

# *Integral Medicine: A Noetic Reader*

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## **FOREWORD**

Ken Wilber

It always struck me as interesting that a major tenet in the Hippocratic Oath, an oath that in various forms has been taken by many physicians around the world for almost 2,000 years, is simply, “Do no harm to your patients.” The positive injunctions are few; but that negative injunction jumps right out at you. Why would it even be necessary to ask a future physician to promise something like that? It is as if Hippocrates understood that, of all the power a physician has, much of it enormously positive and beneficial, one item needs most to be checked: the almost unprecedented capacity to harm a person, legally.

In several versions of the Hippocratic Oath, it is clear that Hippocrates (long thought to be Hippocrates the Great but revealed by recent scholarship to have been a member of a Pythagorean circle, which does the opposite of diminish his reputation) also understands, particularly when it comes to medicine, that there are two ways to do harm: sins of commission and sins of omission. A physician can harm a patient with what he knows; but even more so, with what he doesn't.

The aim of integral medicine can be stated simply as the desire to lessen the harm done by both of those sins, and therefore much more effectively set the stage for the extraordinary miracle that, 2000 years later, none of us yet understand: healing.

Stated more positively, the aim of integral medicine is to utilize as complete and as comprehensive an approach as possible in treating any illness—while, of course, remaining fully cognizant of the pragmatic realities of time constraints, insurance limitations, and office practicalities. The integral medicine that is rapidly developing today has moved significantly beyond early attempts in this area, variously known as “holistic,” “allopathic,” “alternative,” and “complementary.” Although some of the components of those pioneering efforts are retained, integral medicine is being launched from a platform much wider in its reach, more grounded in empirical research, and more effectively related to comprehensive models of human psychology and consciousness. But it is helpful to remember that an integral medicine differs in significant ways from both conventional and complementary medicine, while attempting to include the enduring and effective elements of each.

What would such an integral medicine look like? And how can it effectively be applied given the economic and pragmatic constraints of today's world? The following chapters are attempts to address exactly such questions. Before we outline some of their ground-breaking conclusions, let's set the stage by looking at some of the traditional problems and dilemmas faced by most medical and health-care professionals.

Everybody knows the first dilemma, because for years it was drummed into medical students: “Don’t get emotionally involved with your patients.” At the time, that was certainly not a cruel and uncaring injunction to treat people like objects; it was a genuine and sincere attempt to bring a dispassionate and scientific approach to healing illness. Becoming emotionally involved with a patient not only clouded the physician’s judgment, it constantly drained the physician and accordingly seemed to harm the patient.

And yet, beginning in earnest a decade or two ago, there was an explosion of hard empirical research showing that positively enlisting various emotional factors—on the part of the health-care practitioner as well as the patient—had a profoundly affirmative effect on the treatment, in many cases not only reducing recovery time but medical costs as well. Nor was this a case of “needy” patients doing better if somebody held their hands. Controlled studies consistently showed that, if certain emotional and affective elements are engaged in the healing process, positive effects tend to be seen across all types of patients. Put bluntly, not becoming emotionally involved in some ways could not only increase medical costs but significantly harm the patient. What’s a poor doctor to do?

Medical schools across the country began eyeing this research warily. The whole thing had too much of a “New-Age” ring to it for most conventional medical practitioners. Trying to introduce these “subjective” factors was the opposite of what modern medicine ought to be doing. Nonetheless, virtually all medical schools were forced to confront this issue when research showed that patients were fleeing orthodox medicine and spending some 2 billion dollars annually on types of healthcare that did not ignore these subjective factors. Over two-thirds of medical schools now have courses in complementary medicine, although the relationship between the two approaches remains as uneasy (and even cynical) as it ever was. Part of integral medicine is an attempt to find a framework that can allow both of those approaches—conventional and complementary—to exist in a framework that embarrasses neither.

A second common dilemma faced by medical practitioners is the very difficult problem that has become popularly known as the “Cartesian dualism,” or the mind-body problem, and which, for all its high-flying philosophical accoutrements, simply means this: right now you mostly likely feel that you have some sort of consciousness and free will, and yet physical science proceeds as if reality is a closed materialistic system. Even if philosophically you are a materialist, you have to constantly translate every experience you have into materialistic terms, because that is simply not how your experience arrives. Physicalism, in other words, violates the grain of how the world naturally presents itself (not to mention the fact that the majority of philosophers in the area simply do not believe that consciousness can be reduced to eliminative materialism). And yet, as a conventional physician, you are more-or-less forced to treat a patient as if the patient were essentially a biophysical or material system—medications for this, surgery for that, radiation for this, one physical intervention after another physical intervention. Your patients, when it comes to medicine, are physical machines, and yet in your own awareness you do not feel that you are a physical machine—and neither do your patients. The “Cartesian” problem in the conventional practice of medicine is simply that you are basically forced to treat a patient as if he or she were a physical machine, when both of you know otherwise.

A third common dilemma faced by conventional medicine is that of compliance. It is now estimated that in many cases a majority of treatment failures are due to lack of patient compliance with the prescribed medical intervention (from taking pills to following recommended diet). Patient compliance has always fallen into the rather nebulous area of “subjective psychology”—exactly the area ruled out by the biophysical model of medicine. Once again, the very core practices of biophysical medicine are rendered ineffective precisely by those factors deemed not central to the model.

A fourth dilemma faced by health-care practitioners is rarely spoken about, but it is a topic always lurking in the hushed background: just where do you locate illness? And where do you locate the causes of any illness? It is simply impossible to draw a boundary around any disease

entity, let alone its causes. Arteriosclerotic heart disease has many contributing factors, including diet, with primary culprits including trans-fatty acids, now thought to directly contribute to thousands of deaths annually but are nonetheless widespread ingredients in virtually every packaged food product in this country. Or take the number of hormone-like synthetic chemicals, now numbering in the tens of thousands, around 10% of which are known carcinogens. Can any person be healthy if the biosphere is sick? From this uncomfortable perspective, it appears that as a physician, when you treat any patient, you are being asked to fix one small link in a thoroughly diseased chain of events.

Psychiatrists face this painful dilemma all the time. A teenager comes to the office for treatment of anxiety neurosis; it soon becomes obvious that it is not so much the teenager who is sick as his family, with an abusive father and alcoholic mother. Where is the illness “located?” Not to mention the fact that this teenager has to pass through metal detectors every day in school in order to make sure that he is not carrying an Uzi machine gun. And so what’s the poor psychiatrist to do? Medicate the kid, of course.

This dilemma is simply that, just as in some mysterious way everything is connected to everything else, so all illness is somehow deeply embedded in networks, systems, and chains of pathology, with any individual patient being something like a canary in the proverbial mine shaft, picking up the systemic illness a bit earlier than others and having the good sense to drop dead first.

Whether or not any particular health-care practitioner explicitly thinks of illness as being part of larger (and possibly diseased) systems in the world, there is usually the gnawing sense that one’s efforts at health care are not much different from being a surgeon in a MASH unit during a war: you patch them up and send them right back out on the battlefield to catch the next bullet. The intrinsic insanity of the situation—this impossible *Catch-22* job—seems to be felt to some degree by all sensitive health-care professionals.

Related to that difficult issue of how to define or even locate “illness” is the converse and equally impossible dilemma: what do we mean by “health”? Once it is understood that a human being is not simply an assemblage of physical parts, but contains emotional, mental, and spiritual dimensions that cannot be reduced without remainder to material processes, then what exactly does “health” mean in such a multidimensional being? How many levels of being—physical, emotional, mental, spiritual—should a doctor treat? Can I be healthy if I am spiritually malnourished? If a Nazi’s blood tests come back completely normal, is that person healthy?

“Well, as a physician, that is not, and cannot be, my primary concern.” But that is the same agonizing dilemma, isn’t it? By saying that those areas are not the concern of physicians, we are by default pledging allegiance to the old materialist version of medicine, thus forcing ourselves to treat a person according to a model that both the doctor and the patients know is hooey. And there is the painful dilemma: as a health-care professional, you might indeed have to specialize in one particular area and ignore and compartmentalize all others; but as a human being, you simply cannot do so and retain any sort of basic sanity or decency. The more effective you are as a conventional physician, the less a human being you often find yourself becoming.

Integral medicine is designed, in part, to help with those dilemmas, not so much as they effect the patient or client, but as they effect the physician and health-care practitioner. Integral medicine is also, of course, a way to more effectively and efficiently help patients; but it is, first and foremost, a way to help the health-care professional handle all of those pressing problems and painful dilemmas.

This is one of the defining ways that sets integral medicine apart from both conventional medicine and alternative medicine. It is sometimes said that conventional medicine treats the illness and alternative medicine treats the person. That’s fine, and I personally believe both of those are very important. But integral medicine goes one step further: it treats the illness, the person, and the physician.

Here it is useful to make a distinction between what might be called “an integral approach” and an “integrally informed approach.” As we will see, both of these play an important role in integral medicine, although the former applies more to the patient, and the latter, to the health-care professional. While an integral approach can more effectively help the patient, an integrally informed approach can more effectively help the healer.

All of the dilemmas mentioned above are variations on a common theme: the nature of a human being and his or her relation to a larger scheme of things. Although it might seem at this point that we are taking an unnecessary detour through philosophy, psychology, metaphysics, or some other alarmingly irrelevant field, the whole point about any truly integral approach is that it touches bases with as many important areas of research as possible before returning very quickly to the specific issues and applications of a given practice, in this case, medicine. Fortunately, the results of this particular detour can be summarized fairly simply and succinctly, with its direct relevance to medicine quickly established.

An integral approach means, in a sense, the “view from 50,000 feet.” It is a panoramic look at the modes of inquiry (or the tools of knowledge acquisition) that human beings use, and have used, for decades and sometimes centuries. An integral approach is based on one basic idea: no human mind can be 100% wrong. Or, we might say, nobody is smart enough to be wrong all the time. And that means, when it comes to deciding which approaches, methodologies, epistemologies, or ways of knowing are “correct,” the answer can only be, “All of them.” That is, all of the numerous practices or paradigms of human inquiry—including physics, chemistry, hermeneutics, collaborative inquiry, meditation, neuroscience, vision quest, phenomenology, structuralism, subtle energy research, systems theory, shamanic voyaging, chaos theory, developmental psychology—all of those modes of inquiry have an important piece of the overall puzzle of a total existence that includes, among other many things, health and illness, doctors and patients, sickness and healing.

So an integral approach does not start by asking, for example, “Which of those methodologies are right and which are wrong?,” but instead asks, “What kind of a universe is it that allows all of those practices to arise in the first place?” Since no mind can produce 100% error, this inescapably means that all of those approaches have at least some partial truths to offer an integral conference, and the only really interesting question is, what type of framework can we devise that finds a place for the important if partial truths of all of those methodologies?

If we found such an integral framework, isn't it likely that it would have a direct impact on the practice of medicine and the difficult dilemmas faced by medical practitioners who, in effect, are presently forced to be less-than-integral in their medical practice?—while nevertheless feeling the strain and inner turmoil of wishing to be as whole and as integral as they can as human beings? And wishing to bring that *integrity* to an *integrally informed* practice of medicine? Is it really necessary that the more I become a doctor, the less I become a human? Or is there some way to practice medicine that surrenders not one ounce of the rigorously scientific, empirical, and clinical dimensions that will always be a cornerstone of any modern scientific system of health care, but also makes room, in a coherent fashion, for all of those other dimensions of being-in-the-world, dimensions that, if ignored or repressed, not only subtract from one's humanity but from being a truly effective physician?

To show what is involved, here is an example of how an integral approach has been used in psychology; the example is directly relevant because it is in the dimensions of psychology and consciousness that an integral approach has much to offer conventional medicine.

There are at least a dozen major schools of psychology, East and West, ancient and modern. There are the more “external” and “objective” approaches to consciousness, such as neuroscience, cognitive science, chaos and complexity theory, behaviorism, and neuropharmacology. There are the more “interior” or “subjective” approaches, such as depth psychology, meditation, guided imagery, and phenomenology. There are the “social” approaches that emphasize the relational nature of consciousness, including family therapy, systems theory,

and social psychology. And there are the avant garde approaches, including subtle energy research, metanormal and paranormal capacities, and transpersonal states and stages of consciousness.

When I first began studying psychology and consciousness, it was still common practice to pick one (or at most two) of those schools, decide that those were basically the correct approaches, and then spend the rest of one's professional life vigorously attacking the other ten schools. But as integral perspectives began to have an effect on the field, the central question in psychology and consciousness studies changed from, "Which of those 12 schools is the best or most accurate approach?," to "Why is it that all 12 of those schools exist in the first place?"

Nobody is smart enough to be wrong all the time. The implication was clear: if we are ever to have anything resembling a comprehensive, inclusive, integral view of psychology and consciousness, there is one and only one thing that we know for sure: it will include all 12 of those schools. Hundreds of thousands of decent men and women around the world are *already* practicing neuroscience, or psychiatric pharmacology, or meditation, or subtle energy research, or transpersonal psychology, or contemplation, or chaos and complexity theories. For the most part, they are responsible, sincere, and concerned men and women of integrity, and they honestly believe that the practice of their chosen field is making a positive and helpful contribution to humanity. And you know what? I believe them. And I hope you do, too. It is not a matter of whether they can do that, or should do that, or are mistaken to be doing that. It is simply the case that they are already doing that, and are doing so in knowledge communities that have passed their knowledge forward for decades or even centuries, all of them contributing in invaluable ways to the sum total of understanding of what it means to be a human in the world.

So the really interesting question in psychology and consciousness studies soon becomes, "What theoretical framework can account for the important if partial truths of all 12 of those schools?" And then, "Once we have some sort of integral and nonexclusionary theory, how can that *integral theory* be put into *integral practice*?"

In psychology and consciousness studies, here is one result of such an integral approach. If you put all 12 of those important schools of psychology on the table; if you assume that they all have an important piece of the overall puzzle; if you then ask, “What must the nature of the human psyche be in order that all of those approaches are focusing on some important aspect of it?,” one of the conclusions that you reach is that the human psyche must contain various dimensions or domains in order for the above methodologies to exist in the first place.

The type of integral psychology that I am most familiar with condenses all of those “necessities” down into five of the most important dimensions or components of the psyche, which are called quadrants, levels, lines, states, and types. A few of the following chapters present a general outline of this version of integral psychology, so here I can be mercifully brief—but the point, in any event, is that if we have a more integral psychology, we might very well be getting closer to what it means to be an integral physician.

“Quadrants” is merely shorthand for first-, second-, and third-person perspectives. All major human languages have first-, second-, and third-person pronouns (*first-person*: I, we; *second person*: you, all of you; *third person*: him, her, them, they, it, its). The simplest and least derogatory explanation for that is: those pronouns represent real and enduring dimensions of experience and reality, dimensions that language itself has therefore adapted to and included during evolution. The first-person dimensions of being-in-the-world include, among other things, the interior “I,” self-identity, art and aesthetic expression, meditation, depth psychology, guided imagery, introspection, contemplative prayer, normal and altered states of consciousness, and interior phenomenology. The second-person dimensions of being-in-the-world involve, among other things, the ways that a “you” and an “I” can come together and form a “we” (which is why “you” and “we” are sometimes treated together as second person), and thus second-person dimensions include culture, hermeneutics, mutual understanding, morality (or how we treat each other with regard), intersubjectivity in all its dimensions, and communication itself. The third-person dimensions of being-in-the-world include the more “objective” approaches to reality,

which do not use “I-language” or “we-language” but rather “it-language”—namely, the more scientific approaches that focus on those third-person dimensions of being-in-the-world—approaches that include physics, chemistry, neuroscience, pharmacology, and so on. These “it” approaches are sometimes subdivided into individual and systems approaches, giving us the sciences that focus on an individual or its subcomponents (the more “atomistic” versions of science, including physics, molecular biology, etc.) and those that focus on the collective (such as the numerous forms of systems theory, ecology, and complexity theory). These two approaches are often summarized as “it” (singular) and “its” (plural, collective, systems).

So the quadrants (I, we, it, and its) are just a simple way to keep track of the four major dimensions of being-in-the-world that are not only embedded in all major languages—and are therefore already present and fully operating in both you and your patients—but dimensions of reality that have been intensely investigated by literally hundreds of major paradigms, practices, methodologies, and modes of inquiry. These dimensions of being-in-the-world are most simply summarized as self (I), culture (we), and nature (it). Or art, morals, and science. Or the beautiful, the good, and the true. Or simply I, we, and it. And the interesting point is that, as far as we can tell, none of those dimensions can be reduced without remainder to the others (which is why, as a scientist, you might try to focus exclusively on the “it” dimension of reality, but as human being, you cannot do so without rupturing the fabric of experience).

Of course, for centuries reductionists representing every quadrant have tried to reduce the other three quadrants to sneaky variations on their own, only to be met with one sizzling failure after another. The materialist is an “I” who spends his time trying to prove that “I’s” don’t exist; a subjective idealist is an “I” who looks at “its” and tries to prove that they don’t exist; a postmodern constructivist tries to prove that both “I’s” and “its” are nothing but social constructions of a “we.” Overall, one gets the sense of four limbs of a body each arguing that the others don’t exist, a situation probably best summarized by Lovejoy as, “There is no human stupidity that has not found its champion.” But in any event, such a reductionistic endeavor is

simply not interesting to an integrally informed practitioner, because nobody is smart enough to be wrong all the time.

If you look at these four quadrants, embedded in all natural languages, it soon becomes apparent that there is a simple symmetry involved. “I,” “we,” “it,” and “its” represent the interior and the exterior of the individual and the collective. [This can be seen in figure 000.] The Left-Hand or interior dimensions (of I and we, or the first- and second-person dimensions of being-in-the-world) are “invisible,” in that they can’t be seen with the senses (e.g., mathematics, logic, mutual understanding, love, compassion, introspection, meditation, guided imagery, normal and altered states of consciousness, etc.); but the Right-Hand or exterior dimensions (of it and its) can be seen with the senses, in that they are the objective or third-person dimensions of being-in-the-world, including atoms, molecules, cells, organisms, ecosystems, and so on. If the Left and Right Hand quadrants represent interior and exterior realities, the upper and lower quadrants represent the individual (I, it) and the collective (we, its).

Now the implication of that simple scheme is that all four of those dimensions inextricably go together, if for no other reason than that you cannot have an inside without an outside, nor a singular without a plural (which is probably why reductionism has had such a consistent history of failure). But suddenly this becomes quite intriguing because it directly relates to the practice of medicine. If you simply use the quadrants alone, and lay them out on a table (as in fig. 000), it becomes obvious that conventional medicine has focused almost exclusively on one of the quadrants—namely, on the Upper-Right quadrant, or the third-person singular dimension of being-in-the-world. In other words, conventional medicine has focused almost entirely on the individual organism and the objective physical dimensions of that organism (including its anatomy, physiology, organ systems, and the effects of physical interventions from drugs to surgery)—all of the “it” dimensions of a person, which are definitely real and definitely a crucial part of health—but are, so speak, only 1/4<sup>th</sup> of the overall story presenting itself in your office. If you and your patients have these four dimensions always available and always

functioning in any event, but if, in your practice of medicine, you are only “allowed” to use or treat 1/4<sup>th</sup> of the actual condition, then some sort of horrible rupture has occurred somewhere, and both you and your patients can *feel* it, can feel this wretched fracture in the Kosmos called “going to the doctor.”

It is perhaps obvious that many alternative and complementary approaches to medicine are, in their own ways, attempting to include the other three quadrants neglected by conventional medicine. For example, many alternative approaches attempt to include the important dimensions of the Upper Left (or “I”), including meditation, guided imagery, relaxation techniques, visualization, contemplative prayer, and so on. Other approaches attempt to include the importance of social systems (or the Lower Right), and thus see health issues in a larger context of ecological systems and environmental toxins, social systems and their ills, and the complex networks that involve all living creatures. Other complementary approaches draw attention to the finer dimensions of the Upper Right, such as the subtle energies that seem to surround and permeate the gross physical organism. Still other complementary approaches add the importance of the Lower-Left quadrant or “we”—the importance of culture, of a supportive network of intersubjective understanding (including communication between the doctor, patient, family, and friends), along with support groups or group therapy.

Although it is true, for example, that women with breast cancer who join support groups often have a 30% longer survival rate than those who don’t, the point is that interpersonal culture is a good in itself, a very real and very important quadrant or dimension of being-in-the-world, and one engages that dimension not simply because it makes the physical organism hang around a bit longer, but because it exercises a profound, wonderful, deep dimension of being and consciousness. The fact that people get healthier when they do so is simply to say that comprehensive is better.

Examples abound. An integral framework suggests that every state of consciousness in the individual “I” has a corresponding brain state in the physical organism (or the individual “it”).

You can treat a brain state with pharmacology or neurosurgery; you treat mind states and consciousness with depth psychology and meditation. It is not necessary that as a neurosurgeon, or even as a family practitioner, you must somehow use depth psychology and meditation in your practice (although you certainly can if you wish); but it is the case that an integrally informed medical practitioner is aware of the actual dimensions of being and consciousness that are present in his or her patients and thus can tell when they might need Prozac or when they might need meditation—or both. As it is now, most illnesses in other quadrants are treated with tools that effectively address only the physical organism: diseases of the soul are treated with antibiotics, because the patients demand something.

While most holistic or alternative frameworks acknowledge the importance of those four quadrants or dimensions (intentional, behavioral, social, and cultural), an integral framework continues to expand its heuristic scope by also acknowledging levels, lines, states, and types. This is not merely an eclectic framework, which is present in most alternative or holistic approaches (and which simply asserts that everything is connected to everything else), but an integral framework (or a coherent system that specifically indicates how everything is connected to everything else). Here I will give only a few quick examples to show what is involved, and then we can return to what an “integrally informed” medical practice might entail.

Among specialists in the interior dimensions of the individual (the “I” or the Upper-Left quadrant), we find a general consensus that there are *stages* of consciousness, *states* of consciousness, and *types* of consciousness. Because events in any one quadrant reverberate through all of the quadrants (with health or illness in one tending to induce health or illness in the others), an integral framework gives us a way to begin to correlate the effects of different aspects of consciousness on organic health and illness. The impact of altered *states of consciousness* on health and healing has been documented from shamanic times to today’s psychoneuroimmunology, and you will see several empirical studies on those presented in this volume. Just as important are the existence of *stages of consciousness*. The documented stages

or waves of consciousness appear to span a spectrum from sensory to mental to spiritual; from pre-personal to personal to transpersonal; from subconscious to self-conscious to superconscious. When the ancients talked about a spectrum of consciousness ranging from matter to body to mind to soul to spirit, it seems that they were giving voice to one version of this great spectrum of potentials—physical, emotional, mental, and spiritual—potentials that, like the quadrants, effectively resist reductionism.

(Yes, I know, the attempt to reduce spirit to matter is another folly that has not lacked its champions. But try as one might, one simply cannot reduce spirit to combinations and permutations of frisky dirt. And why this dirt would get right up and start writing poetry has never really been made clear by materialists of any flavor. It's not just that such reductionism violates the grain of the given, it is that it invariably fails on its own terms, importing in an implicit fashion the very things that it attempts to explain away. William James called reductionism "genius backed by prejudice"—it takes genius to be able to make that philosophical game even seem to make sense, and it takes prejudice to want to do it in any event. A more integrally informed practitioner simply sets aside any reductionistic prejudice and, in throwing the theoretical net as wide as possible so as to miss the fewest open secrets, acknowledges what human beings have known pretty much from day one: we all have physical, emotional, mental, and spiritual dimensions of being and awareness.)

Moreover, it appears that each of those dimensions, levels, or waves can exist in healthy or diseased forms. There are not only more ways to be healthy than conventional medicine recognizes, there are more ways to be sick, too.

Of course these things are always intertwined, but there does indeed seem to be physical health, emotional health, mental health, and spiritual health, expressing the levels, stages, or waves of this extraordinary spectrum. Likewise, there seems to be physical illness, emotional illness, mental illness, spiritual illness. As we will see, this great spectrum of health and sickness becomes of keen interest to an integral practitioner.

Through this spectrum of consciousness with its stages or waves run numerous different streams. That is, there appear to be at least two dozen relatively independent developmental lines or streams that progress through the developmental levels or waves of consciousness. These developmental lines include the cognitive line (studied by, e.g., Robert Kegan, Patricia Arlin), the interpersonal line (e.g., William Selman, Cheryl Armon), that of values (Clare Graves), self-identity (Jane Loevinger), stages of faith (James Fowler), morals (Lawrence Kohlberg, Carol Gilligan), needs (Abraham Maslow), among others. These developmental lines or streams are sometimes called “intelligences” in a manner made well-known by Howard Gardner (e.g., emotional intelligence, musical intelligence, kinesthetic intelligence, cognitive intelligence, etc.). The important phenomenon known as “waves and streams” (or “levels and lines”) simply means that a person can be at a fairly high level of development in some lines (such as cognitive), at a medium level of development in other lines (such as interpersonal), and at a fairly low level in yet others (such as moral). This also makes intuitive sense in that we all know individuals who are, say, highly intelligent but not very ethical; or people who are highly advanced in some skills and not as developed in others. An integral psychology makes room for all of those factors.

And all those factors come urgently and unavoidably into play, not just in health and healing, but in the entire arena of what it means to practice medicine, not one mechanic to one machine, not one plumber to one broken faucet, but one human being to another. What if in your little black medical bag you had—not 20 pills, two scalpels, and an orthopedic hammer—but also all quadrants, all waves, all streams, all states, and all types? What if your medical bag included a more comprehensive and integral map of the human being who has to come to you for help, such that you can engage in a truly integral diagnosis covering all the known bases of what might be ailing with this human being standing now in front of you?

“Ah, but unfortunately all of those factors are not my concern. As a physician, I must focus on organic health and illness.” But, you see, they are your concern, because in this culture, when anybody gets really sick, everybody tells them the same thing: “You better see a doctor.” If

you are *really* sick, in virtually *any* area, you do not go to a rabbi, a priest, or a massage therapist. You go to a doctor.

And what's a poor doctor to do? Most general practitioners will tell you that in well over half of their cases, there is nothing physically wrong with the patient. But all that really means is that there is nothing wrong in the Upper-Right quadrant, because there is clearly something wrong in one of the other quadrants (or the other levels or lines or states). Again, it is not necessary that if you are, say, a family practitioner, you must be able yourself to treat all of the illnesses in all of the quadrants or levels or states. Specialization will always be necessary to some degree. But if you aspire to be an integrally informed medical practitioner, you will at least be familiar with the diseases and treatments in the other quadrants and dimensions. An "integral medical practice" is a practice that makes room for the entire panoply of effective treatments across all quadrants and dimensions of human health and illness. There do indeed appear to be physical and emotional and mental and spiritual waves of being and awareness, each of them possessing an "I" and a "we" and an "it" dimension. And through those waves of existence appear to run cognitive streams and self-identity streams and value streams and artistic streams, all rushing and roiling across that extraordinary spectrum from subconscious to self-conscious to superconscious. And it now appears more than likely that every single one of those variables is at work in every single case of health and illness, sickness and recovery, healer and healed.

But the crucial ingredient in any integral medical practice is not the integral medical bag itself—with all the conventional pills, and the orthodox surgery, and the subtle energy medicine, and the acupuncture needles—but the holder of that bag, the integrally informed health-care practitioner, the doctors and nurses and therapists who have opened themselves to an entire spectrum of consciousness—matter to body to mind to soul to spirit—and who have thereby acknowledged what seems to be happening in any event: body and mind and spirit are operating in self and culture and nature, and thus health and healing, sickness and wholeness, are all bound up in a multidimensional tapestry that cannot be cut into without fatal hemorrhaging.

An integrally informed medical practice changes the practitioner first; he or she can then decide which of the treatments—conventional, alternative, complementary, and/or holistic—that he or she wishes to utilize when practicing medicine with integrity. It may include adding new treatments, conventional and alternative; or more conscientiously referring patients to other-quadrant practitioners when an integral diagnosis so indicates; or becoming part of a medical group or center that specializes in integral treatments (by having staff specialists in the various quadrants, states, and levels of health and illness). The only item that is constant in all of those is the transformed practitioner. It is the physician who is healed and whole first, not merely by learning new and complementary techniques, but by inhabiting a new consciousness that makes room for new techniques; and how that integrity then expresses itself in an integrally informed medical practice might vary considerably.

The advantage of integrally informed medical practice over both conventional and holistic approaches might now be a little more obvious. The problem with many alternative, complementary, and holistic practices is that, for all their noble intent and sincere efforts, they often end up simply creating a bigger “grab bag” of treatments without an integrally informed diagnosis or treatment plan. Too often this results in the sense that if I prescribe both doxycycline and Chinese herbs, I am being holistic. Or every radiation treatment gets 15 minutes of guided imagery. The problem with that approach, in my opinion, is that it too often focuses merely on increasing the number and types of treatments in the little black bag, and hence falls into what amounts to the same objectifying tool-kit approach, but now with more types of pills and hammers. That often opens the otherwise sincere holistic practitioner to forms of treatment that are ineffective or even regressive, simply because everything must be included. But to say that none of these alternatives are 100% wrong is not to say that they are 100% right. Integral approaches can be very rigorous in standards of evidence and efficacy, a rigor that some holistic approaches let go of too quickly in an attempt to be “all inclusive.” I truly don’t mean to be

unkind here, but a genuinely comprehensive medical practice does not have to include leeches, eye of newt, or dragon dung, no matter what Eastern name is attached to them.

The net result of this tension between conventional and alternative approaches is that physicians today are very unhappy with the present state of conventional medicine and yet they often distrust the holistic alternatives. They know conventional medicine is crippling them as humans and stunting the healing they can offer the sick; yet they suspect that too much of alternative and holistic approaches have abandoned evidence and rigor in a show of what amounts to a medical version of politically correct thinking: nobody wants to marginalize leeches.

An integrally informed medical practice does not neglect the types of effective treatments that can or should be included in a comprehensive medical treatment. But all of that, truly, comes after the transformation in the practitioners themselves. The one thing that you will have changed if you adopt an integral approach is your own awareness, your own consciousness, your own map of human possibilities, a map that has dramatically expanded from organic interventions to caring for a human being in all of his or her extraordinary richness across an entire spectrum that runs from dust to deity, dirt to divinity, even here and now. An integrally informed medical practitioner is one who has let the most amount of the Kosmos into his or her mind, finds thereby the most potentials for health and healing and compassionate care, and brings that Big Mind to his or her practice in a way that inculcates both more confidence and more humility, all at once.

Integral medicine is in its infancy. As such, the medical and health-care practitioners who are helping to forge an integral practice are on a voyage of incredible discovery, arguably one of the most important that the millennia-old profession of medicine has ever made. In the following chapters you will see some of the most important of these pioneering efforts. Taken together, they cover aspects of virtually all of the quadrants, levels, lines, states, and types. There are exciting chapters on leading-edge science in the objective or “it” dimensions, including new physics; recent research on neuropeptides and other organic communication systems; spontaneous healing and mechanisms of self-repair; the bodily components of healing and their future

evolution; a great deal of empirical evidence on the existence and effects of subtle energies and their role in health and energy medicine. (Please note the strong emphasis that is given to empirical evidence and scientific grounding in these areas. Eye of newt goes into the little black bag, if and only if there is reproducible scientific evidence that it works.) I personally believe that subtle energy medicine is on the verge of scientific breakthroughs that alone could revolutionize the objective dimensions of medical care.

There are also chapters on the vast territory of the “I” dimension with all its waves, streams, and states—including the role of mental factors in organic health and illness; the many ways that the mind and body can neither be reduced to each other nor separated from each other; the nature of conscious healing; ways to transform illness by involving both higher states and stages of consciousness; and ways that the health-care professional can transform his or her own consciousness as well, particularly through service and transformational engagement—the entire spectrum of “opening your heart: physically, emotionally, spiritually.”

There are likewise important chapters on the “we” dimension of health and illness, including cross-cultural perspectives on sickness and healing; participatory medicine; relational medicine; the many ways that each “I” and “it” are nestled in layers of “we”—that is, both subjects and objects arise in cultural backgrounds of intersubjectivity that play an enormously influential role in health and sickness (dimensions made all the more important by the degree of neglect usually accorded them, in conventional and alternative approaches alike). As theoreticians from Heidegger to Habermas have demonstrated, these cultural “we’s” cannot be reduced to the terms of systems theory (or social “its”), nor can they be captured by “I” or “it” approaches, but must be addressed in their own terms, with their own techniques, in their own ways—ways that any integrally informed practitioner would want to be familiar with. In the last analysis, the doctor-patient relationship is not one “I” operating on a slab of “it,” but an extraordinary “we” for which the term “sacred” is very likely the only accurate adjective, and it is from that sacred “we” that all healing arises as a miracle of love and grace that thankfully none of

us will ever understand. (If we did, don't you think we would mess it up rather badly?)

Medicine, when it works, will always be riding a wave of miracle and mystery, of which nothing is more mysterious and miraculous than a "we."

There are significant chapters on the important role played by social systems, the self-organizing systems of dynamic "its," the networks of ecological connectivity that leave no individual untouched. This includes chapters on ecological health, the ecozoic era, the web of life and what it means for us all—the many ways that we are linked not just intersubjectively in cultures of "we" but interobjectively in systems of dynamic processes. Notice that these interlocking systems (such as the web of life) are always described in third-person plural terms (because they are indeed are systems of dynamic and interrelated its), but the whole point, of course, is that every "it" and "its" has "I" and "we" correlates, and all of those dimensions need to be taken into account in any integral approach to medicine. Although intentional "I's" and cultural "we's" cannot be reduced to, or explained by, social systems of ecological processes, they cannot exist without them, either. The web of life covers only one quadrant, but a quadrant all too often neglected in a focus on individual health.

All of those important dimensions of integral medicine are addressed in the following chapters. Because various integral approaches are all in their infancy, it goes without saying that not all theorists in this volume will agree with each other. Certainly not everybody would agree with the version or the terminology that I have been using in this Introduction, nor should they, it seems to me. Have you ever seen those maps that the early European explorers made of the Americas?—where Cuba is the size of Siberia and Florida extends all the way to Brazil? And on the indigenous side of the Atlantic as well—ever seen the similar maps the Aztecs made of the new territories they were exploring? Well, that is almost certainly what our present maps of an integral medicine look like. But that is simply all the more reason to push forward in this extraordinary exploration, yes?

The following chapters are the maps of intrepid explorers pushing into a new territory that can only dimly be seen forming on the horizon of our integral conversations. This is why it is especially important, it seems to me, that all of these approaches be put on the table and held with a gesture of respect, with one integral guideline kept gently in mind: nobody is smart enough to be wrong all the time. In this extraordinary endeavor, everybody has a piece of the integral puzzle, and thus what we are looking for is a framework that can coherently include the most number of approaches without pathologizing the alternatives.

This book, then, is not the last word in integral medicine, but merely the humble first. It is the opening of a dialogue too long ignored, the calling forth of extraordinary potentials too long denied, the acknowledging of a healing love too long left unspoken. Integral medicine is an acknowledgment of the Kosmos in all of its radiant richness; and thus—in some mysterious way that every true physician knows in the depths of the compassionate heart—an integrally informed practitioner is one through whom the Kosmos heals. One in whom the entire spectrum of consciousness is allowed to speak and shout its truths; one who puts self aside in the healing gesture and lets the entire universe come rushing through—matter to body to mind to soul to spirit—in self and culture and nature. The panoramic vista opened to the integrally informed practitioner restructures his or her own being and consciousness, turning the practitioner into something of a beautiful, tender, hollow bamboo reed, hollow so as to resonate with the sound of the entire Kosmos washing upon the shores of the soul, wild and radiant in all its dimensions, overflowing in a healing gesture that leaves no sentient being untouched, a gesture that every now and then glances at that Oath hanging on the wall, knowing that, in this integral regard, no sacred promises have been broken in this office.