

**WHOLISTIC HEALTH CARE
OF, FOR AND BY THE
PEOPLE**

Rev. (Dr.) Jan H. Boer

Wholistic Health Care Project

Christian Health Association of Nigeria

Wholistic Health Care of, for and by the People

Rev. (Dr.) Jan H. Boer

Wholistic Health Care Project

Christian Health Association of Nigeria

1989

Table of Contents

INTRODUCTION

- I. HISTORY OF WHOLISTIC HEALTH CARE PROJECT
 - A. The Problem of Biomedicine
 - B. The 1980 CHAN Statement
 - C. The Chaplaincy Controversy
 - II. ISSUES IN WHOLISTIC HEALTH CARE
 - A. Biomedicine
 - B. Reaching for the Whole Person
 - 1. Chaplaincy and Evangelism
 - 2. A Multi-Dimensional Approach
 - C. Involving the Whole Community
 - 1. The Role of the Patient
 - 2. The Other Team Members
 - D. WHC and Other Healing Traditions
 - 1. Natural Revelation
 - 2. The Cultural Mandate
 - 3. Cultural Distortion
 - 4. Biomedicine and Science
 - 5. Research into Traditional African Medicine
 - 6. "Faith" or "Spiritual" Healing
 - E. Relationship between WHC and Primary Health Care
 - III. THE CURRENT STAGE OF CHAN'S WHC PROJECT
 - A. Recruitment of Fulltime Coordinator
 - B. Establishment of Pilot WHC Clinic
 - C. Training in WHC Concepts and Practice
 - D. Public Enlightenment
 - IV. CONCLUSION
- BIBLIOGRAPHY

INTRODUCTION

It is now widely recognized throughout the medical and allied professions that wholistic health care is an idea whose time has come, an idea that must be implemented through every means possible. One of the means is to draw on the major religious bodies with a view to “assembling, assessing, and applying the wisdom of the faith traditions ... to issues of health care faced by individuals, families and society.” That quotation is from the agenda of Project Ten, an international program of the Lutheran General Medical Center in Park Ridge, Illinois. The books resulting from Project Ten show how the beliefs and practices of the various faith traditions shape and are shaped by encounters with issues in health and medicine.

The above quotation is from the front inside flap of Martin E. Marty’s book, *Health and Medicine in the Lutheran Tradition*. I thought it well to quote it at the beginning of our present endeavour in order to show that our concerns for wholistic health care (WHC) are by no means quaint, unique or isolated. The Lutheran project referred to is in response to a basically American situation, while our present endeavour is tied to Nigerian conditions. Yet we find to our pleasant surprise that those behind that project are moved by concerns similar to those of ours. They are aiming to develop a more wholistic approach to healing and they have decided that one way of getting to it is to analyze the contributions of various religious traditions to issues of health. That is exactly the agenda the Wholistic Health Care Project (WHCP) of the Christian Health Association of Nigeria (CHAN) has set for itself for 1989.

The WHCP has decided to run four zonal workshops on the role of religions in WHC. Various Christian traditions will be examined as well as those of Islam and of African (Nigerian) Traditional Health Care. The purpose of these workshops is to see how the healing ministries of CHAN-related healing institutions can become more wholistic. It is thought that an examination of various healing traditions, including non-Christian, from a wholistic perspective may stimulate our thinking in the desired direction. What are the contributions, the strengths and weaknesses of the various healing traditions? While Project Ten hopes to end up with a series of publications, for now we will be satisfied with a single one that will include most of the papers presented at the workshops as well as the main recommendations emerging from the discussions. We look forward to these discussions and expect them to challenge us so that at the end, this essay will have to be revised considerably. For the views developed within WHCP are indeed still tentative, subject to correction and deepening.

The purpose of this booklet is to set the stage for the 1989 workshop programme. All speakers and other participants are expected to study this booklet as a kind of background to the programme and discussions. The need for it was demonstrated recently at the first workshop where it was not available. We hope that with participants having this booklet at

hand prior to the preparation of their papers, the next workshops will be more precisely focused and thus contribute more effectively to the goals of this programme.

CHAN is a Christian ecumenical organization comprising most Nigerian churches that have medical programmes. The President of the organization is the well-known Prof. Ishaya Audu. CHAN runs four projects: CHANPHARM (importer and non-commercial distributor of drugs), Administrative and Management Project, Primary Health Care Project and Wholistic Health Care Project, all located in or around Jos, Nigeria. The present publication emerges from the last one, the youngest and least developed of the projects.

We trust you will enjoy reading this booklet and that it will challenge your ideas about healthcare. Feel free to make enquiries to our office.

I. HISTORY OF WHOLISTIC HEALTH CARE PROJECT

The notion of Wholistic Health Care (WHC) is not new to the Christian Health Association of Nigeria (CHAN). As I review its history within CHAN, I will at the same time open up for you the nature of the problems this programme is trying to address and help solve.

A. The Problem of Biomedicine

From 1966-1975, I worked as a pastor and evangelist under the auspices of the Christian Reformed Church of Nigeria in southern Gongola State. One of the things that perplexed me was the fact that when any parishioner fell sick, she would frequently go to the Christian hospital nearby. After she had been treated and dismissed by the local Christian hospital, one of the first things to be done would be to pay a visit to a functionary of the local Traditional Religion. Why, I wondered, was this so common?

I decided to investigate the matter. I visited the Christian hospital frequently and engaged both Nigerian and expatriate staff in discussions. I observed what went on in the wards. I arrived at the conclusion that the treatment patients received was too one-sided. The physical aspect of sickness was stressed to the almost total exclusion of other dimensions of health and sickness.

As a pastor, I realized that most people, including Christians, have many questions in their hearts when they become sick. They wonder *why* they have become sick, *who* is the cause of it and *how* it was accomplished. Has an ancestor been offended in some way? If so, what must be done to effect reconciliation to ensure wellbeing? Might someone be practicing

witchcraft? For what reason? How can it be overcome? These are questions very important to the patient but virtually ignored by the hospital staff.

Western missionaries on the staff of the hospital were hardly aware of these questions. Their medical training was almost exclusively concentrated on the body. They were taught a wealth of technical details and procedures to restore any malfunctioning part of that physical machine called the human body. That they were often more efficient than traditional medicine is without a doubt. Furthermore, their work was done in love, concern and with much prayer.

The Nigerian staff have been taught the same basic approach to healing and thus to ignore the fears and questions of the patients. That does not mean that the Nigerian staff have forgotten these concerns. In fact, many of them, when they become sick, have the same questions and fears and they might even secretly resort to a traditional practitioner. However, in their official practice, they pretend these concerns are of no consequence in the work of healing. It seems primitive or pagan or uneducated to take these issues seriously in a modern Christian hospital.

And so it happens that the patient is dismissed from the hospital with none of his fears and questions taken care of, except that an ill-trained chaplain might address them. The work of such a chaplain, however, is usually carried out in total isolation from that of the medical team of doctors and nurses. The spiritual needs of the patient are not considered relevant for the medical people; they are the province of the pastor.

Of course, the patient has little choice but to revert to practitioners of African Traditional Religion. The Christians at the hospital do not have an answer to the deepest problems as identified by the patients themselves. The patient may be grateful that the "whiteman's medicine" is able to overcome the physical symptoms of his sickness, but the real basic problem is not addressed by the staff trained in what is often called "modern medicine." (In this paper I will refer to so-called "modern medicine" as "biomedicine" or some variation of it. Reserving the term "modern" for it places all other approaches at a psychological disadvantage). The basic cause had to be overcome elsewhere. The Christians and their religion seem to have no resources to overcome the powers of witchcraft and others. Those resources are to be found in the Traditional Religion and its related healing practices.

As I began discussing these issues with missionary medicals, their response was in most cases two-fold. First, they complained that their training did not include these concerns. Missionary doctors are by no means the only ones to have mentioned this shortcoming in their medical training. Bernie S. Siegel, a surgeon at Yale University in the USA, came to a similar realization when he became interested in a more wholistic approach. He expressed annoyance at his

training that kept him so ignorant of facets of health and sickness with which those with a more wholistic approach and with less training than his were familiar (p. 19). The same surgeon discovered to his dismay that people trained in the biomedical tradition tend to have the greatest resistance to WHC (p. 6), a point we will do well to keep in mind as WHCP makes further inroads. Similarly, James S. Gordon, a medical alumnus of Harvard University, discovered his own ignorance and the failure of his biomedical training to teach what “had apparently been part of all the world’s healing tradition...” (p. 43). There was a difference, though, between the missionaries and the two biomedics just quoted. Whereas the last two had discovered something wrong, were annoyed with it and determined to overcome this shortcoming in their training and practice, most of the missionaries used it more as an excuse so they did not have to deal with the issues confronting them.

Secondly, treating sickness at the level of such problems and questions would take more time than hospital staff can afford to devote to such issues in view of the large number of people that come to the hospital daily. The medical people found themselves trapped in a vicious cycle that demanded efficiency and speed. A further pressure point was that of economic realities. The salaries of staff and the price of drugs and equipment were so high that the only way to pay for them was by whipping as many patients through per day as possible. It was and is not so much a desire for money and profit as a tactic to survive for further service.

I am the last to minimize the pressures on our Christian hospitals and their staff. Neither do I wish to be found guilty of disparaging the tremendous contributions biomedicine has made to the general level of health. Biomedicine and its surgical procedures are among the outstanding gifts of God to the human race. *Healing by medical means is no less healing from God than healing by laying on of hands and/or prayer.* However, our deep appreciation to God for biomedicine should not prevent us from realizing its profound shortcomings in its almost exclusive emphasis on the physical and its virtual total unconcern for the fears and questions of most patients as well as of other relevant aspects of human life.

B. The 1980 CHAN Statement

It was the problem of its one-dimensional approach to healing that thus became the main reason for concern. The issues were first brought to the attention of CHAN at a conference in 1980 in Ibadan. At that conference a small group of people were asked to produce a definition and short description of WHC. The document they created can be found in the official report of that conference.

Among other things, that document stated:

The term “WHC” can be used in various senses. Here we mean the approach to health and healing exemplified by Jesus, who cared for the whole person, physical, emotional and

spiritual. This implies for us today, using total resources for the total person. Among these resources are African traditional healing, Christian prayer and concern and scientific medical technology. These three streams may be selectively integrated to promote genuine well-being (shalom) on all levels of health care and healing. In this approach we extend Christ's compassion for the suffering and those rejected by society, while witnessing to the continual coming of his Kingdom among us.

Our vision includes a medical care system in which medical personnel have the time to deal with patients as persons, as to discover the root causes of suffering, which could lie in family, cultural or religious dimensions. This approach is effective when the personnel have themselves experienced wholeness in Christ, so that they become caring, listening and praying people. These qualities can be enhanced by providing time for reflection, leisure and rest.

Our vision includes mutual support and understanding between medical and pastoral personnel. All Christians are awakened to their individual and corporate responsibility in health and healing. Both medical personnel and church leaders are radically deepening the people's understanding of Christ's healing and ministry today.

The report also recognizes the obstacles presently found in our health institutions that would prevent the implementation of the above. I quote once more:

1. Lack of time – There are always far too many patients for the medical personnel to see. There is no time to attend to them as one would want.
2. Lack of training – There is lack of Christian training institutions where WHC can be taught.
3. Ignorance of African concepts – There is an ignorance about African concepts of sickness and health. Interest in these issues has been suppressed and not considered proper concerns for anyone undergoing modern health care training. We have been satisfied with the so-called scientific approach and have had little desire to know more about African tradition in this respect – even though our patients largely are steeped in that tradition.
4. Lack of Biblical vision – There is a lack of Biblical vision amongst us, a lack that has resulted in Christians leaving the healing ministry almost entirely to the medical professionals.
5. Lack of sensitivity to the spiritual – The above lack of Biblical vision has affected medical personnel. There is a lack of sensitivity to the spiritual and to other dimensions of sickness and health. We have become captive to a secular medical care system that discourages a wholistic approach.

These issues are important because much of our medical care is partially ineffective. Since we largely deal only with the physical dimension and tend to ignore the underlying causes for many physical illnesses as well as the deepest concern and anxieties of the patients, the healing process is less efficient than one might expect from an allegedly scientific approach. A patient is given some medicine for his ulcer. The medicine may provide temporary relief, but it will hardly take care of the basic problem, since ulcers frequently have a non-physical

cause. The patient may return to the same hospital once or twice. He will then conclude that his problem cannot be dealt with by biomedicine and he will begin to wander off to native medicine men or to some "healing church." What choice does the patient have? We waste his time, his body, his strength, his patience and, not unimportant, his money. Ignoring the basic cause prolongs suffering and increases economic hardship. With our increasing poverty, we cannot afford to either practice or submit to medical care that is partially ineffective and out of reach for many people.

So on the one hand, we have a medical system that can often perform scientific miracles, that is often most efficient and impressive. On the other hand, because of its tendency to reduce the issues to the physical, that same system fails both to satisfy the deepest fears of the patients and to treat the non-physical causes of many physical diseases. These two failures curtail the efficiency of the approach not only, but also render its claim to be scientific questionable: how can an approach that ignores basic causes and other dimensions of life claim to be scientific? And it certainly is not geared to giving peace to the troubled soul.

Since that first discussion at the CHAN conference, further steps have been taken in our struggle towards WHC. The Institute of Church and Society, Northern Area Office (ICS), has since then organized two workshops on WHC in Jos. In 1981, a seminar was held to further explore what WHC might involve and a stenciled report was published under the title, "In Search of Wholistic Health Care." The establishment of the Taskforce for Wholistic Health Care under the ICS was one of the results of that workshop. In 1984, the ICS ran a workshop on the related issue of hospital chaplaincy and published a stenciled report entitled, "Wholistic Health Care and Hospital Chaplaincy."

In the meantime, the struggle for recognition of the importance of these issues and the part of the Christian medical establishment eventually paid off. CHAN recognized the concern of WHC and agreed to adopt the Taskforce as its own. From that time on, the Taskforce was no longer under the umbrella of the ICS but now became responsible to CHAN, while CHAN took full responsibility for its finances. The same part-time coordinator continued to function under CHAN.

I refer to a struggle for recognition. That is no exaggeration. There were many prejudices against the notion of WHC and many points of misunderstanding that needed to be erased from the minds of CHAN members. Some were afraid the Taskforce disparaged biomedical technology out of charismatic sentiments. Others feared that the intention was to introduce "native medicine." There were those who thought the WHC sought to replace the one-dimensional approach of modern medicine with a dualistic one that included both the physical and the spiritual. For that reason, they were confused when they did not hear representatives of the Taskforce pushing for chaplaincy and chaplaincy training.

C. The Chaplaincy Controversy

At first, the Taskforce resisted attempts to include chaplaincy concerns. The reason for this resistance was that the Taskforce identified the main problem to lie elsewhere and that shifting to an emphasis on chaplaincy would amount to diversionary tactics. The Taskforce identified the main problem to be the basic approach of biomedicine as practiced in most hospitals, including most CHAN hospitals. The basic problem was the one-dimensional approach, the exclusive emphasis on the physical that ignores all the non-physical elements that often play a major role in both sickness and health. It was only after the Taskforce agreed to include chaplaincy concerns in its programmes that CHAN eventually adopted the Taskforce as its own. The workshop on chaplaincy was thus an overture on the part of the Taskforce to meet the concerns of CHAN. Since then, the Taskforce has run two one-month in-service training sessions for people interested in counseling hospital patients. Thus, under pressure of CHAN, chaplaincy issues have been integrated in the programme of the Taskforce. The Taskforce came to recognize that, though the main problems may reside elsewhere, the chaplaincy is also a valid concern that is legitimately addressed under the umbrella of WHC. This issue having been settled, CHAN decided to upgrade the Taskforce to the status of Project, which action meant that it was raised to a department of CHAN equal to the other departments, which are referred to as "Project" rather than "departments." At this stage the Taskforce was renamed "Wholistic Health Care Project: (WHCP) of CHAN. From here on we will refer to this project by its new name.

Ironically, while it was agreement on the chaplaincy issue that eventually opened CHAN's door to WHC, WHC became a controversial issue once again, this time precisely because of the chaplaincy issue! It was especially the former Chairman who dropped his hesitation when the chaplaincy programme was accepted. However, a representative of the same denomination who had not noticed these developments suddenly became aware of the existence of the chaplaincy programme. Thinking that the programme was involved in training for the pastorate or priesthood, he expressed vigorous opposition to this aspect of the Project. CHAN, he argued, has no business getting involved in training for the priesthood; every denomination has its own programme. Furthermore, the work of a chaplain, according to him, involves sacraments and here, too, each denomination has its own views. The discussion led to the temporary suspension of this aspect of the Project.

Fortunately, the issue has largely been resolved. The argument was based on a misunderstanding. Training people for chaplaincy skills is not the same as training them for the priesthood. Though it is true that most chaplains are ordained, the skills taught in this programme are counseling skills that in no way prejudice the theology and practice of sacraments. The Rev. Fr. Jack Yali of the Roman Catholic Diocese of Jos has recently been

appointed by the Bishop of Jos to represent him on the Project. Fr. Yali has studied the kind of counseling known as Clinical Pastoral Education (CPE) in the USA and strongly denies that this kind of training is related to the training of priests and sacramental theology, It is true, the programme has reference to chaplains and the approach of CPE includes the term “pastoral.” It is also true that CPE training is geared to pastors or priests. Nevertheless, the training itself is basically designed to enhance one’s skills in counseling patients. Fr. Yali feels he has become a better priest because of his training in CPE, in spite of the fact that he took his training in Protestant institutions.

II. ISSUES IN WHOLISTIC HEALTH CARE

In the above historical account, we have highlighted a number of issues relating to WHC. However, as discussions proceeded through the years, the concept of WHC, it became clear, is wider than first envisioned. The following is a summary of some of the issues that require further discussions and exploration, especially with respect to their practical use in the Nigerian context.

A. Biomedicine

One of the main issues already brought up earlier is that biomedicine largely restricts itself to the physical aspects of health and sickness. This “accusation” should not be misunderstood. WHC, as it is developing in the context of CHAN, in no way aims to make light of the physical aspect of sickness. Of course, the physical aspect is real, important and requires treatment.

We repeat that we recognize biomedical technology as a great gift from God. Though Communist nations and others in which the Christian religion has played a minor role may now equal Western nations in their technological and scientific capabilities, the fact remains that modern science and technology, including modern medical science and technology, received their main impetus in nations where the Christian religion has had the greatest impact over the last millennium. This development took place not in spite of the Christian religion but because of it, as a direct result of it. It would take us too far afield to demonstrate this thesis, but it may be useful to remind ourselves of one of the early proponents of modern science, the strongly Christian Francis Bacon (1561-1626), of whom Hooykaas wrote that he had as:

His ideal ... a science in the service of man, as the result of the restoration of the rule of man over nature. This to him was not a purely human but a divinely inspired word: “The beginning is from God” He concluded the preface to his *Historia Naturalis* with a prayer: “May God, the Founder, Preserver and Renewer of the Universe ... protect the work”

Thus, modern technology, that is, a technology closely connected with science, found its most eloquent advocate in a man who placed it on a decidedly Christian basis ... (pp. 71-72).

Hooykaas' historical analysis is extremely elucidating, convincing and worthwhile reading. However, I would immediately wish to follow up this thesis of the Christian origin of modern science and technology with the reminder that the Chinese and Medieval Muslims had already made great discoveries that can be said to have provided undergirding for modern science and technology. They made contributions without which modern science and technology may not have taken off the way they did. At the same time, for whatever reasons, Chinese and Muslim cultures failed to develop their sciences further; it was left to the West to pick it up and further develop it before it was disseminated and became universal property.

It will not do, therefore, for us to belittle biomedical technology as non-Christian or "secular," as if it has nothing to do with God, with Christianity or with spirituality in general. The false dichotomies and spurious contradictions later generations have posited between science and religion are largely the result of heresies to which many Christian traditions have succumbed, often without realizing it. It is these heresies that have, in the minds of many Christians, driven a wedge between their faith and science and led to increasing distance between the two. But that is at most a wedge between the faith of specific people, of certain Christians, but not between faith and science itself, for science is an intensely religious activity, driven as it is by assumptions and ideology that are articles of faith that cannot themselves be proven scientifically. We must thank God for science, including biomedicine and make grateful use of it. The recent experiences of my own family with smashed elbow and wrist and with appendicitis have reinforced my appreciation for this great gift of God. Whatever shortcomings we may recognize, they should never lead to a reduction of our appreciation for biomedicine. A realistic awareness of its limitations should serve to enhance our appreciation of its capabilities, not reduce it.

B. Reaching for the Whole Person

The major shortcoming of biomedicine is its almost exclusive concentration on the physical aspect of sickness. While it is well known that physical sickness frequently has a non-physical cause or may be complicated by non-physical factors, when a sick person enters most of our hospitals, the prescribed treatment usually assumes the problem to be physical. Seldom is any practical consideration given to possible other factors. In fact, our nurses and doctors appear hardly to have been trained to recognize such factors, let alone taking them into consideration. They have been trained more as bio-technicians than as genuine healers of persons, a complaint aired more than once by Bernie S. Siegel and others as we have already seen. He suggests that there is a need to "revise physician education and create caring,

compassionate physicians, not technicians” (p. vi). Biomedics, he complains, are trained to be “mechanic-lifesavers” (p.5) or to do “things to people in a mechanical way to make them better” (p. 11).

1. Chaplaincy and Evangelism

When one discusses this shortcoming with Christian medics, he not infrequently meets up with the idea that this shortcoming must be countered by adding a spiritual or religious dimension. For such people, the main difference between a secular and Christian approach to medicine is that the latter integrates prayer and evangelism in our medical services. The medical aspect of this approach, however, is hardly any different from that of others. The diagnosis of sickness itself is the same. Anyone denying that this two-track approach is insufficient and still far from wholistic runs the risk of being suspected of having sold out his evangelical faith.

The attitude described in the above paragraph has sometimes led to the establishment of a Chaplaincy Department in hospitals. While the medics treat the patients physically, the chaplains deal with the spiritual life, not infrequently including an evangelistic thrust – but the two hardly ever meet. Their ministries are usually completely separate from each other. This approach fools people into thinking they have become wholistic without having their actual thinking about healing and their practice challenged.

It may well be that this attitude lay behind the insistence of some CHAN leaders that WHC requires concern for chaplaincy. We have come to realize that concern for a chaplaincy ministry is a legitimate part of any WHC programme. However, a more basic concern of WHC is with the way in which a sickness is analysed and treated, whether along the one-dimensional approach of biomedicine or along a more multi-dimensional method.

The role of evangelism in our hospitals is somewhat controversial within CHAN circles, I have noticed, with some parties adhering to quite opposing views. However, where there is an evangelistic thrust, no one should be fooled into thinking that this aspect of the programme now renders the institution wholistic. Now we have a two-dimensional programme that still falls far short of an approach that takes into consideration all the aspects of a person that have contributed to his malady. However, two dimensions is an improvement over one.

Of course, a chaplaincy programme does not necessarily need to have a primary evangelistic thrust. Its primary intention can be counseling and pastoral. Here the theology of the proprietor will play a decisive role. Nevertheless, it would seem to me that as long as we want to be worthy of the name “Christian” we should recognize that true and ultimate wholeness or health requires knowledge of Him whom we know as the great Reconciler and

who was sent for that very purpose. If the basic cause and ingredient of sickness is disharmony in one form or another, a Christian approach cannot and should not avoid reference to the One sent to restore harmony. How that is done will depend on the theology of the proprietor, but without this ingredient, we are missing the basic key to full restoration or wholeness.

2. A Multi-dimensional Approach

It may be recalled from an earlier part of this essay that the report of the 1980 CHAN conference referred to WHC as including “the whole person, physical, emotional and spiritual.” We were satisfied with that description at the time. Instead of one dimension or even two, we now have three. However, since that time we have come to realize that WHC includes more than that also. WHC includes *all* the dimensions of human life, not merely two or three. We are searching for Wholistic Health Care, not for Partial Health Care.

James S. Gordon, a graduate of Harvard and writing in the journal *Harvard Medical*, relates the story of his gradual “conversion” from biomedicine to a more wholistic approach that includes the former. Discussing “holistic medicine,” he affirms that

... its ideal represents an antidote to the narrowness of specialization, a fresh attempt to understand and treat whole people in their total environment. Without neglecting the treatment of disease, it includes an appreciation of patients as mental and emotional, social and spiritual, as well as biological and psychological beings (p. 41).

The human person is involved in a multi-faceted network of relationships with God, with oneself, with one’s community and with the environment. All of these relationships can and do influence one’s sickness or health. And so do one’s lifestyle, one’s economic condition, and a host of other affairs. Fear can cause ulcers; tension can create high blood pressure; hatred can bring about headaches; irresponsibility can create environmental havoc which, in turn, can be the source of many physical ailments. Drinking alcohol can bring intoxication which, in turn, can produce much misery individually and socially, physical and otherwise. Politics on behalf of vested interests can impoverish other social groups and reduce them to despair and hatred, making for widespread suffering and socio-economic sickness with all of its potentials for disease – as we are seeing in Nigeria today.

A pioneer in this area of concern is Paul Tournier, a Swiss Christian psychiatrist. Especially his book, *The Healing of Persons*, has made a deep impression on me. In his foreword to Tournier’s book, Georges Bickel writes:

Among those who come daily to ask for the help of our art, there is indeed a *multitude* of unfortunates for whom the most carefully prescribed medicine and diets are only a palliative,

the insufficiency of which we are the first to sense, because we are convinced that the disease whose symptoms we observe is only the exteriorization of an infinitely deeper malady, the true nature of which the patient does not always permit us to analyze. Thus we feel, as our examination proceeds, that the disease is situated neither at the level of the organs whose failure we observe nor at the level of the nerves whose functional imbalance we are trying to correct, but that the organic disturbances about which the patient is consulting us are the end product of a more intimate disorder which in general will not yield to our objective exploration and will be uncovered only by a completely honest and trusting examination of conscience (pp. ix-x. Italics mine).

Similarly, Jerome D. Frank of the John Hopkins University Medical College in the USA put it this way:

The phenomenal triumphs of modern scientific medicine have been made possible by this emphasis on the physical-chemical aspects of health and disease, and greater triumphs are undoubtedly in store. Yet in one vital respect it will *always* remain insufficient. It does not take into account the powerful influence of meanings derived from the interplay of the individual with his family and his culture on his bodily states. Illness always implies certain meanings. It is never merely bodily pathology, but has implications for the patient's view of himself and for society's view of him. ...illness may create noxious emotions, raise moral issues, disturb the patient's image of himself, and estrange him from his compatriots. Barred from the front door, these intangibles sneak in at the back, and, unless the physician takes them into account, he will often fail. The widespread popularity of nonmedical and religious healers ... attests the fact that the physician must be more than a skilled technician if he is to help many of his patients.

The importance of cultural and spiritual factors in disease and healing is seen clearly in the chronically ill:

To rehabilitate him, the physician must not only treat his body but inspire his hopes, mobilize his environment on his behalf, and actively help him to resume a useful place in society. Sometimes this task includes helping the patient to achieve a philosophy of life ... (Foreword in A. Kiev, pp. viii-ix. Italics mine. I disagree with the word "always" in italics, for I am not fatalist. If we have created the present situation ourselves, we can also change it – if we are serious about it. We are not caught up in an unalterable situation).

Someone may argue that the concerns here under discussion properly belong to the sphere of psychosomatic medicine. That is not the case, according to Tournier. Referring to WHC as "medicine of the person," he explains:

Psychosomatic medicine is a strictly objective discipline, subject only to the methods of the natural sciences, whereas the medicine of the person takes account, in addition, of facts which are accessible only to the moral sciences. Thus it implies a double view of man – that of

the physical, chemical, and psychical phenomena which determine him and which belong to the realm of the natural sciences, and that of his behavior as a *person*, as a spiritual being, free and responsible, involving factors which can be approached only by other methods, which belong to the field of morality rather than to that of technology (p. xii).

Because of the very close interrelationships of all areas of human life with our physical wellbeing, it is most surprising that the biomedical community has for so long been satisfied with an almost exclusive emphasis on the physical, especially when there is at least a theoretical awareness of these relationships. And it is perhaps even more surprising when one remembers that in African traditional medicine there has always been a strong awareness of these relationships.

Even though my own pastoral experiences forced me to think about WHC to begin with, wider explorations and reading not only made me aware of the writings of certain individuals, some of whom I have already quoted, but I also learned that these concerns have occupied a wide variety of Christian organizations, both denominational as well as ecumenical. Conferences have dealt with these issues, reports published and institutes established with the express purpose of exploring WHC issues. The International Association of Mission Studies in its publication, *Mission Studies* lists eleven such conferences, not counting their own conference that published this information (Vol. 2, No. 1, 1985). Martin Scheel summarized all the conferences held under the Christian Medical Commission (CMC) of the World Council of Churches (WCC) since 1979, and comes up with no fewer than ten of them, including at least one in Africa (WCC, 1987, p. 57). Clearly, we are not dealing with a personal idiosyncrasy or even with merely local problems.

In all of these documents the definition of health becomes all embracing – wholistic, if you like. We will satisfy ourselves with that offered by the CMC:

Health is a dynamic state of wellbeing of the individual and the society; of physical, mental, spiritual, economical, political and social wellbeing of being in harmony with each other, with the material environment and with God (*Mission Studies*, Vol. 2, No. 1).

That definition, it should be understood, is very representative of current international and ecumenical thinking. It is one with which I am personally happy – but also one that demands an all-embracing approach to healing.

In the light of the foregoing, I offer a tentative and incomplete working definition of WHC. WHC is healthcare that would search for the root cause of a patient's troubles. It would identify the physical problem and treat it, but it would not stop there. It would search for the cause of that physical problem, which often will be found to be non-physical. That cause may be found within the patient, in his relationship to God, to his community (local, national,

international), or to the environment. Within the context of the WHC centres with which he is associated, Donald Tubesing describes WHC as:

Actively searching with a patient all dimensions of his/her life (physical, emotional, intellectual, spiritual, interpersonal) for causes and symptoms of disease, then creatively exploring these same modalities for treatment strategies to restore or maintain health (p. 89).

We will have ample occasion to return to Tubesing's model as we proceed. However, it should be noted that the meaning of "interpersonal" is not as wide as we would like to see in his framework. The limits of his alternative wholistic approach are very much in line with those described by Marty in that established institutions and practices are not challenged (pp. 68ff, 84).

C. Involving the Whole Community

In the present healing approach of most of the CHAN community institutions as well as those of government and the private sectors the healing team consists almost exclusively of the medical people, the doctors and nurses. WHC would change that by involving the larger community.

1. The Role of the Patient

The first change in this respect would be the role of the patient himself. As it is, the patient is treated largely like an object on which the medical experts perform and for whom they prescribe treatment without explaining fully either the nature of the problem or the reason for the treatment. Often the patient, when asked by relatives, merely shrugs his shoulders in resigned ignorance and comments that he was not told. There is a subject/object relationship in which the medics are the acting subjects and the patient the passive object who has no responsibility beyond carrying out the orders of the experts.

WHC would change all this. The major change would be to transform the patient from passive object to active subject, to be an important member of the healing team and the one with the greatest responsibility for his own health.

Ideal patients, or, as Siegel calls them, "exceptional patients,"

manifest the will to live in its most potent form. They take charge of their lives even if they were never able to before, and they work hard to achieve health and peace of mind. They do not rely on doctors to take the initiative but rather use them as members of a team, demanding the utmost in technique, resourcefulness, concern, and open-mindedness. If they're not satisfied, they change doctors (p. 3).

Though Siegel refers to “exceptional” patients, he is not referring to a small group of patients. Though, in fact, he recognizes that his words apply to only a small group, “everyone can be an exceptional patient” (p. 4).

Siegel’s book is an amazing one for coming out of Yale. He traces his development from an ordinary biomedical doctor to a wholistic one, with a strong emphasis on the role of the patient himself – and all of it based on empirical experiences. Case after case is adduced to make his point. He does not claim to be a Christian or religious, but he does not hesitate to use the term “miracle” (p.6).

I am tempted to quote Siegel extensively, for his book is spiked with surprises and startling statements. Here are just a few samples:

... the outcome of tuberculosis had more to do with what went on in the patient’s mind than what went on in his lungs (p.2).

... medicine ... has rarely studied the people who *don’t* get sick. Most doctors seldom consider how a patient’s attitude towards life shapes that life’s quantity and quality (p. 2).

Other doctors’ scientific research and my own day-to-day clinical experience have convinced me that the state of the mind changes the state of the body by working through the central nervous system, the endocrine system, and the immune system. Peace of mind sends the body a “live” message, while depression, fear, and unresolved conflict give it a “die” message. Thus, all healing is scientific, even if science can’t yet explain exactly how the unexpected “miracles” occur (p. 3).

My role as a surgeon is to buy people time, during which they can heal themselves. I try to help them get well and at the same time to understand why they became sick. Then they can go on to true healing, not merely a reversal of one particular disease (p. 4).

... these healings occur through (the patient’s) hard work (p. 6).

Do not close your eyes to acts or events that are not always measurable. They happen by means of an inner energy available to all of us. That’s why I prefer terms like “creative” or “self-induced” healing, which emphasize the patient’s active role (p. 6).

Sieger is by no means the only one to emphasize the responsibility and ability of patients to heal themselves. WHC, Gordon writes, emphasizes “approaches ... which respect the patients’ capability for healing themselves” (p. 41).

Donald Tubesing has for some years been associated with Wholistic Health Centers in the USA. He quite admires the technology of biomedicine and describes it as “fantastic,” “miraculous” and deserving of “great respect.” Nevertheless, though patients “often encounter treatment that is mechanically superb treatment for their body,” they are often

demeaned as people (pp. 29, 21). Commenting on biomedicine, he writes, “no other culture, at no other time in history, has approached illness and its treatment in such a mechanical, scientific, piecemeal, and divided manner” (p. 29).

Tubesing reports that consumers of biomedicine complain about being treated as irresponsible children who do not know what is good for them, who would not understand any explanation and who have, furthermore, no right to it (p. 41). It is a criticism he repeats frequently in his book. “Counselors, dentists, and hospital personnel all receive the criticism that they keep the patient in the dark.” He tells of a hospital where a nurse could not even tell a patient his temperature and blood pressure. Everywhere there is “the mystique that the patient cannot understand and has no right to know.” In keeping with the other writers on WHC and contrary to the trend in biomedicine, Tubesing insists that “patients are ready and able to take care of themselves” (pp. 41-42). In the biomedical system, the medics promise to deliver health and the patients promise to obey. However, the medics cannot deliver on the promise and get frustrated, while the patients are “robbed of the opportunity or ... responsibility ... of understanding the meaning of (their) own illness and making appropriate life-style decisions in the face of it” (p. 80).

Consequently, in Tubesing’s clinics the “truly revolutionary and basic” aspect is “that the patient is responsible for his sickness and healing. The physician is the coach.” In the WHC centres, “the patient’s ideas are considered seriously” and “the information on the charts belongs to the patient, not the medical system and the medical provider” (pp. 80-81). This new insight receives embodiment in these clinics by having the patient as an important member of the healing team assigned to him. Before the patient actually makes his first visit, he is asked to fill out a very extensive health questionnaire that forces him to begin thinking seriously about his own responsibility for his health and involvement in his healing. The next step is meeting the healing team that initially includes a medic, a pastoral counselor and nurse, all trained in WHC. As a member of the team, the patient participates in exploring his problem and deciding on a course of action (pp. 95-96). All the way through, the patient is one of the active subjects, never a mere object on whom others practice their superior technical skills. This even shows up in the fact that the patient has free access to his own file and can make his own entries and correct those made by others if this is considered apropos (p. 103).

2. The Other Team Members

In Tubesing’s clinics, this team is supported by a host of volunteers and part timers, professionals and others. Many of these volunteers and part timers are former patients who show gratitude for their healing by volunteering or paid part time service at the clinic. In the

Nigerian context, patients who cannot afford to pay for services could be asked to pay by serving in various part time capacities.

Then there are at least two other immediate communities to which various patients might be referred: the biomedical community, -- those with a wholistic policy would be preferred – and the church, including the larger Christian community.

A patient requiring medical care would be referred to such a hospital, preferably one with a wholistic bias. There he would enjoy the wonderful fruit of biotechnology – if he can afford it!

The implication of all this is that WHC is not exclusively medical. The medical people would take care of the medical or physical problem. The healing team would have to include people with training in a variety of disciplines – pastors with special training in counseling, social workers, psychologists, nutritionists or dieticians, and perhaps others. Resorting once again to Tournier, we are told that

In the light of this, the mission of the doctor can also be seen to be twofold: He must first make use of every available technical resource with a view to the curing of the disease, whether it be surgery or drugs, physiotherapy, advice on hygiene, or psychotherapy. But his art remains incomplete if he does not also make some effort to help the patient to solve the problems in his life.

Is this possible? Is it, indeed, the doctor's job? I think it is. But it is clear that in this second function the doctor does not act so much as a scientist, but rather as a man, through his heart and his faith more than through his intellectual knowledge, through the love he bears his patient, by his personal commitment to him, by their personal contact, by the radiation of his own personality (pp. xii-xiii).

Like myself and like CHAN's WHCP, Tournier wrote these words fully conscious that his ideas and insights were continuing to develop and, therefore, subject to change and correction. And I hesitate to improve on the ideas of a man so rich in insight and experience. Nevertheless, great as my appreciation for his contributions to WHC is, I cannot suppress the question whether even Tournier is not reductionistic to some degree. Our previous quotation from him reduces the issues to that of technology and morality. They are, I am convinced, wider than that and include sociology, ecology, economics and politics, to name but a few. Furthermore, he still thinks of the doctor too much in isolation and assigns to him the entire responsibility of healing the patient, apart from the responsibility of the patient himself. WHC, as it is developing within CHAN, emphasizes teamwork and the role of the wider community so that the medical doctor does not have to carry impossible burdens.

The other immediate community consists of pastors and other church leaders at the local level. These need to be equipped more than they are now to recognize and deal with the

problems in the lives of their members before these problems get out of hand and express themselves in a physical way.

The community of the concerned continues to expand. All members of churches are to be made more conscious of their responsibility for each other and minister to each other spontaneously as soon as they recognize problems in each others' lives. Members engaged in various sectors in society should be encouraged to provide relief or to create bodies that can provide relief for the most common problems that bring people to clinics or hospitals.

We are, in fact, suggesting what would amount to a conversion of the Christian community into a more caring group than it is now. Indeed, WHC is not merely a matter for either medical or spiritual experts; it is a matter for all in the spirit of the Body of Christ as we have it described in I Corinthians 12, particularly verses 24-26, where we read,

But God has so composed the body ... that there may be no discord in the body, but that the members may have the same care for one another. If one member suffers, all suffer together; if one member is honoured, all rejoice together.

Elsewhere, the apostle Paul admonishes us that "if someone is caught in sin, you who are spiritual should restore him gently." "Carry each other's burdens, and in this way you will fulfill the law of Christ" (Galatians 6:1-2). We are not first of all talking here about sinners but about sick people, though evil, either individual or general, is not infrequently at the bottom of sickness, as in Psalm 32:3-4 and Psalm 38. Traditional African medicine is often concerned to restore harmony, a concept that reflects an African idea of evil. The Christian faith and African Traditional Religion may have more in common at this point than is often realized or admitted. WHCP needs to enquire into this relationship as it affects matters of healing.

It is high time that Christians cease dividing life into a religious and secular sector. Even our business, our legal and other professions, our politics and whatever else we engage in must be expressions of our service to God and to each other, expressions of our caring for one another. In the monthly bulletin of one local church recently, a professional was interviewed. This professional had music as his avocation and he has achieved a high measure of competence in this area. The thrust of the interview was that he was practicing his service to God in his musical ministry in the church, while his professional life was unrelated to such service. This writer is no Lutheran and most of the readers of this essay are aware of Martin Luther's controversial stature in history, but I doubt that anyone within CHAN would disagree with Luther's statement concerning the various occupations:

Every one of them in his occupation or handicraft ought to be useful to his fellows, and serve them in such a way that the various trades are all directed to the best advantage of the

community, and promote the wellbeing of body and soul, just as the organs of the body serve each other. (quote in Marty, p. 79).

The quotation sounds much like the Pauline words quoted just before, while they represent a Christian insistence on harmony. Unless Christians recognize their entire range of activities to be expressions of service to God and caring for each other, our health care will remain terribly crippled and expensive. Christians who separate service to God and man from their professions are likely to be in the forefront of the professional organizations that serve as fronts to defend and, at the same time, disguise sectional or class interests. They will continue to defend their economic interests as expressed in biomedicine. We have come full circle back to the complaints of Siegel and Gordon, two non-Christians who have gone through it all.

Perhaps the final and widest of the concerned or healing community is the political one. When I recently discussed WHC with Dr. Dennis Ityavvar, a sociologist of medicine at the University of Jos, and told him that WHC as seen in the context of CHAN is healthcare that aims at the root cause of sickness, he asked whether I understood the political implications of this view. I told him I was aware of the fact of political implications, but I was not sure of all the concrete implications. Surely justice, ecological responsibility, recreation, mass communication, transportation, employment, economics, health and educational policies all have an effect on the health of all citizens. If the Christian community wants to get involved in WHC it cannot but get involved in all these issues at a political level. Here is where Christians come in with various forms of training and expertise. Ultimately, the health of all is the business of all. That is WHC. That is the Christian community. That is, in fact, the citizenry in its entirety, Muslims as well as Christians.

It is a personal dream of mine that, once Christians and Muslims in Nigeria have learned to live together, we can cooperate on working towards a national politics that is integrated in the sense that each ministry contributes towards a well-defined concept of social wellbeing and that includes a health policy that moves beyond the present emphasis on biomedicine and primary health care on to WHC. Both religions will be free to practice in terms faithful to their respective theologies. The challenge will be to develop a concept of cooperative pluralism or pluralistic cooperation, working for the national good while retaining each other's individuality.

If I end this section on a political note, it is only because ultimately WHC requires a political expression. By definition it is impossible to develop a policy of WHC that is isolated from other aspects of life, especially one as comprehensive as the political. That is, after all, where the whole community comes in.

D. WHC and Other Healing Traditions

Biomedical technology has usually been practiced with an aura of pride and smugness. Given the tremendous feats performed in its name, one can to some extent understand how such an attitude could have developed. However, there are philosophic-theological, historical as well as practical reasons that press us towards a greater openness to other healing traditions. We will explore some of them briefly in this section.

1. Natural Revelation

The Bible teaches that God has revealed Himself to all people, not merely to some. True, the Christian community, having the Bible and knowing some crucial things about God revealed through Christ, has an important edge on other communities. We know some things that others either do not know or have rejected. However, I do not know of any Christian tradition represented in CHAN that denies the existence of natural revelation. Natural revelation means that God reveals Himself in nature. However sharp real and imaginary differences may have been at the time of the Reformation, both Roman Catholics and Luther agreed that there is such a natural revelation. During the year he died, Luther wrote, "All creation is the most beautiful book of the Bible; in it God has described and portrayed Himself" (Quoted in Marty, p. 27). Psalm 19 clearly teaches that He does so.

This doctrine means, among other things, that all people have access to truth about God and His creation. To be sure, this is not truth at the level Christians enjoy, but a degree of factual truth, though it may be placed in the context of a false framework. As far as it goes, it represents a genuine truth that we must not despise.

Neither do I know any tradition represented in CHAN that denies the validity of knowledge derived from experience, history and research. Whether a car is designed by Christians or non-Christians makes no difference to any of us. Whether the discovery of a certain herb is made by a Christian scientist or by a secular researcher or by an African traditional healer is basically immaterial. When we buy a packaged drug at the chemist shop we do not ask which type of person discovered its effectiveness, whether a Christian or Buddhist or Traditionalist. The question is so irrelevant that it hardly occurs to us to ask.

2. The Cultural Mandate

The first assignment given in the Bible is the so-called Cultural Mandate of Genesis 1:26, 28. Here the assignment is to rule the creation in the name of God. Science and technology are prime examples of how man is ruling the world; they are a major way in which we carry out that assignment. This assignment was given prior to the fall, but the carrying out of this

assignment was so embedded in our created human nature that even sinful and rebellious man after the fall continued to develop the world. In Genesis 4 we read of Cain's clan. Cain built the city Enoch. His great-great-great-grandsons developed important cultural entities that we all accept today: tents, musical instruments like the lyre and pipe, bronze and iron instruments. Even though that clan was not God-fearing, the chapter is telling us that they continued to do that which was part of their created nature, namely to rule or to develop the world. Their contributions have been gratefully used by subsequent generations, including Christ Himself as well as all members of CHAN. None of us reject tents or musical instruments or bronze and iron instruments as evil, even though they were developed by a disobedient and proud generation.

The burst of development that led to modern science and technology received its greatest impetus from the Christian faith that liberated men from the shackles of traditions and superstition and from contempt for the material creation. However, development to some degree took place in all societies, not merely there where the Christian faith left its greatest mark over the centuries. And in all cases, consciously or not, such developments were the response of various societies to the urge created within us to develop and rule the world. In some societies this urge was dulled because certain religio-cultural views were hostile to such developments and slowed them down to a snail's pace, while in others this urge was so highly developed that they rode roughshod over many aspects of a very sensitive ecosystem.

3. Cultural Distortion

In addition to the above considerations, it would seem that the amazing and apparently infinite variety that the Almighty has embedded in the creation is almost too much for man to absorb. Every culture has latched on to certain aspects of that creation and developed it, while others were ignored and thus left undeveloped. This is another way of saying that every culture tends towards one-sidedness and thus to distortion.

Western culture has highly developed its technology but at the expense of many human values that Westerners themselves are now beginning to realize. Christianity, as it developed in the West, has shared in that one-sidedness and distortion. It is, for example, very difficult for the average Western Christian to accept or understand an open universe in which God is free to act as He sees fit, free enough to set aside normal "natural" law and enact what many like to call "miracles." That same Western distortion has led to the development of biomedicine that, for all its great achievements, has severe limitations that are inherent in his approach.

Africa may not be famous for its technology and its Traditional Religions along with their accompanying health care methods have often been scorned. However, its many cultures are

rich in music and in their concepts of human relations, while their views on property are much closer to those we find in the Bible than Western concepts are. The relationship between religion and culture has been wholistic. As to its healing traditions, patients are not analytically chopped up in little segments, each of which is then analysed in isolation of the entire person. A patient's entire network of relationships, spiritual, physical, social, etc. are taken into consideration in the healing process. While the African healer may be weak in research and not always knowledgeable about the possible negative side effects of prescribed herbs, he is strong in psychology and religion.

Of course, as modern Christians we are aware of the negative aspects of traditional African medicine. Many of us are all too ready with a weighty arsenal of horror stories. I could show you a file of many newspaper clippings of herbalists who use various parts of the human body that are obtained by many devious means, including murder and desecration of graves. Our attempt to take a serious look at the positive aspects of the tradition does not mean to deny the negatives anymore than our criticism of biomedicine denies its positive contributions. We must be realistic, not ideologically blind to the facts.

My conclusion from all this is that to the extent a culture is one-sided and fails to take into account all of reality, whether physical or otherwise, to that extent that culture is distorted – and no culture is free from that. On the other side of the coin, since one culture emphasizes and develops what another ignores, every culture has its profound and legitimate contributions to make to the full truth. This conclusion has profound implications for truth in healing, for it implies that no healing tradition has an exclusive corner on the truth. Each can contribute to and learn from other healing traditions. Unfortunately, adherents and practitioners of biomedicine have neither always appreciated the positive to be found in other traditions nor always realized the inherent limits of their own approach.

That being the case, WHC implies an open mindedness to various healing traditions, not only to biomedicine. Mark well: being open minded is not the same as accepting something, lock, stock and barrel. Since healing practices and medicines are part of the way in which the human race is seeking to express their created urge to rule and develop and since in general Christians and non-Christians both participate in such development and make use of its fruits, we owe it to ourselves not to cut ourselves off from the fruits of various traditions and cultures because of pride and prejudice as if those traditions and cultures have nothing to contribute at all. We accept godless Tubal-Cain's instruments of bronze and silver. Why not the deep psychological insights of the African Traditional medicine man or the touch of a Chinese practitioner of acupuncture or the herb from a Muslim healer – long enough at least to measure their validity from the perspectives of science and religion both? Part of WHC is to

search for the validity or lack of it in all traditions, not merely in that of the biomedical one. Restricting ourselves to only one tradition is only at our own expense.

4. Biomedicine and Science

We may legitimately raise the question whether biomedicine is even scientific in the full sense of the word. When it is known that a person is more than a conglomeration of isolated bodily parts, can one consider an approach that ignores that basic insight truly be called “scientific?” When it is known that a person’s spiritual condition can affect his physical makeup, can one pretend that the spiritual is not important and still be thought of as scientifically responsible? When it is realized that social relations profoundly influence one’s physical wellbeing, but a doctor avoids that whole realm in his diagnosis and treatment, should he even be allowed to continue his practice? I leave the answers to these questions for you to ponder.

Recently I had a discussion on WHC with a Christian biomedic, a member of a CHAN church, but who had never heard of CHAN before! When I tried to explain WHC to him, he asserted that he was a strict adherent to the germ theory of disease. Unfortunately, the brother was under extreme pressure of time with half a dozen people demanding his attention simultaneously. Under such circumstances it was not possible to conduct a viable discussion on the subject and I am sure I did not satisfy his curiosity. However, I wish to state it here for all to read that even though the germ theory is partially valid and, we repeat, we admire the biomedical technology based on it, there are at least three fronts where it falls short. First, the invasion of germs can be facilitated by non-physical factors. Treatment that concentrates exclusively on eliminating the germs is therefore often no more than symptomatic. Secondly, even where the basic cause is germs, patients have a wide arsenal of attitude available to them that can overcome the negative effects of the germ, more than most biomedics will allow. Thirdly, the opposite side of the coin of the last statement is also true: lack of confidence or faith can undermine any germ treatment and render it ineffective. The empirical studies and experiences of both Tournier and Siegel leave us with no doubts on that score. The germ theory, it would seem, is correct only in so far as it goes. For the theory to be an effective weapon against disease and to be truly scientific it must be placed within the framework of a more wholistic theory.

Apart from historical and religio-philosophical considerations, do we not all know of many patients who could not be helped in a Christian biohospital but who received healing at the hands of those who practice what we officially deny or despise? Do not our relatives and, indeed, we ourselves resort to so-called “Black Man’s medicine?” I know a Christian who can cure a scorpion sting in a matter of moments. His skill should be available in every hospital. I

have been involved in more than one case that was finally concluded in the compound of a traditional healer after all efforts by a biomedical Christian hospital failed miserably.

5. Research into Traditional African Medicine

These considerations have led a sizeable number of CHAN members to call for sympathetic research into African Traditional Medicine. As a matter of fact, it will be remembered that CHAN itself has already at its 1980 Ibadan conference agreed to include aspects of this tradition in its emerging concern for WHC. In addition, at least nine members of CHAN have called upon the government to do “serious research into the whole area of traditional medicine and favour the immediate use of proven traditional remedies” (TEKAN, p. 32). These churches are: NKST, Church of Christ in Nigeria (COCIN), Christian Reformed Church of Nigeria (CRCN), United Methodist Church (UMCN), Lutheran Church of Christ in Nigeria (LCCN), Ekklesiyar ‘Yan’uwan Nijeriya (EYN), Church of Christ in Central Nigeria (CCCN) and Mambila Baptist Convention of Nigeria (MBCN).

With CHAN itself and so many of its members favouring a move in this direction, it is surprising that the CHAN National Council was so hesitant to allow representatives of Traditional Healing participate in the WHC workshop for which this paper is written. Not even the representatives of these members supported the presence of such people. One can only suspect that those who represent their churches in CHAN are neither aware of what their churches have decided nor do they consult their church leaders on matters relating to CHAN. It is time for CHAN and its members to be more serious about their decisions as well as about the kind of people they send to represent them in ecumenical fora.

6. “Faith” or “Spiritual” Healing

Then there is the whole range of issues related to so-called “faith” healing or “spiritual” healing. These are important issues for any Christian consideration of WHC. To begin with, let me express a basically affirmative attitude on the part of WHC to direct divine intervention and healing. Whether healing comes directly from Him or through indirect means, the glory is His for He is the healer. It is unbiblical to pit direct divine healing and healing via instruments against each other, for the technology used is also His gift. It is also unbiblical to reject biomedicine as we have seen, though we should be aware of its inherent limitations.

As to faith, all forms of healing are based on faith. Without faith on the part of the patient, no biomedic, traditional healer or practitioner of WHC is able to heal. In other words, all healing is faith healing. A patient, whether Christian or anything else, is not likely to heal without having faith in the medic, the medicine or the method applied. It does not even have to be faith in God. This has been made especially clear by Bernie S. Siegel of Yale University in his

book, *Love, Medicine and Miracles*. The difference for the Christian is that he knows God to be the ultimate healer and he seeks healing from Him, whether directly or through means. He also may have learned certain formulae for wellbeing from the Bible, formulae perhaps not available elsewhere. The forgiving grace of God has tremendous healing power in the case of those with an uneasy conscience.

The assumption of WHC in CHAN is that of an open universe run by God the Creator and Preserver, usually by following the laws He Himself embedded in creation, but which He is free at any time to suspend or bypass. WHC is looking for a method of healing in which faith and prayer will play a consciously dominant role. It will acknowledge and encourage healing by prayer without discounting the role of healers. Though we recognize the role of faith in all healing, in the clinic that WHC is planning to establish, patients will be encouraged to have faith in and pray to God, the Father of our Lord Jesus Christ, for He is the anchor and reason for all of CHAN. The patient will also be urged to follow a lifestyle consonant with the message of the Bible. Unlike Western biomedicalists who dare tell a patient he has only three months to live, team members of this clinic, including the patient himself, will never give up hope, even when all known medical possibilities have been exhausted. The problem is never beyond God to intervene and heal. But God will not be appealed to in emergencies only: He will be a recognized member of the healing team from the start. Unlike the incident in the American TV serial so popular in Nigeria, *"Another Life,"* where an incident of direct divine healing was an embarrassment to the medical doctors, including Christians among them, this clinic will proclaim God not as the emergency healer but as the primary healer. This aspect of the programme will not be the special preserve of a religious specialist, a chaplain: all members of the team are expected to go out of their way to integrate this great Christian insight in their healing work all along the line. "Miraculous" cures will not be regarded as isolated incidents; they will be among the expected and regularly occurring types of healing. Though they will be carefully screened to eliminate charlatans, those having the gift of healing by prayer will be welcome. I would expect that we would have a regular team of volunteers having this gift working with the staff and the patients.

E. Relationship between WHC and Primary Health Care

Another issue that begs treatment is the relationship between WHC and primary health care (PHC), CHAN has a PHC project as well as a WHCP, but so far these projects have been quite separate. According to Moses Thliza, Coordinator of CHAN's PHCP, his department works more in the rural areas, whereas WHCP is just as much concerned with the urban situation. Plans are to discuss their future relationship. It is my opinion that eventually they should be directed by one coordinator, not two. That coordinator, however, will need to have a wholistic vision if the WHC emphasis is not simply to disappear. However the eventual

arrangement will be, they cannot go on separately indefinitely, for there is too much overlap between them.

III. The Current Stage of WHCP

At this point I want to summarize for you the present stage of the WHCP of CHAN and plans for the immediate future. Salient elements of the programme have already been mentioned. The agenda at the moment includes the following activities:

A. Recruitment of a Fulltime Coordinator

Recruitment of a fulltime coordinator is now in process. We will be looking for a medical doctor who has experience and/or training in general or family practice and who has an interest in WHC issues. An acceptable alternative would be a highly-trained and experienced public health officer who is interested in the WHC approach. Once that appointment has been accomplished, the programme will make more headway than it has in the past. The appointee is expected initially to serve as assistant to the present part time WHC Coordinator.

B. Establishment of a Pilot WHC Clinic

The establishment of such a clinic is a crucial step the time for which has come. Its purpose is, among other things, to lift WHC concepts out of the realm of ideas up to the level of reality, to practice it, to hone it. It is also to show whether or not it is economically viable.

The economic question is a real one. Many existing Christian hospitals have to rush patients through in order to make ends meet. Can a wholistic clinic with its more relaxed approach beat the economic pressure? It remains to be seen. The other side of the coin is that such a clinic is not likely to require all the expensive equipment of a biohospital, since patients requiring biotreatment will be referred to a biohospital. This feature should reduce the costs of the treatment considerably.

In distinction from the subject-object relationship that exists in the biomedical approach between the doctor and patient, in this WHC clinic the patient will be considered to be the party bearing the greatest responsibility for his own healing. He will be promoted from the status of object on whom certain actions are performed, frequently without understanding the purpose of these actions, to that of subject. He will be the main member of the healing team, other members of which will be the various specialists in the clinic. Initially, the team will probably comprise a general practitioner, a nurse and a pastoral counselor, all well trained in WHC concepts, supported by a team of part timers and volunteers.

The clinic will also serve as a referral centre. Some patients will be referred to a hospital for biomedical treatment, but it should be a hospital that adheres to WHC philosophy so that even biomedical treatment will be in conformity with the basic healing approach started at the clinic. Other patients may be referred to their own pastors who, in the future, hopefully will be better equipped to deal with the problems of their members than many of them are presently. These pastors, perhaps in the farther future, will benefit from WHC counselor's training programme, whether that pioneered by CHAN or by existing programmes now being developed as, for example, that of the Baptist Theological Seminary in Ogbomosho. Still other patients may need to be referred to rehabilitation centres of one type or another or they may need help in finding employment.

Thus, there will be a lot of liaisoning to be done by the team members. They may have to seek the involvement of many different groups in society and in church. They may need to encourage the formation of a group of concerned businessmen to develop facilities for the express purpose of providing employment for patients that need it for their healing.

A pioneering aspect of the clinic will be a careful attempt to integrate the best of other healing traditions, especially that of Traditional African Medicine. Aspects that will receive special attention include various techniques, the efficacy of certain herbs, traditional psychology, the role of the community and the influence of religion in their practice. No doubt, in all this the clinic will make use of research done in universities, hospitals as well as in existing WHC clinics, especially one in Ghana, where various healing traditions are reportedly working together. Carefully selected practitioners of other traditions will be invited for discussions, cooperation and limited participation.

An important difference between such a clinic and most existing CHAN-related health institutions will be the search for the root cause of the patient's problem, while the physical will also be attended to. It will not simply be assumed that a patient's basic problem is physical. And, of course, if the initial analysis is different, the treatment is bound to be so.

The long-term ideal relationship between the clinic to existing health institutions can best be left to experimentation. However, a tentative decision will have to be made at the beginning as to how or where to start: in an independent clinic or in one attached to a hospital? Or in a church?

In an earlier section of this essay, we have already discussed the role of faith and prayer healing. That will constitute a prominent aspect of the healing process. There will be no fear of or embarrassment for "miracles," but they will not be regarded as the only indication of divine healing.

As a concluding remark on the planned pilot WHC clinic, its purpose will be to establish an approach to healing that is more scientific, more in tune with the Bible, Christian tradition and theology, more appropriate to Nigerian culture and, hopefully, more affordable. WHC as envisioned within CHAN will, I believe, meet all four requirements.

C. Training in WHC Concepts and Practice

WHCP has already run one workshop on the issue of chaplaincy and has also run two short in-service training courses for counselors in the WHC tradition or, more precisely, in the CPE tradition, i.e. Clinical Pastoral Education. Such in-service training will hopefully be started up again and is likely to feature prominently in WHCP's programme for years to come.

However, the possibility of setting up a permanent training institution for counselors in the tradition of WHC will be seriously explored. Such a centre would probably run a combination of short in-service courses alongside a full time course of two to three years for efficient and professional training based on recognized international standards for CPE.

A suggestion raised at the first workshop held recently is that there should be a Centre for WHC, where not only pastors and other counselors would be trained, but also other professionals, especially medical doctors and nurses. Training sessions could be of various duration from short in-service courses to those lasting a year or more. That suggestion is worthwhile pursuing and may well constitute an improvement over the idea of only training pastors and other counselors.

D. Public Enlightenment

Acceptance of the above programme will require a great deal of public enlightenment among the medical profession, church leadership and the general public. For this reason the programme will include conferences, lectures and workshops as well as the production and distribution of literature. The series of workshops for which this paper is written is an example of a combination of public enlightenment and deepening of insight into what WHC entails. This conference is meant to increase our interest in and knowledge of WHC. It is the first of a series of four to be held in 1989. We hope to publish a report of these meetings so that their results can be disseminated far and wide among all relevant parties. In addition to such reports, we hope to publish tracts that will appeal to specific sectors and deal with limited aspects of WHC. And, expensive as it is, we will try to slowly build up a small library with WHC materials for interested people to do research in the subject.

E. Conclusion

WHC is a difficult theoretical concept, but as a practice it is likely to prove even more difficult. How does one bring about the required total revolution from biomedicine to a national politics conforming to WHC? Surely it is far easier to simply continue with our present mix of biomedicine, traditional medicine and prayer houses, each going its separate way. It would leave all the major actors undisturbed. It would not ruffle any vested interests. Biomedical specialists could continue to demand millions of government naira for their esoteric interests that benefit a minor segment of the population. But it would be neither Christian to so continue nor scientific – let alone economical.

Bibliography

Becken, H. "The Churches as a Healing Community," *Mission Studies*, Vol. 1, No. 2, 1984, pp. 35-43.

Boer, Jan H. Various speeches and reports produced in the context of the Wholistic Health Care Project of Christian Health Association of Nigeria.

-----, (ed.). "In search of Wholistic Health Care." Stenciled seminar report, Jos: Institute of Church and Society, 1981.

----, *Christians and Mobilization*. Jos: Institute of Church and Society, P.O. Box 6485, Nigeria, 1989.

Gordon, James S. "Holistic Medicine: Fringe or Frontier? Explorations beyond the Biomedical Model." *Harvard Medical*, LVII (Fall/Winter, 1983), pp. 40-45.

Hooykaas, R. *Religion and the Rise of Modern Science*. Grand Rapids: Eerdmans, 1972.

International Association of Mission Studies. "The Church as a Healing Community." *Mission Studies*, Vol II, No. 1, 1985.

Marty, Martin E. *Health and Medicine in the Lutheran Tradition*. New York: Crossroad, 1983.

Siegel, Bernie S. *Love, Medicine and Miracles: Lessons Learned about Self-Healing from a Surgeon's Experience with Exceptional Patients*. New York: Harper, 1986.

Towards the Right Path for Nigeria. Jos: TEKAN, P.O. Box 475, 1987.

Tournier, Paul. (Trans. E. Hudson). *The Healing of Persons*. New York: Harper, 1965.

Tubesing, Donald A. *Wholistic Health: A Whole-Person Approach to Primary Health Care*. New York: Human Sciences Press, 1979.

Who Lives, Who Dies, Who Cares: Listening and Caring. Report on a European Consultation on the Christian Understanding of Health, Healing and Building Community, held in Budapest, Hungary, September 3-9, 1986. Geneva: World Council of Churches, 1987.