than me that I have a relationship with and that I see as a positive influence in my life even in bad times" (McNamara, Interview). Thus, all faculty members of WPC in their interviews describe spirituality in terms of at least one dimension of the so-called healing connections (except for Allen who was not afforded the opportunity to comment). My interview with Mount corroborates that not only healing connections are directly implicated in spirituality but so too is the capacity to find meaning.

> Spirituality is relational in its expression ... it is very important to me to distinguish between religion and spirituality. We all in my opinion have a very significant existential inner life (the way I am using the word spiritual existence) and to say we didn't have would be to be using the language differently like saying I don't breathe. It comes with the territory of being human, because we all have existential issues to do with consciousness and life, and we all have to construct a context of meaning, and we're all driven to identify something more. We yearn for something greater and more enduring than the self to provide what Victor Frankl thought is the end goal, which is meaning. I would submit that he's only partly right – that the meaning isn't the end in itself; that the meaning is significant. We find it significant, because it leads us to where we find the meaning: through what we've come to call healing connections. And it's places or issues through which we have identified a sense of connectedness. (Mount, Interview)

WPC describes the spirit and the inner life in precisely this manner as well. "Spirit is relational in its expression. That is, it is expressed in relationship, love and community, in dialogue, in communion with others, including God (the Other), however conceived" (Mount and Hutchinson 10).[48] And "Recall that our inner life is relational in its expression" (Mount, "Commandments" 50).

Transcendence

In The Nature of Suffering and the Goals of Medicine, Cassell draws attention to transcendence in the context of medicine, particularly its central role in the relief of suffering and restoration of personal integrity and wholeness (41). WPC draws much of its own interpretation of transcendence directly from this work of Cassell. For instance, Mount describes the transcendent dimension as "broadly defined by Cassell in this secular age as the need to identify with something greater than ourselves" ("WPC" 30). Mount, Boston, and Cohen further explain: "Cassell suggests that the 'transcendent dimension' is fundamental to this shift [towards wholeness and integrity in the face of death]. He defines transcendence as '... a life of the spirit, however expressed or known'" ("Connections" 386). In the shared vocabulary initiative, Mount and Cassell offer the following definition:

> "Transcendence is a response of the self that enables an individual to rise to challenging and deeper levels of living and endurance. It involves development of new capacities, new forms of living, new insight into living."[49] In the transcendent response, the person identifies with something greater and more enduring than the self, resulting in a sense of expanded purpose, meaning, and quality of life. "Transcendence is probably the most powerful way in which one is restored to wholeness after an injury to personhood. The sufferer is not isolated by pain but is brought closer to a transpersonal source of meaning and to the human community that shares that meaning. Such an experience, need not involve religion in any formal sense; however, in it its transpersonal dimension it is deeply spiritual. (Mount, Lawlor, and Cassell 305)[50]

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[48] Mount also describes the spirit in this way in the article "Whole person care: Beyond psychosocial and physical needs" (34).

[49] Mount, Lawlor, and Cassell draw from a number of quotes to compose their definition of transcendence. This sentence in particular comes from personal communication with M. Jeffery in 1999.

[50] In this last sentence, Mount, Lawlor, and Cassell quote a passage from Cassell's The Nature of Suffering and the Goals of Medicine. This quotation is perhaps the most frequently cited passage in the WPC literature. WPC refer to this quote in numerous proposals, research articles, and editorials.

In short, WPC roots the terms spiritual, spirituality, and transcendence in the spirit (and inner life) whereby these three dimensions of personhood find their expression in not only a sense of meaning and purpose, but also through connectedness at the four levels described – through the self, others, the phenomenal world, and the Divine. Thus, and as we saw in chapter one, these dimensions are of pivotal importance to WPC's conception of healing and wholeness.

Religion

Although all the aforementioned terms are strongly interrelated or even synonymous, WPC makes a purposive and significantly stark differentiation between these and religion. But first, how does WPC define religion? Mount, Boston, and Cohen follow the OED's definition. "Religion is, 'a system of faith and worship, a recognition on the part of man of some higher unseen power as having control of his destiny and as being entitled to obedience, reverence, and worship" (Mount, Boston, and Cohen, "Proposal" 7). In the shared vocabulary initiative, Mount, Lawlor, and Cassell give an alternative interpretation of religion as "a system of teachings and practices concerning the living of one's faith, generally in an experience of community with others who honour the same beliefs" (305). In sum, these comments characterize religion as definitive teachings, practices, rules, and a system that is organized, institutional, and hierarchic.

Generally, WPC distinguishes religion and spirituality in the following way: whereas the spirit – or spirituality for that matter – is a universal reality inherent in all people, religion is an artificial, human institution that offers a means to the spirit.

> It is important for us to first make a clear distinction between the spirit and religion. The spirit is the essence of what it is to be human. It is the dimension of personhood pertaining to values and meaning. It is part of each of us. Religion is a belief system that enables conceptualization and expression of spirituality. The spirit is part of our being like kidneys, pancreas, or mind, while religion is a construct of human making. (Mount, "WPC" 34)[51]

[51] WPC discusses this distinction between religion and spirituality in the following articles as well: Mount, Boston, and Cohen's "Proposal for the Development and Implementation of Education and Research Programs in Integrated Whole Person Care" (7); Mount and Hutchinson's proposal (5, 11); and Mount's "Whole Person Care: Beyond Psychosocial and Physical Needs" (34).

Drawing a distinction between religion and spirituality for WPC is most important for two reasons. First, Mount, Lawlor, and Cassell assert that in fact some people not only propose but also submit to such a distinction themselves and as such more intimately identify themselves with the spiritual dimension of their personhood (306). Second, these authors draw attention to the misconception that spirituality necessarily indicates religiosity and also the respective pitfalls of such a position. For instance, Mount, Lawlor, and Cassell argue that the failure to draw a distinction between these two concepts can lead to the assumption that spiritual needs are irrelevant to people who do not profess a religious affiliation. "A narrow use of the term religious has led to a failure to appreciate the broader, metaphysical understanding of the word spiritual and the presumption that if someone does not profess a recognized religious faith they have no spiritual discernment or need" (King et al. qtd. in Mount, Lawlor, and Cassell 306). As a consequence, a domain that could potentially modify quality of life and the experience of illness is effectively foregone. These authors too argue that social or cultural forces are more important for religiosity (Mount, Lawlor, and Cassell 306).

Since all the articles that make this differentiation between spirituality and religion are written either wholly or in part by Mount, it is important to determine whether or not other faculty members maintain it. And indeed they do for the most part. Even though McNamara "struggle[s] about the distinction of religion and spirituality," she offers the following:

> When it comes to spirituality and connection with God, which I see as a very different dimension – I'm not trained in theology – I see that as a more personal relationship than externally jumping through hoops that are part of organized religion. So I have a kind of ... not a conflict but I see the two as very different. One [spirituality] is authentic for me, and the other [religion] is something I do to meet needs or external demands. (Interview)

According to A.F.M., "Religion is a type of rules. It's an organized way of a certain faith. There are symbols and written symbols ... there are some written things involved." And for Dobkin,

> Religion has to do with organized religion where people adhere to a certain belief or dogma and usually practice together in some form or another be it at church, mosque, synagogue and there's in some ways a prescription of how to live and think and believe, whereas, for me, spirituality is not that. It's more about being connected and connected

> to other people, being connected to what's alive, being connected to what's out there. (Interview)

Hutchinson conceives of religion as

> ... a set of beliefs and practices aimed at some kind of understanding of a larger sense of the world ... it's a very clear cut way of implementing that – very hierarchical, very clear. You don't have to worry. They know exactly what they think about everything, and this is the way. So it has that sense of clarity. I think all religions have a strong element of that ... [whereas] I would say that my experience of spirituality is that when you're present to what's actually happening, there is a sense of something deeper, more important, more rewarding going on. (Interview)

Therefore, McNamara, A.F.M., Dobkin, and Hutchinson maintain the distinction Mount posits between spirituality and religion. Some faculty members, however, define themselves as also religious in the institutional sense. McNamara admits: "I would consider myself religious. Why? Because I attend church when I can. I am involved in the church community ... I'm not sure where that comes from me and whether it comes from how I was raised" (Interview). Mount too notes: "do I find meaning through any particular organized religion? Yes, I do" (Interview).

In this last point, Mount – the primary purveyor of the religion and spirituality distinction – negotiates an important point of intersection. This is further evident in the ways in which he practices them respectively. "[Spirituality] is a major area of my reading interests. But, meditation is a pretty major part [also]" (Mount, Interview). And in a similar manner, when I asked Mount "to what extent do you participate or exercise your religious aspect" he responded as follows: "I by and large would attend weekly services and so forth. That has been difficult since the trach[eostomy]. And more, or as significant as going to services, I've been a meditator for almost thirty years." This most likely issues from Mount's assertion that religion allows for the expression of spirituality but is not conditional upon religious adherence or participation (Mount, "WPC" 34; Mount and Hutchinson 11). Other authors too describe religions' capacity for the expression of the spiritual dimension. Hutchinson posits that religion is "aimed at some kind of understanding of a larger sense of the world and trying to put people in touch with whatever this non-material essence is" (Interview). Furthermore, Cassell asserts that, "Everybody is spiritual. Religion is one expression of it" (Interview).

In personal interviews, some members explicitly express an inextricable and complicated interconnection between these two spheres. In discussing how she implements whole person care practices in her own life, Allen says the following: "I don't think that in my desire to balance my life do I give spirituality much attention and that's partly because of the ways in which I still see religion and spirituality as intertwined in complicated ways" (Interview). A.F.M. reiterates: "Religion and spirituality for many people are sometimes interconnected. It is for me as well [in] my faith" (Interview). This is reflected in the ways in which she practices her spirituality and religion. When I asked about her religious practices, she stated the following: "I practice religion everyday even in my yoga and my meditation. It's part of it even in my prayers everyday." When I asked her to describe her spiritual practices, she responded similarly: "What I'm doing in my personal life is yoga and meditation as much as possible, and that's the way I try to find more integration, more balance." At the same time, she accepted an organizational component to her religious practices. "The organized way [that I practice my religion] is that I go to church, attend mass, and ceremonies."

In sum, most WPC faculty members draw a distinction between religion and spirituality. These can be classified into four types or positions. First, some members such as Mount, Cassell, and A.F.M. see religion as a complement to spirituality. Second, religion, as is the case for McNamara and Dobkin, is considered important but lesser to that of spirituality. Third, religion is perceived as antithetical to the spiritual domain.[52] And in the fourth case, religion is conceived as too complicated to be separated from spirituality, as Allen so describes. In general, though, WPC focuses on spirituality while religion is – in the worst case – reduced to a human construct that impedes understandings of human healing and wholeness and – in the best – allows for the expression, experience, and conceptualization of spirituality but nothing more. In the final analysis, however, WPC does not want the incorporation of the spiritual domain to be impeded by the obstacles imposed by divergent religious worldviews (Mount, "WPC" 34; Mount, Boston, and Cohen, "Proposal" 5; Mount and Hutchinson 10). Mount states,

[52] For reasons of privacy, I have omitted the explicit identification of faculty members with this particular position.

> Can we discuss the spiritual domain without stumbling on the barriers and semantics erected by religious thought? This is a most important question for caregiver teams who operate in a pluralistic society since, to many people today, the terms of religious vocabularies are irrelevant, anachronistic, and even offensive. We are able to discuss body and mind with science to guide us, but when the topic of the spirit is opened, our personal positions as Christian, Jew, humanist, agnostic, or a hundred other perspectives can easily interfere ... We must respond to the spiritual dimension without resorting to dogma, or better stated, through living out the meaning of our personal beliefs in a way that transcends speech and opens windows of understanding without erecting barriers. ("WPC" 34)

Although WPC draws heavily from Jungian psychology, as we have seen, the latter does not strike a differentiation between the domains of religion and spirituality. Nevertheless, their views on religion and spirituality are not as divergent as it might seem. They simply employ a different nomenclature: WPC uses the term spirit and spirituality to characterize the authentic experience of the numinous whereas Jung uses the term religion.

> I should like to call attention to the following facts. During the past thirty years, people from all the civilized countries of the earth have consulted me. I have treated many hundreds of patients, the larger number being Protestants, a smaller number Jews, and not more than five or six believing Catholics. Among all my patients in the second half of life – that is to say, over thirty-five – there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost that which the living religions of every age have given to their followers, and none of them has been really healed who did not regain his religious outlook. This of course has nothing whatever to do with a particular creed or membership of a church. (Jung, Modern Man 229)

Palmer further explains: "[Jung] argues that religion is necessary for human psychic development ... Precisely because religion is a psychic function, as inseparable from the individual as any other instinct, any attempt to deny its significance will result in a loss of psychic equilibrium and thus a descent into neurosis" (142). The divergence in opinion between WPC and Jung is not rooted in differing conceptions of healing per se but is rather a result of WPC defining religion purely in the institutional sense, as a system of creeds and dogmas of human making for the living out of one's faith. Jung, too, deems religious creeds or membership as unimportant. As reiterated above, he states the following: "I want to make clear that by the term 'religion' I do not mean

creed" (SW 239). At the same time, he does not deny the value of religious creeds altogether; he asserts that psychology can potentially provide better means by which to envision religious creeds and dogmas by opening people to their true, underlying meaning (SW 264). Nevertheless, "the term religion" for Jung "designates the attitude peculiar to consciousness which has been changed by experience of the *numinosum*" (Jung, SW 239). But what does Jung mean by the term *numinosum*?

> In speaking of religion I must make clear from the start what I mean by that term. Religion, as the Latin word denotes, is a careful and scrupulous observation of what Rudolph Otto aptly termed the *numinosum*, that is, a dynamic agency or effect not caused by an arbitrary act of will. On the contrary, it seizes and controls the human subject, who is always rather its victim than its creator. The *numinosum* – whatever its cause may be – is an experience of the subject independent of his will. At all events, religious teaching as well as the *consensus gentium* always and everywhere explain this experience as being due to a cause external to the individual. The *numinosum* is either a quality belonging to a visible object or the influence of an invisible presence that causes a peculiar alteration of consciousness. That is, at any rate, the general rule. (Jung, SW 239)

Palmer describes how, ten years after Psychology and Religion, Jung defines religion as archetypal and in doing so renders it "an essential component of the psyche ... and requires that the religious attitude is the collective attitude ... in other terms, it is recognized as expressing an archetypal dimension that is intrinsic to human nature" (138, 142). It is important to note here that Jung too describes the spirit as archetypal. "The psychic manifestations of the spirit indicate at once that they are of an archetypal nature – in other words, the phenomenon we call spirit depends on the existence of an autonomous primordial image which is universally present in the preconscious make up of the human psyche (Jung, SW 125). This indicates that the spirit for Jung is also an intrinsic dimension of humans, as WPC so asserts. And lastly, for Jung,

> Religion is the relation to the highest or most powerful values, be it positive or negative. The relation is voluntary as well as involuntary, that is to say that you can accept, consciously, the value by which you are possessed unconsciously. That psychological fact that wields the greatest power in your system functions as a god ... We do not create 'God,' we choose him. (Jung, CW 11: 80)

Thus, WPC and Jung are referring to a similar phenomenology (an account of the numinous as a universal reality that relates to meaning and values) with the former

classifying such experiences in the domain of the spirit and spirituality and Jung with that of religion. Simply put, they are merely employing different terminologies to account for the same phenomenology.

Religious Dimensions of WPC

In order to account for divergent religious and cultural belief systems in health care institutions while at the same time trying to incorporate the spiritual and existential realities of illness, WPC also selectively draws from the Ancient Greek Religion, Christianity, and Buddhism. This is evidenced in WPC's theories of Asklepian healing, the Wounded Healer Archetype, and Mindfulness-Based Meditation.

Asklepian Healing

The work of Kearney in general and his theory of Asklepian healing in particular are fundamental to WPC both in theory and practice. Specifically, in 2002 and 2003, WPC hosted Kearney as a part-time visiting professor. During this time, he contributed to the "healing" initiative of the Faculty of Medicine's undergraduate curriculum at McGill (Mount and Kearney 657). WPC extensively draws upon Kearney's principles of Asklepian healing, particularly his concept of the inner healing potential of patients and the role of health care professionals in this process (such as the creation of a safe and secure environment for patients in the patient-physician relationship and physician self-care and self-reflective practices).[53] Kearney appeals to theories of Jungian psychology at considerable length as well as those authors, such as Carl Kerenyi and Guggenbuhl-Craig, who aided in the further development of a Jungian interpretation of Asklepian healing.

To address the present inadequacies with the current state of health care delivery, Kearney proposes a complementary system of care in A Place of Healing.

[53] WPC cites Kearney in numerous instances particularly with respect to his contributions in applying Asklepian Healing to the current biomedical context. These include the following: Mount et al.'s "Healing Connections" (384), Boston et al.'s "Spirituality, Religion, and Health: the Need for Qualitative Research" (373), Mount's "Existential Suffering and the Determinants of Health" (42) and "Healing and Palliative Care: Charting our Way Forward" (657, 658), "The Caregiver's Perspective on Existential and Spiritual Distress in Palliative Care" by Boston and Mount (14, 25), Mount and Hutchinson's "A Proposal for the McGill Programs in Whole Person Care" (1-3, 6, 13, 14, 20), and Mount, Boston, and Cohen's "A Proposal for the Development and Implementation of Education and Research Programs in Integrated Whole Person Care" (4, 5). Needless to say, in most of WPC's literature its authors cite Kearney.

Drawing from the mythology of ancient Greece, he designates this complementary system as the "Asklepian healing model," which focuses on the care of those suffering from chronic, incurable, and/or life-threatening disorders and contrasts it to the present western system of medical care, which he associates with the long-standing medical tradition of Hippocrates. Because medicine is no longer providing adequate treatment and care in the realm of critical and chronic illness, the Asklepian healing model for Kearney represents the epitome of what is needed to redress such limitations. These two models of care existed not only alongside one another but also cooperatively in ancient Greece. Therefore, medicine in the twenty-first century should integrate the Asklepian model with the already existing system of Hippocratic medicine (Kearney, Healing xx, xxi).

For Kearney, the prudent integration of Asklepian and Hippocratic medicine is embodied in the symbol of the caduceus, or the twinned serpents coiling around the staff (Healing 35). This is also the case for WPC because it uses the caduceus as its identifying symbol (See Figure 3). As a result, this indicates the concept's pivotal importance to WPC.[54]

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[54] The McGill Office of Curricular Development and the Physicianship Program too uses the symbol of "Asklepius," the snake and staff, but as found on the Osler Library's stained glass windows (See Figure 4). Its website accounts the following description of the snake and staff windowpane: "The second frame of the windows shows the staff of Asclepius, from the Greek word "Asklepas," meaning snake. Both the snake and the staff are symbols of healing." In comparison to WPC's symbols, though, this one depicts only one snake rather than two. This is consistent with Donald Boudreau's assertion that all medical care constitutes healing and, accordingly, Eric Cassell's submission that the curing/healing and disease/illness distinctions – and correspondingly Kearney's Hippocratic/Asklepian differentiation (Kearney, Healing 35) – however useful, are in fact erroneous. For them, then, the single snake ostensibly represents the dissolution of these binary distinctions and subsequently, the complete unification of healing as inherently involving both approaches and perspectives.

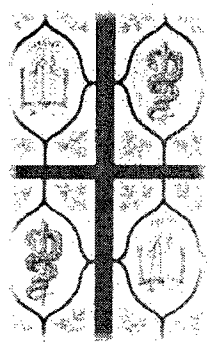

Figure 4. Identifying Symbol of the Office of Curricular Development and Physicianship Program for McGill Medicine, as it archives in the Office of Curricular Development and Physicianship.

Figure 3. Twinned Snake Coiled Around a Staff: The Identifying symbol of WPC (McGill WPC)

Kearney describes Asklepian healing as "a form of psychological and spiritual healing based on the ritual practice of Asklepios, the Greek god of healing" (Healing xxi). This clearly indicates that Asklepian healing draws from the religious tradition of Asklepios in the Ancient Greek religion. It is associated, moreover, with specific religious practices and ceremonies for healing such as pilgrimage and rituals.

In ancient Greece, Asklepian healing centered on a pilgrimage to the site of an Asklepian healing temple and participation in a process called dream incubation. These sites of Asklepios were deliberately situated in peaceful and healthy environments characterized by seclusion, mineral springs, clean air, and shelter from tumultuous wind. Once pilgrims arrived, priests or priestesses of Asklepios greeted them and ultimately served as their guides and attendants throughout their visit to the temple. After this meeting and a time of rest, pilgrims underwent ritual purifications such as bathing in springs and fasting. Then, they provided ritual offerings and sacrifices in supplication to the god, Asklepios. These were meant to facilitate a state of mind for dreaming, which is the primarily vehicle for communication with the divine healing source. Once these devotees of Asklepios experienced a decisive moment, such as a sign or some inner sense, and their priestly attendants validated this experience, pilgrims undertook additional rites of purification and ablutions in order to begin the process of dream incubation. This process began by participants (or incubants, as they are called) entering into the sleeping quarters during the night where they surrendered themselves to the realm of sleep and dreaming in order to access Asklepios, the divine source of healing. Incubants waited until they received a vision, dream, or epiphany from the god. While some waited for a long time and others to no avail, some of the incubants quickly experienced a favorable dream from Asklepios, which occasioned a healing experience. Afterwards, these incubants

discussed the experience with their attendants and provided offerings of thanks to the god before returning home (Kearney, Healing 69, 72-75, 77, 79, 80).

For Kearney, the Asklepian healing rite is based on two primary principles. First, healing is born out of the depths of the individual's suffering. The rite of Asklepian healing is devised in such a way as to facilitate and encourage this inner process by means of a tranquil natural environment and self-reflective ritual practices. But even more, it is through facilitating an environment conducive for dreaming and the dreams themselves that enable inner healing to occur. In quoting Kerenyi, Kearney explains that, "Characteristically, [a] cure is sought in sleep and dreams. In sleep the patient withdraws from his fellow men and even his physician, and surrenders to a process at work within him" (Healing 35). The second principle of Asklepian healing is that this approach to healing is contingent upon an encounter with the divine. This is evidenced in the process of dream incubation itself as the incubants wait for the divine encounter from Asklepios while sleeping in a dream or vision (Kearney, Healing 67). According to Emma and Ludwig Edelstein, "Dreams ... were supposed to give men a share in divine wisdom. In dreams the soul came into contact with those divine powers surrounding men and the world, which it could not apprehend when it was awake" (2:157). Taken together, then, Asklepian healing originates not only within the self but also within the divine. As such, it is called the healing rite of the sacred encounter. This leads to the conclusion that access to the divine can be found within the self. By extension, if only the divine can heal and the divine is in the self, then only the self can activate the inner process of healing.

The principles of the Asklepian healing rite that Kearney delineates clearly coincide with Jung's theories. With regards to Kearney's first principle, Jung argues that, "There is in the psyche a process that seeks its own goal independently of external factors" (SW 255). Palmer explains: "Jung, we should add, no less than Freud, believes in the *vis medicatrix naturae* – that is, in the healing power of nature, by which man has the capacity, through his discovery of his unconscious life, to heal himself" (92). Second, as Kearney argues that this process is spontaneous – "that this moment of healing could not have been prescribed, or willed, or given" (Kearney, Healing 103, 104) – so Jung describes healing as a "spontaneous activity of the psyche" (Modern Man 242). Third, dreams for Jung constitute the means by which to promote psychic balance and thus, the process of individuation – in other words, the

uniting of the conscious ego and the unconscious Self to become "a psychological 'in-dividual,' that is, a separate, indivisible unity or 'whole'" (Jung, CW 9:275).

> The dream is a little hidden door in the innermost and most secret recesses of the psyche, opening into that cosmic night which was psyche long before there was any ego-consciousness, and which will remain psyche no matter how far our ego-consciousness may extend ... All consciousness separates; but in dreams we put on the likeness of that more universal, truer, more eternal man dwelling in the darkness of primordial night. There he is still whole, and the whole is in him, indistinguishable from nature and bare of all egohood ... It is from these all-uniting depths that the dream arises. (Jung, CW 10: 144)

> Dreams are impartial, spontaneous products of the unconscious psyche, outside the control of the will. They are pure nature; they show us the unvarnished, natural truth, and are therefore fitted, as nothing else is, to give us back an attitude that accords with our basic human nature when our consciousness has strayed too far from its foundations and run into an impasse. (Jung, CW 10: 149)

Kearney himself refers to these quotations in A Place of Healing to explain that, "Dreamwork, which is taken here to mean *attending to and being animated by a dream*, was central to the ancient rite of Asklepian healing" (Kearney 111). He describes, moreover, how "Jung believed that by attending to our dreams we were attending to the language of our original and deepest nature, our aboriginal self, a source of profound wisdom and healing" (114). Because Kearney views dreams as "a creative expression of the uncharted wilderness of the depths of the psyche" (110), working with dreams is a means by which caregivers and patients can harness the healing potential of nature, where nature here refers to not only the natural realm, such as the earth, trees, animals, and rivers, but also nature's kindred relation to the body and psyche. Other approaches include image work, art therapy, musical therapy, and creative ways of physically being in the real environment or wilderness (Kearney 67, 104-107, 110, 122). Drawing again from Jungian psychology, Kearney's inextricably connects the domains of nature and psychotherapy. It is specifically the natural realm of the psyche and the exterior environment that facilitates healing. "To know one's kin, to find one's place in the natural world, in what Oliver calls, 'the family of things', is to know healing" (Kearney 108). Last, as in Asklepian healing, Jung highlights the divine within the self and its capacity to bestow healing. As Palmer asserts: for Jung, "God is a *psychic phenomenon*; that he is an immediate,

direct and self-evident fact of psychic experience encountered by [individuals] within the depths of their own being" (126). And, a direct experience of God within is expressive of an attempt to attain healing and wholeness (110, 126). Jung most poignantly expresses this point in the following quote – at the same time, summarizing the parallels between his own thought and Asklepian healing:

> It is as though, at the culmination of the illness, the destructive powers were converted into healing forces ... As the religious-minded person would say: guidance has come from God. With most of my patients I have to avoid this formulation, for it reminds them too much of what they have to reject. I must express myself in more modest terms, and say that the psyche has awakened to spontaneous life. And indeed this formula more closely fits with observable facts. The transformation takes place at that moment when in dreams or fantasies themes appear whose source in consciousness cannot be shown. To the patient it is nothing less than a revelation when, from the hidden depths of the psyche, something arises to confront him – something strange that is not the "I" and is therefore beyond the reach of personal caprice. He has gained access to the sources of psychic life, and this marks the beginning of the cure. (Modern Man 242)

Although Kearney goes to great lengths to describe the ancient Asklepian rite of the sacred encounter, by no means is he suggesting that patients and health care professionals ascribe to the Asklepian religious tradition of healing or become respective adherents or devotees in order to fulfill their mandate as healers. The practice of the ancient Greek religion, after all, died out several millennia ago. Rather, he applies the concepts and practices of Asklepian healing within the context of medicine today in what he comes to call "the containment of care," "a therapeutic use of self," and "dreamwork."

In the containment of care, Kearney draws upon Asklepian healing in the following way: just as the priests and priestesses facilitate a state of readiness and openness in the patients/pilgrims specifically through their relationship and rituals of preparation, so too must health care professionals in the current medical context facilitate such a safe, secure, trustworthy, and receptive state and space for their patients. In particular, this requires that health care professionals accompany their patients and "contain" the emotional material that the experience of suffering, illness, and dying engender. According to Peter Speck,

> The word 'containment' is not used here in a physical sense but refers to the emotional and psychological capacity to hold powerful and

> conflicting feelings, which are aroused in oneself unconsciously by others, without either retaliating or offering mindless reassurance. Such containment is a prerequisite of any therapeutic community. (qtd. in Kearney, Healing 87)

Jung also spoke of "containment" and employs the metaphor of the alchemical vessel to explain: "The *vas bene clausum* (well-sealed vessel) is a precautionary measure very frequently mentioned in alchemy, and is the equivalent of the magic circle.[55] In both cases the idea is to protect what is within from the intrusion and admixture of what is without, as well as to prevent it from escaping" (CW 12: 167). Christopher Perry further explains Jung's analogy:

> The *vas* ... represents the container in which the *prima material* (= "first matter," in sense of "essential being") of analyst and patient ... are transformed so as to produce the goal of individuation ... that is, self-realization. The container refers to the analytic setting and to the analyst's interventions, which are required to keep the heat at a level of anxiety optimal to the patient's self-discovery and the analyst's development both as an analyst and as a human being. (154)

Kearney argues that health care professionals can exercise this containment in the relationship with their patients and team members through good intra- and inter-disciplinary communication, acceptance of the varying skills that different disciplines have to offer, as well as clinical competence in the Hippocratic or biomedical tradition of medicine. Health care professionals can then consider and process "the contained material at an individual and team level and then responding in an appropriate way, the health care professionals can begin to meet the patient's needs and empower that individual to live with his or her own ambivalent feelings" (Healing 90). In doing so, they are able to facilitate the inner healing potential within their patients and create an environment for "miraculous transformation," a transformation marked, on the one hand, by an experience of psychological wholeness (Jung's individuation) and, on the other, by the ability to adapt to life's challenges (Kearney, Healing 85). But in order to appropriately contain the suffering of patients, health care professionals must assimilate this process with "a therapeutic use of self."

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[55] For Jung, the magic circle refers to the *mandala*, a symbol of the goal of individuation, psychic totality, and thus representative of the archetype of the Self (Jung, Memories 384).

Kearney derives the therapeutic use of self from the fact that Asklepios was both the patron of physicians as well as patients. This indicates the importance of caregivers themselves in the process of containment. "In Asklepian healing the being (who we are and how we are with the patient) is *primary* and the doing (the actual practice of skilled and effective caring) follows on from this" (Kearney, Healing 91). As such, Kearney encourages health care professionals to undertake a process of self-development and self-introspection and become more aware or mindful of the psychodynamics of the patient-caregiver relationship. This includes health care professionals being sympathetic to their patients' suffering, illness, death, and finitude as well as confronting their own (Kearney, Healing 92, 97-100). In discussing the "therapeutic use of self," Kearney points directly to Jung (Kearney, Healing 91, 92).

> The psychotherapist, however, must understand not only the patient; it is equally important that he should understand himself. For that reason the *sine qua non* is the analysis of the analyst, what is called the training analysis. The patient's treatment begins with the doctor, so to speak. Only if the doctor knows how to cope with himself and his own problems will he be able to teach the patient to do the same. Only then. In the training analysis the doctor must learn to know his own psyche and to take it seriously. (Jung, Memories 132)

The "containment of care" and the "therapeutic use of self" are ways by which health care professionals can work with patients' innate, natural healing potential. In addition to this and in keeping with the Asklepian healing model, Kearney states that health care professionals can encourage patients to attend to and reflect on their dreams (Healing 110). He goes at length to delineate not only an approach to working with dreams, which he refers to as dreamwork, but also a guide for directing an introductory workshop on this topic. It is precisely Jung who points to this option (Kearney, Healing 110). This is no surprise since, as we saw above, Jung employs the use of dreams in his own psychoanalytic approach.

Taken together, Kearney draws extensively from Jung and his theories of individuation and psychoanalysis in presenting a new yet complementary model of healing. Throughout, Kearney is clear about Jung's prevailing influence on his work; however, he is not as explicit about Jung's influence on his use of mythology from the Greek religious tradition. To explain: for Jung, there exists a collective unconscious, a repository of mythological motifs and primordial images, which he

terms "archetypes," whose presence manifest as experiences of the numinous in conscious life (Storr 16). Jung states that, "All the most powerful ideas in history go back to archetypes. This is particularly true of religious ideas" (CW 8:342). As such, "Jung saw the purpose of his analytical psychology as helping us re-establish connection to the truths contained in religious symbols by finding their equivalents in our own psychic experience" (Ulanov 316). In drawing upon the myth of Asklepios from the Greek religion, Kearney is attempting to reconnect his readers, particularly health care professionals, to the truths that abound in a religious tradition of healing that in the current biomedical context remains consciously forgotten within the depths of the collective unconscious. What's more, such (re)connections to the primordial and mythological truths in the collective unconscious are able to generate experiences of the numinous (Ulanov 316). Kearney is attempting to establish what Jung himself was able to do: "provide a clinical method to include our experience of the numinous in the enterprise of healing" (Ulanov 330).

It is important to keep in mind, however, that Kearney and WPC focus almost exclusively on Jung's archetype of the Self (the archetype of wholeness, the experience of which is the experience of the divine) and the individuation process for its subsequent realization and integration with other psychic processes. Jung's theory of the collective unconscious, on the other hand, as well as his constellation of additional archetypes remains largely excluded from their discussions. For instance, Kearney and WPC never mention Jung's shadow or anima/animus archetype. They do mention the collective unconscious, but only as one characteristic of the deep or unconscious mind in their model of the psyche. Boston and Mount refer to it in order to define what Jung means by the term archetype (see footnote on the following page). And Mount refers to it, once more, as expressive of spirituality because it is, at a psychic level, constitutive of an experience of relatedness with others ("Suffering" 41).

In this interface of religion and medicine, there is another important divergence to note between WPC's use of Kearney and Jung. Although both Kearney and Jung emphasize the role of the divine in the healing process (it is after all the second principle of Asklepian healing), WPC on no account makes this point in its literature. In the context of WPC, rather, its authors draw attention only to the first principle of Asklepian healing, namely, that healing arises out of the depths of the

individual. They describe it accordingly: patients contain within themselves an innate or inherent capacity for self-healing ("Report Faculty Working Group" 1; Mount and Kearney 657) and, similar to Jung, "the psyche, it would seem, has an intrinsic tendency toward healing, a will-to-wholeness as it were" (Mount, "Commandments" 50). Nevertheless, WPC through Kearney draws upon the myth of Asklepios in devising a necessary complement to the model of health care today. They do so primarily through promoting the concept of the Wounded Healer Archetype.[56]

The Wounded Healer

> Without too much exaggeration ... a good half of every treatment that probes at all deeply consists in the doctor examining himself, for only what he can put right in himself can he hope to put right in the patient ... it is his own hurt that gives the measure of his power to heal. This, and nothing else, is the meaning of the Greek myth of the wounded physician. (Jung, CW 16:116)

In this quote, Jung summarizes the concept embodied in the Wounded Healer. Clearly, this relates to Asklepian healing through Kearney's "therapeutic use of self." But what's more, it is here that Jung makes his only reference to the myth of Asklepios. In referring to "the Greek myth," Jung cites a work entitled Asklepios: Archetypal Image of the Physician's Existence by Kerenyi, "an authority on Greek mythology and ancient religion and with whom he wrote a work on mythology" (Jackson 22). And for Kearney, Kerenyi's work constitutes a primary source for his own work on Asklepian healing. Following Jung's brief reference to the wounded physician, Jungian analysts provided further discussion on and development of this topic so that it is now referred to as "the Archetype of the Wounded Healer" and "the myth of the Wounded Healer" (Jackson 23). Such Jungian analysts include Guggenbuhl-Craig, Jess Groesbeck, and David Sedgwick. For their discussions on the Wounded Healer Archetype, WPC and Kearney draw predominantly from the work of Guggenbuhl-Craig.

For Guggenbuhl-Craig, all people contain the patient-healer (or wounded-healer) archetype but do not necessarily maintain an appropriate balance between the

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[56] WPC refers to an archetype as that which is "postulated by Jung" and "is understood to be a specific inherited pattern of energy in the collective unconscious that is an evolutionary product of previous human experience; an inborn latent potentiality of behaviour that is evoked by a typical, constantly recurring situation" (Boston and Mount 24). This is the only description of Jung's archetypes in the WPC literature.

patient and healer poles. A clear example of this is in the health care context where, in general, the patient pole is suppressed in physicians and, conversely, the healer pole repressed in patients. This bifurcation creates damaging consequences, which include the perpetuation of power differentials as well as the inability for patients to access their healing potential within and for physicians to engage themselves on a humanistic level with their patients. In order to redress the imbalance in this archetype and hence its subsequent consequences, physicians must undertake the necessary psychological work (87-89). This self-development consists mostly of undertaking reflective exercises such as mindfulness-based meditation so as to become aware of the patient or woundedness existing in all of us (Kearney, Healing 99). Guggenbuhl-Craig summarizes:

> The image of the Wounded Healer symbolizes an acute and painful awareness of sickness as the counter pole to the physician's health, a lasting and hurtful certainty of the degeneration of his own body and mind ... If he is capable of experiencing sickness as an existential possibility in himself, and of integrating it, then the [the physician] becomes a true Wounded Healer ... bear in mind that despite all [physician] knowledge and technique, and in the final analysis, he must always strive to constellate the healing factor in the patient. Without this he can accomplish nothing. And he can only activate this healing factor if he bears sickness as an existential possibility within himself. (89, 90, 92)

Guggenbuhl-Craig proceeds by asserting that the quintessential embodiment of the Wounded Healer is precisely Jesus Christ, the Son of God, as professed in the Christian religious tradition.

> Jesus Christ is an historical and religious reality, and therefore only with the greatest reservations is he to be understood as a psychological symbol. But where better than in him can we see the Wounded Healer? He was not only a healer of sickness on the physical level but a healer of man's existential sickness in sin and death. Jesus Christ was wounded and bore the sins of humanity. He came to heal the world of sin and death, yet he bore all sins and had to die. He refused ever to make use of power, acknowledging only God his father as powerful. Thus he is the Wounded Healer in the highest sense. (Guggenbuhl-Craig 92)

As a Jungian analyst, it is no surprise that Guggenbuhl-Craig's position concerning Jesus Christ originates with Jung himself.

> The life of Christ is understood by the Church on the one hand as an historical, and on the other hand as an eternally existing, mystery. This

> is especially evident in the sacrifice of the Mass. From a psychological standpoint this view can be translated as follows: Christ lived a concrete, personal, and unique life which, in all essential features, had at the same time an archetypal character ... The life of Christ is no exception in that not a few of the great figures of history have realized, more or less clearly, the archetype of the hero's life with its characteristic changes of fortune ... The life of Christ is archetypal to a high degree. (SW 247, 248)

> The man who uses modern psychology to look behind the scenes not only of his patients' lives but more especially of his own – and the modern psychotherapist must do this if he is not to be merely an unconscious fraud – will admit that to accept himself in all his wretchedness is the hardest of tasks, and one which it is almost impossible to fulfill ... How can I help these persons if I am myself a fugitive, and perhaps also suffer from the *morbus sacer* of a neurosis? Only he who has fully accepted himself has "unprejudiced objectivity". But no one is justified in boasting that he has fully accepted himself. We can point to Christ who offered ... a sacrifice to the god in himself. (Modern 235, 236)

In this way, Jesus not only epitomizes the archetype of the Wounded Healer but more so the archetype of wholeness and thus the "Self." Indeed, Jung describes that, "The Christ-symbol is of the greatest importance for psychology in so far as it is perhaps the most highly developed and differentiated symbol of the [S]elf, apart from the figure of the Buddha" (SW 268). This quote draws attention to the importance of Christ not as a historical or religious reality, as Guggenbuhl-Craig mentions above, but as representative of a universal image in the collective unconscious. "Hence in its scientific usage of the term "[S]elf" refers neither to Christ nor to the Buddha but to the totality of the figures that are its equivalent, and each of these figures is a symbol of the [S]elf" (SW 267). Palmer provides further clarification:

> Thus we are once more on the familiar territory of assessing an image – in this case, a biblical image – not on grounds of historical reliability or rational consistency, but in terms of its expression of a particular psychic and primordial experience ... The gospels, accordingly, do not provide historical evidence that Jesus was the Christ, but only bear witness to a particular psychic experience evidently had by their authors: "Here is the living and perceptible archetype which has been projected upon the man Jesus and has historically manifested itself in him." (135)

Thus, just as Guggenbuhl-Craig describes, Jung views Jesus as a "psychological symbol" of the Wounded Healer. Even more, though, he is a symbol of wholeness.

Another correlation between Christianity and the Wounded Healer can be found in the dictum "Physician heal thyself," which Kearney uses to encapsulate the concept of the Wounded Healer (Kearney, Healing 37, 91). This statement comes directly from the Christian Bible: "And He said unto them, Ye will surely say unto Me this proverb, Physician, heal thyself: whatsoever we have heard done in Capernaum, do also here in thy country" (NKJV, Luke 4:23). The author of Word Biblical Commentary John Nolland considers this passage a "cynical demand for a display of dazzling miracles to dispel the impression that only Joseph's son is here" (35A: 200). According to this interpretation, then, Luke 4:23 offers no insight into the concept of the Wounded Healer that WPC, Kearney, or Guggenbuhl-Craig promotes. To the contrary, for Reverend Dean Brady this passage

> ... suggests that people will be far more likely to enjoy the spectacular aspects of Jesus' career than they will feel moved to the profound response of faith and humility that he is actually placing at the center of his call to become his disciples, and to constitute thereby the core of the redeemed Israel in God's soon-to-be-realized Kingdom.

Therefore, although the concept of the Wounded Healer is seemingly rooted in the Christian religious tradition, Kearney and Guggenbuhl-Craig, in fact, derive it from Jung's psychoanalytic interpretation of Jesus as the symbolic embodiment of the Wounded Healer Archetype. WPC not only cites the concept of the Wounded Healer Archetype throughout its literature, but also makes it an overarching principle in WPC's medical education initiative that teaches undergraduate medical students the healing role of physicians.[57,58,59]

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[57] WPC refers to the concept of the Wounded Healer in the following articles: Mount's "Existential Suffering and the Determinants of Healing" (42); Mount and Kearney's "Healing and Palliative Care: Charting Our Way Forward" (658); and "Caregiver's Perspectives on Spiritual Distress" by Boston and Mount (24, 25).

[58] Guggenbuhl-Craig's article on the Wounded Healer Archetype constitutes one of the required readings for WPC's "Physician as Healer" course (McNamara and Hutchinson 39-44). Generally, this concept forms one of the pivotal principles of the medical education initiative as WPC promotes physician self-care, self-development, and self-awareness throughout it (McNamara and Hutchinson 59).

[59] Dobkin also concurs with this concept and mentions its integration in her seminar series discussion and meditation initiative:

> So when I spoke on Friday about the Wounded Healer, we're all wounded in some way and whether or not we're able to be with. That's what I talked about with meditation. What does it do? It allows you to be with and accept what is. So if I can accept my woundedness maybe I can help you accept yours and by accepting it we learn to work with it – you work with yours and I work with mine and then we both learn from each other. (Interview)

Interestingly, however, Kearney and WPC selectively emphasize one particular aspect of the Wounded Healer, namely that healers themselves must have knowledge of their own wounds and actively and perpetually participate in them in order to impart healing. Jess Groesbeck draws attention to another. Although she agrees with the aforementioned interpretation, she argues that the concept of the Wounded Healer additionally involves physicians recognizing that they contain within themselves the potential for wounding just as much as the potential for healing with respect to patients as well as themselves (Groesbeck 124, 144). For Groesbeck, this second aspect of the Wounded Healer Archetype reflects the following two principles: "He who sent death gave life" and "He who wounds also heals" (124, 125).

Mindfulness-Based Meditation

Drafted and secured in 2005 and 2006 respectively, Dobkin and Hutchinson formulated a proposal with the Development Office of McGill to initiate a clinical meditation program modeled on Kabat-Zinn's Mindfulness-Based Stress Reduction Program at UMass Medical School ("Progress Report 2005" 4; "Progress Report 2006" 1). Dobkin describes the meditative technique employed in Kabat-Zinn's program as

> ... a refined, systematic attention-based strategy aimed to develop both stability of mind and insight into an array of mental and physical conditions that inhibit an individual's capacity to respond effectively and proactively in demanding, or more commonplace everyday activities. ("MBSR" 3)

As such, this program is designed to teach effective coping techniques for patients living with various chronic medical conditions and the health care professionals treating them. In general, Santorelli, the Executive Director of the Center for Mindfulness in Medicine, Health Care and Society at UMass, describes the program as a "simple, provocative Way of relating to self, others, and the world" ("Centre Brochure"). Dobkin claims that it has helped approximately 13,000 patients in the past twenty-five years. Currently, there are nearly 240 academic medical hospitals, free standing clinics, and university health centers and services implementing programs based on Kabat-Zinn's prototype (Dobkin, "Wellness Project" 3).

McGill WPC's Mindfulness-Based Meditation and Stress Reduction Programs draw from Jungian psychology in a similar manner to that of Asklepian healing. Both the patient-specific and health care professional-specific programmatic arms aim to harness the technique of mindfulness meditation so as to foster personal wellbeing by means of self-care measures. WPC intends these to galvanize individuals' innate resources and healing capabilities within to more effectively integrate coping strategies into the everyday life of a breast cancer patient or health care professional (McGill Programs). The WPC website describes the Mindfulness-Based Whole Person Care in this way:

> Individuals who are willing to become collaborators in their own health and well-being are welcome. You will learn how to work effectively with your own stress, pain, and illness. By participating with others engaged in the same struggles, you can bring to bear in your life both the uniting force of community and the solace and power of your own inner strength. In this way, you can actively encourage the healing process.

The WPC website reiterates the same for the Mindfulness-Based Medical Practice program. The goals and objectives of Mindfulness-Based Medical Practice are as follows: "1) to aid health care professionals in identifying and dealing effectively with stressors; 2) to introduce the concepts and practices of Mindfulness-Based stress reduction; and 3) to improve patient care by enabling physicians to practice medicine mindfully" ("Brochure"). Consistent with Jung, the Mindfulness-Based Medical Practice promotes caregiver self-reflection, self-development, and self-care so that they in turn can be better equipped to care for their patients.

An abstract introducing Kabat-Zinn's presentation for one of Google's Tech Talks reveals the association of Kabat-Zinn's Mindfulness-Based Stress Reduction Program with Buddhism. "[Kabat-Zinn's] work has been instrumental in bringing Buddhist meditative practices, as he likes to say, 'without the Buddhism' to full acceptance within the mainstream of medicine, psychology, and health care." And in fact, Hutchinson and Mount restate this connection by describing that mindfulness-based meditation is "derived from Buddhist practice" (21). In particular, Kathleen Garces-Foley describes Kabat-Zinn's program as applying *vipassana* as well as Zen meditation to stress reduction (347). Thus, in addition to Jungian psychology, the

WPC meditation programs selectively employ theories and practices from the Buddhist religion such as the tradition of *vipassana.*

Even though Kabat-Zinn's program explicitly dissociates the Buddhist religion from his meditation techniques, WPC still considers it important to preserve its transcendent or spiritual dimension. For Mount, "We all experience moments of awareness of the transcendent. The circumstances may be diverse ... a contemplative moment, a time of meditation that goes beyond thought, word and images ("WPC" 35). To further this point, Mount, Lawlor, and Cassell argue that meditation ought not be reduced to a mere relaxation response, because it is able to engender in people "transformative experiences that they regard as spiritual" (Mount, Lawlor, and Cassell 306). Nevertheless, WPC authors still cite the clinical effectiveness of such meditative techniques in the context of pain, stress, and general quality of life management (Mount and Hutchinson 21, 22). Thus, they maintain both perspectives: mindfulness-based meditation is a way of experiencing spirituality as well as a means to cope with pain, stress, and the problems of everyday life. Such an approach allows WPC to negotiate between the secular and religious. In particular, it can provide evidence of its clinical effectiveness when it needs to define itself as secular as well as attest to its ability to generate experiences of the transcendent dimension when promoting its own worldview.

Nevertheless, the mindfulness programs remain a means of promoting Buddhist doctrines particularly as the programs are rooted in the Buddhist tradition of *vipassana.* As one of two forms of Buddhist meditation, *vipassana* or "insight meditation," is an experiential technique for the direct apprehension of Buddhist truths with the ultimate aim of attaining liberation (*nirvana*). This meditative technique encourages the meditator "to bring the critical faculties fully into play in a detailed reflexive analysis of the meditator's own state of mind" (Keown, Introduction 98) leading to the cognition that the characteristics of the natural order are impermanent (*anitya*), without essence (*anatman*), and sorrowful (*dukkha*) ("vipasyana"). In the context of WPC's meditation programs, however, it is the Buddhist doctrines of nonattachment, impermanence, and momentariness that permeate the meditative practice Hutchinson and Dobkin endorse.

In Buddhism, the doctrine of impermanence (*anitya*) testifies to the transitory nature of all things, in other words "all things arise and pass away, and while existing

they are in a state of constant change" (Mitchell 36). Kogen Mizuno describes the contemplation of this doctrine in this way: "The mind opened to [the experience of impermanence] is defined as one that trembles with the fear at the thought of impermanence ... A[n] effect of the contemplation of impermanence is that the importance of each moment is understood, with the result that each is lived fully" (125). It, thus, relates to the doctrine of momentariness (*ksana*) – the notion that all phenomena exist only momentarily in time. "It analyzes apparently continuous existence into something like the apparently continuous existence of the image cast by projected movie film: a succession of discrete momentary existences comes to appear as a continuous existence" ("momentariness"). This perfectly parallels Dobkin's statement that, "Healing happens in the moment – *this moment* – and then it changes and then it happens again. I think everything is moving and you have to be able to move with it and not be afraid of the fact that everything is *impermanent*" (Interview; emphasis added).

In Buddhism, the principle of nonattachment is incorporated into what is called the "Four Noble Truths." These truths encapsulate the four major axioms of the Buddhist religion, the first two of which postulate that 1) life is suffering (*dukkha*) and 2) the cause of this suffering is a consequence of personal craving or selfish attachment (*tanha*). Such attachments include for instance desire, material wealth, and immortality. And since the cause of suffering is specifically this selfish craving, then the solution to this problem, the third noble truth, is to cease such attachments or cravings (Keown, Introduction 48-58). The fourth noble truth consists of the mechanism by which to achieve this cessation, which is through undertaking the Eightfold Path. One element of the eightfold path involves "right meditation" (Keown, "Origins" 290, 291). Therefore, one potential means to cease suffering is by engaging in meditative practice. Hutchison advances precisely the Buddhist principle of nonattachment when he describes mindfulness meditation as "moment-to-moment attention to the process at hand. This attention involves *letting go of attachment* in the past moment and of interest in the next" ("Left Atrium" 391; emphasis added).

Thus, whether cognizant of it or not, Hutchinson and Dobkin advance the Buddhist doctrines of impermanence, momentariness, and nonattachment or at least employ its rhetoric. If we submit to the conception of religion as a system promoting particular beliefs and prescriptions of behaviour for living out these beliefs – as the

WPC faculty members suggest – then their mindfulness programs remain inseparable from their Buddhist roots. This is not to say, however, that the instructors and participants of the meditation programs are Buddhists. Rather, they are selectively borrowing Buddhist meditative techniques and religious language for patients and health care providers coping with death, dying, and chronic illness (Garces-Foley 342).

This selectivity is most clearly demonstrated in WPC's clear omission of the Buddhist doctrine of *anatman*. As mentioned above, *vipassana* meditation cultivates cognition of Buddhist principles including the doctrine of *anatman*, which can be translated as "no essence" or "no self." Rahula explains:

> It must be repeated here that according to Buddhist philosophy there is no permanent, unchanging spirit which can be considered 'Self', or 'Soul', or 'Ego', as opposed to matter, and that consciousness (*vinnana*) should not be taken as 'spirit' in opposition to matter. This point has to be particularly emphasized, because a wrong notion that consciousness is a sort of Self or Soul that continues as a permanent substance through life, has persisted from the earliest time to the present day ... *Atman* [the permanent Self], 'I', Soul, Self, or Ego, is considered only a false belief, a mental projection. This is the Buddhist doctrine of *Anatta,* No-Soul or No-Self. (23, 24, 55)

It is no surprise that WPC does not appropriate or perpetuate this principle either in its literature or its meditative programs, because it directly opposes WPC's belief in the universal reality of the spirit (or soul) in general and the Jungian model of the psyche and human wholeness in particular.

This process of selectivity is a trend occurring within the wider North American context. For instance, the Buddhist meditative technique of *vipassana* was primarily adapted to the North American context in the 1960's through the efforts of Jack Kornfield, Ruth Denison, and others. Having learned *vipassana* in Burma, these Americans transformed this practice upon returning to the United States (Garces-Foley 346). As Richard Seager explains,

> These Americans later returned home and began to teach one or another form of vipassana meditation, more or less divorcing it from traditional monastic and lay elements in the religious life of Theravada immigrant communities. These teachers also developed an eclectic style in their efforts to indigenize the dharma, freely drawing upon other schools of Buddhism, other religions, and humanistic psychotherapy to create readily accessible forms of Buddhist practice. (146)

Garces-Foley further emphasizes the mutual influence of humanistic psychology and Buddhism, particularly arguing that the former served as a key translator of Buddhist doctrine and practices.

> Humanistic psychology was a key meditator in this process as Buddhist teachers turned to this discourse for translation of their concepts, while psychological theorists, such as Carl Jung, interpreted Buddhism through psychological categories. Words like mindfulness, meditation, intentionality, insight, spiritual growth, and loving-kindness and phrases like cultivating compassion and practicing awareness, which reflect recurring themes of Western counterculture movements have now become distinguishing markers of Euro-American Buddhism. (Garces-Foley 347, 348)

It is, thus, to be expected that WPC's meditation programs reflect a Jungian interpretive framework (and accordingly, eliminate the Buddhist doctrine of *anatman*) as it endeavours to promote a Buddhist meditative technique within a secular, North American context. And indeed, Buddhism's ability to adapt to this context has been one of the keys to its success in the health care context in general and palliative care in particular. As Garces-Foley explains, its success is a result of its nonsectarian language of spirituality.

> Like the American hospice movement in general, [socially engaged Buddhist organizations such as Zen Hospice Project] ZHP, Upaya, and Rigpa strive to be religiously inclusive. No attempt is made to convert patients to Buddhism, and hospice volunteers and staff need not be Buddhist as long as they are willing to engage in mindfulness practice ... The emphasis on compassion and meditation is appealing to people from a range of religious backgrounds. While these organizations are clearly Buddhist, they also claim to offer a universal, spiritual approach to dying. (Garces-Foley 349, 350)

This spiritual approach is exemplified in the Zen Hospice Project's mission statement as it aims "to seed the culture with innovative approaches to end of life care that reaffirm the spiritual dimensions of dying" (qtd. in Garces-Foley 348).

Garces-Foley provides additional reasons for the wide-acceptance of Buddhism in the medical context. First, Buddhism offers practical and therapeutic methods such as *vipassana* for dealing with the challenges of illness. Second, Buddhists and others perceive this religion as particularly pertinent to and, thus, expert in dealing with end-of-life issues (Garces-Foley 352). Tony Walter argues that, "Clearly Buddhism, with its concept of non-attachment as a lifelong practice, may be

better preparation for the final letting go than either the more this-worldly religion of Protestantism or the acquisitiveness of capitalist consumerism" (136). Third, there has been a proliferation of Buddhist ideas and practices through organizations, publications, and public lectures often by Buddhists themselves (Garces-Foley 352). Nevertheless, the language of religious inclusiveness and universal spirituality from Buddhist hospice movements in North America is sufficient reason for its assimilation into the programs of WPC; such understanding directly aligns with WPC's and Jung's theory on the universal reality of the spirit (in other words, the numinous) in religious and secular experience.

Universalizing the Experience of the Spirit

In a parallel attempt to divorce itself from religious associations, WPC is also explicitly appealing to the universal reality of the spirit however particularly experienced or conceived. There are extensive examples of this endeavour both within WPC literature and in interviews with its respective faculty members. Mount, Boston, and Cohen question in their initial proposal for WPC "if spirit is embedded in the human condition, is it not likely that all persons experience its presence irrespective of culture, creed, and their assumptions concerning the nature of reality" (7)? Moreover, Mount asserts that "We have all at some time experienced a sense of oneness, of unity, of the transcendent ... we all experience moments of awareness of the transcendent" ("WPC" 34, 35). Cassell as well reiterates: "Evidence of the universal reality of the spirit can be found in the frequency with which people have intense feelings of bonding with groups, with ideals, or with anything larger and more enduring than the self" (Nature 41). In asking Hutchinson if he considers himself spiritual, he responds as follows: "Yes, in the sense that I think everybody does whether they like it or not" (Interview). And similarly, Mount explains: "We all in my opinion have a very significant existential inner life. And the way I am using the word spiritual existence – and to say we didn't have [one] would be to use the language differently like saying, 'I don't breathe'" (Interview). But the most compelling evidence of WPC's efforts to universalize the spirit as an intrinsic dimension of human existence is in Mount, Boston, and Cohen's following description:

> The nature of the spirit has been expressed in religious thought. In the Judeo-Christian tradition, Jesus, a Jew, observed, "the Kingdom of

> Heaven is within (or among) you." Spirit is the pneuma of Christian writing, the animating spark that permeates the whole in Jewish thought. The Hindu Upanishads speak of Atman, the Spirit of man, the Self in everyone and in all. In the Buddhist tradition, Nirvana, as experienced by Buddha, is the Nirvana described in the Bhagavad Gita as "the peace supreme that is in me". The Taoist philosopher Chuang-tzu advocates, "Don't listen with your ears, listen with your mind. No don't listen with you mind, but listen with your spirit. Listening stops the ears, the mind stops with recognition, but spirit is empty and waits on all things. The Way gathers in emptiness alone. ("Proposal" 6, 7)

As such, Mount describes the universal essence of the spirit by noting its presence within various religious traditions. Thus, it also provides support for the inextricable relationship of religion and spirituality in the theory of WPC despite its attempts to solicit the contrary. However, this is not the only reference. Since WPC equates the spirit with the Self of Jung – as described previously – Mount provides the following argument:

> The Self is conceived as that archetypal aspect of the psyche that holds the personal potential for wholeness ... It is involved in healing; noted in all wisdom traditions, and rendered conscious (in collaboration with the ego) in the process of individuation. For PW Martin, it is the Deep Center. Martin notes that all wisdom traditions identify this inherent potential of the psyche. He notes that in Christian parlance, it is the 'Kingdom within' (gospels); the 'living Christ' (St Paul); 'the unknown gate remembered'; 'the still point' (TS Eliot); the 'birth of God within' (Richard Law); 'the seed,' 'that of God in every man' (Quakers). In other traditions, it is the 'Atman' (Hindu); 'the Secret' (Islam); 'the diamond center' (Chinese wisdom traditions); 'the Kundalini serpent' (Tantric yoga); 'the inner source of strength' (Marcus Aureliua); the open center (Confusian); the pedestal of awareness (Buddhist); 'the mysterious pass,' 'the primal opening' (Taoist). The Deep Center may be conceived as exercising its healing potential through opening, accepting, slowing, centering, trusting, hoping and letting go. ("Suffering" 41)[60]

This quote demonstrates that WPC in general and Mount in particular are not only universalizing religious beliefs and practices but also psychologizing them (as has been the case for the Buddhist hospice movement). As we have seen, this has been the trend for WPC's appropriation of Asklepian healing, the dictum embodying the Wounded Healer Archetype "physician heal thyself," and Mindfulness

[60] Here, Mount is citing Experiment in Depth: A Study of the Work of Jung, Eliot, and Tonybee by P.W. Martin. As the title suggests, this work draws directly from the work of Jung (Martin v).

Meditation. In short, WPC relegates and/or disregards those beliefs that do not support a Jungian or psychological interpretation. This may be, in part, a result of WPC's own efforts, but is more likely a consequence of these traditions' reinterpretation and incorporation into North American culture and parlance.

But what's more, there also seems to be a trend of secularization as well.[61] As indicated in Mount's quote above, experiences of the spirit or Self seem not to involve religious or spiritual practices per se but such exercises as trusting, hoping, and letting go.[62] However, this is not the only evidence of such a tendency. Kabat-Zinn himself admits that he is also attempting a process of secularization in his "Mindfulness-Based Stress Reduction Programs" through explicit attempts to divorce Buddhism from Buddhist mindfulness meditative practices as previously mentioned. And since WPC's meditation programs are founded on this model, this secularization is also occurring in them by extension. Not only this, but the application of Asklepian healing has undergone this process since WPC and Kearney emphasize not the second principle of Asklepian healing, that the divine is the ultimate source of healing, but rather that individuals contain an innate or inherent capacity for self-healing. And lastly, WPC appears to appropriate particular terms such as inner life and quality of life that appeal to a more secular audience in place of such terms as spirit, healing, and suffering, despite their religious and spiritual connotations. Nevertheless, WPC is attempting to find a place for spirituality in the midst of secularity by means of selectively drawing from a number of religious traditions and sources particularly the psychology of Jung.

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[61] These trends of universalizing, psychologizing, and secularizing of religious beliefs and practices should not be viewed as independent but inextricably related phenomena, and perhaps even constitutive of an overarching North American and/or New Age trend (Hanegraaff 514).

[62] It is important to keep in mind that WPC most likely derives these seemingly areligious practices from religious concepts. For instance, the expression of the spirit in "letting go" is ostensibly rooted in the Buddhist precept of non-attachment: the "letting go" of selfish attachments and cravings.

CHAPTER 4: An Ethical Analysis

The WPC literature professes many of the same slogans that authors such as Kristine Alster, Hans Baer, and Phyllis Mattson associate with the holistic health movement (HHM) (Alster 54; Baer xiii, xiv; Mattson 9-21, 28-55).[63] Although it is beyond the scope of this thesis to examine this point in detail, I draw from these authors as well as their critiques of the corresponding HHM slogans and apply them to the context of WPC. By no means, though, do I consider the philosophies and practices of WPC and the HHM homogenous. I merely draw from the HHM literature as a point of departure to explore some of the ethical issues and challenges associated with the following: 1) health is more than the absence of disease; 2) in the midst of illness there is the potential for discovering wholeness and inner peace; and 3) healing can be facilitated by a caregiver but is ultimately dependent on an innate potential within the patient.

In terms of the HHM, Alster argues that these slogans represent the spirit of the movement and the basis of its theoretical framework (Alster 55). Cassell, too, refers to them as slogans but more frequently calls them moralisms[64] in the context of WPC (Interview). Although similar to Cassell's moralisms, I specifically argue throughout this chapter that they are more akin to precepts.[65] This is because they form not only part of WPC's theoretical foundation but also provide a normative framework for both patients and health care professionals; they serve more as maxims or rules for moral conduct and action rather than merely a comment or judgment on preferential practice or behaviour. This terminology indicates that they require ethical examination to ensure that, if promoted, they are done so in such a manner as to minimize patient harm and reduce potential risks to health care professionals. I also delineate some of the WPC faculty members' responses to these critiques as obtained

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[63] The holistic health movement refers to the diversity of theories and practices associated with holistic health, an understanding of health in which the individual is considered intimately interconnected not only from within (in body, mind, and spirit), but also from without (in the social, familial, cultural, and physical environment). The movement itself is characteristically amorphous so many authors such as Alster, Baer, and Mattson describe it in terms of a series of statements or concepts some of which correspond with those of WPC.

[64] Moralism, according to the New Oxford American Dictionary, is "the practice of moralizing, esp. showing a tendency to make judgments about others' morality" and moralizing is to "comment on issues of right or wrong, typically with an unfounded air of superiority."

[65] According to the Oxford English Dictionary, precept refers to "a general command or injunction; a rule for action or conduct, especially a rule for moral conduct, a maxim."

in the qualitative interviews I conducted with them. In this chapter, my aim is to promote dialogue as well as development so as to advance the ethical delivery of these concepts.

"Health is More than the Absence of Disease"

As we have seen, the impetus for creating and establishing WPC was predicated on the notion that there is more to a sense of being healthy than the amelioration or deficiency of a disease or pathophysiology (Mount, Boston, and Cohen, "Proposal" 9). This idea may come from the World Health Organization (WHO), which defines health as "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity" (qtd. in Callahan 77). As health is more than the absence of disease, what dimensions of personhood encompass this so-called true meaning of health? For Mount and Kearney, "Concern for body and mind must be expanded to embrace all elements of the ancient metaphoric classification of human experience – body, mind, soul, and spirit" (658). Yet it is not just the body-mind-spirit complex that influences the experience of ill health, *all* aspects of the person and *all* domains of human experience are relevant determinants of health, which include but are not limited to the physical, emotional, psychosocial, familial, environmental, spiritual, existential, religious, and cultural dimensions (Mount, "Suffering" 40; Mount, "CD", Mount, Boston, and Cohen, "Connections 373, 385). For Mount, Boston, and Cohen,

> Illness both affects, and is affected by, all domains of the sufferer's being and therein lies the failure of the paradigm. In the absence of demonstrable disease, despite the persistence of illness, the doctor may conclude, "there is nothing wrong"; "there is nothing more I can do." The psychosocial and spiritual variables that at the very least color and may produce illness are not understood. The significance of the meaning of illness for the sufferer is missed. (8)

By describing health as encompassing not only the absence of disease but all dimensions of human experience and personhood, WPC is instituting a definition of health that, according to some, is simply "too broad to be useful" (Alster 83). H.T. Engelhardt, for instance, argues that such statements are so idealistic that most people cannot justifiably be classified as healthy (qtd. in Alster 79). Daniel Callahan too makes this critique but at the same time defends this definition for its amelioration of

mind-body dualism. He argues that this definition intimately connects what is good for the body with what is good for the self both in terms of the individual self and the self that exists within a particular social context (77, 86). Nevertheless, Callahan decries that it lacks intrinsic limitations (84) and "Its attractiveness as an ideal is vitiated by its practical impossibility of realization (87). Alster summarizes:

> Definitions such as these have been criticized (like the WHO version from which they are derived) as being too broad and too vague. Because they believe health is complex, holists try to include in their descriptions the many aspects of which it is comprised. The results are elaborate definitions that may vary in scope from author to author. That health is more than the absence of disease is accepted as a given; less agreement exists on which positive factors accrue to health. (Alster 79)

WPC faculty members demonstrate the broadness, vagueness, and variability in holistic health definitions when I asked them to what extent is health more than the absence of disease and what human phenomena are excluded from this concept of health? In response, Dobkin replies that,

> Wellness is influenced by so many factors. So I would guess that that's coming closer to a broader view of what health is and when I evaluate people I look at where in their life things are well for them and where they're not. So they might be okay at work, but not okay in their family life or vice versa ... it's not just the physiology ... so all of that has to do with it. (Interview)

A.F.M. similarly responds:

> It includes the social component. It includes the political component. It includes all those different determinants, which influence who is that patient whom I have here in front of me. His cultural background would have an influence on who he is. His educational background would have an influence, his social background. So all those different issues will definitely have an influence and I think this is again holistic care. And that's what I said: we need to look to the patient in his or her environment. That's all the other issues from the puzzle that we need to look at. It's not just that disease or one piece of the puzzle; it's that whole environment or whatever – the whole – all the determinants in place and you look to them. So it can be very broad. (Interview)

Mount also describes the many dimensions of personhood relevant to health and wellbeing purposively drawing from Cassell's topology of persons ("WPC" 30). In this schema, personhood consists of a body, a past, roles, personality and character, a cultural background, family relationships, a secret life, a political dimension, an

inner world of the unconscious, and a transcendent dimension (Cassell, Nature 36-41). For Mount, all of these dimensions impact health status. Cassell further admits that this is by no means an exhaustive list. "Is that the totality of persons? I mean, I tried to set it up in this book[66] ... But you know, it's not that simple" (Cassell, Interview). In general, then, the notion that health is far more than the absence of disease for WPC ostensibly subsumes within it the entire compass of human experience and phenomena.

Definitions and objective standards in medicine are extremely useful particularly in providing a mechanism for health care institutions and professionals to distinguish the sick from the healthy, thus not only determining but also validating those individuals requiring its attention (Cassell, Nature 144). Taking this into consideration, how can the medical profession operationally apply such an all-inclusive and ever expansive definition of health into a health care system that seeks to generate the best health for the most people? This is an extremely formidable task for both health care institutions and providers. Arguably, the obligations of health care professionals expand to such an extent that they are required not only to inquire into an infinitely staggering amount of information for "adequate assessment" but must help their patients achieve a level of personal wellbeing that is influenced by just as many factors. As Alster, Callahan, and Sally Guttmacher all individually argue, this substantially broadens the purview of medicine, thus contributing to the ever-increasing trend of medicalization[67] in Western culture (Alster 87; Callahan 78; Guttmacher 17, 18).

Nevertheless, medical standards are never wholly objective but are subject, for instance, to social, cultural, and political determinations. Even the relationship between a patient and health care professional influences whether that individual is classifiably sick or healthy. Cassell explains that, "By definition, a person could not

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[66] Here, Cassell is referring to a book he is currently writing on the topic of healing. In this book, he plans to expand upon his topology of persons found in The Nature of Suffering and the Goals of Medicine (Interview).

[67] According to Alster, "the term 'medicalization' has been used to describe the growing tendency to view many social problems from a therapeutic perspective: "Medicalization refers to the extension of the range of social phenomena mediated by the concepts of health and illness ... Alcoholism, child abuse, opiate addiction, obesity, problems with sexual functioning, and violence have all become matters for medical diagnosis, and the label of illness has been attached to them" (87).

become a clinical entity except by agreement" (Nature 145). Therefore, some subjectivity must be taken into consideration by health care institutions and providers.

Hutchinson agrees with not only the requirement for objective determinations of disease and health but also attempts to negotiate a place for subjectivity in the clinical context.

> The whole idea of disease I think is good and I would never want to get rid of that ... I'm not too interested in abstract ideas of what health is: trying to come to some zenith or some perfect wider health and so on. No. So now I would say that ... we have to realize that there's more to medicine than treating disease. We also need to be taking into account people's subjective quality of life and that's about as far as I would go. Because the difficulty is, I think, that it's easy to define medicine based on conquering disease and then when we loose that, we can get into very fudgy notions of total health or some larger version of health, which I'm not sure is helpful ... [For] whole person care, then, you have to deal with psychological health, social health, and so on. You know, to me that would be endless.

Hutchinson's response is by no means shared by WPC faculty and affiliates. Rather, they propose potential applications of a broad definition of health rather than questioning the legitimacy of it in the first place. For instance, Dobkin argues that integrated and multidisciplinary care is necessary for its application, whereas McNamara and A.F.M. advocate a patient-centered approach. Alster thinks, however, that a patient-centered approach does not help resolve the ambiguity and variability of the holistic definition of health but renders it increasingly idiosyncratic and relative. This makes it even more tenuous to operationally employ (Alster 80). A.F.M. recognizes this point:

> From an organizational point of view or a management point of view ... there needs to be some kind of regulation about that. If you have people from all different languages or all different backgrounds or whatever then, yes, they need some kind of protocol to do that. But from an individual point of view, I think it is really necessary to take all those determinants into consideration when you take care of patients. (Interview)

On the other hand, Allen and Mount are not troubled by a vague definition of health and its feasibility in the medical context. For them, how to apply such a definition into medicine is a misguided question. Allen says:

> Part of me thinks that's the wrong question. Like, part of me thinks that a society that really valued health wouldn't ask that question. It

> would do what it took to get a person back to a place where the person felt healthy. And obviously that's an ideal, but maybe the problem is having to worry about resources and those kinds of things ... that constrain our understanding of what health can be. We end up having to define health because of money. We end up having to limit health because of money. So it becomes "You're healthy enough. You only need two rounds of dialysis to be relatively healthy. I don't care if you feel better on four. We can't afford four. So we're just going to do two a week." I don't know. Is one health and the other one isn't? I don't know. (Interview)

To the question about operationally applying this definition, Mount responds:

> First of all, it is not about definitions. It's about the way people are and its about reality ... I would go back to the person asking that question. Do you think that quality of life is important for that person you're talking to? I haven't met anyone whose said "No, it's not important." And if they say, "Yes," if they said, "I don't think quality of life is important," I would say to them "Wait until you have been sick or until you've had loved ones sick. You will think that it is important." And if they say, "Well it is important," then I'd say, "Then if it's important then you should be asking what are the determinants of quality of life." It isn't a matter for us to say, "Well it shouldn't be inner life and spirituality because that gets really hard to measure." Well have you tried to measure it? Whole person inter-activeness is just the way it is. (Interview)

With the exception of Hutchinson, most WPC faculty members do not find the definition of health as more than the absence of disease problematic in itself and furthermore deem its intrinsic problems resolvable when applying it to the current health care system. Mattson provides some insight into this: "The unattainability of the holistic concept of health is no problem to its advocates. Rather, it underscores the premise that continual growth and evolution toward that holistic state is the real meaning and purpose of life" (Mattson 11). Mount confirms the paramount importance of this goal: "Healing is the central goal of life. I am not speaking of physical healing, a person can die healed: what I mean by 'healing' is a shift in our quality of life away from anguish and suffering, toward an experience of integrity, wholeness, and inner peace" ("Commandments" 50). In a personal interview, he further defines health as involving personal potential and human wholeness.

> [Health] is described ultimately in terms of potential. It isn't just about disease, but it is about all of the things we talked about ... a sense of integrity and wholeness, a sense of wellness ... and the degree to which we have been able to form healing connections. Do you recall

> those particular subjects, all of whom were facing death and life-threatening illness, the ones who were most able to face that situation with a degree of equanimity and inner peace – those who identified what we came to call healing connections? (Mount, Interview)[68]

Cohen et al. support this definition of health from personal conversations with their patients. They state that, "Patients with advanced cancer define health as a sense of personal integrity and wholeness, rather than normal physical, emotional, and social functioning" (576). As argued in previous chapters, WPC derives such ideas from Jungian psychology (particularly individuation) mostly through the work of Kearney. Cassell, who is involved in integrating the concept of healing into the Faculty of Medicine's Physicianship Program, confirms that WPC's interpretation of health, particularly that of Kearney's, is indeed rooted in the psychoanalytic work of Jung and goes on to question the legitimacy of its incorporation into modern biomedicine. "I don't happen to believe that the Jungian view of health is a very good view of health and that's Michael [Kearney]. Michael is a very nice man and very smart but that Jungian shot is bullshit in terms of being imported into healing. I think it's just plain wrong" (Cassell, Interview).

In interviews, McNamara and, again, Cassell draw attention to whether this interpretation of health ought to be incorporated into the purview of medicine and its respective scope of responsibilities. McNamara specifically does so by drawing a distinction between health and wellbeing:

> From the medical point of view I see that we have a duty or a responsibility to bring people back to as healthy a state as possible. But you can be healthy and not feel well – you just don't feel good in yourself. Well is that in the purview of medicine? I'm not sure. It depends on if there's a concurrent illness [or disease] that we can work with. But if the illness has been cared for inasmuch as it can be without further follow up – which often happens, you know – you have a chronic disease; you get your treatment – we have to modify the treatment until we find a drug or regiment that works best for you in your life at this particular time etc., and then you get discharged from care because everything is working and it's going well. But the wellbeing part might not have been achieved. And is it reasonable to expect the medical profession to be responsible for something that at the end of the day becomes the responsibility of each person

[68] In this quote, Mount is referencing his research study entitled "Healing Connections: On Moving from Suffering to a Sense of Well-being" co-authored with Boston and Cohen. It examined the experiences of subjects afflicted with life-threatening illnesses who were able to demonstrate a sense of integrity and wholeness (Mount, Boston, and Cohen, "Connections" 372).

> him/herself? And I'm not sure where that transition is, and it may be different in different specialties. I work in obstetrics and gynecology, and currently we don't see patients beyond six weeks after delivery and that's something that I feel very strongly about that's wrong and needs to change. Some of my research in the future will address that question. But at what point do you stop being a patient and return to being a person? And that's a very important transition. You don't want people to suddenly take on a victim role or a patient role and live out the rest of their life as a patient. You want them to go into that patient mode and help them to get back to "Now I'm a person with diabetes and not a patient." And unfortunately, the longer you're associated with doctors, the more you are a patient. (Interview)

In discussing the statement that health is more than the absence of disease, Cassell similarly responds:

> Yes, it doesn't tell you anything. That's the UN's definition of health. Oh yes it's wonderful, but mine is that you're healthy when you can meet your goals and purposes. Now somebody can stop and say, "Wait, [she] has very limited goals and purposes ... She doesn't go out, she doesn't do anything, she doesn't see any purpose in any of those things." Is she healthy? Well by her life she is. Right? Is it my job to tell her she's not healthy? It may be my job as a teacher to help her achieve larger goals. Is that part of medicine? I'm not sure it really is. (Interview)

There are obvious tensions existing among WPC faculty members' understanding of health. Hutchinson is clearly disinterested in a broad view of health whereas Dobkin, Mount, Allen, and A.F.M. champion it, although for the latter not at a macro-organizational level. However, it is not entirely evident how Hutchinson's call to care for the whole person (Mount and Hutchinson 3) is any different from instituting a broad definition of health into medical delivery; both maintain implicit prescriptions for consideration and assessment of the many dimensions of personhood, suffering, and quality of life.

"In the Midst of Illness There is the Potential for Discovering Wholeness, Integration, and Inner Peace"

As we have seen, for WPC, "emotional wellbeing, life satisfaction, quality of life, and a sense of being healthy may be experienced even in chronic and life-threatening illness" (Mount, Lawlor, and Cassell 305). Mount, Boston, and Cohen go so far as to argue that it is paradoxically possible to die healed ("Proposal" 9): that

even in the "extremes of human deprivation and the crucible of terminal illness ... even in the direst circumstances, peace is possible" (Mount, "Suffering" 40)(Cassell 250; Kearney, Healing 104; Mount, CD; Mount, Lawlor, and Cassell 305).[69]

Even though WPC witnesses the potential for wholeness in their experiences with patients in palliative care, and as appealing as it may be especially for those patients experiencing illness to which there is seemingly "nothing more that can be done," there is nevertheless an important caveat: this process is nothing less than arduous and all consuming; it requires patients not only to confront difficult emotional, psychological, and existential issues (Kearney, Healing 114, 138) but also to wholly devote themselves to the teleological goal. Mount clearly expresses this: "There is no shortcut to healing. Carl Jung put it this way, 'The attainment of wholeness requires one to stake one's whole being. Nothing less will do; there can be no easier conditions, no substitutes, no compromises'" ("Commandments" 51).

Kearney delineates some of the risks associated with whole person care in general and psychological work in particular.

> For the patient ... amplification of his or her suffering, an increased sense of isolation and an "acting out" of the distress in behaviour that is self-destructive. For the carer the potential dangers are also real, multiple, and may harm the carer him- or herself and/or the therapeutic relationship. These include the situation of the carer reacting unconsciously to counter-transference feelings of dislike, anger, or fear in ways that may be mutually damaging. There is also the risk of what Jung called "unconscious infection" and of the "illness being transferred to the doctor"; where the carer falls ill (physically or psychologically) because of unconscious contagion by the patient's psychic contents in the transference. Finally, there is the danger of "inflation," where the carer, unconscious to the splitting of the wounded-healer archetype, overidentifies with the "healer" pole of the archetype and feels and acts like God in a manner that turns his patient into an object of his power drive. (Kearney, Healing 146)

Because caregivers are enjoined to undertake psychological work – in other words, training analysis – in keeping with the tradition of Asklepian healing and the

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[69] For instance, Mount similarly proclaims that, "even in the face of physical decay there is also the possibility of healing, transcendence, and grace" ("WPC" 31). Kearney has "witnessed patients becoming more human and alive, even as their bodies wasted away" (Healing xx). A host of WPC faculty members state that there is a "potential for healing in the face of progressive disease" (Mount, Boston, and Cohen "Proposal" 8; Mount and Hutchinson 8). Hutchinson argues that, "patients can die healed, that is, with a sense of integrity and equanimity despite physical decline" ("ESRD" 273). Mount and Kearney describe that, "Indeed, it is possible to die healed" (657) as does Mount, Lawlor, and Cassell (305).

Wounded Healer, caregivers can be subject to the same risks as the patients themselves. Nathan Schwartz-Salant provides further warnings:

> But the [Self] is filled with paradox, and it too can create chaotic states of mind that can endanger a person's sense of identity. Usually this has a greater goal of enriching and widening the scope and values of the personality. But it also has its dangers. "Many have perished in the work" is an alchemical saying that Jung quotes to offer a balance to any overly optimistic attitude. (qtd. in Kearney, Healing 86)

P.W. Martin draw attentions to the unforeseen risks associated with exploring the unchartered territory of the psyche, and thus individuation (or what P.W. Martin terms "depth work").

> Beyond lies the deep unconscious. Here, all is at hazard ... Cumulated upon this uncertainty is the harsh fact that our knowledge of the other side of consciousness is still, for the most part, in the earliest stages of hypothesis ... In making the experiment in depth there are bound to be casualties, casualties that could not reasonably be foreseen. It is well to realize that one' own name may figure among them. (Martin 205)

Palmer also describes that "What the patient, in other words, is enjoined to do is follow the path of his neurosis, to let himself be led into the world of his unconscious by the very thing that torments him" (107). Dobkin too describes risks of psychological work, but with a personal example.

> I would think [risks occur] only in the case where someone has a serious psychiatric problem. I remember when I first came to Quebec and I was working in French – and my French was not bad but not great – I had inherited a case in a public health clinic when I was replacing somebody. So I got this case out of the blue, and this woman had been put through what they call a rebirthing experience. I had never heard of this. To me this is not standard care. I don't know who did this, but she literally had a breakdown and ended up being hospitalized for very, very severe depression. And when I had looked at her history, it was clear that she was psychiatrically vulnerable and should never have been exposed to such a weird experience. I mean, she had people around her, and they were all encouraging her to regress, to be born new – strange stuff. And this woman became totally dysfunctional. She broke somehow inside, and I'm not sure what did that to her, but she was very vulnerable. So I would say that with some people who have psychiatric illnesses, one would need to be very careful and be able to assess whether they are vulnerable in that way so that you are not in anyway meeting someone somewhere where they may be terrified or traumatized ... the problem is that you can't foresee everything so you have to be careful: some people are vulnerable, some people need to have a different kind of support. I

> think of people who are paranoid. It is probably difficult for them to trust anyone enough to go into any kind of depth work, because of their psychiatric problem of paranoia. So, you know, some people are very vulnerable because of psychiatric problems and you would have to be careful because do no harm is important. (Dobkin, Interview)

McNamara similarly explains:

> I think it is clearly possible for [patients] to be harmed in this process if it's being facilitated by somebody who is not qualified to do so. For example, I would not want an orthopedic surgeon or an obstetrician to be trying to help somebody find meaning through confronting terrible issues in their childhood, for example, because orthopedic surgeons and obstetricians such as me are not trained in how to guide a patient through that difficult period and contain them and help them while they are experiencing that. So, I totally agree that you can die healed. I totally agree that healing can occur in the midst of the worst possible illness that has no cure. But this is a very dangerous situation, and it makes me very nervous to hear people who are not necessarily trained or qualified exploring people's psyches and trying to help them die healed even if it's well motivated. It can do even more damage. (McNamara, Interview)

For patients and caregivers functioning within the medical context, do the prospective gains of experiencing healing and human wholeness in the midst of illness necessarily outweigh the potential harms? Keeping in mind the aforementioned risks, a few additional points need to be taken into consideration. First, not only is healing a slow, difficult, and wholly demanding process, according to Mount, the goal (wholeness) itself is unattainable. For Mount "the journey is everything" ("Commandments" 50). To further explain, Sherry Salman describes individuation as a continuous and thus never-ending dialogue between the conscious and unconscious with progression marked only by a change in the nature of their interaction (60, 61). From a purely utilitarian standpoint, then, the potential risks by no means reasonably outweigh the benefits if the goal itself is unreachable. Kearney argues, however, that, "Outcome is not the fundamental issue in dreamwork. What matters here is whether or not we trust the psyche"(Healing 210). Second, for those towards the end-of-life, when death is both imminent yet indeterminate, this tumultuous journey appears, for lack of a better word, nothing less than unwelcoming primarily because it is difficult to foresee whether the patient will experience any direct benefits. And indeed, attempting to discover inner peace in the midst of illness is overwhelmingly associated with patients towards the end-of-life – those

experiencing life-threatening illness, death, and dying – because, according to Kearney, the process of individuation is catalyzed by impending death. This creates real challenges, at least in the short term, for health care professionals. Even Kearney himself experiences such challenges (Healing 138). Through anecdotal experiences, he reveals pangs of hesitancy and guilt over the value of undertaking psychological work with patients, particularly with dreamwork where some patients demonstrate increases rather than decreases in pain and suffering, notably, in the midst of death and dying. Thus, he himself demonstrates some of the risks involved to both patients and caregivers but also a disconcerting uncertainty over whether such processes ought to be embarked upon in the first place (12, 141). He is seemingly consoled by the fact that "at best, it is like peering into the vast depths of the ocean. There is so much there we do not or cannot ever see or understand" (Kearney, Healing 141). Yet, this is far from encouraging and provides further grounds to be wary of such practices and the concepts upon which they are based, particularly in a medical context – and not a psychiatric one – and furthermore with patients experiencing life-threatening illness and encroaching death.

In interviews, some WPC faculty members seem defensive of whether the journey towards healing and wholeness is potentially harmful in the first place. According to Mount,

> If you reread those cases of Michael [Kearney]'s, they felt considerably better after the guided imagery and so we're just beginning to understand what the possibilities are ... But how often do people get into some great crisis by feeling they're listened to or by imaging themselves sitting on the edge of a lake, a calm lake, and taking a little boat out on the lake. You know, I've never seen anybody ... well maybe it happens. (Mount, Interview)

Hutchinson similarly responds and makes particular note that in the opposite case – when illness is only seen as a negative experience – this too can incur harm and suffering to patients.

> So the view of disease, which simply sees it as a downward path, a negative course that transmits itself to patients, can be very damaging. But we're talking in terms of the possibility that what you call healing is not meant to be an expectation that we place on patients, but an openness to ourselves and that we're open to try to facilitate that in the patient ... Do I think that can be harmful? I don't really think so. (Hutchinson, Interview)

Mount's promotion of healing, wholeness, and inner peace as end goals gives rise to additional issues. The aim of achieving these ends for Mount is more than merely one value amongst many: it is *the* chief teleological value people ought to strive for. As we have seen, not only does Mount state that the central goal of life is healing, the quest towards wholeness, but so too does Jung. Cassell and Allen clearly consider this problematic. Cassell submits:

> Anytime you can help somebody doing something, you can harm them. And anytime you make people understand that they have to achieve inner peace, you stand a good chance of harming them. After all, who's definition of peace is it? And anytime you think that they have to achieve a different place in their – how should I put it – where their psychic energy lies, aside from running slightly into the bullshit area ... I think its just plain wrong. In part, that's setting goals for people that just haven't got to do with them. I think one of things about whole person care is that it should be about that person, not my view of what a whole person is. It's their view that counts. Would I like to see their view enlarged? Maybe. But is that my job? Does that create happiness? Supposing I go to enlarge your view of your place in the planet and your place in relationship to God – if you believe in one – and what you should be doing to be closer to God and closer to God's work. And, I could spend a lot of time on that, couldn't I? And a lot of people have, right? There's some pretty thick books about it. And if you read them, you could see that maybe you yourself might say, "I could never do that. I will never do that. I like too many things. I'm vain," right? How do I know that? So, doesn't it matter what you wanted to do, not what I wanted you to do; what you care about and what that means to your relationship to your body; not what I think you should do? ... There's a taint in it of moralism. I don't like that. I mean, that's bad for people. A moralistic statement I must say ... And moralism suggests being righter than thou, holier than thou – I know the true way to inner peace. Oh you do? Well that's interesting. (Cassell, Interview)

Allen expresses similar concerns.

> In the instance of somebody intervening like that in a dream thing or in other sorts of psychotherapeutic approaches, part of me thinks you don't know when this person is going to die; you don't know if you're going to get to your goal before they die. And there is something also that makes me angry in somebody saying I'm going to get you to a place of peace and I'm going to get you there by my psychotherapeutic intervention or by this dreamwork stuff – and I may be totally misinterpreting Michael Kearney. There is a kind of condescension ... and it's a condescension that I associate with religion frankly – it's this paternalistic, you poor lost soul, I'm going to intervene because I do have inner peace and I'm going to help you achieve inner peace, which

> is really what everybody wants. And there is an assumption that they have the answer or that there is an answer that everybody's life, everybody's end of life is best if they achieve a place of peace. But I'm not sure that's true, you know. Maybe some people need to rage, rage against the dying of a life. Maybe that rage is full of life. I don't know. And I think that the part about palliative care that I find most compelling is the part where you shut up and you listen and you say, "What can I do?" And you're honest when you can't do anything, but you try your damndest to do what the patient says they would like to see happening to bring them to whatever place they feel they want to be. Now if they want to be left alone to rage against the dying of a life, then I think they should be allowed to do that, you know. I don't think that there's one kind of recipe for a good death. (Allen, Interview)

For Cassell and Allen, the statement that even in the midst of illness there is a possibility for discovering inner peace, healing, and wholeness is more than an innocuous statement of perspectives. It is a precept – a principle guiding moral behaviour and conduct in the service of attaining its teleological goal. Kearney quotes the following passage from Jungian analyst Albert Kreinheder to this effect:

> There is a way to die. It doesn't matter when you die so much as how you die. Not by what means, but whether or not you are altogether in one piece, psychologically speaking. I remember frequently those words of Kieffer: "The object of healing is not to stay alive. The object of healing is to become more whole. Death is the final healing. (Healing 117)

But it is Mount in particular who decisively reveals the underlying prescription (or moralism as Cassell prefers to refer to it) to discover wholeness in the midst of illness. Mount incorporates it into his Ten Commandments of Healing, which clearly mirror the Christian tradition's Ten Commandments or prescriptions for ethical conduct that God bestows upon Moses.

> You are a unique experiment in creation, with a particular potential to contribute to this world. What is it that you alone can do, *must* do, if you are to fully express your potential ... Celebrate. In the direst of circumstances, boundless peace is to be found within. Recall Victor Frankl's hard-won observation, "Everything can be taken from a man but one thing: the last of human freedoms – to choose one's attitude in any given set of circumstances, to choose one's own way." If Frankl can find life worth celebrating in Auschwitz, chances are I can find my cup half full, perhaps full to overflowing, here and now. These are the 10 commandments of healing that our teachers have given us. (Mount, "Commandments" 50, 51)

Thus, Mount is prescribing a normative framework for illness and dying, particularly attitudes, conduct, and practices that he views as most valuable. What's more, based on the discussion in chapter three, and as Allen mentions, this normative framework is rooted in spirituality and religion. WPC not only conceives of healing and wholeness precisely in terms of spirituality but also selectively derives its ideas and concepts from a Jungian framework, particularly his religious (i.e. spiritual) worldview, and Buddhism. Still, as Cassell and Allen suggest, the dangers associated with this notion – that in the midst of illness, peace is possible – can be limited if appropriate measures are taken to ensure its ethical promotion and implementation. Certain qualifications need to be emphasized, particularly the requirement to remain patient-centered and appreciate divergent perspectives especially those that conflict with WPC. And indeed, WPC recognizes these important qualifications, although it is my opinion that they do not sufficiently emphasize them. Boston and Mount argue that there is a "need to recognize that the patient's experience of suffering and healing may differ from that of the caregiver" (16). Mount further explains that, "for each of us the path toward healing will be different. The most certain path I have found is meditation. I do not imply that it is the only path. It is just the only path I know" ("Commandments" 51). He also notes that, "We must take care in passing judgment on, or criticizing, the transcendent experience of others" ("WPC" 35). Lastly, he says,

> But I would argue the model is not prescriptive. It isn't the job of my oncologist or my ENT surgeon or my internist or any of these guys I have hanging around. It isn't their job to make me whole. We're all on the path toward individuation, or not, and the locus of control for that is within the person. Only I can – to use Philip Simmons – "learn to fall"; only I can take the step out and try "letting go" the ego-defense mechanisms. We all have to do it for ourselves. And so in my view, as a care provider on the model of whole person care, my goal isn't to have you become a whole person in that sense. My goal is to meet you where you are, not where I think you should be. My goal is to produce and be part of, what Parker Palmer calls a circle of trust to help understand – to the degree that it's possible – what your reality is. This is not because I'm going to make it all better but because the more I can hold this space, as Michael calls it, where healing can occur, the more it's likely to occur. But, that's out of my hands ... the goal of whole person care, I would argue, is simply to hold the space that permits healing. It's exactly what Michael said in a place of healing. What do you mean by that, that's very flowery language? Well, I mean where the person feels safe, feels heard, feels listened to. (Mount, Interview)

In interviews, Hutchinson, A.F.M., Mount, and Cassell could not agree more. For Hutchinson, "Healing is not meant to be an expectation that we place on patients, but that we're open to try to facilitate that in the patient: not force, not push, not promote but simply be open to facilitating that in patients" (Interview). According to A.F.M.,

> We need to guide a patient and where he or she is on that path to more wholeness ... We don't need to force anything on a patient. It's up to the patient where they are. We can only help them through that process. We cannot force anything on them ... the main thing is where is the patient in that process and what are his or her needs, what are his or her concerns, and then you can help them in a different way.

"Healing Can Be Facilitated by a Caregiver but is Ultimately Dependent on an Innate Potential within the Patient"

WPC argues that the potential for healing, wholeness, and inner peace in the midst of illness is ultimately dependent on patients themselves and their inner healing resources (Mount and Kearney 657; "Report Faculty Working Group" 1; Dobkin, "Wellness Project"). This statement clearly shifts the role of patients from that of passive recipients to active agents in their own healing. It also indicates that the responsibility for healing is ultimately within the individual's locus of control. Mount explains: "How do we find healing? We must take up the journey anew each day ... No one else can do it for me. No one else can do it for you. Hillel expressed it succinctly, 'If I don't do it, who will do it? If I don't do it right now, when will I do it'" (Mount, "Commandments" 51). However, Alster explains that,

> To be responsible for my health means minimally that I have some influence over it. To the holists, it means that I am obligated to exercise that influence. If I do not, I will fall ill, and my illness will expose my lack of responsibility ... People who truly believe that they are responsible for their health will necessarily feel guilt upon becoming ill ... the distinction between responsibility and blame has been lost ... guilt is the natural response of people who perceive they have failed to meet their responsibilities (123, 126-128)

WPC frequently argues that the meaning patients ascribe to their illness can significantly impact not only their subjective experience of ill health but also the disease trajectory itself. What's more, it can also substantially impact whether patients are willing to comply with recommended treatment protocols. As Aronowitz

argues, "Although our etiologic understandings often have a more secure scientific basis than they did in the past centuries, values and social interests continue to play determining roles in the appeal of particular notions, willingness to change our behaviour, and the assignment of blame and responsibility" (178). Thus, increasing feelings of guilt from personal moral failings can exacerbate patient suffering psychologically, emotionally, and physically, which is precisely what WPC is attempting to reduce in general and through this concept in particular. One of the many benefits of scientific medicine is that it has consequentially dissociated the disease from the patient and thus also that of morality. Hutchinson agrees:

> I think the notion of disease is a tremendously important notion – really useful at times. I said I don't like concepts, but that to me is a really useful concept because it serves people in a number of ways. It's really good. It takes the responsibility away from them. This is not something wrong with me as a person; it's simply that I have this disease. So it objectifies, it externalizes, it takes away responsibility and it can empower people. (Interview)

McNamara comments on the limitations of promoting personal responsibility in health and when it is appropriate to do so.

> Sometimes we do forget with all this emphasis on taking your own responsibility for healing and all this great lingo that these are damaged people who are in our offices and they don't have, in a lot of instances, the ability or the judgment or the expertise or the knowledge. And I'm not being paternalistic. If anything I'm maternalistic. I mean no disrespect to anybody, but I've been in the situation of being a patient myself where I would be the last person to decide my care. And I am very conscious of that ... I think that is very, very dangerous, because I think that, yes, we all have this capacity to heal within us ... I think that if you're in a dire straits situation ... that is absolutely not the time to be telling patients that they have the ability to heal within and that it's their responsibility. So I think it's a fact, but how and when one reminds the patient is critical. And it's not in the first interactions with the physician; it's at the end of what the physician can do that you either remind or encourage. (McNamara, Interview)

The critique that personal responsibility for health necessitates guilt and blame on patients is also applicable to biomedicine. Allen draws attention to this.

> Blaming the victim is more problematic in current medical practice ... I mean, that's a really odd critique of holistic medicine because the whole issue of compliance centers around whose fault is it. I mean talk about blaming the victim. You see that everywhere. You see that

> around issues of diabetes, obesity. You see it around lung cancer. There's all kinds of things where people are held accountable directly or indirectly for their disease and, in some instances, of course that's a marketing campaign to get people to stop particular behaviors by saying this is what it does to you. And there's no question that's a good thing ... But there is a prevalence already of "It's your fault that you're sick" in the system: massive, the whole compliance adherence, for people who are suffering with end stage renal disease who have all kinds of complicated health problems and have an extremely restrictive diet – extremely restrictive diet. There's tons of stuff you can't eat when you have kidney failure. And when other complications come into their health profile, people are quick to say – some people anyways whom I've met – health professionals are quick to say noncompliance. He doesn't take his medicine or she doesn't have a proper diet. And I just think, and I bet you don't floss your teeth every night.

However, drawing attention to the failings of the biomedical model by no means eliminates the problematic of patient blame and guilt in promoting the idea of self-healing potentiality and personal responsibility in health.

An additional shortcoming and potentially harmful consequence of a hyper-individualistic health focus is that it fails to take into consideration the underlying social, political, and economic structures that significantly contribute to disease etiology, thus evading social and political criticism, responsibility, and reform. Increasingly, medical research is demonstrating the significant impact of social and environmental determinants on disease manifestation and progression. For instance, the nascent field of genetics ubiquitously reveals that environmental cues and genetic composition interact in and influence human development and physiology. Further, the prevalence and incidence of disease correlates with social determinants such as race, class, and age, which are not wholly a reflection of disparities in medical access but also of increased exposure to hazardous environmental conditions and limited opportunities to effectively cope with external stressors (Guttmacher 18).

> By focusing on individual development and on the spiritual dimensions of cure, holistic ideology may further mystify perceptions of the cause and distribution patterns of disease. More immediately, in the concern for quick remedies, holistic practice may channel the discontent of those who are at high risk (the poor, the unemployed, certain groups of industrial workers) into forms of action (meditation, physical exercise, diet) that may be good for the individual but that do nothing to change pathogenic aspects of the social and economic

> structure which placed him or her at high risk in the first place. (Guttmacher 18, 19)

An exclusive focus on personal responsibility in health exhorts individuals into taking preventative and adaptive health measures in illness at the cost of remedying health-related social, economic, and political factors that are clearly beyond the individual's range of influence. Such factors include cost containment and resource allocation as well as economic and social practices such as consumerism, capitalism, and competitiveness (Alster 157; Baer 21; Guttmacher 19). As with the aforementioned criticism, the failure to address the social, economic, and political failings through emphasizing personal responsibility is evident in both whole person care and biomedicine since, inevitably, both medical approaches function within the same social, political, and economic context (Guttmacher 20). Nevertheless, according to Michael Lerner,

> For a movement that prides itself on being holistic, this failure to look seriously at the economic, social, and environmental determinants of health is an extraordinary shortcoming. Now, to be fair, we should add that mainstream medicine also fails to focus on the social, economic, and environmental determinants of health ... The difference is that medicine does not claim to be holistic, whereas complementary medicine does make that claim. (qtd. in Baer 157, 158)

In fairness, although WPC emphasizes that the locus of control for healing lies within the patient, it concurrently and openly acknowledges the impact of external determinants on health and even aims to improve public health through instituting modifications, albeit preliminary, to the medical system. As we have seen, one of the most revealing examples is WPC's contribution to Physicianship, McGill Faculty of Medicine's developing undergraduate medical program. WPC and the Faculty of Medicine are introducing curricular changes at the institutional level in hopes of creating a more humanistic medicine through teaching students on their path to becoming physicians their role as both healers and professionals.

Although modification to the system of training itself is a significant institutional change, it has its own limitations and both Dobkin and Allen, in unrelated discussions, draw attention to this. Dobkin states it most explicitly in the following:

> Well, I think that it's not just the training, it's the structure of the health care system. That's the problem. And that was part of my

> sabbatical work. We were looking at health care systems in Australia, in France, and in the V.A. system in the U.S. for chronic pain, but we can expand that to other illnesses. And if the structure of the health care system isn't set up to promote whole person care, it's very hard to provide it. So even in the best of circumstances – someone is trained to do it, wants to do it, sees the importance of it – if they're in an environment that discourages it, even subtly, it'll be really hard to do it. So there's a lot of obstacles to overcome, but one is the system itself. (Interview)

The most promising avenue for WPC to tackle some of the social, economic, and political dimensions influencing health and subjective quality of life is Allen and Hutchinson's project entitled "Living with End-Stage Renal Disease (ESRD): Multiple Perspectives on Suffering and Healing." In this project, Allen and Hutchinson investigate some of the challenges and quality of life issues in ESRD for both patients and health care providers through conducting videotaped focus group sessions with these populations separately. In so doing, they draw attention to systemic issues for ESRD patients in the Montreal health care system that impact patient suffering and quality of life. Such issues include inadequate informed consent procedures for patients beginning kidney dialysis as well as the elimination of resources such as food and transportation.[70] In short, one of the goals of the research project, according to the WPC website, is precisely "to promote changes in the medical system which will promote healing and hence a better quality of life." Allen describes this in her interview.

> These things are considered by many [health care professionals] to be non-medical – so issues around transportation and food services and

[70] Food and transportation issues are particularly pertinent in the context of ESRD because, according to Allen, the majority of these patients live at the poverty level (95% of dialysis patients are unemployed and 50% are unable to work because of age and functional disabilities arising from high rates of co-morbidities such as vision and mobility impairment). Furthermore, they are frequently at the hospital since dialysis treatment occurs three times a week for four hours each (Allen, "Quality of Life"). Hutchinson further explains:

> If we took it seriously the idea that we're trying to at least not adversely effect and hopefully positively effect [ESRD patients'] subjective quality of life then we take steps to consider the way they're greeted, the way its organized, so when they're started on dialysis, when they come to the dialysis unit. What happens right now: they're all queuing up and they're trying to get on and the nurses are busy and so on and it's really an unpleasant kind of situation. One other example is that these people need to get there three times a week. They're often on welfare since they can't work so they need transportation. And some people in the hospital have said, "Well we're not in the transportation business. We're in the medical business treating kidney failure. How they get here is their business." Well that to me is a very good example of where you narrow down the definition of medicine to the specific treatment of disease and not take into account other aspects of people's life problems. (Interview)

> things like that for dialysis patients. [These patients] see them very much as part of their care. But the hospital or the health system doesn't necessarily view it as part of their care.

Since this research project is on-going, it has merely observed the existing deficiencies for dialysis patients in the health care system. In the future, it may address the need for change at the institutional level and for this specific patient and care provider population. Nevertheless, it remains to be seen if, and to what extent, WPC chooses to pursue this goal and thus respond to the critique that emphasis on personal responsibility in holistic health ideologies necessarily abrogates social and political commentary, responsibility, and reform.

Throughout this chapter, I have delineated some of the major ethical issues and challenges associated with the slogans of WPC. Although WPC maintains some significant benefits for patient care, particularly within a society that is seemingly disenchanted with current medical practice, these slogans are concurrently mired with intrinsic risks. They require ethical evaluation so as to appropriately protect patients – who are characteristically vulnerable by virtue of their designation – in addition to the health care professionals providing their care. The fundamental risk is that some of these slogans are anything but benign. I argue that, in comparison, they convey an underlying belief system and as such necessitate prescribed conduct and guidelines for appropriately living them out. It is of my opinion, then, that these slogans are more appropriately akin to precepts. Callahan's argument concerning the WHO's definition of health is particularly relevant here.

> For a certain class of concepts – peace, honor, happiness, for example – it is difficult to keep them free in ordinary usage from a normative content. In our own usage, it would make no sense to talk of them in a way which implied they are not desirable or are merely neutral: by well-ingrained social custom (resting no doubt on some basic features of human nature) health, peace, and happiness are both desired and desirable – good. For those and other reasons, it is perfectly plausible to say the cultural task of defining terms, and settling on appropriate and inappropriate usages, is far more than a matter of getting our dictionary entries right. It is nothing less than a way of deciding what should be valued, how life should be understood, and what principles should guide individual and social conduct. (Callahan 84)

This argument applies to not only WPC's definition of health but also to that of healing. Mount promotes the Jungian idea that health indicates human potentiality

and healing a path towards the teleological goal of wholeness and integration. In advancing these definitions and the corresponding "precepts" for each section of this chapter, WPC is endorsing a normative framework for both patients and health care professionals. Namely, patients are to discover inner peace and wholeness in the midst of illness and dying through assuming a greater degree of responsibility for their health while health care professionals are to consider all determinants of health including body, mind, and spirit and facilitate the aforementioned process of healing in patients through creating a space for healing, by exhibiting the necessary qualities of the healer role (such as presence, empathy, compassion, and willingness to accompany) and through engaging in the same introspective process as the patient ("Report Faculty Working Group" 8).

Clearly not all of WPC faculty members agree with this normative framework or at least portions of it. Nevertheless, they all recommend means by which to ensure its ethical promotion. I have indicated some of them in this chapter, but in general WPC suggest that there are three major recommendations to minimize patient and caregiver harm: 1) care needs to be integrated; 2) it needs to remain patient-centered; and 3) it needs to be based on the adequate training and qualification of health care professionals. For instance, Dobkin argues that,

> Care [should] be integrated. There's not one health care professional who could possibly provide everything that's needed for a patient with a chronic illness ... So, integration to me is the key ... and there's a fine distinction because multidisciplinarity can be sequential and the difference with integration is that the health care professionals communicate between each other. (Interview)

Cassell clearly argues the second point:

> I think you are acting ethically when you do something that is in the good of the person whom you are doing it for; that when you act for their benefit, as *they* see their benefit, not as you see their benefit, when you are acting for somebody as they see *their* benefit and in *their* terms and on *their* time, you are being ethical about your relationship with that person. (Interview)

This recommendation has its own limitations, however. It is important to keep in mind that in certain circumstances what patients may consider as the best course of treatment – in terms of their benefit and best interests – may not necessarily be the most appropriate. McNamara draws attention to this in the above discussion.

Nevertheless, A.F.M. too posits that, "it is feasible to [integrate a broad concept of health into medicine] if you know from a patient perspective what he understands about what is health for him and that it can be different from one patient to another." With regards to the third point, Dobkin argues that health care professionals would have to

> Know how to assess a person: know whether or not they have, let's say, delusional thinking or someone who has had psychotic breaks in the past or someone who's had recurrent clinical depression. So these are the things you'd have to be competent as a health care professional to determine. Is it safe for this person to explore this kind of issue ... So one has to be trained and knowledgeable. (Dobkin, Interview)

In fact, this is precisely Dobkin's approach in WPC's mindfulness-based meditation initiative. As I have mentioned, the leaders of the program, Hutchinson and Dobkin, undertake pre- and post-interviews with potential participants in order to evaluate their program suitability including psychological contra-indications. Dobkin explains:

> When I do the mindfulness-based stress reduction program, I interview everybody individually first, and I make sure that it's safe for them to enter this program, because for most people meditation can be an interesting experience or a new experience that they are curious about or they're willing to try because they don't know what it is. And that's all fine, but let's say someone who's been raped and you try to do a body scan and you're in the lower body in the pelvic region, well, they might have flashbacks of trauma and you need to know what to do with that. You can't just allow a person to suffer more with the intervention they're doing so you have to be aware. I probe for trauma. I probe for depression. I probe for any psychiatric illness that might make this not a good experience for them, and then we talk about it. And it's possible to accept someone into the program, let's say, who has manic depression in their past. If they're on lithium, and it's controlled, and they have a psychiatrist and they have support and we have a connection so that should anything going on in the class wake up some issues for them, they feel comfortable enough to come to me afterwards and say, "Look, I really got scared when you did this or that," and then we look at that. (Interview)

Although no faculty members of WPC deny the need for appropriate qualifications and competencies of health care professionals in this area, it appears as though, for Mount, the training required to do so – at least in terms of whole person care – is not restricted to the domain of a specific profession such as psychiatry. Mount explains:

> I think in an ideal world we are all mandated to provide for each other whole person care – to be concerned. I guess we all fall short most of the time. But there are specialists who hopefully – in again an ideal world – have been really well-trained in clinical pastoral education programs that are well thought out, and they are able to bring a rich array of skills and insights to the needs we have been talking about. I would see the pastoral care person as the specialist in this area, ideally. Where I would differ in my views from many, and lock horns with some pastoral care providers in a hospital, is that everyone – including the cleaner – has that mandate of caring for people in the hospital. As a surgeon, as a physician, as a nurse, as a physio – whatever my role may be – I have a position to be present that no one else has ... What I mean, then, is that everybody has a mandate of being a pastoral care provider. But the pastoral caregiver, the professional, has a particular set of tools that have hopefully been refined to enable that person, in particular, to be helpful dealing with complex needs ... We all require as much sensitivity training as we can get. Some of us require more than others.

Kearney as well reiterates this but also warns against moving beyond professional boundaries. "My intention throughout has not been to encourage carers to dabble in what is outside their area of expertise but to suggest that all who care must know how to attend to unconscious as well as conscious events in others and in themselves in ways that are appropriate" (Kearney, Healing 210). Ultimately, he argues that only on occasion is it necessary to request the expertise of a professional (Kearney, Healing 210). As noted above, many WPC faculty members are seriously perturbed by the prospect of caregivers exploring the psyches of patients and although all warn against it if unqualified, I think WPC needs to delineate specific procedures and boundaries for its use within the whole person care context, especially since, for Mount, all people have a mandate for caring and, for Kearney, this caring requires attending to the psyche. As Callahan points out: "It is important to keep clear and distinct the different roles of different professions, with a clearly circumscribed role for medicine, limited to those domains of life where the contribution of medicine is appropriate" (83). Otherwise for him, "it makes the medical profession the gatekeeper of happiness and social wellbeing. Or if not exactly the gate-keeper, then the final magic-healer of human misery" (Callahan 81).

CONCLUSION

The concepts of healing and whole person care form the basis for the theory of WPC. Relevant to these concepts are the distinctions between disease and illness, curing and healing, suffering and wholeness, and healing and wounding, many of which arise in the context of WPC's quality of life continuum. As one of the central aims of WPC is to redress the preoccupation with the body and mind in medicine through incorporating the spiritual dimension, it constructs a theory of healing and whole person care to facilitate this. It is of utmost importance to recognize that this theoretical formulation is primarily influenced by the work of Jung, Cassell, and Kearney but also, in part, through the writings of Frankl, and Buber. Drawing from these sources and its research, WPC concludes that healing is a response shift from an experience of suffering and anguish towards an experience of wholeness and integrity; it need not involve a return to physical health but an improvement in quality of life through experiencing a deeper and more profound sense of meaningfulness or connectedness to the self, others, nature, and/or the Divine, however conceived. Given this central aim, WPC's conception of wholeness, suffering, meaning, and healing connections is fundamentally rooted in the spiritual and transcendent dimension. This is evident in the following. The concept of wholeness comes directly from Jung and is understood as a teleological, normative, and intrinsic tendency of the psyche towards integration and an experience of the Self, the God within us. Creating meaning, as Frankl explains, is a means to exercise spiritual freedom, the freedom to choose how to bear life's sufferings. And healing connections involve connectedness with the self, which WPC equates with the individuation of Jung's Self, and with others, in the spirit of Buber's "I-Thou" relating, a form of interaction that mirrors the genuine relating of humans with the Divine.

WPC dynamically applies its theories to its major programmatic initiatives. These include 1) an educational component to undergraduate medical students in the Physicianship Program and to the general public through a seminar series, film series, and book club, 2) a wellness component that consists of Mindfulness-Based Meditation and Stress Reduction Programs, and 3) a research component that focuses largely on qualitative research methodologies. Although some endeavours highlight

WPC's theories more explicitly than others, their breadth and applicability are evident throughout. In general, though, these programs not only underscore WPC's understanding of healing, particularly its theory of creating meaning and healing connections, but in fact actualizes it through actively encouraging participants – both patients and health care professionals alike – to draw upon their inner healing resources. This is accomplished through self-reflective practices and communal relating so as to engender transformation, self-awareness, and ultimately, healing and wholeness. Additional concepts underpinning these initiatives include an emphasis on the individuality, context-specificities, and subjectivity of both patient and physician particularly with regards to the spiritual dimension as well as the importance of tacit, experiential learning.

WPC recognizes that there are challenges to incorporating the spiritual dimension into medicine, the most noted of which is the diversity of beliefs and practices among health care professionals and patients. As such, one of its major objectives is to create a shared vocabulary with which to discuss the spiritual dimension in medicine that transcends varying belief systems, particularly religious language and dogma that impede shared understanding and the experience of healing and wholeness in general. This objective reveals WPC's perspective on religion and spirituality as does the following set of terms that constitute its shared vocabulary: spirit, inner life, spiritual, spirituality, transcendence, and religion. Through exploring these terms in detail, we have seen that, although ambiguous and employed circumstantially, these terms indicate WPC's position, which champions spirituality as a universal component of the human condition and reduces religion to merely an institutional structure of human making. All the WPC faculty members maintain this position although in different ways: whereas some view religion as important but lesser to spirituality, others view them as complementary, and a few conceive of them as antithetical or, conversely, as inextricably linked.

Although WPC conspicuously recognizes that its objective of a shared vocabulary and subsequent distinction between spirituality and religion are necessary in a pluralistic medical context, it does not make explicit mention of the respective challenges it confronts in integrating them into a secular medical context. Nevertheless, its theoretical framework, programmatic initiatives, and general worldview demonstrate a dynamic negotiation between the realms of the secular and

religious. As we have seen, WPC secularizes religious beliefs and practices through 1) appositely employing the term inner life to avoid negative associations with the term spirituality, 2) attempting to divorce the Buddhist religion from the Buddhist practice of *vipassana* meditation, as Kabat-Zinn proposes, particularly when highlighting its stress-reducing capacities, and 3) exclusively emphasizing the individual self's inner potential for healing and human wholeness in Asklepian healing rather than the interpretation of Jung and Kearney that promotes the divinity within as an additional source. Interestingly, however, Jung not only recognized the reason for this but also circumstantially subscribed to it with his own patients. "As the religious-minded person would say: guidance has come from God. With most of my patients I have to avoid this formulation, for it reminds them too much of what they have to reject. I must express myself in more modest terms, and say that the psyche has awakened to spontaneous life" (Jung, Modern Man 242).

WPC appeals not only to the secular domain but also to that of the religious. It appropriates beliefs and practices from the Greek religious tradition, Christianity, and Buddhism albeit selectively (as discussed above) and specifically through a Jungian interpretation. For instance, through Kearney, it draws upon the myth, ritual beliefs, and practices surrounding Asklepios to help re-establish a connection to an archetype found in a past religious tradition of healing. In terms of the tradition of the Wounded Healer, WPC, again through Kearney and Guggenbuhl-Craig, refer to Christ as its embodiment and the biblical verse "Physician heal thyself" as its dictum. However, WPC does so only in so far as Christ is seen as a psychological metaphor of wholeness *par excellence* and the biblical phrase is interpreted in terms of Jung's concept of training analysis (physician self-development). And lastly, although it employs the rhetoric of the Buddhist doctrines of impermanence (*anitya*), momentariness (*ksana*), and nonattachment through its meditation programs, it clearly omits the Buddhist principle of *anatman* or no-self because it completely contradicts its and Jung's conception of the spirit or Self as a universal reality of human experience and personhood.

It is evident that a psychological interpretation (or the psychologization) of religious beliefs and practices through a Jungian lens is pivotal to WPC's negotiation between the secular and religious domains. And indeed, Jung is noted as a prominent visionary in this regard. As Cary Baynes writes,

> Between [the] two extremes of traditional faith and militant rationalism, every conceivable shade of opinion about this great problem of humanity's next step in psychic evolution is to be found. It may be said that the middle position is held by those people who know that they have outgrown the Church as exemplified in Christianity, but who have not therefore been brought to deny the fact that a religious attitude to life is as essential to them as belief in the authenticity of science ... They do not wish to sever the real piety they feel within themselves from the body of scientific fact to which reason gives it sanction. They are convinced that if they can attain to more knowledge of the inner workings of their own minds, more information about the subtle but none the less perfectly definite laws that govern the psyche, they can achieve the new attitude that is demanded without having on the one hand to regress to what is but a thinly veiled mediaeval theology, or on the other, fall victims to the illusions of the nineteenth-century ideology. It is to this last group that Jung speaks in convincing terms. He does not evade the difficult task of synthesizing his knowledge of the soul, gained in his many years of practice as psychiatrist and analyst, into a fund of information available and applicable to everyone ... The point of view he lays before us is a challenge to the spirit, and evokes an active response in everyone who has felt within himself an urge to grow beyond his inheritance. (viii, ix)

Because of this, WPC draws upon a range of Jungian psychology from his conception of healing, wholeness, and individuation in general to the use of dreams and mythology, training analysis, and the containment of care in particular. What's more, WPC appropriates Jung's conception of spirituality that is defined as an account of the numinous and a universal reality that relates to meaning and values. It notes this experience within varying religious concepts (such as the "living Christ" of Christianity, the "Atman" of Hinduism, and "the Secret" of Islam), psychoanalytic theories (such as the Deep Centre of P.W. Martin), and secular practices (such as hoping, letting go, and trusting). Thus, WPC universalizes this experience and, like Jung, makes it available to all regardless of personal cultures or creeds.

There are some additional drawbacks to WPC's position that situates the universal experience of the numinous within the domain of spirituality. Although it may provide a solution to the problem of pluralism in medical institutions, it, nevertheless, reduces the rich and nuanced expression and experience of the sacred that can be found in specific religions. WPC's position would also render religion superfluous if it did not note that religion is a means to this experience of the numinous albeit an unnecessary one. Moreover, this position provides no concessions

to those who regard themselves as neither religious nor spiritual. For instance, some individuals ascribe to a third category in what King et al. refer to as "philosophical beliefs." This term describes "a search for an existential meaning in a particular life experience, without reference to any external power or being" (qtd. in Mount, Lawlor, and Cassell 306). So, some may regard existential questions as important and integral to human life but not an experience of something greater and beyond the self, which is, notably, the defining point for WPC's conception of spirituality. In other words, a perspective at variance with WPC is that the spirit and spirituality is not a universal dimension of personhood. This provides evidence for the following dilemma that faces WPC: shifting medicine towards spirituality necessarily shifts it away from secularism, and vice versa.

The interpretation of spirituality as a universal dimension in all people is part of a greater trend occurring in the extension of the United Kingdom hospice movement to North America. Initiated primarily at St. Christopher's hospice, London, through the efforts of Dame Cicely Saunders, the hospice movement was originally developed with, and firmly rooted in, a religious interpretation of spirituality. Saunders writes,

> St. Christopher's Hospice is a religious foundation, based on the full Christian faith in God, through Christ. Its aim is to express the love of God to all who come, in every possible way; in skilled nursing and medical care, in the use of every scientific means of relieving suffering and distress, in understanding personal sympathy, with respect for the dignity of each patient as a human being, precious to God and man. ("Modern Hospice" 45)

But in North America, this religious interpretation was ousted for a secularized and psychologized one. Garces-Foley notes the following: "Eschewing a Christian framework, most American hospices stress a broader notion of spirituality and spiritual care than the English model. In the American hospice system, "spiritual" has come to mean a universal human dimension of life" (345). As Ann Bradshaw explains "There is undoubtedly a profound ideological rejection of the traditional understanding of the spiritual dimension of care exemplified by Cicely Saunders, accompanied by a redefined concept of 'spirituality" (415). She offers a compelling argument for this trend. "Society is secular and the interpretations of spirituality should – indeed must – reflect this ... Hence, traditional, orthodox spirituality, the

human being in relationship to God, has been replaced by a conception of spirituality as a personal and psychological search for meaning" (Bradshaw 415). Nevertheless, as we saw in chapter three, spirituality is a vague term and does not wholly constitute a secular or psychological interpretation. As Garces-Foley states, "Though the hospice understanding of spirituality *can* be framed in secular terms, it would be a mistake to push this point too far since the vast majority of Americans and hospice workers are neither atheist nor agnostic" (Garces-Foley 345).

The reason behind this interpretation of spirituality in North America, according to Garces-Foley, is precisely the same as that of WPC: a religiously pluralistic society requires it (345). But what's interesting about this position is that although the North American hospice movement and WPC draw extensively from a Jungian interpretation of the numinous, they employ a different terminology to define this experience: whereas Jung defines it as religion, WPC allocates it within the domain of spirituality. As we have seen, however, this is not a substantive issue but based on terminology. The reason for this is ostensibly at an even deeper, cultural level; it is greatly influenced by the holistic health movement (HHM)[71] and new age movement (NAM)[72], which, according to Bruce Barrett et al, have sufficiently permeated the social matrix of health care choices throughout North America (943). Although an explicit description of each of these movements in detail is beyond the scope of this thesis, there are some elements that correspond with WPC's own position.

Drawing considerably from Wouter Hanegraaff's work[73], Hans Baer argues that the HHM and NAM are significantly interrelated in terms of their underlying philosophies, therapies, and cultural influences. Philosophically, these movements are unified in their insistence on individual responsibility for health, wellbeing, and transformative methods that improve personal wellness and quality of life.

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[71] See the first footnote in chapter 4.

[72] In the 1920's, Alice Bailey coined the phrase "New Age" to denote the coming of the Age of Aquarius, a time of peace, utopia, and harmony (Baer 9). As with the holistic health movement, it eludes decisive categorization historically, philosophically, and in its practices (Hanegraaff 1). Nevertheless, Hanegraaff provides a preliminary orientation by describing the following five elements as constitutive: (1) a this-worldly orientation, (2) a holistic perspective particularly in its rejection of dualism and reductionism, (3) evolutionism, (4) psychologization of religion and sacralization of psychology; and (5) expectations of a coming New Age (514, 522).

[73] Here, I am referring to Hanegraaff's book entitled New Age Religion and Western Culture: Esotericism in the Mirror of Secular Thought. It is the first comprehensive and thematic analysis of the New Age Movement.

Furthermore, these movements are both characterized by a skepticism towards science and technology, an affinity towards "natural" healing, an emphasis on spiritual development, inner peace, wellness, or self-actualization, a holistic perspective regarding the interdependency of self and the cosmos, a rejection of organized religion, the sacralization of psychology or conversely the psychologization of religion, and a view of health as a state of harmonious equilibrium. In practice, both camps employ similar therapeutic techniques such as guided visualization, reflexology, and iridology to name but a few (Baer 9, 10, 12-13). And in terms of cultural forces, they are both strongly rooted in the countercultural movement as well as the human potential movement, particularly as they challenge conventional norms and promote spiritual development, self-actualization, and expanded consciousness (Baer 9; Hanegraaff 10). Hanegraaff argues that the new age movement in particular is a cultural criticism of western culture. The NAM has a secularized esotericism (514, 520-522). Moreover, both draw on ideas from Western metaphysics, Eastern religious traditions – particularly Buddhism and Hinduism – Jungian psychology in addition to metaphorically applying new scientific paradigms to health and living such as quantum mechanics and chaos theory (Baer 10).

This brief description indicates the considerable extent of overlap between these movements and WPC. However, WPC diverges from these movements in its attempt to integrate their healing perspective with western biomedicine. In this effort, it does not demonstrate a whole-hearted skepticism with science and technology or the Hippocratic tradition but describes its successes, current limitations, and the need for the prudent coalescence of both models of care. There are also a number of HHM or NAM practices that WPC does not incorporate into its programs, such as iridology, rebirthing, and traditional Chinese medicine. This most likely arises from the requirement to assiduously integrate biomedicine with holistic medicine. For instance, holistic medicine's clinical safety and efficacy is a highly contentious and, at this point, largely unresolved issue.

All things considered, WPC's selective appropriation of religious and psychoanalytic beliefs and practices and its largely secular terminology indicate that in its attempt to transcend pluralistic worldviews it is in fact composing its own. And it is the failure of WPC to discern its own underlying worldview – particularly its set of precepts that promote a normative framework for both health care professionals

and patients – that ultimately gives rise to the ethical concerns I delineate in the last chapter. These concerns, which I notably derive from critiques of the HHM, include 1) how to pragmatically and ethically apply a vague and all-inclusive definition of health into medicine, particularly one that is based on a Jungian interpretation; 2) the ethical implications and corresponding benefit-risk ratio of discovering inner peace and wholeness in the midst of illness, death, and dying; and 3) the potential risks of emphasizing individual responsibility including the corresponding tendency to evade political, social, and institutional health reform. As Callahan argues, "A failure to discern the operative underlying values, the conceptions of reality upon which [even the most pragmatic judgments] are based, and the definitions they entail, sets the stage for positive harm both to patients and medicine in general" (78). These potential harms imposed by WPC's normative framework and corresponding precepts require not only acknowledgement and consideration but also an agenda in place to appropriately address and qualify these issues in all domains of WPC – its literature, practices, and initiatives. WPC has already instituted some ethical assurances, although others remain merely recognized, mired in controversy, or altogether neglected. WPC has the potential to significantly improve its programs if it examines its own constructed worldview particularly in terms of its ambiguities, inconsistencies, and normative implications. This will better facilitate its entry into the predominantly secular institution of medicine and, as such, more adequately redress the limitations of the currently prevailing biomedical model.

Appendix 1. Faculty Members of the McGill Programs in Whole Person Care

Initial Core Administration (1999):

Director: Balfour Mount, MD
Associate Director: Patricia Boston, RN, PhD
Associate Director: Robin Cohen, PhD
Executive Administrative Assistant: Eileen Lavery

Current Core Administration (2008):

Director: Dr. Tom Hutchinson, MD, FRCP(C)
Founding Director: Dr. Balfour Mount, MD, FRCP(S)
Faculty: Patricia Dobkin, PhD
Steve Jordan, PhD
Anonymous Faculty Member (A.F.M.)
Helen McNamara, MD, MSc (Faculty Scholar)
Dawn Allen, PhD (Research Fellow)

Administrative Staff: Eileen Lavery; Nancy Gair; Megan Wainwright

Part-Time Visiting Professorships:
Dr. Michael Kearney (2002-2003)

Faculty Biographies:

Balfour Mount
Dr. Mount is a trained urologist and surgical oncologist. He also received training in end-of-life care under the auspices of Dame Cicely Saunders at St. Christopher's Hospice, London. He is a pioneer in the field of Palliative Care as he established the first in-hospital palliative care unit in North America at the Royal Victoria Hospital, Montreal, Canada. He was founding director of the Royal Victoria Hospital Palliative Care Service in 1974-1975. In 1991, Dr. Mount initiated the Palliative Care Division of the Department of Oncology at McGill and in 1994 he was awarded the newly developed title Eric M. Flanders Chair in Palliative Medicine. In 1999, he developed the McGill Programs in Integrated Whole Person Care and served as the founding director until 2004 (McGill WPC). According to J. Seely, "Dr. Mount has contributed more than any other individual, apart from Dr. Cicely Saunders, the Founder of the modern Hospice movement, to raise the awareness, knowledge, skills and importance of end of life / palliative care for persons suffering with advanced illness, both nationally and internationally" (3).

Patricia Boston
Dr. Boston has a background in nursing, education, psychiatry, family therapy and qualitative research methodology (Seely 3). At McGill University, she was an Associate Director for the McGill Programs in Integrated Whole Person Care and an Assistant Professor in the Departments of Transcultural Psychiatry, Education, and Oncology ("Notes" 335). She is currently the director of the Division of Palliative Care in the Department of Family Practice at the University of British Columbia.

Robin Cohen
Dr. Cohen was an Associate Director of the McGill Programs in Integrated Whole Person Care. During this time, she was also a Research Director for the Division of Palliative Care in the Department of Oncology at McGill University and an Associate Professor in its Departments of Oncology and Medicine as well as its School of Nursing (Seely 3).

Tom Hutchinson
Dr. Hutchinson is trained in nephrology, clinical epidemiology, palliative medicine, and family therapy. In 2003, he became the Associate Director of the McGill Programs in Whole Person Care. He was instituted as its Director in September of 2004 and continues to occupy this position presently. He is also a professor in the Departments of Medicine and Epidemiology and a palliative care physician at the Montreal General Hospital ("Newsletter 1" 4; McGill WPC).

Patricia Dobkin
Dr. Dobkin is a clinical psychologist with a specialization in behavioural medicine. In 2005, she became a faculty member of the McGill Programs in Whole Person Care ("Newsletter 1.2" 1). She is also an Associate Professor in the Faculty of Medicine and the Department of Social Studies in Medicine at McGill University (McGill WPC).

Steve Jordan
Dr. Jordan is a faculty member of the McGill Programs in Whole Person Care. He is also the Department Chair of Integrated Studies in Education at McGill University and an Associate Member of its Department of Oncology.

Helen McNamara
In October 2005, Dr. McNamara began her work with the McGill Programs in Whole Person Care as a Faculty Scholar. She remains a faculty member of the McGill Programs in Whole Person Care to this day. She is also an Assistant Professor at McGill University in the Department of Obstetrics and Gynecology and a member of its Centre for Medical Education ("Newsletter 1.2" 1; McGill WPC).

Dawn Allen
Dr. Allen is post-doctoral fellow of the McGill Programs in Whole Person Care. She began this position in 2005 (McGill WPC). Her past education comprises the following: an undergraduate degree in French and Linguistics, a Master's degree in English as a Second Language, and a PhD in Second Language Education. Her thesis work on identity theory forms the basis for her current research project with WPC (See Appendix 2C)(Allen, Interview).

Appendix 2. WPC's Major Qualitative Research Studies

A) Systematic Review of Spirituality and Health Literature

In 1998, Larson et al. published a four-volume report entitled The Faith Factor that examined over 325 peer-reviewed research studies and 35 review articles on the topic of religion and spirituality in health. According to Freedman et al., it constitutes the most extensive report of its kind in the English language (90). WPC undertook a critical review of Larson et al.'s work in "Spirituality, Religion, and Health: A Critical Appraisal of the Larson Report." WPC's research sought to critically examine the generalizability of the Larson report's conclusion, the appropriateness of qualitative research in assessing the spiritual domain, and its proffered definitions of religion and spirituality. Although the results are representative of Caucasian, American, and Christian subjects, the WPC authors conclude that the research surveyed in the Larson report does not adequately reflect the diverse age groups, cultures, religions, and clinical settings characteristic of the multicultural or pluralistic society in Montreal or elsewhere. Based on this report, the authors also strongly advocate for more qualitative research studies investigating spirituality and health issues (Freedman et al. 90, 93). This conclusion drastically departs from those made by Larson et al. who in comparison urge for more quantitative research in the form of randomized control trials. Given that WPC perceives qualitative research as more amenable to questions relating to spirituality and health and, moreover, that the Larson report examined quantitative research almost exclusively (qualitative research accounted for a mere five per cent of the total research studies reviewed), WPC advocates for an alternative approach that includes more qualitative analysis (Boston et al. 373). And lastly, in the WPC article the authors ascertain the need to create a shared vocabulary for discussing spirituality and religion in a health care context since the Larson report does not adequately account for the distinction individuals often make between religion and spirituality (Freedman et al. 92).

B) The Development of a Shared Vocabulary

According to WPC, to ensure effective and efficient communication on clinical and research issues relating to the body and mind, medicine has established and maintained an adequate set of terms, a shared language. However, vocabulary relating to the spirit often creates barriers in communication and obstructs shared understanding. As such, Drs. Mount, Lawlor, and Cassell undertook research to address this problem. In the subsequent publication "Spirituality and Health: Developing a Shared Vocabulary," they compile their work and propose working definitions relevant to spirituality and health by defining such terms as spirit, spirituality, religion, sacred, faith, healing, and transcendence (Mount, Lawlor, and Cassell 303, 304, 306).

C) Investigating the Determinants of Suffering and Quality of Life

Using almost exclusively qualitative research methodologies, some of the investigative studies WPC has undertaken are the following: evaluating palliative caregivers' perspectives on existential and spiritual distress using qualitative focus group methodology and thematic analysis (Boston and Mount 14); a

phenomenological study examining the relevance of existential and spiritual dimensions to the suffering, healing, and quality of life of patients with life-threatening illness (Mount, Boston, Cohen "Connections" 374); and using the "McGill Quality of Life" (MQOL) measurement developed by Cohen and Mount in addition to patient interviews to investigate self-rated changes to quality of life in patients admitted to palliative care units (Cohen et al. 364- 365). More recent research projects include an examination of quality of life issues and challenges in end-stage renal disease for both patients and health care professionals through the implementation of participatory action research methodology (Allen, "ESRD" 4). Furthermore, WPC is evaluating its Mindfulness-Based Stress Reduction Program using both quantitative and qualitative data (the Mindfulness Attention Awareness Scale and Coping with Health Injuries and Problems questionnaire as well as focus groups, respectively) (Dobkin 8). In addition, WPC conducted research exploring the feasibility and effectiveness of medical student support groups employing parallel charting (i.e. student reflective journals on student-patient interactions) and discussion groups in the apprenticeship component of the medical school curriculum ("Newsletter 3" 3).

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