

2022

# Wholistic Healing: The Physician Perspective of the Tibetan Medical Philosophy

Emma J. Brooks  
*Walden University*

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# Walden University

College of Psychology and Community Services

This is to certify that the doctoral dissertation by

Emma J. Brooks

has been found to be complete and satisfactory in all respects,  
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Walden University  
2022

Abstract

Wholistic Healing: The Physician Perspective of the Tibetan Medical Philosophy

by

Emma J. Brooks

MS, Walden University, 2008

BA, Pace University, 1991

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Psychology

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August 2022

## Abstract

In Western medicine, anatomy is divided into multiple disciplines with specialists focused on their specialization, thereby limiting the whole system medical approach within the diagnosis, practice, and treatment of illness. The purpose of this qualitative study with an emergent design was to explore how physicians of Tibetan medicine viewed treating the whole person through the lens of *Sowa Rigpa*. Inquiry and analytical thinking were viewed through the lens of Otto and Knight's principles of wholistic healing, Wilber's integral model, and the philosophy of Merleau-Ponty. Phase I consisted of key informant interviews with four participants that were recent graduates of Tibetan medicine or scholars knowledgeable in Tibetan medicine. Phase II consisted of interviews with seven Tibetan medicine doctors. Inductive coding and thematic analysis showed nine themes associated with whole person care and wholistic healing: an applied philosophy of wholism, the anatomy and physiology of wholism, the pathology of disease, health and wellness, disease prevention, patient assessment and diagnosis, treatment and healing, self-awareness and healing, and the doctor and doctor-patient relationship. The findings may provide positive social change through insight for allopathic physicians and scholars on how to address the complex factors associated with healing and curing from a whole person perspective while also promoting engaged collaboration among cultures and medical disciplines.

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## Dedication

I would like to dedicate this to my mother, Clementine S. Brooks. She transitioned while I was on this journey. She always showed unconditional love, allowed me to explore and organically evolve, and allowed me to chase any dream my heart desired. She set me free so that I could fly and discover my song. I would also like to dedicate this to Dr. Levine, my first chairperson, who also transitioned while I was on this journey. She believed in my vision and laid the foundation.

## Acknowledgments

The present study focused on the phenomenon of whole person care. It was my pleasure to work with the participants and physicians of Sowa Rigpa. Thank you for your time and patience. I could not have explored this topic without the cooperation of researchers, scholars, and doctors in the field of Tibetan medicine. I am filled with gratitude. This body of work is not as in-depth as I would have liked because of the limited amount of information I could present. I could have easily expanded the discussions further. There is so much left undone and an unlimited amount of data to appropriately explore this vast topic. Throughout this project, I constantly double-checked, doubted, and second-guessed the presented information. The knowledge and practices obtained from coursework, compounding and using the medicines, and practicing the Sowa Rigpa meditations kept me moving forward. I did my best on this journey under the circumstances; Sowa Rigpa has forever changed me. As I researched whole person care and Sowa Rigpa, the journey provided insights into my subjective experiences through the lens of Sowa Rigpa.

I want to acknowledge Dr. Ellen Levine for her patience throughout this process. There were countless challenges, but her belief and support of allowing “what is” throughout my dissertation journey until she passed away were beautiful. Thank you, Dr. Stadlander, for creating a support group during one of the darkest hours of my life after my mom’s passing, for all your wisdom and knowledge, then taking over for Dr. Levine after her passing, and for holding the torch for doctoral students on the Ph.D. journey. Dr. Wilson, thank you for the opportunities and for accepting the offer as my committee

member. Thank you, Dr. Spillet, for your guidance and support. I could not have completed my journey without you! I am forever grateful! Thank you, Dr. Astin and Dr. Gil, for your presence. Thank you, Dr. Barrows, for your insight and revisions. Thank you, Greg Murphy, for your advice and guidance over the years. Thank you, Emory University for Emory-Tibet Week, which provided an opportunity to learn from the rich topics discussed related to Tibetan culture. Thank you, scholars, for your support and guidance. Thank you, Center for Contemplative Science and Compassion-Based Ethics, I appreciate all the support and guidance I received from the scholars and community; the support was instrumental in my Tibetan medicine journey. Thank you, Dr. Lobsang Tenzin Negi, for your wisdom and gift of compassion. Thank you, Dr. Brendan Ozawa-de Silva, for providing me with the readings needed to start my journey. Thank you, Dr. Blount, MD., for your advice and support during some challenging times; you will be missed.

Thank you, Dr. Nida Chenagtsang, for your work, allowing me to learn from you, and the beautiful environment you created at Pure Land Farms and the Sowa Rigpa Institute. Your wisdom and knowledge have expanded my awareness. Thank you, Dr. Ben Joffe, for your support, guidance, and advice on terminology and cultural accuracy. I am forever grateful. I incorporated your revisions to the best of my ability, given the allotted timeframe. Thank you, Delores Hart, for endless discussions and support during my proposal. Thank you, Yetta, for getting me through this journey; your support and friendship were invaluable. Dr. Ethel Perry, you rock; thank you for everything! I would also like to thank all my friends and extended family who offered support and



encouragement during this fantastic yet arduous journey. In addition, thank you to those who were there for me during the home stretch, cheering me on through the losses and frustrations. I am profoundly grateful to everyone because I could not have completed this journey without your wisdom and support. It takes a village!

I started this journey as a preteen, absent of awareness of Sowa Rigpa. I was always attracted to the Tibetan culture, and the karmic force kept pushing and nudging me. I often drew quietly the same flower repeatedly. I never understood why and did not know the type of flower was unknown to me. One day as an adult in 2001, I succumbed to an illness and needed clarity and answers. Intuitively, I felt healing would be possible if I could escape to a monastery, but that was out of my reach. I saw the flower in a store and asked the owner about the flower, and it was a lotus. Synchronicities occurred, opportunities were presented, and one step led to another, leading me to research whole person care and Tibetan medicine. It was not an easy road (i.e., my mother and chairperson passed, computer crashes), and I often wanted to give up. I am pleased that I continued, one step at a time, with support. If I did not mention you, charge it to my mind and not my heart. Please know that I am forever grateful for your assistance and support.

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## Chapter 1: Introduction to the Study

A paradigm shift has occurred in the field of health care and medicine. Local and national media have discussed the prevalence of financial hardship related to noncommunicable diseases (NCDs) and significant increases in overall prescription drug use and polypharmacy (Kantor et al., 2015). For example, for cancer-related illnesses, financial hardship was 43.3% for the uninsured, 42.3% for the publicly insured, and 23.7% for the privately insured; psychological hardship was 48.9% for the uninsured, 31.1% for the publicly insured, and 30% for privately insured (Yabroff et al., 2016). Additionally, patients are taking an increased interest and responsibility for their health and well-being, as well as an increased interest in noninvasive approaches, unproven treatments, and more natural approaches that aid in curing, healing, and maintaining health (A. Ali & Katz, 2015; Anderson & Taylor, 2012; L. I. Black et al., 2015; Deng & Cassileth, 2013; Goertz et al., 2013; Okoro et al., 2013; World Health Organization [WHO], 2015). Other commonly used complementary health approaches include chiropractic or osteopathic manipulation as well as nonvitamin and nonmineral dietary supplements (L. I. Black et al., 2015). Kim et al. (2018) assessed multiple sclerosis patients in the United States and found increased use of complementary and alternative medicine (CAM) in individuals after a multiple sclerosis diagnosis. Patients and physicians are becoming increasingly aware that the current system is not fully meeting patients' needs (C. M. Martin & Félix-Bortolotti, 2014).

Due to the increase of chronic conditions and treatment is not always effective, other medical perspectives may help augment the biomedicine model's approach to

practice, diagnosis, and treatment. Tibetan medicine is a traditional medical system that takes a whole systems approach to diagnose and treat diseases and disorders. Based on the findings in the literature related to treating the whole person within the Western medicine paradigm, the goal of the current study was to understand the phenomenon of the practice of wholistic medicine from a physician's perspective. It is also essential to understand the doctor–patient relationship in the practice, diagnosis, and treatment of the patient within the theory and practice of Tibetan medicine. Continued exploration into traditional whole systems medical approaches (e.g., Tibetan medicine) may provide further insight into diseases and disorders, holistic approaches to healing, and doctor–patient relationships, thereby increasing knowledge exchange between Western and non-Western approaches to practicing medicine. Chapter 1 summarizes health issues and the health system as it relates to treating the whole person. The topics discussed include foundational information on medical systems, traditional medicine, and traditional knowledge. The discussion also addresses Western medicine, Tibetan medicine, and the differences between the two medical systems. The intention is to provide a foundation for Chapter 2.

### **Background**

The general problem is that in Western medicine, anatomy is divided into multiple disciplines with specialists focused on their specialization (Uher et al., 2020), thereby limiting the whole system medical approach within the diagnosis, practice, and treatment of illness. Treating the whole person is increasingly vital due to the health challenges of today's population, where risk factors for diseases and a multitude of

factors (e.g., lifestyle, environment) affect the approach to care, particularly treatment for patients with complex conditions (Frey et al., 2013). Health issues are becoming a significant concern, and as the population ages, chronic diseases (also known as NCDs) have become the leading cause of death (Magnusson, 2009). According to the WHO (2015), the financial cost of health care is rising and is a global concern. Murray et al. (2013) analyzed the data on the state of health within the United States from 1990 to 2010 and found that life expectancy had increased. Still, morbidity and chronic disability contributed to half of the health burden. Researchers in the field of chronic disability have not been as successful with finding solutions or associated risk factors (Murray et al., 2013). Traditional medicines have been used to treat chronic diseases and for health prevention and maintenance (WHO, 2015). Traditional treatments are also used in many countries, and there is an increased interest in physicians and practices from traditional medical systems (WHO, 2015). Treating the whole person using knowledge from traditional medical practices, from a whole medical system approach, may provide more insight into disease causation and healing (M. K. Ali et al., 2015; Frey et al., 2013; Micozzi, 2014a). The WHO (2013b) asserted that collaborative efforts within traditional medical health systems might help mitigate the increase of NCDs.

### **Health Care System**

Considering the many factors contributing to the health care crisis in the United States, a contextual view of health and illness as it relates to perceptions, theory, and practice of medicine may move providers closer to a health model in which whole person care is the primary focus. Medical systems that are characterized as whole system

medicines may be able to provide some insight. Whole system medicines such as Chinese medicine, Ayurvedic medicine, Tibetan medicine, homeopathy, and naturopathy, which diagnose and treat the whole person, have valuable contributions to make to the health care system (Thornton, 2013). Thornton (2013) suggested “adopting a framework that can explain healing practices as well as whole systems of medicine” (p. 57) to assist with integrating these practices into the medical model and health care system.

What is not known is how other whole medical health systems (e.g., Ayurveda, Tibetan medicine, homeopathy) could fit into the integrative medicine paradigm (Hu et al., 2015). When assessing treatment and prevention factors associated with depression and the reduction of inflammation, there is limited literature examining the effects of alternative and integrative medicine approaches on these conditions (Haroon et al., 2012). There is also limited research on the practice of natural health practitioners and the experience of holism worldwide (Carruthers, 2013). When researching traditional medical systems, it is essential to keep the integrity of the theory, practice, and treatments because it is a whole systems approach to medicine. In contrast, biomedicine is more materialistic and reductionistic (Bauer-Wu et al., 2014). This dichotomy presents challenges for evidence-based medicine (Shelton, 2013). Further research related to the collaboration of Tibetan medical practitioners and biomedical researchers is warranted (Bauer-Wu et al., 2014).

### **Medical Systems**

Medical systems fall under various categories, “codified (have written tradition), orthodox (accepted as doctrine), legitimate (upheld by law), and effective (usually

measured by biomedical standards)” (Erickson, 2008, p. 2), which may influence how they are viewed or practiced within other medical practices. The medical systems in which these categories are applicable but do not use biomedicine techniques to heal are American chiropractic, Ayurvedic, and traditional Chinese medicine (Erickson, 2008). None of these practices are based on scientific materialism. However, most (excluding chiropractic) follow the naturalistic explanation of the causation of disease and illness, including biomedicine and homeopathy, where homeostasis would be considered a healthy state of the body (Erickson, 2008). Another major factor associated with medical systems not based on scientific materialism is the interdependence of the mental and physical body (Erickson, 2008; Gold, 1985; Ozawa de Silva & Ozawa de Silva, 2011). Training practitioners within medical systems are also codified as formal (e.g., education, licensure) and informal (e.g., self-taught, apprenticeship; Erickson, 2008). By Western medicine’s standards, the latter might be applicable to traditional healers. However, generalizing traditional medical practitioners as traditional healers are limiting because classifications (e.g., folk healer, sacred healer, physicians, pharmacists) for practitioners of traditional medicines are culture specific (Tabi et al., 2006).

### **Traditional Medicine and Traditional Knowledge**

Traditional medical systems and medicines have existed for centuries prior to modern Western medical methods. The physicians of traditional medical systems take an integral approach to addressing the relationship between body and mind as well as other external factors within the theory of practice, diagnosis, and treatment of care (Johnson, 2009; Ozawa De Silva & Ozawa De Silva, 2011). Modern Western medicine’s

foundational roots are based on ancient Greek principles (Falagas et al., 2006; Uher et al., 2020). Traditional medicines have been accepted in other countries, as well as Western countries (WHO, 2015), by low- and middle-income individuals, and various cultures in industrialized countries (Gureje et al., 2015). The acquisition of knowledge for traditional medicine is driven by traditional knowledge, also known as traditional ecological knowledge (TEK; Berkes, 1993).

There is an exchange of traditional knowledge taking place in countries and the field of medicine (Ben-Arye et al., 2011; Ben-Arye et al., 2015), knowledge and healing practices (Ebijuwa & Mabawonku, 2015; Hewson, 2015), and nature (L. Mason et al., 2012; Weiss et al., 2013). The foundation of this movement is the attempt to embrace treating the whole person, holism with a “w,” and the interconnectedness of all things.

Traditional medicine, such as medicines and other therapies used by Tibetan medicine doctors (TMD), is more wholistic and synergistic. In contrast, allopathic medicines are targeted based on symptoms or disease, not systemic imbalances (Chow et al., 2016), thereby making Tibetan medicine an ideal collaborator with Western medicine (Bauer-Wu et al., 2014). Using a focused approach to treat complex diseases addresses only part of the problem (Cassell, 2011); therefore, physicians should do so with caution (Bauer-Wu et al., 2014). Wholism and synergism are essential components when diagnosing, treating, and healing patients with chronic conditions such as cancer or mental disorders.

## **Western Medicine**

Prescientific medicine was a mixture of religion, magic, and philosophy, and Asclepius was the founder of this ancient Greek approach to healing dating back to the 6<sup>th</sup> and 5<sup>th</sup> centuries (Falagas et al., 2006). The historical foundation of scientific medicine (6<sup>th</sup> century B.C.E) can be traced to Hippocrates, the father of Western medicine (Bulger & Barbato, 2000; Falagas et al., 2006; Shim et al., 2008). Hippocrates's approach was holistic in nature. However, as medicine continued to evolve within the Western paradigm, holistic healing became a separate entity that was not naturally integrated into the biomedical approach to healing due to the legacy of Cartesian dualism in Western thought (i.e., the separation of mind and body; Gold, 1985; Ozawa de Silva & Ozawa de Silva, 2011). Under these terms, the mind does not exist in unison with the body; illnesses or diseases within these two ontological approaches are not connected or related to external factors (e.g., nature, social, cultural, etc.). The mind–body separation has “resulted in disease being viewed as separate from the larger experience of the patient suffering the disease” (Shelton, 2013, p. 439). Hippocrates's view of holistic healing appears to be practiced within the biomedical or Western approach to healing in the form of integrative medicine or person-centered approach models; these models continue to evolve and are relatively new, but their concepts are based on traditional whole medical systems (Chow et al., 2016; P. R. di Sarsina et al., 2011; Johnson, 2009; Maizes et al., 2009).

Existing research on holistic medicine under the Western paradigm is biomedical in nature, and the mind, body, and spirit are treated as separate components. CAM



treatments and interventions are not fully applied or assessed from a systemic holistic perspective because CAM is outside the biomedical mainstream model of medicine. Many CAM treatments originated from whole medical systems and are used within medical traditions that view the body as a complex organism. However, CAM is viewed as holistic healing within the Western medical model even though CAM treatments may not be used as intended within the medical system in which they originated (Freeman, 2009; Hsu et al., 2009; Thachil et al., 2007). The interconnectedness of the mind–body connection or mind, body, spirit aspect is not fully addressed in some CAM systems. The holistic aspect of treating disease or disorder is not present. Western medical research is challenged with systemically testing treatment modalities (Osterman et al., 2013; Shelton, 2013). Hollenberg and Muzzin (2010) posed the following question: “Could biomedicine change such that CAM could be fairly integrated into an equitable form of integrative medicine (IM) while respecting and incorporating the fundamental aspects of CAM paradigms?” (p. 53). Traditional medicine practices and treatments appear to embody the essence of a holistic medical system.

However, for decades researchers have supported the need to address the complex physiology of the body within mainstream biomedicine (Cardinal-Fernández et al., 2014; Engel, 1960, 1977; Fleming & Gutknecht, 2010; Haroon et al., 2012; Iris, 2012; Micozzi, 2014a; Picard et al., 2013; Smuts, 1926/1936; Waller, 2010; Weil, 1998; Yan, 2011). In addition, scholars and physicians have been advocating the need to address the holistic dimensions of the human experience (Branch, 2014; Engel, 1977; Ishikawa et al., 2013; C. M. Martin & Félix-Bortolotti, 2014; Otto & Knight, 1979b; Smuts, 1926/1936) as well

as the mind–body connection in health and disease (Ader & Cohen, 1993; Gariup et al., 2015; Kern & Ziemssen, 2008; Krogh et al., 2014; O’Donovan et al., 2013; Xiu et al., 2014).

The wholistic dimension movement is also prevalent within the medical educational system. Students within their medical school training programs gain insight into how to treat illnesses from a biopsychosocial perspective in palliative and geropsychology programs (Molinari et al., 2005; Quill et al., 2003). There are curriculums within medical programs that may also include an integrative medicine perspective. For example, modifications have been made in the educational approach to medicine in some universities (e.g., University of Arizona, Boston Medical Center) with researchers (Berz et al., 2015; Kesler et al., 2015; Lebensohn et al., 2014) studying the inclusion of integrative medicine as well as traditional healing within the medical school’s curriculum for medical in residency programs. There is also considerable interest within mainstream Western medicine in personalized care (R. di Sarsina et al., 2012; Hutchinson et al., 2011; Liben, 2011; C. M. Martin & Félix-Bortolotti, 2014; Yan, 2011), integrative care (Adhikari et al., 2014; Albrecht et al., 1998; Kessler & Stafford, 2008; Khatri et al., 2008; Picard et al., 2011), and the doctor–patient relationship (Hutchinson & Brawer, 2011).

Recent research on whole person care under the allopathic scope indicated a need for continued research on whole person care on terminology (Thomas et al., 2018) and the doctor–patient relationship (Thomas et al., 2020a). Other areas that require further research are the challenges in applying whole person care (Thomas et al., 2020c) and

models of whole person care (Jonas & Rosenbaum, 2021). Ongoing research may help streamline terminology, improve standardization, obtain the physician's perspective of applying the practice, and clarify patient outcomes.

### **Tibetan Medicine: A Traditional Medical System**

Tibetan medicine's written theories of medicine dating back to the 7<sup>th</sup> and 8<sup>th</sup> century C.E. include a synthesis of healing methods from Indian, Chinese, Himalayan, pre-Buddhist shamanic, Indigenous practices, and Greco Persian traditions (Clifford, 1984; Ergil, 2014). The philosophy of Tibetan medicine is that the substances or humors (*nyes pa*) within the body are (in ordinary, unenlightened humans/beings) always in a state of imbalance or disturbance (Ergil, 2014). A comprehensive approach to healing using the *nyes pa* is interwoven within the system of Tibetan medicine as outlined in *rgyud bzhi* or the four medical tantras (Clifford, 1994; Ergil, 2014; Gonpo, 2011a). The four tantras, which are the canon texts of the Tibetan medical system, are as follows: the Root Tantra or *rtsa rgyud* (Gonpo, 2011a), the Explanatory Tantra or *bshad rgyud* (second tantra; Gonpo, 2011a), the Oral Instruction Tantra or *man ngag rgyud* (third tantra), and the Subsequent Tantra or *phyi ma'i rgyud* (fourth tantra; Gonpo, 2011b). All four tantras have been translated into English.

The Tibetan view of healing has a long lineage of what is now classified as personalized medicine (one treatment does not fit all), person-centered, and preventive medicine (Bauer-Wu et al., 2014). The Tibetan medical philosophy takes a wholistic approach with the understanding that the manifestation of disease or disorder is an indication of a disturbance of homeostasis within the mind–body connection and may be

rebalanced through the three *nyes pa* (humors, energies, or vital substances); *rlung* (often translated as “wind”), *mkhris pa* (often translated as “bile”), and *bad kan* (often translated as “phlegm;” Bauer-Wu et al., 2014; Cameron et al., 2012; Clifford, 1984; P. R. di Sarsina et al., 2011; Ergil, 2014). The historical connection and worldview of Buddhist philosophy (Joffe, 2019), contemplative science, and psychology (Dakpa & Dodson-Lavelle, 2009a) are the foundation of Tibetan medicine. The worldview of Buddhism is embodied by the practitioners of this ‘*science of healing*’ (*gso ba rig pa* [*Sowa Rigpa*] in Tibetan), reminding the practitioner that compassion and the practice of medicine are interconnected and that one cannot exist without the other (Dakpa, 2014; Ergil, 2014).

Research on Tibetan medicine has been conducted in the field of ethnopharmacology: inflammation (Eliaz, 2004; Li et al., 2010; Yi et al., 2010; L. Zhang et al., 2009), cancer (Bauer-Wu et al., 2014; Choedon et al., 2011), immune function (Horani et al., 2012) cardiovascular (Shih et al., 2008), oxidative stress (Qian et al., 2011), Alzheimer’s disease (Aiqin et al., 2012), hepatic fibrosis (Ginsburg et al., 2009), mercury in medicines (Sallon et al., 2006), and peripheral arterial occlusive disease (Melzer et al., 2006). Other areas of research were related to the Tibetan medicine model and longevity (Dakpa & Dodson-Lavelle, 2009b), contemplative self-healing (Loizzo, Charlson, & Peterson, 2009; Loizzo et al., 2010), weight loss, and dietary and behavioral modification (von Haehling et al., 2013), subtle energies (Dakpa & Dodson-Lavelle, 2009a), medical interpretation of multiple sclerosis (Husted & Dhondup, 2009), validity testing of a constitutional self-assessment (Cameron et al., 2012), and mental disorders (Deane, 2014; Jacobson, 2002; S. E. Lewis, 2013). Several books have been written on

Tibetan medicine that outline the theory and practice (Bradley, 2013; B. Clark, 1995; Clifford, 1984; Dönden & Hopkins, 1986; Y. Dhonden & Wallace, 2000; Khangkar, 2009), investigation techniques, the nyas pa and their associated disorders and treatments (T. Gyatso & Hakim, 2010), psychiatry (Clifford, 1984), and the social ecologies of physicians and medicines (Craig, 2012).

However, little is known in allopathic medicine about Tibetan medicine as a wholistic system, and research in the field of Tibetan medicine among Western scientists is limited (Cameron et al., 2012). Tibetan medicine has a rich culture, is an intricate medical system, and has a long history of treatment effectiveness (P. R. di Sarsina et al., 2011; Reuter et al., 2013; von Haehling et al., 2013). The Tibetan model of diagnosis and treatment allows diverse symptoms to be diagnosed and treated in the same way, which is fundamentally different from the disease-focused systems approach with a biomedical model (Yoeli-Tlalim, 2010). The Tibetan model of diagnosis and treatment epitomizes the wholistic aspects of medicine.

Additionally, clinical research on Tibetan medicine in the West is scarce and limited in availability and the English language (Reuter et al., 2013). Compared to medicines, practices, and treatments from China, Korea, Japan, and India (e.g., acupuncture, herbal medicines, Ayurvedic material medica), research is more developed than in Tibetan medicine (Ergil, 2014). Most of the study and practice of Tibetan medicine is conducted outside of the United States, and research is lacking around “its multimodal individualized approach” (Reuter et al., 2013, p. 1) as well as a wholistic systems approach (Cameron et al., 2012). Reuter et al. (2013) suggested that an increase

in quality trials and an overview of the use of Tibetan medicine would aid in future research. Exploring this ancient medical system could provide insight into a documented traditional medical system that embodies a wholistic approach to healing. This is relevant because Tibetan medicine's theoretical and applied approach addresses multiple illnesses by focusing on the imbalances within the patient's physiology (Bauer-Wu et al., 2014; Gonpo, 2011a). Reuter et al. also suggested that the literature review indicated a palliative and curative potential for chronic conditions. Bauer-Wu et al. (2014) analyzed three case studies (gastric carcinoma, chronic myelogenous leukemia, and red cell aplasia) and found positive changes in quality of life, disease remission, and disease regression, as well as remission in patients with cancer. For example, after treatment with Tibetan medicine, a patient with low hemoglobin levels showed increases within 2 weeks of treatment. Another patient diagnosed with chronic myelogenous leukemia after 3 months of treatment showed increases in both hemoglobin levels and white blood cell count. Finally, a patient diagnosed with gastric carcinoma after 29 months of treatment showed no evidence of cancer and reported an increase in quality of life after 30 months (about 2 and one-half years).

### **Tibetan Medicine and Biomedicine**

Physicians of Tibetan medicine and physicians of biomedicine approach health and the root cause of disease from different perspectives. There are two significant differences between Tibetan medicine and biomedicine, Tibetan medicine's (a) use of the humoral frameworks and treatments and (b) its ability, through the use of the humoral theory, to identify 10 different etiologies for one disease diagnosis within the

biomedicine paradigm (Tokar, 1999). Physicians of traditional medical systems (e.g., Tibetan medicine, Ayurveda) treat the whole person by trying to discover patterns within the body's complex system through the exploration of all aspects of the patient's history, the patient's behavior (e.g., mental, physical, and verbal) and sensory experience, and the effects of the natural environment (Chenagtsang, 2018; Chow et al., 2016). Tibetan medicine is also based on TEK, while biomedicine is based on scientific ecological knowledge. Within the biomedical paradigm, the emphasis on the physical (body and disease causation) is the premise of biomedicine (Erickson, 2008). It is here where the experiential or subjective experience (Wilber's *I*) or social and ecological context (Wilber's *ITS*) is omitted from the assessment process (Erickson, 2008; see also Wilber, 2005).

Tibetan medicine's dynamic and interdependent relationship between body and mind supports a wholistic approach to healing through the linkage between the mind, physical body (gross body), and subtle body (energetic body; Bauer-Wu et al., 2014; Clifford, 1984; Dakpa & Dodson-Lovelle, 2009a). The subtle body is the link between the mental (medicine of religion) and the physical (scientific medical system), which are interconnected within Tibetan medicine (Clifford, 1984), thereby making it a valuable model for exploration within modern biomedicine (Bauer-Wu et al., 2014; Ozawa De Silva & Ozawa De Silva, 2011). Tibetan medicine's theoretical foundation is in the middle of the Cartesian dualistic and monistic continuum because it integrates the science of healing (Sowa Rigpa) with Buddhist philosophy (Ozawa De Silva & Ozawa De Silva, 2011). The dualistic nature of biomedicine with its subject-object views of existence or

the grasping of the permanent separate self (ego-clinging) is what removes the wholistic healing aspect from the medical model (Clifford, 1984). According to Clifford (1984), the theoretical foundation of Buddhist philosophy, psychology, and medicine theorizes that ego-clinging is the source of all delusion, suffering, and disease experienced within the human condition.

van Pelt (2009) suggested that medicine should encompass everything that leads to the detection and elimination of disease within the body and within the psyche, thereby making it holistic in nature. However, according to van Pelt, health care refers to caring for the health and wellness of the patients; this is different from the elimination of the disease. Therefore, it is necessary to integrate the defined views of medical services and health care into one system to meet the needs and demands of patients and society (van Pelt, 2009).

Other researchers' contributions to the literature supported van Pelt's recommendation. Samuel (2013) suggested that the Tibetan medical system's spiritual dimension and its diagnostic techniques may provide insights into medicine by aiding in assessing the relationship between the subjective (experiential) and objective (physical) aspects mentioned in Ozawa De Silva and Ozawa De Silva's (2011) and Clifford's (1984) discussions on the mind–body dualities of Western medicine and healing. The mind–body linkage within the Tibetan medical system is organized to access the interconnectedness of emotions and physiological and ecological aspects of the patient via the *nyes pa* (B. Clark, 1995; Dakpa & Dodson-Lavelle, 2009a; Dönden & Hopkins, 1986; Ergil, 2014). Husted and Dhondup (2009), through their analysis of the *nyes pa* and



the TMDs' interpretation of multiple sclerosis (MS), suggested that Tibetan medicine might provide a framework for understanding and treating MS as well as chronic conditions.

### **Problem Statement**

There are three primary concerns with the biomedical approach to medicine: (a) It is primarily disease-focused, (b) treatments are specialization focused in which the specialist might not consider the mind–body connection or treatment effect on other internal systems, and (c) pharmacological treatments are overutilized. Based on the literature, researchers have acknowledged that health or disease is from a complex interaction of a multitude of factors (Dönden & Hopkins, 1986; Engel, 1977; Gonpo, 2011a; Micozzi, 2014a; Picard et al., 2011; Weil, 1998; Whorton, 2002). However, these researchers stressed that conventional medicine emphasizes the biomedical model as the primary form of diagnosis and treatment. Even though the biomedicine approach to disease has been crucial in the comprehension of the multitude of systems within the human body (Cardinal- Fernández, 2014), the human body is a complex system consisting of an interconnected web of subsystems that do not operate in isolation, and there is so much more to discover (Micozzi, 2014a; Smuts, 1936/1926; Waller, 2010).

Biomedical treatments continue to evolve by incorporating and treating the whole person through personalized care and personalized medicine, which are critical to treating and understanding chronic conditions and illnesses (C. M. Martin & Félix -Bortolotti, 2014). According to Shelton (2013), the core concern of the Western paradigm is the mind–body dualistic lens and working with the body as a complex system (Jonas &

Rosenbaum, 2021). Other medical systems in which whole person medicine is the foundational lens might supply insight. Another challenge is that existing research methods are not designed for assessing alternative treatment approaches. This limits the availability of treatments and the inclusion of other whole medical systems (e.g., Ayurveda, Tibetan medicine, naturopathy; Osterman et al., 2013) into the Western medical paradigm. Shelton's position is that "in order to balance the emphasis on scientific and clinical over and against humanistic values in medical education, we need to examine the broader structural context of modern medicine itself" (p. 423).

Studying a traditional medical system's approach to wholism in a broad context may assist with increasing collaborative dialogue and opportunities to explore how to address the complex factors associated with whole person care within Western medicine (Shelton, 2013) in the United States. There is a dearth of research on Tibetan medicine and Tibetan diagnosis concerning the mind–body approach to healing. Most research thus far has focused on the herbal compounds of Chinese medicine and Tibetan medicine, personalized medicine, or meditation. However, based on the literature review, there appears to be no research addressing wholistic healing from a Tibetan perspective.

Researchers are aware that health is a complex phenomenon (Picard et al., 2011), diseases and disorders are not generalizable, and there are social and cultural factors in the approach and treatment of medicine (Cassidy, 2011; Picard et al., 2011). There is also a clear understanding that the body can heal itself, and healing is an internal process (Waller, 2010). Treating the whole person may be relevant to health and healing for patients with chronic conditions (Frey et al., 2013). Treating the whole person requires a

comprehensive, collaborative, and integrative approach to medicine (S. R. Cohen, 2010; Engel, 1977; Hayes & Hodson, 2011; Hutchinson et al., 2009; Manahan, 2011; Thornton, 2013). Researchers are becoming aware that indigenous science and physicians may help allopathic practitioners understand traditional medicines and medical systems as well as bridge the gap between Western and traditional medicine (Eggertson, 2015; Massey & Kirk, 2015).

Many cultures believe that to fully comprehend physical or mental illness, a psychological, biological, and spiritual approach to healing is most effective because traditional medical systems acknowledge all three components in assessing diseases (Kang, 2010). However, Western medicine's approach to treatment is based on a biomedical model stemming from the Cartesian dualistic perspective, which makes it challenging to begin to study and address the wholistic aspects of diagnosis and treatment of illnesses with the intent of focusing on health instead of disease. The Tibetan medical system is wholistic and could be viewed as an integral approach to medicine. To my knowledge, at the time of the current study, no research existed on Tibetan medicine's view on the experience and practice of treating the whole person in Western literature within the United States, specifically from an integral perspective.

### **Purpose of the Study**

I aimed to understand how physicians of Tibetan medicine practice wholistic medicine, including the theory and practice, the physician-patient relationship, diagnosis, and treatment of patients. In existing research on Tibetan medicine and person-centered care (Bauer-Wu et al., 2014; Cameron et al., 2012; P. R. di Sarsina et al., 2011; R. di

Sarsina et al., 2012), individualized or personalized care using multimodal treatments (Ginsburg et al., 2011; Reuter et al., 2013), palliative care including cognitive impairment and Alzheimer's disease (Crawford et al., 2006), regeneration (Dhondup & Husted, 2009), cancer (Bauer-Wu et al., 2014; Choedon et al., 2011; Choedon et al., 2014), and central nervous system (CNS) disorders (Ginsburg et al., 2011), researchers suggested that Tibetan medicine treatments, theory, and practice may benefit physicians and patients in the United States through collaborative efforts. Researchers have also indicated that Tibetan medicine treatments and modalities may be beneficial for inflammation and pain, arthritis, enhancing the quality of life (QOL; Loizzo et al., 2010), stress reduction (Loizzo, Charlson, & Peterson, 2009), and behavioral health (Crawford et al., 2006). Tibetan medicine is an integrative medical system that might offer opportunities for collaboration for practitioners of Western medicine to gain insights into energetic systems affecting psychophysical processes in the areas of neuroscience and modern technologies (Dakpa & Dodson-Lavelle, 2009a).

The present study addressed how physicians of Tibetan medicine interpret and experience wholism in reference to clinical practice, diagnosis, and treatment. Findings may prove educational, increase awareness and research, and encourage collaboration between the Tibetan and Western medical communities in the United States. By exploring TMDs' experience and practice of wholism, the potential outcomes are (a) to understand the contextual view of treating the whole person through the lens of Tibetan medicine (see Reuter et al., 2013); (b) to understand the perspective of the practice and diagnosis of Tibetan medicine from a wholistic framework in a way that Westerners in

the United States can understand (see Reuter et al., 2013); and (c) to provide an alternative narrative of a traditional medical system in a way that will enhance the understanding of health, illness, and disease through the lens of Tibetan medicine, thereby allowing a cross-cultural perspective to be observed (see Yoeli-Tlalim, 2010). There is little research and a lack of data on efficacy related to Tibetan medicine (Luo et al., 2015) and traditional medicine practices more generally (WHO, 2015). I hoped to contribute to existing research on Tibetan medical theory and practice related to a whole systems medicine approach. Increasing awareness of a traditional medical system may provide insight into treating the whole person in allopathic medicine (see Luo et al., 2015; Niemi & Ståhle, 2016; Stanifer et al., 2015; Wang et al., 2015).

I also explored the phenomenon of wholistic healing and the approach to whole person care within the Tibetan medical system, and how TMDs apply this approach to curing and healing their patients. The research design was initially phenomenological. However, due to the need to be responsive to the needs of the study, a qualitative approach with an emergent design was used to explore the phenomenon. The study was a two-phase process: Phase I consisted of key informants (e.g., participants familiar with the medical tradition) with an unstructured explorative interview format to develop the key informant physician interview guide for Phase II. In Phase II, I used the interview protocol developed in Phase I to interview the traditional Sowa Rigpa physicians. The study may increase awareness among laypersons, professionals, and those with a scientific interest in the system of Tibetan medicine by highlighting its potential relevance for Western medical practice.

### **Research Question**

The research question was the following: How do physicians of Tibetan medicine view treating the whole person?

### **Theoretical Lens and Framework for Study**

There were three theories used as a lens that informed my thinking, understanding, and questioning that aided in the exploration of whole person care: wholistic healing (Otto & Knight, 1977), phenomenology of perception (Merleau-Ponty, 2012), and the integral model (Wilber, 2005). To interpret the data, I used the traditional framework of Sowa Rigpa, which aligned with the acquisition of traditional knowledge. Researchers' discussions on the pedagogic tools (e.g., mapping or trees) used to learn (Sabernig, 2020) and make links (Nicolas & Caussidier, 2016) in Sowa Rigpa helped with understanding whole systems medicine through a Tibetan medicine lens.

### **Wholistic Healing**

Otto and Knight's (1977) theory provided a foundation to explore wholism through eight principles of wholistic healing. The premise behind wholistic healing is whole person care, with the understanding that "the mental/emotional, physical, social, and spiritual dimensions" (Otto & Knight, 1977, p. 3) are integrative and synthesized as part of a person's being. The eight principles of wholistic healing (Otto & Knight, 1977) allow the physician to use methods that make use of the body's natural ability to heal through "self-regenerative and self-reparatory processes" (Otto & Knight, 1977, p. 3), which help in rebalancing the body. Literature on wholistic healing is limited to the religious perspective (Ziebarth, 2016). However, Otto and Knight (1979b) used the term

wholistic in the context of treating the whole person. The premise of Otto and Knight's (1979b) principles is also used within the older population to improve QOL.

### **Merleau-Ponty's Philosophy of Perception**

Merleau-Ponty's (2012) philosophy provided a lens for viewing the physicians' experience as they engage with the world and their patients. Merleau-Ponty posited that constant exchange of information exists in the dynamic interaction between the individual and all aspects of their environment. Through the understanding of the perceptual world, there is a lens in which there is an embodiment of the experience where "the subject who learns to type literally incorporates the space of the keyboard into [their] bodily space" (Merleau-Ponty, 2012, p. 146/180). In the physicians' experience, the keyboard (object) is the patient's body, and the learning to type is the sensory information collected. The physician's body becomes "the anchorage in a world" (Merleau-Ponty, 2012, p. 146/180) as the instrument for diagnosis and understanding in whole person care. The body is the instrument that senses, interprets, and perceives where experience does not exist in isolation. Merleau-Ponty's perspective supported my role as the researcher throughout the current study and the physician's role within the Tibetan medical system. Researchers discussed Merleau-Ponty's work in the context of embodied learning (Stolz, 2015), nursing (González-Soto et al., 2021), medicine (Argentieri, 2018), and doctors adjusting to an unfamiliar environment (Harris, 2011).

### **Wilber's Integral Theory**

The integral model (2005), also known as all quadrants, all levels (AQAL) or the integral map, provided a lens for inquiry to help identify patterns of wholeness. The

application of the integral map works across disciplines (e.g., organizations, medicine, psychology) and aids in ensuring all aspects are accounted for when taking an integral approach to what is studied (e.g., medicine, family development, organizational processes). Wilber's (2005) integral model at the basic level consists of four quadrants: interior-individual, subjective, and experiential (I), exterior-individual, objective, and scientific (IT), interior-collective, intersubjective, and cultural (WE), and exterior-collective, interobjective, and social (ITS). The integral model is a systematic approach allowing a comprehensive approach to an inquiry from several viewpoints (Huffaker et al., 2015). Researchers in medicine and health used the model as an approach to treatment (Astin & Astin, 2002); green sustainability medicine to address the needs of the physician, patient, environment, and community (Kreisberg, 2007); caring and healing in nursing (C. Clark, 2012); community-based programs (Vieten et al., 2015); transpersonal medicine (Epstein et al., 2014); whole systems health care (Schlitz, 2008); and a step toward integral health care (Kreisberg, 2012).

### **Sowa Rigpa Medical Trees**

Sowa Rigpa, in the teachings and acquisition of knowledge, uses the medical trees to help with learning, communication, and understanding complex wholistic medical systems (Nicolas & Caussidier, 2016). The medical trees are an early example of mind mapping that helped manage and link complex ideas together (Nicolas & Caussidier, 2016). The trees and branching diagrams were used as visual aids to organize and retain information throughout history (Sabernig, 2020). Trees are also significant in Sowa Rigpa because Siddhārtha Gautama became enlightened under the Bodhi tree (Sabernig,



2020). Additionally, trees are essential to the ecosystem by sustaining life in TEK. To maintain the knowledge structure and to show the essence of the complex thought of Sowa Rigpa, I used a non-Western philosophy as an interpretive lens.

Otto and Knight's (1977) principles of wholistic healing, Merleau-Ponty's (2012) theory, and the integral model (Wilber, 2005) informed the interview questions for Phase I and Phase II. These theories informed my thinking and aided in deriving the focus of inquiry. The integral model is a theory to help with identifying patterns of wholeness and was initially used during the interpretation analysis and interpretation of findings. The complexities of Tibetan medicine and the integral model's theoretical concepts required me to have in-depth knowledge of both to interpret the results, thereby making the integral model less ideal as a model of interpretation for this study's audience. Instead, I used medical trees, drawings, and mind maps to interpret the findings.

### **Nature of the Study**

The study explored the Tibetan medical system from a wholistic integrative perspective. The phenomenon studied was whole person care. A qualitative approach was used because it allowed me to understand the TMDs' view of wholistic care within their social reality (see Biggerstaff & Thompson, 2008; Merriam & Tisdell, 2015). The research tradition was qualitative with an emergent design because the study required a responsive approach to information obtained throughout the research process (see Ravitch & Carl, 2019). The emergent design also encouraged the participants' perspectives, participant engagement flexibility, and data collection and analysis flexibility (see Ravitch & Carl, 2019).

In Phase I, I used Otto and Knight's (1977) wholistic principles as the form of inquiry to create the interview guide for Phase II. In-depth semistructured interviews in Phase II helped me prioritize the perspective of practicing TMDs and understand the essence of Tibetan medicine and its unique forms of wholistic care (see J. A. Smith et al., 2009). Inductive coding and thematic analysis helped me identify themes and subthemes related to whole person care and wholistic healing. Otto and Knight's wholistic principles, Merleau-Ponty's (2012) embodied perception, and Wilber's (2005) integral model informed the inquiry and analytical thinking throughout the study.

### **Definitions**

*Alternative medicine:* When a therapy is used instead of conventional Western medicine (Barrett et al., 2003).

*Complementary health approaches:* "A group of diverse medical and health care systems, practices, and products that are not considered to be part of conventional or allopathic medicine. Most of these practices are used together with conventional therapies" (National Center for Complementary and Integrative Health [NCCIH], 2016, p. 6).

*Complementary medicine:* "The terms 'complementary medicine' or 'alternative medicine' refers to a broad set of health care practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant health-care system. They are used interchangeably with traditional medicine in some countries" (WHO, 2015, p. 16).

*Complementary medicine:* When a therapy is used along with conventional Western medicine (Barrett et al., 2003).

*Holistic health:* “Health as viewed from the perspective that humans and other organisms function as complete, integrated units rather than as aggregates of separate parts” (PubMed Database, n.d.).

*Indigenous knowledge:* “Indigenous knowledge (IK) has been described as a way of knowing, seeing, thinking, and doing things by the people in a community over time such that it becomes a part of them and is being orally transmitted from one generation to another” (Ebijuwa & Mabawonku, 2015, p. 59).

*Integrative medicine:* “The term usually used to refer to a style of practice that places strong emphasis on a holistic approach to patient care while focusing on reduced use of technology. Physicians advocating this approach generally include selected complementary health practices in the care they offer patients, and many have established practice settings that include complementary health practitioners” (NCCIH, 2016, p. 6).

*Mind and body practices:* “Complementary health approaches that include a large and diverse group of procedures or techniques administered or taught by a trained practitioner or teacher such as yoga, chiropractic and osteopathic manipulation, meditation, acupuncture, and massage therapy” (NCCIH, 2016, p. 6).

*Natural products:* “A group of complementary health approaches that includes a variety of products such as herbs (also known as botanicals), vitamins and minerals, and probiotics. These products are widely marketed, readily available to consumers, and often sold as dietary supplements” (NCCIH, 2016, p. 6).

*Reductionism*: Reducing the mind to biological processes; reducing consciousness to biology; reducing energy to matter (Wollman, 1982).

*Salutogenesis*: “The process of healing and health creation. Salutogenesis is the reverse process of disease, illness generation, and breakdown of function; in a broader, more holistic context, process of healing in all dimensions of a person – body, mind, social, and spirit” (Jonas et al., 2014, p. 82). “The whole organism is returning to its natural state, which is why we also call this process existential healing” (Ventegodt et al., 2011, p. 418).

*Spirituality*: An integrative energy that unites and directs all human dimensions (Goddard, 1995).

*Traditional and complementary medicine*: “T&CM merges the terms TM and CM, encompassing products, practices and practitioners” (WHO, 2015, p. 16).

*Traditional medicine*: “Traditional medicine has a long history. It is the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as the prevention, diagnosis, and improvement or treatment of physical and mental illness” (WHO, 2015, p. 16).

*Vitalism*: “The theory that animal functions are dependent upon a special form of energy or force, the vital force, distinct from the physical forces” (Stedman, 2006, p. 2137).

*Whole person care*: An approach that considers multiple dimensions of the patient and their context, including biological, psychological, social, and possibly spiritual and

ecological factors, and addresses these in an integrated fashion that keeps sight of the whole. Whole person care includes a range of treatment modalities to achieve this aim. Additionally, it emphasizes the therapeutic value of the doctor–patient relationship, characterized by an attentive, supportive, and collaborative approach, including recognition of the doctor’s humanity (comprising self-awareness and attending to their health) and adopting a view of health as more than the absence of disease (Thomas et al., 2018).

*Whole person medicine:* A medical approach that treats the whole person rather than the disease. The doctor would attempt to treat a patient within the context of their environment or perhaps recognize the problems of being removed from that environment (Pietroni, 1997).

*Wholistic healing:* “Wholistic healing deals with the totality of a person’s being ... means treating the whole person, helping the person to bring the mental/emotional, physical, social, and spiritual dimensions of [their] being into greater harmony using the basic principles and elements of wholistic healing and, as much as possible, placing reliance on treatment modalities that foster the self-regenerative and self-reparatory processes of natural healing” (Otto & Knight, 1977, p. 3).

*Wholism/wholistic:* The “w” in holism emphasized in the current study was intended to raise awareness of the whole person in a person’s care instead of nonconventional treatments. Otto and Knight (1977) suggested that everyone is “understood as a whole person within the context of the total environment in which [they] function” (p. 3). Strandberg et al.’s (2007) perspective of wholistic versus holistic

suggested: that “the word holistic should really be spelled ‘wholistic’ to avoid confusion with complementary and alternative medicine” (p. 7), aligned with the use in the current study. Smuts’s (1926/1936) meaning of holism aligned with the use of the “w” in holism and considered all aspects of an organism, with the understanding that there are parts within the whole interacting with or affecting the organism as well as inorganic substances; systems within systems are forever evolving as interconnected parts. The “w” represents the whole and begins to streamline the body of literature focused on wholism.

### **Assumptions**

I assumed that TMDs would accurately represent their teachings and practice. Due to the limited size of the population, I recruited from within the United States and internationally to cast a wider net to gain access to *menpas/Amchis* where they lived. There was the hope that physicians of Tibetan medicine would be available and interested in contributing their time and knowledge and could provide an in-depth understanding of Tibetan medicine based on their experiences.

### **Scope and Delimitations**

The population consisted of individuals knowledgeable of Tibetan medicine (e.g., scholars trained in Tibetan medicine, professors) and traditionally trained TMDs able to read, speak, and write in Tibetan. In Phase I, I interviewed scholars and professors knowledgeable of Tibetan and Western medicine practices. Some participants could speak, write, and read the Tibetan language, which was not required for key informants. In Phase II, I interviewed TMDs who had received training from the Tibetan Medical University in Lhasa; Men-Tsee-Khan: Tibetan Medical and Astro-Science Institute in

Dharamsala, India; Tibetan monasteries; or directly from a Tibetan doctor. Phase II individuals consisted of practitioners of Tibetan medicine. Some had worked in Tibetan settlements, had received extensive clinical training, were registered with the Central Council of Tibetan Medicine, were researchers, or were in academia. Phase I and Phase II participants lived in the United States or internationally. I did not exclude individuals based on ethnicity, socioeconomic background, or spiritual or religious beliefs. I explored a wholistic approach to treating disorders within the Tibetan medicine system.

### **Limitations**

The main limitation of this study was the inability to include physicians who were fluent only in Tibetan. I could not use a translator for this study without addressing all the research protocols and translation ethical concerns. All documents for the participants needed to be translated into Tibetan and reviewed by the institutional review board (IRB). Additionally, in qualitative research, the interviewer is the data collection tool. Because I was not fluent in Tibetan, the interpreter would have been the interviewer and would have had to translate the data into English for me to analyze. In qualitative analysis, it is essential to assess word choice, tone, and phrases. Subtleties are often lost in translation when analyzing word choice and tone, and there is an increased probability of bias. The translator would have needed research training to minimize these ethical concerns; otherwise, this process would have lacked scientific rigor for dependability and confirmability. A translator with this skill set was not readily available; therefore, the IRB disapproved of using a translator for this study. Language prevented the inclusion of potential participants eager to contribute and limited access to others. The ability to speak

and write in Tibetan would have provided a richer exchange of knowledge and understanding. Participants often recited Tibetan excerpts in the language of the medical text. There are a minimal number of Tibetan practitioners within the world and fewer than in the United States. This study's findings are not generalizable to other medical traditions outside of Tibetan medicine. Another limitation was the inability to include research articles from countries in which the primary written language was other than English.

### **Significance of the Study**

The out-of-pocket limit for health insurance plans from the Marketplace in 2015 was \$400 and \$800 less than the 2016 plans for individual and family plans, respectively (Yabroff et al., 2016). According to the National Center for Health Statistics (2015), the selected use of prescription drugs within a 30 day interval was higher by 78% for gastric reflux, 54% for cholesterol-lowering, 40% for antidepressants, and 29% for antidiabetic when comparing data from 2009–2012 with 1999–2002. The National Center for Health Statistics (2019) also found that among adults aged 45 to 56, 66% of the population took one prescription drug, and 36.5% took three or more prescription drugs within the last 30 days from 2015 through 2018. Among adults aged 65 and older, 88.5% took one prescription drug, and 66.4% took three or more prescription drugs within the last 30 days. With the rise of NCDs, the WHO's (2015) plan suggested that now is a suitable time to explore and strengthen collaborative efforts toward the exchange of traditional knowledge and traditional medicines with the Western conventional medicine paradigm. Two of the four mental health 2013–2020 plan's objectives set by the WHO (2013a) are



to (a) implement strategies for promotion and intervention and (b) strengthen research between national and international research centers allowing more interdisciplinary knowledge exchanges between countries. Following the WHO's (2015) plans in traditional medicine, the NCCIH (2016) intends to prioritize complementary and integrative scientific efforts in methods development, nonpharmacologic management of pain and mental illness, disease prevention and health, and the integration of CAM approaches (identified as complementary health) into health care.

Continued exploration into traditional medical systems globally and within the United States, in this instance Tibetan medicine, may help decrease the prevalence and cost associated with excessive use of pharmaceuticals for chronic conditions. Traditional medical systems may be helpful in primary care services (Wang et al., 2015), diagnostic techniques (Niemi & Ståhle, 2016), and global health care (WHO, 2015). Additionally, traditional medical systems may provide insight into research on whole system medicines (Luo et al., 2015) and may be beneficial for disease management with less expenditure for the patient (Luo et al., 2015; Stanifer et al., 2015). Increased research in Tibetan medicine may also guide research design for future studies in the West on Tibetan medicine and the mind–body connection. Future development in the field of complementary and integrative health depends on researchers understanding the knowledge of traditional medical systems practices as well as the complexities of the properties and active elements involved in the treatment modalities (NCCIH, 2016).

In an effort to preserve and promote the practice of Tibetan medicine, “investigating the mind-body relationship in Tibetan medical theory and practice”

(Ozawa-De Silva & Ozawa-De Silva, 2011, p. 114) may enrich the literature in Tibetan medicine and psychiatry. By exploring a traditional medical system’s approach to treating the whole person, allopathic professionals may open the discussion for collaborative efforts on treating chronic conditions, understanding the mind–body relationship, and using methods that may be cost-effective and enhance doctor–patient relationships (Bauer-Wu et al., 2014; Luo et al., 2015; Niemi & Stähle, 2016; Ozawa-De Silva & Ozawa-De Silva, 2011; Stanifer, 2015; Wang et al., 2015).

### Summary

The main differences between allopathic and Tibetan medicine are that Western medicine is disease-driven, analysis of illness is primarily on biological processes, and scientific methods (quantitative) are used as an inquiry into the causes of disease (Cardinal-Fernández et al., 2014). Tibetan medicine is systemic and considers the interconnectedness of all systems (e.g., physical, environmental, cosmological, social) that may be involved in treating the whole patient (Chow et al., 2016; Loizzo, Blackhall, & Rapgay, 2009; Tokar, 1999). However, these differences may be viewed as complementary, meaning as equal separate systems in which an exchange of knowledge could assist both medical traditions, thereby creating a cohesive approach to research, theory, and the practice of modern medicine.

Furthermore, it is essential to note that Sowa Rigpa is not “Buddhist medicine” and is for Buddhists and non-Buddhists (Gonpo, 2011a). During the gathering in *lta na sdug* (*Tanadook*, the City of Medicine; Gonpo, 2011a), “the master was surrounded by four retinues: a retinue of gods, a retinue of sages, a retinue of non-Buddhists and a

retinue of Buddhists....At that moment of that time, each word taught by the Master was understood by each of the four retinues in accordance with the tradition and system of their own Master” (Gonpo, 2011a, pp. 8–9). The sages in this text are also known as “scientists” (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort).

The potential contribution of this study was to continue to bridge the communication between Western medicine in the United States and Tibetan medicine with the hopes of increasing curiosity about a system of health care and theory of practice that is vastly different from the traditional Western paradigm. Embracing the unique qualities of both medical systems may provide an open discourse that may offer important insights into the practice of medicine for both traditions. Building a bridge creates the potential to open doors to a wholistic medical paradigm cultivating increased collaborative research and the exchange of knowledge. Chapter 2 consists of an in-depth review of Western medicine and the Tibetan medical system concentrating on the history, theory, diagnosis, treatment, and practice.

## Chapter 2: Literature Review

The U.S. health care system is challenged with providing affordable health care to the existing population. There is also an increased concern for sustainability as it relates to older individuals and the future older adult population. The discussions around health reform are mainly focused on cost containment, improved quality of care, and increased access to care (Federoff & Gostin, 2009). However, “little attention is paid to how medicine is currently taught and practiced” (Federoff & Gostin, 2009, p. 994). There is also a need for increased services for disease prevention and health promotion for all Americans, but resources are limited, making it unclear how the need for services will be met (Koh & Sebelius, 2010). As the cost of the health care system continues to rise along with the increased presence of chronic conditions within the United States, wholism becomes increasingly important for meeting the patient’s needs (Frey et al., 2013). Taking an either-or approach to adherence to the Western model of curative vs. comfort may result in significant harmful effects (Frey et al., 2013). There are several factors (e.g., genetic, psychological, social, and lifestyle) affecting the development and progression of NCDs (M. K. Ali et al., 2015). Treating the disease from a wholistic view is comprehensive and includes not only the physical but also the spiritual, ethical, psychological, social, and cultural concerns of the patient (Cassidy, 2011; Frey et al., 2013). It is crucial for physicians from all medical systems to understand the role these constructs play in the effects on health (Frey et al., 2013; Shelton, 2013). The human body is a complex system requiring continuous research and exploration, and taking a

comprehensive approach to treating the patient would help treat all illnesses (Federoff, 2009; Micozzi, 2014a; Picard et al., 2011; Picard et al., 2013).

### **Content of Review**

The purpose of the literature review was to take a closer look at the history of medical systems as well as the theory and practices, specifically Western and Tibetan medicine, to gain an understanding of the challenges faced within the current allopathic medical system while also gaining insight through the literature on how treating the whole person may be plausible within the context of a traditional medical system. The discussion investigated the divisions of Western medicine within a reductionist paradigm to help expand from the existing paradigm into a more wholistic paradigm. Otto and Knight (1977) and Merleau-Ponty (2012) provided part of the inquiry and analytical lens that informed the investigation and thought processes. Wilber's (2000, 2005) integral model also informed my investigation and analytical thinking. Sowa Rigpa's medical trees were used as a model for interpreting the data. Literature was reviewed on Tibetan medicine, a traditional medical system, to discuss why it should be considered a possible avenue to explore because its approach to medicine has been considered wholistic.

### **Organization of the Review**

The review starts with the theoretical lens and conceptual framework. The literature review continues with the following topics: history of Western medicine, theory and practices of modern Western medicine, models of health, the human body, and mind-body medicine. The literature discussion continues with the exploration of the whole person care paradigm shift and the next steps toward the evolution of medicine and health

care. Chapter 2 concludes by exploring the acquisition of knowledge in traditional medicine and Tibetan medicine as a traditional medical system.

### **Literature Search Strategy**

Searches were conducted using EBSCOhost Research Databases, Health Sciences Databases, and Thoreau. The following databases were used: Science Direct, PubMed, CINHALL Plus and MEDLINE simultaneous, ProQuest Health, and Medical Collection. Additional delimiters defined as part of the search criteria were scholarly (peer-reviewed) journals followed by *traditional medicine*, *Tibetan and medicine*, *integrative* (MeSH Terms; PubMed), *Tibetan medicine and physician* (AB; ProQuest), *Tibetan medicine and physicians* (all fields; Science Direct), *Tibetan medicine and physicians* (keywords) and *United States and Tibetan* (topics; Science Direct), *Tibetan medicine and physicians* (all fields) and *Tibetan* (topics; Science Direct), *Tibetan medicine and integrative medicine* (keywords; Science Direct), *Tibetan medicine* (AB; CINHALL Plus and MEDLINE), *physicians* (AB; CINHALL Plus and MEDLINE), *traditional healers* (AB; ProQuest), and *treating the whole person* (AB; ProQuest). I used CINHALL Plus, MEDLINE, ProQuest, and Google Scholar to search the term *whole person care* within quotes (title; CINHALL; AB; CINHALL and MEDLINE; exact phrase; Google Scholar), *whole systems medicine* (exact phrase; Google Scholar), *treating the whole person* (AB; CINHALL and MEDLINE), *treating the whole person* (AB; CINHALL Plus), *physician* (AB; CINHALL Plus), and *wholistic health* within quotes (SU; CINHALL Plus). Cited sources were further screened for relevant resources.

### **Theoretical Lens and Conceptual Framework**

Researching treating the whole person using whole system medicines, such as Tibetan medicine, requires frameworks and methods that operate from a nonlinear scientific approach. The human body, which is a multilevel system, is limited in allopathic medicine by reductive processes that take a narrow view of the biological complexity of human anatomy, thereby possibly preventing practitioners of Western science from seeing the contextual view as well as identifying the general principles of certain diseases and disorders (Wolkenhauer & Green, 2013). Researchers in systems science use theories grounded in general systems theory (von Bertalanffy, 1950/2008) and cybernetics (Wiener, 1948) as theoretical research models to assess the treatment's effect and the interaction of the various subsystems within the human anatomy. In attempting to overcome the preoccupation with molecular details and provide a more encompassing structure, systems medicine became the solution.

However, systems medicine at its foundation is still reductionistic (Wolkenhauer & Green, 2013). Based on systems theory and cybernetics, researchers of systems medicine have researched alcohol addiction (Spanagel et al., 2013) and respiratory failure (Cardinal-Fernández et al., 2014). The focus of the research appeared to be applicable for understanding pathophysiology and pathogenesis of illnesses and other biological processes through the interaction between different subsystems by focusing on tissue-level and organ-level functioning, which may work well with augmenting other higher level models (Cardinal-Fernández et al., 2014). However, in an integrative approach, systems theory has been recommended (Wolkenhauer & Green, 2013). Wolkenhauer and

Green (2013) recognized the importance of understanding and connecting various systems and subsystems that pertain to the whole organism. These researchers did not suggest that reductive approaches, as these relate to organizing principles, are no longer necessary but rather that complementing reductive approaches with more integrative strategies are needed to overcome the challenges presented through reductive methods. Other theories and frameworks have also emerged from general systems theory and have been used in research on medicine (Jonas et al., 2014; C. M. Martin & Félix-Bortolotti, 2014; Rioux, 2012).

The theories that appear to be most relevant to whole systems medicine are complex adaptive theory, complex systems theory (chronic illness management; C. M. Martin & Félix-Bortolotti, 2014), systems theory (effects of naturopathic medicine; Louise, 2001); nonlinear dynamic systems (NDS; Rioux, 2012), and healing-oriented practices and environments, which use salutogenesis as the theoretical foundation (Jonas et al., 2014). The latter has been used to assess healing, well-being, and clinical and economic outcomes (Jonas et al., 2014).

Tibetan Medicine is also closely affiliated with Ayurveda medicine, both use similar ingredients for their medicines and have standard translations for the humoral theory, but they are also vastly different (Dhonden & Wallace, 2000). Therefore, the theory of NDS was most relevant to investigating Tibetan medicine because of its use in Ayurveda medicine (Rioux, 2012). NDS identifies patterns in whole systems and provides a lens for the complex system of the individual (patient; Rioux, 2012). The researchers reported that the NDS demonstrates promise for future research on Ayurvedic



medicine (Rioux, 2012). System theories in research have been used to focus on treatment approaches using medicines of traditional whole medical systems as well as to provide perspectives on the interrelationship of internal and external factors associated with health (Rioux, 2012).

To explore whole person care, however, the approach used included three theories as a lens that informed analytical thinking and inquiry, understanding, and questioning: wholistic healing (Otto & Knight, 1977), the phenomenology of perception (Merleau-Ponty, 2012), the integral model (Wilber, 2005). Finally, the traditional framework of Sowa Rigpa was used to interpret the data, which aligned with the acquisition of traditional knowledge.

### **Wholistic Healing**

There are eight principles of wholistic healing (Otto & Knight, 1977). The premise behind wholistic healing is whole person care, with the understanding that “the mental/emotional, physical, social, and spiritual dimensions” are integrative and synthesized as part of a person’s being (Otto & Knight, 1977, p. 3). The eight principles allow the physician to use methods that make use of the body’s natural ability to heal through “self-regenerative and self-reparatory processes,” which help in rebalancing the body (Otto & Knight, p. 3).

The application of wholistic healing encourages the use of a healing team or a collaboration with other practitioners to provide care that is aligned with the needs of the patient while addressing the root cause of illnesses (Otto & Knight, 1977)—additionally, fostering the use of a range of diagnostic tools and modalities “including those not

commonly accepted” (p. 16). This healing model encourages patients to become active participants in their healing using self-regulating resources. Finally, a healing environment, both interpersonal and physical, is paramount in the patient’s recovery process. Otto and Knight’s (1977) wholistic healing was a lens used as a first step to engage in a dialogue on whole person care. There is minimal research on “wholistic healing,” the principles, however, are closely aligned with the quality of life care. For further discussion, see the paradigm shift section, the wholistic healing subsection, and the associated eight concepts. Although following is a summary of the eight principles.

The first principle addresses the complex electrochemical subsystems by embracing the energetic system of the human body. The second principle incorporates “self-awareness and self-understanding” as a path to “health and vitality” (Otto and Knight, 1977, p. 9). The third principle, the patient’s first step toward healing, is seeking help, which allows the physician to be facilitatory in the healing process. Patients must become active participants. The fourth principle is the “interpersonal relationship environment,” where physicians and support systems consistently offer compassion, empathy, and understanding (p.10). The fifth principle relies on self-regulating processes of the body in the treatment program prior to escalating to more evasive treatments such as surgery. The sixth principle incorporates group work as a therapeutic part of healing. The seventh recognizes lifestyle, diet, social environment, and interpersonal conflicts as contributing factors to disease and disorders. Finally, the eighth understands the importance of spiritual resources and beliefs as a role in healing. Thereby addressing “the totality of a person’s being” (p. 3).

## **Merleau-Ponty Philosophy of Perception**

Merleau-Ponty (2012) considers the engaged interaction that exists between the individual and all aspects of their environment where there is a constant exchange of information. The following provides insight into the perceptual experience and the interconnectivity between the said subject and object, where they are all one at the moment of exchange and only exist in the presence of the other.

Perception's silent thesis is that experience, at each moment, can be coordinated with the experience of the preceding moment and with that the following one, that my perspective can be coordinated with the perspectives of other consciousnesses – that all contradictions can be removed, that a monadic and intersubjective experience is a single continuous text – and that what is indeterminate for me at this moment could be determinate for a more complete knowledge, which is seemingly realized in advance in the thing, or rather which is the thing itself (p. 54/80).

Interpretation, perception, and experience do not exist in isolation (Merleau-Ponty, 2012). The human subject is an embodied “being in the world” (Merleau-Ponty, 2012, p. Ixxvii/13) where the subject and object are part of and are an extension of the external world (Matherne, 2014). Gallagher's (2010) classification of Merleau-Ponty's phenomenological approach is about being in the world without separation in time or space with the understanding that the experiencing subject can never be entirely separated from the other or environment. Merleau-Ponty's perspective supports the role of the physician within the Tibetan medical system and the role of the researcher.

Interwoven within Tibetan medicine's healing framework is an interconnected conscious awareness within the physician-patient relationship. According to Professor Thurman, parts of the educational curriculum include contemplative practices to cultivate the physician's development of wisdom and compassion "with the intuitive clairvoyant insight" into the patient's condition during the diagnostic process enabling the doctor to be an effective healer (Chenagtsang, 2014, p. XI). Merleau-Ponty's theory of embodiment and cognition points to the human's (physician) ability to sense and experience patterns and behaviors in the body of others (patient), thereby reinforcing the concept that we are all one (Dobrowolski, 2014). Tracey et al.'s (2003) research on family physicians asserted that physicians of evidence-based medicine (EBM) described intuition as being a "necessary tool for strong clinical decision making" (p. 4) as well as complimentary in the practice of EBM.

Researchers discussed Merleau-Ponty's (2012) work in the context of embodied learning (Stolz, 2015), nursing (González-Soto et al., 2021), medicine (Argentieri, 2018), and in a study on doctors adjusting to an unfamiliar environment (Harris, 2011). González-Soto et al. (2021) found the embodiment philosophy aligned with the nursing field and how they care for their patients. Harris (2011) discusses the practice of medicine and the challenges migrant doctors face when moving from place to place. Harris discovered that the migration doctor needs to consistently adjust from the "past to present moment," thereby requiring them to rely more on embodiment and sensory experience (p. 317). These studies support and provide insight into the work of Merleau-Ponty (2012).

### **Wilber's Integral Theory**

The use of the integral theory is emerging in the field of psychology as well as medicine (e.g., integral medicine), which may be due to the heuristic aspects and the multiple components that scholars and practitioners may use as a lens at the micro-level within the dynamics of a macro-level system, thereby accounting for a genuinely integrated and interconnected representation of all things. The integral model (all-quadrant, all-Level; AQAL) bridges the spiritual aspects with the scientific from “matter to body to mind to soul to spirit” through an empirical lens (Wilber, 2000, p. 66). The AQAL model appears to be an ideal framework for all human inquiry that may be viewed through a lens of interior and exterior realities, spiritual and scientific experiences, and subjective and objective realities (Wilber, 2000).

As a basic introduction to the AQAL model, at the contextual level, four quadrants represent the internal and external aspects of the individual and collective, respectively, and may be used to view anything: “I” (internal aspects of the individual; upper left [UL]), “IT” (external aspects of the individual; upper right [UR]), “WE” (internal aspects of the collective; lower left [LL]), and “ITS” (external aspects of the collective; lower right [LR]). The four quadrants can also be viewed from four perspectives: “I” (self and consciousness), “IT” (brain and organism), “WE” (culture and worldview), and “ITS” (social system and environment; Wilber, 2007). Wilber (2005) posited that within each of these quadrants exist levels, lines, states, and types. Levels or stages are the developmental aspects within each quadrant and apply to any developmental line. Lines are movements within the levels or stages. However, according

to Wilber (2005), states (e.g., meditative, conscious) are temporary because they come and go, while stages of consciousness are considered permanent. Finally, types are present at any stage or state within a quadrant and may be represented as the idea of types (e.g., Myers Briggs: feeling, thinking, sensing, and intuiting; Briggs et al., 1943; Stilwell et al., 2000). It is a systematic approach allowing a comprehensive approach to an inquiry from several viewpoints (Huffaker et al., 2015). Wilber's (2000) model may be helpful for practitioners and researchers interested in providing a contextual view of medicine while also identifying areas (e.g., the interconnection between the subtle world and the physical world; M. H. Cohen, 2006) that might be overlooked (Huffaker et al., 2015).

Literature associated with health and healing using the integral model exists in the following topics: caring and healing in nursing (C. Clark, 2012), community-based programs (Vieten et al., 2015), transpersonal medicine (Epstein et al., 2014), integral health care (Kreisberg, 2012), philosophy of chiropractic (Senzon, 2010), and integrative public health (Hanlon et al., 2010). The integral model has been suggested as the answer to whole person care (Huffaker et al., 2015), medicine (Astin & Astin, 2002), green health care (Kreisberg, 2007), and whole systems health care (Schlitz, 2008). Astin & Astin (2002) pioneered the use of the integral theory in behavioral medicine as a comprehensive heuristic framework to conceptualize a view of health and illness that would assist evidence-based medicine with treatment modalities while “exploring the multifactorial nature of disease and informing research methodology and medical education” to aid in clarifying the terms “holistic” and “integrative” within the Western

paradigm (p. 75). This provides a strong foundation for exploring other medical systems, such as Tibetan medicine.

The integral theory was used because of its emergence in the field of medicine and its dynamic integrated framework. As Kreisberg (2012) suggested, the integral theory allows for the unfoldment of thought and knowledge, the inclusion of other approaches, and the unique characteristics of every individual as defined in the three principles discussed by Kreisberg: unfoldment, nonexclusion, and enactment, respectively. These terms are defined by Kreisberg as follows: “nonexclusion inquiries into the techniques used in all types of science and social science fields to evaluate validity” (p. 370); “unfoldment is the recognition that our understanding of the nature of the universe is growing” (p. 371); enactment is the idea that “our intention directly affects the system with which we interact,” thereby offering a place for the uniquenesses and life stories of the individual (p. 370).

### **Sowa Rigpa Medical Trees**

*Sowa Rigpa*, in the teachings and acquisition of knowledge, uses the medical trees to assist with learning, communication, and understanding complex wholistic medical systems (Nicolas & Caussidier, 2016). Medical trees are an early example of mind mapping that helps organize and link complex ideas (Nicolas & Caussidier, 2016). The use of trees and branching diagrams as visual aids to organize and retain information have been used throughout history (Sabernig, 2020). Trees are also significant in *Sowa Rigpa* because Siddhārtha Gautama became enlightened under the Bodhi tree (Sabernig, 2020). Trees are also important to our ecological system by sustaining life in traditional

ecological knowledge. Therefore, to maintain the knowledge structure and to show the essence of the complex thought of *Sowa Rigpa*, a non-Western philosophy will be used as an interpretative lens.

The intended use of Wilber's (2005) integral theory was to provide a lens for interpretation of the findings. Instead, Otto and Knight (1977), Merleau-Ponty (2012), and Wilber (2005) informed the approach to inquiry for Phase I and Phase II and analytical thinking to understand the phenomenon of whole person care. See Appendix C. Otto and Knight's (1977) principles of wholistic healing discussed in detail under the section *paradigm shift*, subheading *wholistic healing*, provided a foundation to explore wholism in Phase I (see Appendix B) to create an interview guide for Phase II. See Appendix A. The interpretive lens used in Chapter 5 was the Sowa Rigpa medical trees, artwork, and mind maps to provide an organized traditional way and visual representation of knowledge transfer. See Appendix J through Appendix O.

## **Literature Review**

### **History of Western Medicine**

Documented medical systems date back as far as 3100 B.C.E in the regions of Mesopotamia, Egypt, India, and China and predate the medical traditions of Greece, Rome, and Persia (Erickson, 2008). The medical practices from Greece, Rome, and Persia include some of the earliest texts of Western pre-scientific medicine (Erickson, 2008; Nutton, 2013). Medicine was a mixture of religion, magic, and philosophy, and Asclepius was the founder of this ancient Greek approach to healing (Falagas et al., 2006; Nutton, 2013). He was considered a "Pan-Hellenic deity" around the 4<sup>th</sup> century (Nutton,



2013, p. 107). During this era, in 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> century Greece, physicians were considered priest-healers and known as Asclepiads (Falagas et al., 2006; Nutton, 2013). They profoundly influenced those suffering from psychosomatic disorders (Falagas et al., 2006). Discussions around theories and methods of medicine were open to laypeople as well as practitioners (Nutton, 2013). When illnesses were presented, the primary interest of physicians was focused on the cause and the possible natural explanations for the disease (Nutton, 2013). Significant contributors to medicine during this era were Empedocles, Alcmaeon, Democedes, and Democritus (Nutton, 2013). It is essential to mention that the theories attributed to Empedocles (the four basic elements and human physiology) and Alcmaeon of Croton (theory of health) are remarkably similar to traditional (e.g., Ayurveda, Tibetan medicine) medical theoretical models of today. The practice of medicine took place in healing centers. The healing centers, temples, medical schools, and libraries all existed within isolated parts of the region near scenic locations, natural springs, or mountains (Falagas et al., 2006; Nutton, 2013). During that time, the treatments that played a vital role in the therapeutic aspects of healing were diet, exercise, and baths (Falagas et al., 2006; Nutton, 2013).

### ***Postscientific/Classical Era***

However, the historical foundation of scientific medicine (6<sup>th</sup> century B.C.E) can be traced to Hippocrates of Cos (Nutton, 2013), who is known as the father of Western medicine (Bulger & Barbato, 2000; Falagas et al., 2006; Shim et al., 2008). Hippocrates lived from 460 to 370 B.C.E. and is associated with Aristotle, Plato, and Democritus (Bulger & Barbato, 2000). As the leader of scientific medicine, the works of Hippocrates,

his students, and possibly other historical physicians known as Asclepiads were collected together in the *Corpus Hippocratus*. These writings, written in the fourth and fifth century B.C.E., formed a textbook of medicine containing ethical and historical approaches to therapy with descriptions of diseases and known treatments (Bulger & Barbato, 2000; Falagas et al., 2006). Driven by the movement of naturalistic philosophy, Hippocrates removed the speculative philosophical aspects of medicine that were practiced: magic, religion, and superstition, by distinguishing the practice of medicine from philosophy (Falagas et al., 2006). However, there are still remnants of the deities of the past in Western medical symbolism, represented by the Caduceus (Katsaras et al., 2020; Shetty et al., 2014) and in the Hippocratic Oath (Shetty et al., 2014). Hippocratic medicine introduced the scientific approach to practicing medicine with reason using a framework driven by scientific knowledge that included three fundamental principles: observation, experience, and rationale (Bulger & Barbato, 2000; Falagas et al., 2006).

### ***Theory, Diagnosis, and Treatment***

During this era, several schools of thought emerged in the sciences (Ionian, Pythagorean, Cnidus, and Coan). The Cnidians' theoretical approach concentrated on disease and diagnosis with the primary focus on the organs by observing the illness's physical signs and symptoms (Falagas et al., 2006). The Cnidian approach appears to be present in modern Western medicine today. In contrast, the Coans took more of a holistic-psychosomatic approach to medicine by focusing on prognosis and the patient (Falagas et al., 2006). Hippocrates used his theoretical foundation of the four humors (blood [warmth], phlegm [coldness], yellow bile [dryness], and black bile [moisture]) for

diagnosing and treating his patients (Falagas et al., 2006). Hippocrates also considered the elemental aspects of nature (wind, fire, water, and earth; Falagas et al., 2006). The Coan's approach is reflected in Hippocrates's philosophical approach to medicine and the physician-patient relationship.

### ***Physician–Patient Relationship***

Hippocrates's philosophical approach to medicine was that “the interaction of nature, the patient, and the physician determined the outcome of the illness” (Bulger & Barbato, 2000, p. S4). He treated his patients with dignity and viewed the diseased body as sacred with a primary focus on doing no harm, thereby building the present-day foundation of the physician-patient relationship (Bulger & Barbato, 2000). Another philosophical view of Hippocrates was treating the whole person by taking into consideration every aspect of the patient's life, “promoting the holistic approach in medical science” through the following methods of clinical examination: inspection, auscultation, and palpation (Bulger & Barbato, 2000; Falagas et al., 2006, p. 1947).

### **Modern Western Medicine Theories and Practices**

The dominant model of disease as well as the blueprint for evidence-based medicine (EBM) research today is the biomedical model (Engel, 1977; Frey, Powell, & Gott, 2013; Nunn, 2012) within Western American societies and is the pre-eminent model, which has been “widely disseminated throughout the world” (Hahn & Kleinman, 1983, p 191; Nunn, 2012). The biomedical model has been defined as “a conceptual model of illness that excludes psychological and social factors and includes only biologic factors in an attempt to understand a person's medical illness or disorder” (Stedman's

Medical Dictionary, 2006, p. 1217). Through germ theory, the biomedical model has made significant contributions to the study of infectious diseases, sanitation, pharmaceuticals, and life expectancy (Johnson, 2013).

Various terms are used to discuss and reference this form of medical practice in addition to biomedicine: Western medicine, modern medicine, allopathic medicine, evidence-based medicine (EBM), cosmopolitan medicine, and scientific medicine (Hahn & Kleinman, 1983). Each of these terms carries implications and highlights some aspects of biomedical practice while obscuring others. The terms used in this study to reference the conventional element of medicine were: Western, biomedicine, conventional, and allopathic.

Western medicine is a scientific model designed for the study of disease rather than the underlying root causes of illnesses and disorders and focuses on human and animal (e.g., pigs) biology, physiology, and sometimes pathophysiology (Engel, 1977; Hahn & Kleinman, 1983; Lunney, 2007). There are only two overarching educational medical paths within the medical scientific community, allopathic and osteopathic. Western medicine is a medical system that effectively treats surgical and medical emergencies, trauma, and acute infections (e.g., bacteria and parasites; Weil, 1998). However, chronic conditions have been more of a challenge for this highly regarded medical system.

The biomedical model is the foundation of current evaluations, clinical practices, research, and diagnosis and treatment of diseases and disorders (Borrett, 2013). Biomedicine is based on general, objective, and quantitatively measurable signs and

symptoms and generally excludes the subjective experience of the patient's illness and treatment (Borrett, 2013; Gergel, 2013). According to Jonas et al. (2014), a disease model is not focused on healing.

### ***Philosophy/Theory***

The philosophical foundation of modern scientific medicine is based on the works of Rene Descartes (Leder, 1992). In the Cartesian dualistic foundation, the mind and body are separate ontological entities (Godman & Kingma, 2013; Leder, 1992). Molecular biology is the framework of the biomedical model; this scientific model was designed to study disease with the intent of isolating and controlling or destroying the organism that appears to be the cause of the illness (Engel, 1977). O'Leary (2021) argues that dualism is an inaccurate assessment of biomedicine, that it is instead monistic where the immediate concern is the absence of the person within the biomedical model. The analysis is mechanical in nature, a type of puzzle-solving, focusing on the disease and not the patient (Frey et al., 2013). Symptoms are not viewed as interconnected phenomena but as clues for diagnostic criteria, leaving little room for other contextual variables (e.g., psychological, environmental, social, and spiritual) which may contribute to illness. This laser focus to analysis minimizes opportunities to treat the phenomena (Engel, 1977; Frey et al., 2013). According to Goddard, *personhood* in the Western world is separated into the following distinct components: spiritual, psychological, and biopsychosocial (Goddard, 1995). From a whole-person perspective, the spiritual-component is considered interchangeable with the psychological, while the mind and body remain separate.

Several biomedical beliefs exemplify reductionist thinking, according to Wade and Halligan (2004): (1) all illnesses and symptoms are due to internal abnormalities associated with either functioning or structure of specific organs; (2) all diseases eventually present with symptoms, which may be influenced by other factors, but these factors do not contribute to the development or manifestation of the disease; (3) Health is the absence of disease; (4) Mental phenomena are unrelated to any presented disturbances of bodily function; (5) The patient is not responsible for their illness; and (6) the physician expects that the patient will be passive during treatment and adhere to the treatment prescribed.

### ***Mind–Body Dualism***

Descartes’s view of the mind being separate from the body, with the soul being independent and not dying with the body, is not the limitation in the lens. It must be understood that the biomedical model, driven by biology, is incomplete because it does not allow for an integrative component or variable within the mind, soul, and body that is interacting and interdependent (S. Lewis, 2009). It should be noted that the term spirit is not part of the Eastern language (Rapgay, 2005). Terms such as consciousness or inner self that are found in the language of contemplative practices may be more appropriate.

According to Frey, Powell, and Gott (2013), the biomedical theoretical view has practitioners of the model treating patients as “repositories of disease, dissected into their component parts, and divided among the various subspecialties. In a counter position to this, the whole person and [their] complex interactions and relationships are relegated to a ‘non-medical’ status” (p. 353). Fox suggested that the biomedical model is a curative

model where there is a separation between the disease and the patient; there is no need for the physician to take a humanistic approach to treatment (as cited in Frey et al., 2013).

Therefore, new tools, techniques, or processes might be needed to affect progress. It might also be helpful to explore if a cure exists for mental disorders. It may be concluded that the allopathic approach is just masking or pacifying the disorder with pharmaceuticals. The latter is more relevant to mental disorders due to biomedicine's disassociation between the mind and body but may also apply to physical diseases.

For more than three decades, the biomedical model has been the primary mental health model in the United States (Deacon, 2013). In a model driven by pathology and a belief in a separation between mind and body (Wade & Halligan, 2004), all mental phenomena in the biomedical paradigm must be explained by somatic processes defined by measurable biological variables (biochemical or neurophysiological), which are deviations from what has been described as "normal" (Deacon, 2013; Engel, 1977). Therefore, embracing mind–body dualism, mental disorders within the biomedical model are considered biologically based brain diseases. Thus, the primary focus of treatment is pharmacology to assist with balancing biological abnormalities (Deacon, 2013).

Andreasen (1985) provided a little more insight into the reductionist mindset through the list of core tenets for the approach to mental illness: (a) the root causes of mental disorders are due to biological abnormalities found in the brain, (b) mental diseases and physical diseases follow the same diagnosis, and (c) treatments, like physical diseases, are biologically focused. The primary focus for all research within the

biomedical paradigm regarding mental disorders is the discovery of the biological causes (Deacon, 2013), but this could apply to diseases in general.

### ***Doctor–Patient Relationship***

Depending on where it is being practiced, the doctor–patient relationship under the Western paradigm is hierarchical in nature (Frey et al., 2013). In the hierarchical physician–patient relationship, the physician is seen as the expert, and the patient takes more of a submissive role by following the treatment protocol outlined in the tenants discussed by Wade and Halligan (2004). The relationship is not known to be collaborative; the patient is expected to accept the diagnosis and the treatment, which is not personalized. When viewing treatment from a long-term perspective (e.g., oldest-old), barriers may potentially be created during palliative care driven by the physicians’ perceptions or beliefs (Frey et al., 2013). Attitudes, beliefs, and self-perception play a vital role in the treatment, behavior, delivery of care, and practice of medicine (Frey et al., 2013).

However, there is a movement toward the collaborative approach linking mind and body, which may be referenced as integrative, interdisciplinary, and collaborative or coordinated care in the medical and behavioral health fields (Kessler & Stafford, 2008). The collaboration paradigm also operates on a continuum, with “minimal collaboration” being at one end of the spectrum and “close collaboration in a fully integrated system” being at the other end of the spectrum (Kessler & Stafford, 2008, p. 5). The health care system within the United States is still considered fragmented, and physicians’ collaborative efforts tend to fall under the minimal collaboration category (M. P. Martin



et al., 2014). M. P. Martin et al. (2014) conducted a systematic review of the literature on the program characteristics of integrated primary care (IPC) within the United States. Based on what was reported in the literature, M. P. Martin et al. concluded that communication between providers and collaborative efforts between providers were conducted less than half the time, with the latter being even less prevalent.

Following are the benefits of collaboration between medicine and behavioral health: cost savings for the patient (Grenier & Chomienne, 2008; Lebovits & Levey, 2008), cost savings for the health system (Grenier & Chomienne, 2008), benefits for the uninsured (Khatri et al., 2008), enhanced quality of care (Grenier & Chomienne, 2008), and addressing the illness efficiently and effectively (Grenier & Chomienne, 2008; Lebovits & Levey, 2008; Thorn et al., 2008). In more recent research on collaboration and psychiatric disorders, Huffman et al. (2014) identified that collaborative interventions were consistently successful in research, clinical intervention, and cost-effectiveness through a systematic analysis of existing research. Huffman et al. also suggested that improved outcomes might have been superior when mental illnesses and chronic conditions were equally addressed compared to targeting just mental disorders.

### ***Approach to Health***

Another factor within the biomedical paradigm is the approach to health and disease. *Health*, as defined by the constitution of the World Health Organization (WHO, 1989), “is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (p.1). This concept dates back to Hippocrates (460-377 B.C.) but changed during the Cartesian mind–body dualism changes in thinking that

birthed modern science and medicine (Shelton, 2013). *Disease*, according to Engel (1960), is “the failures or disturbances in growth, development, functions, and adjustments of the organism as a whole or any of its systems” (p. 459).

Patients within the biomedical model of care are merely viewed as hosts for diseases where the symptoms are clues that aid in the diagnosis, hence fostering a treatment plan aligned with the disease and symptoms (Frey et al., 2013). In this diagnostic process, the physician-patient relationship is disconnected, and two new connections are bridged, the physician-disease relationship and the physician-patient-with-disease relationship, thereby creating two relationships to manage where treatment intentions are dichotomous (Hutchinson & Brawer, 2011). There are two separate tracks; one is for *curing* (Hippocratic approach) the other is for *healing* (Asclepiad approach). In the therapeutic relationship, the physician cures the disease and heals the patient. Within this medical dichotomy, the constructs for the doctor (e.g., communication, epistemology, validity) and patient (e.g., possibility, action, and goal) have associated characteristics that are different for curing and for healing (Hutchinson & Brawer, 2011). For example, the communication characteristic for curing is conscious, while for healing, it is unconscious.

The epistemology for curing is scientific, requiring scientific knowledge associated with evidence-based practices (Hutchinson, 2011a; Hutchinson & Brawer, 2011). Curing eradicates disease or corrects the problem (Kearney, 2000). In contrast, the epistemology for healing is artistic and is considered more of an art form than science that taps into the intuitive aspects of the physician-patient relationship (Hutchinson,

2011a; Hutchinson & Brawer, 2011). For clarity, Hutchinson and Brawer (2011) postulated that it is through the standardization of the double-blind, randomized clinical trial that researchers of scientific medicine found validity for curing as real and healing as a placebo. This led researchers to conclude that the healing aspect of treatment was not scientific and, therefore, invalid. Suppose the two are mutually exclusive (Hutchinson & Brawer, 2011) and not complementary. How will healing emerge if the practices of medicine and the medical environment are not conducive to supporting healing (Jonas et al., 2014)?

Weil (1998) and Waller (2010) view healing as an internal process where the body naturally attempts to restore equilibrium when homeostasis is disrupted. Mount and Kearney (2003) defined healing as a response to the disruption (disease or illness) in homeostasis that provides the patient with a sense of integrity and wholeness (Mount & Kearney, 2003). Jonas et al. (2014) suggested that healing is “the process of recovery, repair, renewal, and reintegration that contribute to a whole person’s (physical, mental, social, and spiritual) health and wellbeing” (p. 82). The healing process requires the physician and the patient to engage in the process fully (Hutchinson, 2011a). Based on these various views of healing, it may be concluded that curing and healing are needed and should be integrated for good health care (Jonas et al., 2014).

The soul and the body as integrated entities are what epitomized health from Plato’s perspective (Stempsey, 2001). Therefore, both entities require treatment when the body is imbalanced; curing just the body from this perspective is not treating the whole person (Stempsey, 2001). The practitioners of the biomedical worldview are strictly

concerned with the disease process (Frey et al., 2013), where the patient and the disease are separate entities that require a dual relationship (Hutchinson & Brawer, 2011).

According to Frey et al. (2013), biomedical thinking is symptom and disease-focused, where the symptoms direct the physician's treatment plan in the attempt to treat the disease. On the other hand, holistic practitioners treat both the disease and the patient as one (Frey et al., 2013) from an inclusive perspective at the micro and macro levels.

Treatment is comprehensive when considering Engel's (1977) approach to care as well as an integral approach from Wilber's (2000) worldview. Molecular inclusion is only one aspect, one entity at the micro-level. There is an entire universe, a complex system within the human body that is influenced by other external factors at the macro-level of existence that contributes to health and disease. Biomedicine is only one part of the whole. Therefore, it can be concluded that the worldview of a physician is critical to the care and should be one of collaboration and partnership as well as the inclusion of various medical theoretical views to assist the needs of the patient better.

### **Holistic Medicine: Modern Day Perception**

According to the American Cancer Society (ACS, 2013), there are many views on how holism is applied and defined in modern medicine. For some, holistic medicine is confined to complementary and alternative approaches to treatment, which are outside of the biomedical mainstream model of medicine (Mainstream medicine; ACS, 2013, Holistic Medicine). Others define it as treating the whole person through diet, behavior, social support, counseling, the use of botanical supplements, and the inclusion of complementary alternative medicines (CAM). Then there is holistic care, also known as

integrative medicine and holistic oncology, which focuses on emotional and spiritual care while also considering previously mentioned approaches (Hu et al., 2015; Hunter, Corcoran, et al., 2013). Therefore, there is a diverse view within the field of holistic medicine and how the term is defined and used. Holistic medicine appears to be more of an approach to life and health that considers the physical, mental, and spiritual (American Cancer Society, 2013, Holistic Medicine). An approach to life differs from an approach to diagnosing, treating, and healing diseases and disorders.

### ***Complementary and Alternative Medicine***

As previously noted, the term holistic is prevalent in research associated with CAM. Holistic under CAM represents modalities supporting natural healing that are historically found in traditional complete medical systems (e.g., classical Chinese medicine, Ayurveda) as well as complete nonconventional medical systems (e.g., homeopathy, chiropractic, naturopathy) and are used as supplemental treatment within the biomedical model (Hawk et al., 2012; Cowan, 2014). There are four CAM categories outlined by Cowan (2014): (1) natural products (e.g., dietary supplements), (2) mind-body medicine (e.g., meditation, yoga, biofeedback), (3) manipulative and body-based practices (e.g., massage, craniosacral, acupuncture, chiropractic), (4) and other CAM practices (e.g., nutritional counseling, transcranial magnetic stimulation, life-coaching); the use of some of these modalities may also affect energetic levels to assist in the healing process.

Researchers found an increased prevalence of CAM in the United States (Clarke et al., 2015; Okoro et al., 2013) amongst the older population (Siddiqui et al., 2014) and

military personnel (Goertz et al., 2013). Additionally, CAM has been used in the treatment of anxiety and depression (D'Silva et al., 2012), dementia caregivers (D. S. Black et al., 2013), cancer symptom management (Anderson & Taylor, 2012), and smoking cessation (Carim-Todd et al., 2013). Other researchers have also found CAM to benefit patients with chronic conditions (Peltzer et al., 2016), irritable bowel syndrome (IBS; Usher, Fox, Lafarge & Mitchell, 2013), and type 2 diabetes in Malaysia (Siew Mooi et al., 2013). Pharmacy students in Pakistan agreed that CAM should be included as part of the curriculum in the pharmacy program (Hussain et al., 2012). Finally, in a study conducted in Australia on consumers' experiences of CAM and conventional medicine, the researchers found that consumers' perceived CAM usage was effective for long-term therapy and conventional medicine usage for emergency treatment. They also felt a sense of empowerment using CAM and held positive relationships with their CAM practitioners (Emmerton et al., 2012).

CAM is viewed as holistic healing within the Western medical model even though the treatments are not used or assessed within the original theoretical context of a whole systems medical approach (Freeman, 2009; Hsu et al., 2009; Thachil et al., 2007). The interconnectedness of the mind-body connection or mind, body, and spirit aspect is not fully addressed. The wholistic part of treating diseases or disorders does not appear to be an aspect of the Western paradigm. Most CAM research has been driven by the biomedical model and focused on treating symptoms and disease (Hawk et al., 2012). However, efficacy and safety still need to be substantiated through evidence-based studies and practices (Siddiqui et al., 2013). Patients are using CAM modalities as an

alternative to biomedical treatments; therefore, biomedical physicians may benefit from increased knowledge of CAM and non-evidence-based approaches to better serve their patients (Cowan, 2014; Siddiqui et al., 2014).

Many practitioners of CAM apply evidence-based perspectives to training and practice to aid in increased multidisciplinary collaborations to better meet the needs of integrative clinical approaches (Zwickey et al., 2014). Collaboration between CAM practitioners and conventional medical practitioners could be beneficial (Emmertson et al., 2012). It could also be helpful to include traditional whole system medicine practitioners as part of the collaboration to bridge the gap between Western and traditional medicine (Massey & Kirk, 2015). Outside of the United States, other countries are benefiting from collaboration with traditional healers (Eggertson, 2015), Indigenous traditional medicine practitioners (Ebijuwa & Mabawonku, 2015), traditional knowledge (Ebijuwa & Mabawonku, 2015; Hewson, 2015; Mason et al., 2012; Weiss et al., 2012), and traditional medicines (Ben-Arye et al., 2015; Luo et al., 2015; Stanifer et al., 2015).

### *Naturopathy*

Naturopathy is a distinct system of medicine for primary health care that focuses on prevention and the body's ability to heal itself (Bastyr University, 2015; Fleming & Gutknecht, 2010). Naturopathic doctors (NDs) blend the use of centuries-old healing traditions from various cultures with conventional biomedicine along with scientific research from multiple disciplines to aid in diagnosis and proactive prevention as well as to support naturopathic treatments (Fleming & Gutknecht, 2010; McWilliams, 2015; Poorman et al., 2001).

As discussed earlier, the body is a human organism with complex systems and factors (physical, mental, spiritual, genetic, emotional) that interact within the body as well as externally with other subsystems (environmental, social) to maintain optimal health (Litchy, 2011; Poorman et al., 2001). Naturopathy is known for its whole person care and philosophical views of the body as a system with subsystems that exist and interact within a macrocosm. The naturopathic physician intends to remove barriers that interfere with the body's optimal balance of health and restore the balance with noninvasive treatments that are closest to nature.

**History.** Naturopathic medicine appears to have a strong history associated with the hydropathic movement in Germany, going back to the 1800s with Priessnitz, the father of hydrotherapy, and Rausse alias Francke (Beer et al., 2013). Naturopathy is a term accredited to Scheel in 1895 (Harrison, 2012; McWilliams, 2015). However, it dates to Hippocrates and is derived from Greek and Latin, meaning “nature disease” (Kirchfeld & Boyle, 1994; McWilliams, 2015). The origin of naturopathy is in monastic medicine, which is based on Hippocratic and Galenic theory along with medieval theology and is influenced by Judaic tradition (McWilliams, 2015). During the sixth through the twelfth centuries, monastic medicine was the predominant form of health care. Monastic medicine was grounded in Christianity, and its philosophy addressed the “healing of the body with that of the soul” (McWilliams, 2015, p. 90). The healing practices included bloodletting, some surgery, hygiene, herbalism, and dietetics (McWilliams, 2015).

The renaissance of naturopathy, which started in the early twentieth century, is contributed to the Catholic priest Kneipp who was born in Germany in 1821 (Beer et al.,



2013; Kirchfeld & Boyle, 1994; Locher & Pforr, 2014; McWilliams, 2015). Lindlahr and Lust were inspired by Kneipp and brought the knowledge to Illinois and New York, respectfully (Harrison, 2012; Kirchfeld & Boyle, 1994). Lust, attributing his cure of tuberculosis to Kneipp's treatment "My Water Cure," devoted his life to the development of naturopathy after immigrating to North America in 1892 (Locher & Pforr, 2014, p. 522; Weil, 1998). In 1901, Lust legitimized naturopathic medicine as a formal system of medicine in the United States by establishing the first Naturopathic Doctor (ND) degree program in New York and later the Naturopathic Society of America (Locher & Pforr, 2014; McWilliams, 2015; Weil, 1998). In the present day, Bastyr (1912-1995) is considered the "Father of modern Naturopathic medicine" (Kirchfeld & Boyle, 1994, p. 218).

**Philosophy/Theory.** In the naturopathy paradigm, illness is viewed as an imbalance or disturbance to the body's homeostasis. Diseases were once described as either originating from circulatory disturbances or dysfunction of blood composites (Beer et al., 2013). Symptoms are viewed as a disruption of the psychophysical organism; therefore, the root cause is the disruption, and that is what is treated (Litchy, 2011). Kneipp believed that the body contains self-healing powers (Locher & Pforr 2013), which is the foundational premise of Naturopathy. The body's physiological systems have an innate ability to heal itself, allowing recovery to operate within the philosophy and principles of natural medicine (Fleming & Gutknecht, 2010; Poorman et al., 2001). The practice of naturopathy is based on disease prevention and maintaining health (Fleming & Gutknecht, 2010; Poorman et al., 2001). Naturopathic physicians (NDs)

scope of practice may be in the role of an independent primary care provider (PCP) or within a group practice as a specialist part of an integrative medical team (Litchy, 2011). Six principles guide the naturopathic approach: 1) first, do no harm (*primum non nocere*); 2) the healing power of nature (*vis medicatrix naturae*); 3) find the cause (*tolle causam*); 4) treat the whole person (mind, body, and spirit); 5) preventive medicine, and 6) doctor as a teacher (Docere; Fleming & Gutknecht, 2010; Harrison, 2012; Litchy, 2011; Poorman et al., 2001).

**Doctor–Patient Relationship.** The ND sees the patient as unique, the doctor–patient relationship as a partnership, and symptoms as communication of imbalances within the body (Fleming & Gutknecht, 2010; Poorman et al., 2001). In the practice of naturopathy, the physician’s goal is to restore the body to homeostasis by providing natural treatments to facilitate its innate ability to heal itself. NDs spend approximately ½–1 ½ hr during the first visit with the patient taking a detailed account of medical and family history, stressors, lifestyle, diet, self-care, forms of exercise, and present circumstances with the intent of discovering the underlying blockages or causes of the presenting symptoms (Poorman et al., 2001). The ND also encourages patients to take an active role in health care and in maintaining optimal health (Fleming & Gutknecht, 2010; Poorman et al., 2001). The diagnostic technique of NDs is an intuitive healing process that includes clinical investigative skills specifically designed to meet the patient's needs (Poorman et al., 2001).

**Treatments.** Naturopathy and other non-allopathic systems see the *root cause* of illness differently than allopathic medicine; in non-allopathic systems, the treatments are

not symptom focused but are personalized to the unique imbalances within the patient (Fleming & Gutknecht, 2010). Gentle methods are highly favored to stimulate the body's natural ability to heal, and surgery and strong allopathic medicines are used as a last resort (Weil, 1998). The physicians practicing naturopathy use clinical and diagnostic testing; which tools are used and if they are similar to conventional medicine is unclear. The naturopathic modalities used are hydrotherapy (Priessnitz's), medicinal herbs, exercise, nutrition, and regulative therapy (added by Kneipp; Locher & Pforr, 2014). However, Beer et al. (2013) attributed these naturopathic treatments, also known as the "five columns," to Josef H. Kaiser, who made use of the same terms noted above, but with regulative therapy termed as "Ordnung" representing the balance of mind and body (p. 3). Lust added additional treatments to the above modalities: chiropractic, massage, osteopathy, psychology, and sunbathing (Locher & Pforr, 2014; Weil, 1998).

### **Models of Health**

Psychoneuroimmunology (PNI) is the field of study where insights into the mind–body connection are analyzed via the biological systems interactions and networks of the physiological, immunological, psychological, and neurological processes (Amirghofran, 2012; Bauer-Wu, 2002a; Haroon et al., 2012; Kubo & Chida, 2006; Maier et al., 1994; Taliaferro, 2012; Yan, 2011). PNI beginnings are attributed to the investigation of classical conditioning on rats, which resulted in a change in the immune system due to behavioral conditioning (Ader & Cohen, 1993). The research provided a

foundation for the now numerous observations both (a) that the manipulation of neural and endocrine functions alters immune responses, and the antigenic

stimulation that induces an immune response, results in changes in neural and endocrine function, and (b) behavioral processes are capable of influencing immunologic reactivity and, conversely, the immune status of an organism has consequences for behavior (Ader & Cohen, 1993, p. 53, 54).

Researchers in this field, studying the communication network of the central nervous system (CNS) and the immune system, which are “the most complex systems involved in the maintenance of homeostasis” (Ader & Cohen, 1993, p. 51), created a scientific discipline that supports that the mind and body are not mutually exclusive (Ader et al., 1995; Bauer-Wu, 2002a; Kern & Ziemssen, 2008; Kubo & Chida, 2006; Nemeroff, 2013; Zachariae, 2009), thereby challenging the Cartesian dualistic thought within Western medicine. The PNI model of health is collaborative and interdisciplinary by nature, with the inclusion of the following disciplines within Western medicine: neurology, immunology, psychology, and endocrinology (Khubo & Chida, 2006). The literature review and empirical studies addressing the effects of stress on autoimmune disease (Ken & Ziemssen, 2008; Khubo & Chida, 2006), mental disorders (Garui et al., 2015; Hall et al., 2016; Herbert & Cohen, 1993; Janssen et al., 2010; Leonard & Myint, 2009; Pace & Heim, 2011), inflammation (Bower & Irwin, 2016; Haroon et al., 2012; Krysta et al., 2017; Lotrich, 2015; Suzuki & Nakai, 2016; Valkanova et al., 2013), personalized medicine (Yan, 2011), and health and disease (Hultman et al., 2015; Zachariae, 2009) show that Western medicine has a scientific model that can provide a common language across disciplines. Research from a PNI perspective may also be a way

to scientifically explore traditional medical systems (Husted & Dhondup, 2009) and be a common language between traditional medical and Western medical paradigms.

Some recent studies supporting the mind–body connection are on suicidal ideation and inflammatory markers (O’Donovan et al., 2013), the correlation between Interleukin-6 (IL-6), C-reactive protein (CRP), depression, and cognitive function (Krogh et al., 2014), Interleukin-10 levels (IL-10) and schizophrenia (Xiu et al., 2014), and Interleukin-8 and immunity biomarkers and mental disorders of children and adolescents (Gariup et al., 2015). O’Donovan et al. (2013) found that patients with major depressive disorder (MDD) had significant correlations between suicidal ideation and increased levels of IL-6 and CRP. On the other hand, after adjusting for lifestyle factors, researchers found no significant correlation between IL-6 and CRP levels in healthy patients experiencing depressive symptoms (Krogh et al., 2014). However, Krogh et al. (2014) found that inflammatory markers increased in patients with cancer or heart failure experiencing depression. The authors also found that increased levels of CRP were related to decreased cognitive function. Xiu et al. (2014), in a limited study, found IL-10 levels were lower in patients experiencing the early onset of acute schizophrenia, suggesting a relationship between cognitive function and the disorder. Gariup and colleagues (2015), in their research on children’s and adolescents’ cytokine levels and psychosocial stress, found significant correlations between some inflammatory markers, psychopathology, and stress. It must be noted that cytokine levels may be affected by other mechanisms (Krogh et al., 2014; Xiu et al., 2014). It is apparent that continued research in these areas is warranted, but the findings are promising.

### ***Biopsychosocial***

Engel (1977) is the founder of the biopsychosocial model (BPS). Engel published a vast number of articles related to philosophy, theory, and research around disease and disorders as it relates to his approach to illness and health. Engel acknowledged the extensive contributions in the field of medicine based on the biomedicine model (Borrell-Carrió et al., 2004), a disease model with foundations in germ theory and cellular pathology (Main et al., 2000). However, Engel (1977) found the biomedical model perspective to have a limited view of health and illness. Engel's (1977) identified the following points that he found to be limiting within the biomedical model that inspired the emergence of his new approach to health and illness: (1) the omission of the personal experiences of a disease (e.g., diabetes), exclusion of other concepts or external variables that may contribute to the biochemical defect; (2) its inability to include the behavioral and psychosocial data as variables, which he believed was essential in building "a relationship between particular biochemical processes and the clinical data of illness" (p. 132); (3) the interaction between psychophysiological responses and existing somatic factors affecting onset, severity, and disease outcome; (4) inability to determine the onset of the patients illness as well as the patient's acceptance of their illness; (5) treatments focusing on the biochemical abnormality doesn't necessarily affect the treatment outcome of the patient; (6) the importance of the physician-patient relationship and need for the physician to be more of an educator and psychotherapist to induce the patient's peace of mind and their "faith in the healing powers of the physician" (p. 132).

**History.** The BPS model, developed by Engel (1960, 1977, 1980), emerged in the latter half of the 1900s as a new concept of health and disease to assess the nature of the illness based on Weiss and von Bertalanffy's (1968) systems approach to biology. The literature in the 1900s on the BPS model was on the following topics: conceptual philosophy (Engel, 1960, 1977), clinical applications (Engel, 1980), the use in rehabilitation (Mullins et al., 1966), ways to empirically test the model (Schwartz, 1982), and its role as a medical model (Main et al., 2000; McLaren, 1997). As we moved into the next century, researchers began to explore the model's role in medical research (Alonso, 2004), health psychology (Suls & Rothman, 2004), depression (Garcia-Toro & Aguirre, 2007), and psychosomatic medical education (Novack et al., 2007).

By 2009, researchers began to revisit the model's relevancy (Adler, 2009), role as a more integrated approach to the practice of medicine (Havelka et al., 2009), potentiality amidst conflict and controversy (Melchert, 2010), use as a patient-centered interviewing method (R. C. Smith et al., 2013), and use in the military (Crawford et al., 2013). The increased recent research interest in the BPS model is attributed to medical professionals interested in a humanistic approach to medicine in addition to a method that encompasses a multimodal and a multifactorial approach to assessment and treatment, thereby bridging the gap between the mechanistic and contextual thinking style of health and illness (R. C. Smith et al., 2013; Schwartz, 1982). The abovementioned literature is not the breath of work on the BPS model; it is merely a glimpse. There is an abundance of articles on the BPS model to aid in evidence-based research, discovery, and understanding of an

approach to health and healing. Philosophy and the theoretical application of the mentioned literature will only be addressed.

**Philosophy.** The BPS model was developed as a new medical model to address not just the biological aspects of the disease but also to consider the psychological and social elements not included in the philosophy of the biomedical model (Engel, 1960, 1977). To think of “disease as an entity or separate from man” is the philosophy of the biomedical model as well as the natural thinking of the human mind (Engel, 1960, p. 460). The various concepts of disease, together with the inhibiting influence of nosology, inspired the emergence of the BPS model (Engel, 1960). Engel (1960) believed the clarification of the phenomena of disease left little room for the constant evolution of the disease. In his view, the diagnostic label only captured the static form without the contextual factors associated with the phenomena of disease or patient. Engel (1977) agreed with the *taxonomy progression of illness*, where symptoms turned into clusters of symptoms and progressed to syndromes leading to the pathology of the disease. However, according to Engel, the argument for medicine to continue the reductionist path as a model for the progression of illness by scientifically isolating only the disease element (e.g., biochemical abnormalities) and excluding the processes and stages that led up to the diagnosis is limiting.

Engel explored Kety’s understanding of the process of illnesses, who posited that the somatic, together with psychosocial factors, were present in both mental diagnoses (e.g., schizophrenia) and somatic diagnoses (e.g., diabetes) with a range of etiologies with both genetic and environmental influences (as cited by Engel, 1977). Engel wanted to



explore all the factors leading up to a disease with specific pathogenesis and pathology without sacrificing the essential contributions of the biomedical model. The limitation of the biomedical model, in this regard, allowed Engel to conclude: “To provide a basis for understanding the determinants of disease and arriving at rational treatment and patterns of health care, a medical model must also take into account the patient, the social context in which [they] live, and the complementary system devised by society to deal with the disruptive effects of illness, that is the physician role and the health care system” (Engel, 1977, p. 386), hence the birthing of the BPS model.

**Theoretical Application.** Using a systems theoretical approach from biology, which was over 50 years old, as a framework, Engel allowed the physician to apply a scientific method to the application of practice and patient care (Engel, 1980). Engel incorporated the human experiences (social and psychological systems) of the patient as part of the clinical assessment (biological systems), thereby providing a more inclusive perspective of the physician’s understanding of disease and health (Engel, 1980). The premise of systems theory is based on the hierarchy of natural systems where “every unit is at the very same time both a whole and a part” (Engel, 1980, p. 537). At the lowest level, there are subatomic particles, and at the highest level, there is the biosphere; in between, there are atoms, cells, organs, central nervous system, person experience and behavior, family, culture-subculture, etc. (Engel, 1980). From this viewpoint, systems exist within systems, each having unique characteristics, properties, and dynamics influenced by the other within boundaries where information is passed from one system to the other, always within a more extensive system (Engel, 1980). Therefore, this

exemplifies that “nothing exists in isolation” and all things are interconnected where one system is dependent upon another to thrive (Engel, 1980, p. 537).

From an application standpoint, the physician-patient relationship is the first level of interaction (a two-person system) where the data gathering begins (Engel, 1980). The data consists of internal (e.g., feelings, opinions) and external (e.g., behavior) aspects. The screening data (e.g., age, employment, gender) are systems characteristics, and the patient’s relationship or thoughts of their illness are considered psychological styles (Engel, 1970). The systems characteristics and the psychological styles provide a deeper contextual view into the biological assessment for diagnosis (Engel, 1970). This is where the bridging of the systems-oriented scientist merges with the factor-analytic approach (Engel, 1970).

It may be concluded that the BPS model, with its roots in systems theory, is a scientific, comprehensive approach to medicine that integrates biological, psychological, and sociocultural dimensions needed to understand health and illness in addition to human psychology (Melchert, 2010). Engel’s vision of seeing the need for a multidisciplinary approach to health and disease is still desired today (Frey et al., 2013; Melchert, 2010; R. C. Smith et al., 2013). On a contextual level, the biopsychosocial framework of natural systems is designed for collaboration with other specializations in medicine and other fields (e.g., physics, biology, psychoneuroimmunology, psychology, sociology), thereby allowing all disciplines to play an active role in health and healing. The BPS model supports Frey et al.’s (2013) vision for increased whole person treatment in palliative care, along with Melchert’s (2010) expressed need for a unified framework

in mental health care. It is still unclear why the medical community has not entirely accepted this model.

Engel's seminal work has pioneered the development of specialization in health psychology and psychoneuroimmunology (Havelka et al., 2009). The BPS model allows the physician to assert their technical skills and see the patient as a human being by embracing empathy and compassion while also engaging in the nuances of the illness (Frey et al., 2013). Internationally, Engel's model has been used as a model in public health to improve physician-patient relationships, in addition to a way to understand the disease and its causes (Frey et al., 2013). However, integrating the BPS model into clinical medicine has been limited (Adler, 2009; R. C. Smith et al., 2013). It has, however, been successful in undergraduate clinical education and other areas abroad and within the United States (Adler, 2009).

The lack of the BPS model being scientifically integrated is attributed to the lack of a "behaviorally defined patient-centered method that identifies BPS data in a repeatable way" (R. C. Smith et al., 2013, p. 268). R. C. Smith et al. (2013) hypothesized that the BPS model might be applicable in future scientific studies through a patient-centered interview method. The BPS model, from this perspective, might be helpful to the intervention level with the suggested modifications. The BPS model may also pair well with psychoneuroimmunology as the scientific component (Novack et al., 2007). Moving forward with a more inclusive approach to health and disease will require cooperation, collaboration, and common ground that may not yet exist (Melchert, 2010). For change to occur, the reigns on the exclusive reliance on biomedicine being the only

approach to health and illness must be loosened or removed to make room for an innovative approach to health care (Engel, 1977).

### **The Human Body as a Dynamic, Complex Organism**

Micozzi (2014a) asserted that health or disease is derived from a complex interaction of a multitude of factors (e.g., environmental, mental, emotional, spiritual, genetic, physical, dietary, lifestyle, etc.). The human body is a complex system that attempts to instantaneously adapt physiologically through the internal balance of homeostasis as it responds to environmental and internal factors influencing an individual's health (Micozzi, 2014a; Waller, 2010). Smuts (1926/1936) understood that the human body was more than the sum of its parts. Smuts also knew that assessing whole organisms through a narrow scope by focusing on aspects was limiting. Therefore, *holism, the Greek term coined by Smuts*, represents the fundamental wholeness of the world (Smuts, 1926/1936). Holism, as it relates to the world and medicine, is not limited to just biology; the term encompasses inorganic substances and mental structures together with the human spirit (Smuts, 1926/1936). The definition of holism that may be applied to the human body and medicine is expressed by Smuts (1926/1936) in the following:

Taking a plant or an animal as a type of a whole, we notice the fundamental holistic characters as a unity of parts which is so close and intense as to be more than the sum of its parts; which not only gives a particular conformation or structure to the parts, but so relates and determines them in their synthesis that their functions are altered; the synthesis affects and determines the parts, so that they function toward the "whole;" and the whole and the parts therefore

reciprocally influence and determine each other, and appear more or less to merge their individual characters: the whole is in the parts and the parts in the whole, and this synthesis of whole and parts is reflected in the holistic character of the functions of the parts as well as of the whole (p. 85).

Holism is a creative synthesized process where the wholes are forever evolving, creative, and dynamic entities (Smuts, 1926/1936). Weil (1998) finds the term “holistic,” a term representing the characteristics of “holism” (Smuts, 1926/1936), to be awkward, ambiguous, and a synthetic way of describing “whole.” Weil’s (1998) position is quite understandable because the literature within the research community does not conform to this definition. The usage is mainly associated with the use of nonconventional treatments rather than from a practice and theory perspective. Smuts (1926/1936) recognized the whole as a collective of synthesized parts, “which may be physic-chemical or organic or psychical or personal” (p. 86).

Treating the whole person is increasingly important when meeting the patient's psychological, physical, spiritual, and environmental needs to assist in health and healing for patients with chronic conditions in particular (Frey et al., 2013). However, Frey et al. (2013) suggested that a potentially harmful perspective would be to use an either-or treatment approach to adherence to the BPSs approach to healing (Frey et al., 2013). Wholism is the theoretical foundation for viewing the psychological, physical, spiritual, and environmental as a dynamic process with a collection of synthesized parts forever evolving, which may benefit patients with chronic conditions.

There is a complexity to this form of diagnosis and treatment where biomedical methods focused on de-vitalized parts in isolation without considering the context of the whole organism becomes problematic (Micozzi, 2014b; Picard et al., 2011; Picard et al., 2013). Complex systems require systemic frameworks, transdisciplinary perspectives, and medical approaches that operate from a comprehensive systems perspective to address the multifaceted aspects needed to sustain health and reduce the occurrence of disease (Picard et al., 2013). The patient's well-being and whole person care should be the goal (Cassell, 2011). However, the challenge is that multiple disciplines (e.g., molecular biology, sociology, cognitive psychology) within conventional medicine conceptualize and operationalize health and disease in different ways (Picard et al., 2011). This approach makes the breadth of knowledge challenging to integrate from a practice and health research perspective (Picard et al., 2011). To further complicate the situation, there is an "ever-increasing fragmentation of medicine with the creation of still new specialties" (Adler, 2009, p. 610). Picard et al. (2011) thoughts on health and disease supported the need for a transdisciplinary approach to health by pointing out that distinct domains interact in complex ways and that there are semantic plus conceptual differences within specialties or disciplines (e.g., cognitive psychology, molecular biology). According to Picard et al. (2011), specialized disciplines based on reductionism "informs us on the details of 'the parts' but tells us little or nothing about the 'whole'" (p. 182).

### **Mind-Body Medicine**

Researchers are gaining insight into how the human body is a complex organism in diverse ways, along with addressing the mind-body connection. PNI, as previously

discussed under models of health, is the field of study where understanding the mind–body connection is explored. For example, research on understanding inflammation and behavior has been viewed through the PNI lens (Haroon et al., 2012), and PNI is reflective as a scientific bridge for personalized medicine (Yan, 2011). In addition, there is research in systems medicine related to clinical practice (Cardinal-Fernández et al., 2014), psychiatry (Iris, 2012), methodology and theoretical approaches for person-centered health care (M. P. Martin & Félix-Bortolotti, 2014), and alcohol addiction (Spanagel et al., 2013) to bring insight into the need for a whole person approach to treatment and healing.

Another area is integrative medicine research related to mental health (Lake, Helgason, & Sarris, 2012), development of health measurements (Hunter, Corcoran, et al., 2013), primary care (Hunter & Leeder, 2013), and the definition and terminology of integrative medicine (Hu et al., 2015; W. Zhang et al., 2015), to assist with further defining this area of practice as well as streamline terminology. Furthermore, researchers in the field of collaborative medicine have explored primary care (Blount & Adler, 2008; Thorn et al., 2008), chronic conditions (Bacho et al., 2008; Khatri et al., 2008; Prinsloo et al., 2008), and pain management (Bayona, 2008) to assess the potential benefits of the role of collaboration in health and healing.

### ***Doctor–Patient Relationships***

Olsson et al.'s (2013) work focused on the importance of communication in person-centered care or patient-centered medicine from the physician's perspective in the doctor–patient relationship. They discovered that the competency of the patient is also

just as important. Ishikawa et al. (2013) addressed humanism as a crucial aspect of the doctor–patient relationship, including a way to bridge science and humanistic medicine while creating stronger doctor–patient relationships as part of treating the whole person. The humanistic side of medicine is emerging within the doctor–patient relationship through listening skills, expression of empathy, values, and the teaching of these skill sets (Branch, 2014). In the field of person-centered care relating to patient-physician communication and person-centered care efficacy, similar challenges, such as the lack of a unified definition and measurements, are also being critiqued in research (Ishikawa et al., 2013). However, these areas are relatively in the infancy stage of the paradigm shift and the emergence of humanistic medicine. Although integrative medicine, collaborative medicine, and person-centered medicine are in their preliminary stages of development, they are attempts to move the medical system toward treating the whole person.

### ***Research Methodologies***

The complex nature of the human body and chronic conditions require researchers to take more of a whole systems medicine approach. There is a need to recognize the dichotomy between curing and healing and that the whole is not divisible (Hutchinson & Brawer, 2011). New principles or constructs that are expansive enough to incorporate or explain the mind–body relationship and the role external factors play in health and disease are necessary (Louise, 2001). Methods currently used are not designed to assess the efficacy of treatment modalities that originated from whole medical systems (Shelton, 2013). There is a need to enhance how living systems work within conventional medicine (NCCIH, 2016). Therefore, within NCCIH’s (2016) scientific initiatives for 2016, it was



acknowledged that if researchers are to understand the physiological aspects of mind–body interventions, further development is required in scientific methods to aid in researching CAM, and integrative medicine approaches.

### **Paradigm Shift**

The term whole person care is used in various ways, which is consistent with Ziebarth's (2016) research findings on wholistic health care and is reflective in its use within the following categories: whole person model of care (Hayes & Hondson, 2011; Thornton, 2013), wholistic healing (Otto & Knight, 1979a; Shallat, 2010); collaborative care (Kessler & Stafford, 2008), multidisciplinary care (Adhikari et al., 2014; Norris et al., 2014; Nowicki et al., 2009), integrative medicine (P. R. di Sarsina et al., 2011; Hu et al., 2015; Hunter, Corcoran, et al., 2013; Johnson, 2009; Maizes et al., 2009), transdisciplinary care (Albrecht et al., 1998; Choi & Pak, 2006; Picard et al., 2011; Rosenfield, 1992), whole person healing (Koithan et al., 2007), whole person care (Hutchinson, 2011a), and whole systems medicine (Koithan et al., 2012; Manahan, 2011). In addition, multiple definitions of each term may be found, thereby creating a lack of continuity. For this paper, emphasis was placed on whole person care (Hutchinson, 2011a) and wholistic healing (Otto & Knight, 1979a) as it relates to treating the whole person since these views are from a physician's perspective. Other Western medicine approaches discussed under conventional medicine address potential solutions to the evolving approach to treating the whole person (Hu et al., 2015; Hunter, Corcoran, et al., 2013; Johnson, 2009; Maizes et al., 2009).

### ***Whole Person Care***

Literature on whole person care spans several topics within medicine: palliative care (Hutchinson, 2011a), suffering and goals of medicine (Cassell, 2011), healing (Fuks, 2011; Hutchinson et al., 2011), physician-patient relationship (Hutchinson & Brawer, 2011), empathy and compassion (Liben, 2011), death and anxiety (Solomon & Lawlor, 2011), prevention (Hutchinson, 2011b), complementary and alternative medicine (Grossman, 2011), medical education (McNamara & Boudreau, 2011), and genetics (Rosenblatt & Fitzpatrick, 2011). Hutchinson (2011a) addressed *whole person care* from the practice of palliative care. From Hutchinson's (2011a) perspective, whole person care does not require the physician to know all aspects of the patient (e.g., spiritual or social); neither is the physician responsible for taking care of all the complex dimensions involved. Hutchinson (2011a) believed this was an impossible task, and others appeared to agree (Carruthers, 2013). It is from Hutchinson's (2011a) worldview that attempting to approach whole person care from this perspective will only fail as well as cross the personal boundaries of the patient. Hutchinson concluded that the only requirement needed to meet the patient's expectations is medical competency. However, Hutchinson did agree that it is crucial to reflect on the various dimensions that may contribute to the patient's presenting problem because it may lead to a resolution (Hutchinson, 2011a). Information may be too much to process all at once, thereby creating a need for a reductionist approach to minimize the physician's feeling of being overwhelmed (Hutchinson, 2011a).

This discussion on whole person care does not reflect the existing breadth of work related to treating the whole person (e.g., collaborative healing, multidisciplinary care, interdisciplinary care, etc.). It only attempted to provide solutions to practicing and theorizing medicine in a way that considers the complexity involved in curing and healing the human body. Hutchinson (2011a) identified a set of second challenges to whole person care, the epistemologies of curing and healing. Curing, healing, and health become truly relevant in the discussion of whole person care. The complex dynamics of this form of care, the integration of healing and curing, which leans more toward personalized care, is not in alignment with or part of the foundation of the allopathic medical model of care, thereby leaving the physicians to take an either-or approach to practice (Hutchinson, 2011a). However, there is a newly found focus on ways to improve our health and live a healthy lifestyle. The media discussions have increased regarding exercise, healthy eating, food as medicine, and mind–body approaches to health and healing. Many advocates (Engel, 1977; Gordon, 1997; Micozzi, 2014b; Weil, 1998) have supported this approach for a while. Perhaps modern medicine is coming full circle back to Hippocrates’s vision.

### ***Wholistic Healing***

Literature on wholistic healing is mainly from the religious perspective (Ziebarth, 2016). However, the term wholistic was used by Otto and Knight (1979b) in the context of treating the whole person. The premise of wholistic healing (Otto & Knight, 1979b) is that the body can heal itself and is an approach used to improve quality of life (QOL). There are “eight basic concepts:

1. Every human being has untapped potential, resources, and powers.
2. Self-awareness and self-understanding play an important role in the healing process and in maintaining health and vitality.
3. Reliance on the capacities and resources of the individual is a key factor in mobilizing the healing processes and in maintaining health.
4. Interpersonal relationships and physical environment should have a life-supportive and life-enhancing function.
5. Self-regulatory processes and therapies need to be implemented before any illness reaches the point at which chemotherapy or surgical intervention is required.
6. The dynamic therapeutic forces inherent in group interaction and work are effective in developing and sustaining the life-affirmative attitudes and perspectives that are associated with health and longevity.
7. A lifestyle that permits the harmonious integration of goals, aspirations, and values with day-to-day living is essential both to healing and to maintaining good health.
8. Spiritual resources and belief structures continue to play a supportive role in the life of the [older] person” (Otto & Knight, p. 142).

These eight principles used in the context of the older population seem to be viable throughout the lifespan of human development. Why wait to address the principles associated with QOL late within the developmental lifespan?

Palliative care practitioners are concerned with QOL for the patient and the family. Practitioners use palliative care to make patients more comfortable through serious and terminal illnesses (Center to Advance Palliative care, 2011). In hospice and non-hospice settings, palliative care comprises a comprehensive set of services using an interdisciplinary team. Palliative care is available in most hospitals in the United States, but physicians rarely use the services for their nonpalliative care patients (Fadul et al., 2009; Kelley & Meier, 2010). As a last result, physicians mainly refer patients when the illness is in its later stages due to the perception of palliative care leaving the patient and family feeling a sense of hopelessness (Fadul et al., 2009; Kelley & Meier, 2010).

Treating the whole person later in life explains the biomedicine approach that is evident in teaching programs where the knowledge of the science of the body and disease, as well as the biopsychosocial and spiritual knowledge of the patient, are brought together at the bedside, but not integrated into the practice, diagnosis, and treatment process (Cassell, 2011). The person is seen through the lens of biology (O'Leary, 2021), where physicians take a disease-oriented approach to care (Cassell, 2011). Cassell's (2011) position is that the two kinds of knowledge in medicine are divided and are treated as two separate elements. Other authors recognized that the disease and symptoms approach is just a tiny aspect of whole person care (Cassell, 2011; Engel, 1977; Micozzi, 2014a).

Hutchinson's (2011a) postulation that treating the whole person is an impossible task differs in the practice of care for physicians from traditional medical systems that take an integral approach to their practice and diagnosis. The integral approach offers a synergistic treatment that can treat the whole person, thereby considering both the healing

and curing aspects of care. From a biomedical approach, we may not be able to realistically look at all the dimensions associated with whole person care at this moment; however, we might be able to use the integral model as a template for areas to consider when current treatments are no longer sufficient as well as identify gaps in care.

### ***Conventional Medicine***

Conventional medicine is considered materialistic, not holistic and *vitalistic* like traditional whole medical systems (e.g., Ayurveda, Traditional Chinese medicine, Naturopathic medicine, Homeopathy, and others), thereby presenting a challenge to conventional medicine's approach to healing (Micozzi, 2014a; Osterman et al., 2013). Picard et al. (2011) stressed that the challenge with conventional medicine is that the organization of knowledge within the conventional model of medicine is approached from a multi-causal and additive way limiting the inclusion of elements from other disciplines. Even though a multidisciplinary approach may be more advantageous, there is still a challenge with representing the complex nature of human health (Bell & Koithan, 2006; Albrecht et al., 1998). The recommendations presented to assist with these challenges have been, by some, in the form of new frameworks: whole person care (Hayes & Hodson, 2011; S. R. Cohen, 2010; Thornton, 2013), whole systems medicine (Koithan et al., 2012; Manahan, 2011; Procter et al., 2000), and the global health framework (Picard et al., 2011). Others, such as Engel (1977), suggested a solution to conventional medicine's challenge to address the human domain of the whole person from a medically scientific perspective, which is the BPS model. However, after all these years, the integration of Engel's model into mainstream medicine has not been successful

(R. C. Smith et al., 2013). Hutchinson et al. (2009) believed caring and healing were the keys to whole person care and should be embodied in medicine, students, faculty, hospitals, and all clinical settings.

The conclusion is that researchers' and health care professionals' approaches to health and disease might benefit from integrating multiple components, including a collaborative team (Picard et al., 2011). Integrating various medical disciplines and bodies of knowledge from traditional medical systems will only enhance researchers' and physicians' medical expertise, including their approach to health and healing (Kessler & Stafford, 2008; Picard et al., 2011). Picard et al. (2011) asserted that a systematic integration of knowledge reflecting: "the complex, dynamic, and emergent aspects of human experience should contribute to our ever-evolving comprehension of health as a complex phenomenon" (p. 182). Decades later, Picard et al.'s assertions speak to Engel's (1992) emphasis on scientific medicine requiring a paradigm that can include the human dimension. Picard et al. presented the global health framework as a way of facilitating an integrative and transdisciplinary way of thinking regarding the complex phenomenon of health.

The health reform discussions focused on the goals of cost, containment, access to care, and improved quality of care (Federoff & Gostin, 2009). However, Federoff and Gostin (2009) asserted that little discussion is given on how medicine is practiced or taught. In addition, when treating and viewing disease in isolation, a more comprehensive approach, which includes genomics, behavior, and environmental aspects related to health and illness, is neglected. If modern medical practitioners continue to exclude the

dynamic integrative systems within the human body (Federoff & Gostin, 2009), the patient and the evolution of medicine may be at risk.

Proponents of a new approach in medical education and practice look toward “systems medicine,” which incorporates the complex biochemical, physiological, and environmental interactions that sustain living organisms. Although a holistic approach to medicine should benefit patients and society, consideration of the sociologic, ethical, and economic implications is essential (Federoff & Gostin 2009, p. 994).

There is also an urgent need to provide all Americans with disease prevention and health promotion services. NCCIH (2016) intends to “foster research that examines the potential contributions of complementary approaches in promoting healthy behaviors and preventing diseases and disorders across the life course with a strong focus on the developmental stage” with the intent of meeting the needs of all socioeconomic populations as well as the disadvantaged (p. 24). Furthermore, the potential benefits and cost savings to the usage of CAM by the patient are promising (Kooreman & Baars, 2012). Kooreman and Baars (2012) analyzed a health insurer’s doctor-patient dataset and compared the performance of general practitioners trained in CAM to general practitioners practicing conventional medicine. The authors found that health care costs and mortality rates decreased by 0–30% depending on the form of CAM (e.g., anthroposophy, homeopathy, acupuncture) and the age of the patient (Kooreman & Baars, 2012). The cost-effectiveness is possibly due to fewer hospital visits, prescription drugs, and out-of-pocket expenses (Kooreman & Baars, 2012).



## **Traditional Knowledge**

Traditional medical systems and medicines existed for centuries before modern Western medical methods. The physicians of traditional medical systems take an integral approach to addressing the relationship between body and mind as well as other external factors within the theory of practice, diagnosis, and treatment of care (Ozawa De Silva & Ozawa De Silva, 2011; Johnson, 2009). The use of traditional medicines are accepted in other countries (WHO, 2015) among low- as well as middle-income individuals and is well received by various cultures in industrialized countries (Gureje et al., 2015). The acquisition of knowledge for traditional medicine is driven by traditional knowledge, also known as traditional ecological knowledge (TEK). TEK is knowledge learned, experienced, and documented over thousands of years of direct human contact with the surrounding environment (Berkes, 1993). There are nine principles of TEK defined by Berkes (1993; p. 4): (a) is qualitative; (b) contains an intuitive component; (c) is holistic; (d) acknowledges mind and matter are one; (e) is moral; (f) is spiritual; (g) its scientific approach is based on empirical observations and accumulation of facts by trial-and-error; (h) its research is based on data generated by resource users themselves; finally, (i) the data is diachronic (e.g., long time series specific location).

Scientific ecological knowledge (SEK), on the other hand, consists of the following principles: (a) is quantitative; (b) is rational; (c) is reductionist; (d) premise is the separation of mind and matter; (e) is value-free; (f) is mechanistic; (g) the scientific approach is experimentation and systematic based on an accumulation of facts; (h) research data is generated by a specialized group of researchers; and (i) is based on

synchronic data, e.g., short period of time, large area (Berkes, 1993, p. 4). These principles are the direct opposite of the TEK principles (Berkes, 1993; L. Mason et al., 2012).

There is an exchange of traditional knowledge taking place in various countries as well in the field of medicine (Ben-Arye et al., 2011; Ben-Arye et al., 2015), knowledge and healing practices (Ebijuwa & Mabawonku, 2015; Hewson, 2015), and nature (L. Mason et al., 2012; Weiss et al., 2013). For example, in the Middle East, researchers of oncology programs are becoming aware of the need to enrich research through collaborative efforts by sharing cultural, traditional, and complementary alternative knowledge within an integrative cancer care model (Ben-Arye et al., 2011; Ben-Arye et al., 2015). In Nigeria, alternative health care and Indigenous knowledge are used in primary health care settings in treating maternal health care, other medical conditions, and HIV/AIDS (Ebijuwa & Mabawonku, 2015). In the effort to manage wildlife, the integration of traditional and scientific knowledge was to bridge the two approaches to maintain the health of nature and natural resources (Mason et al., 2012; Weiss et al., 2013). In South Africa, where Western medicine is the accepted standard yet traditional healers for health and healing are frequently sought, Indigenous knowledge is being incorporated into medical clinical teaching settings (Hewson, 2015). It may be concluded that the very foundation of this movement is the attempt to embrace treating the whole person, holism with a “w,” and the interconnectedness of all things.

Traditional medicine, such as medicines and other therapies used by TMDs, is more wholistic and synergistic than medicines used in a reductionist approach to

treatment (Bauer-Wu et al., 2014). As an integrative strategy, Tibetan medicine may be an ideal collaboration with Western medicine (Wolkenhauer & Green, 2013). Using a reductionist approach to treat complex diseases addresses only part of the problem (Cassell, 2011); therefore, it should be done with caution, according to Bauer-Wu et al. (2014). Chronic conditions are complex human diseases; treatment that focuses only on molecular components is limiting because it is only part of the contributing factors associated with the disease (Iris, 2012). Most human diseases are derived and dependent on other contextual entities and subsystems, not just molecular components (Iris, 2012). Wholism and synergism are essential components when diagnosing, treating, and healing patients with chronic conditions such as cancer or mental disorders.

#### **A Whole Systems Medical Approach: Tibetan Medicine**

The practice of Tibetan medicine is both an art and science based on Buddhist philosophy, which is primarily psychological in nature and focused on understanding the nature of the mind and developing compassion and awareness (Clifford, 1984; Cameron et al., 2012). As a comprehensive medical health care system, according to some researchers, Tibetan medicine may be viewed as the first integrative, person-centered, and oldest known traditional medical system (Bauer-Wu et al., 2014; Loizzo, Blackhall, & Rapgay, 2009). The Tibetan medical approach to chronic conditions, as well as health and healing, emphasizes diet, mental and spiritual dimensions, and the role of the natural environment (e.g., seasons, five elements; Horowitz, 2007). It is through the inclusion of this environmental perspective that physicians practicing ancient scientific theories are prepared to comprehend the effects of the natural environment on the body, which some

may view as unscientific (Tokar, 2006). Tibetan medicine is holistic in nature, emphasizing the relationship of mind to body as a microcosmic structure and of the embodied psycho-organism to the macrocosmic structure (L. Y. Dhonden, 1974; Clifford, 1984), with the mind equating to the vastness of consciousness (L. Y. Dhonden, 1974). The body is seen as an “ecological system, microcosm directly related to the macrocosm of the natural world” (Tokar, 1999, p. 53). Therefore, the balance must be restored internally and externally for equilibrium or homeostasis (Clifford, 1984).

The challenge is that Tibetan medicine’s ecological theoretical approach, based on qualitative theories, and intersubjective methods (Loizzo, Blackhall, & Rapgay, 2009), provides an extra level of complexity for evidence-based medicine (EBM), suggesting that new methodological approaches are needed to study Tibetan medicine’s effectiveness and applicability in the United States (NCCIH, 2016). For example, Bauer-Wu et al. (2014) suggest that extractions of herbs should be used with caution because the synergistic aspects of the treatment may be lost. Maintaining the integrity of the herbal compound is essential due to the interactive components operating within a holistic framework, hence creating the synergistic effects of the formulation (Bauer-Wu et al., 2014). All medical traditions must establish a common language of communication that will allow practitioners to begin to understand that diagnostic or treatment techniques “are the result of the scientific, cultural, and spiritual knowledge that gave rise to these therapeutic applications” (Tokar, 1999, p. 51). Rich with information and possibilities, various principles from Tibetan medicine’s medical system may provide a new worldview for biomedicine (Tokar, 2006).

## *History*

Tibetan medicine, known as *Sowa Rigpa* or the *Tibetan ‘Science of Healing,’* dates to the 7<sup>th</sup> and 8<sup>th</sup> centuries and is a synthesis of Indian, Chinese, Himalayan, pre-Buddhist shamanic, and Greco Persian Traditions (Clifford, 1984; P. R. di Sarsina et al., 2011; Ergil, 2014; S. D. Gyatso, 2016; Loizzo, Blackhall, & Rapgay, 2009; Ozawa De Silva & Ozawa De Silva, 2011; Reuter et al., 2013). S. D. Gyatso (2016) posits there are four divisions of the science of healing: “knowledge of diseases, knowledge of the origin of diseases, knowledge of how to eradicate the disease, knowledge of how to prevent the disease from reoccurring” (p.46). Practiced for over 2500 years, Tibetan medicine history is firmly rooted in Buddhism and Indigenous Bön or pre-Buddhist culture (P. R. di Sarsina et al., 2011; S. D. Gyatso, 2016). During the 8<sup>th</sup> century, an international medical symposium for skilled physicians is said to have been held by King *Trisong Detsen* (Ergil, 2014; Tokar, 2006) in *bsam yas*, Tibet (Dakpa, 2014). Knowledge and medical expertise were shared and demonstrated by physicians from India, Kashmir, China, Persia, Guge, and Nepal (Dakpa, 2014; Ergil, 2014). It is during this period that the Four Medical Tantras (*rgyud bzhi*) are said to have been compiled by *g.yu thog yon tan mgon po* (*Yuthok Yönten Gönpö*, physician to the 36<sup>th</sup> and 37<sup>th</sup> kings; Brant-Zawadzki, 2005; Dakpa, 2014; Ergil, 2014) and the *Tanadook* (*lta na sdug*) medical school was established in Southern Tibet (Dakpa, 2014). *Yuthok Yönten Gönpö* is also known as the father of *Sowa Rigpa*.

The *rgyud bzhi* is made up of four Tantras or treatises, namely, the *rtsa rgyud* (Root Tantra), *bshad rgyud* (Explanatory Tantra), *man ngag rgyud* (Oral Instruction

Tantra), and *phyi ma'i rgyud* (Subsequent Tantra) which together comprise the canonical text or textbook of Tibetan medicine used by TMDs, including those trained at the Dharamsala Men-Tsee-Khang, which was reestablished in exile in 1961 (Gonpo, 2011a, p. xvii; Samuel, 2001). The original Tibetan Men-Tsee-Khang (*smam rtsi khang*), or central Tibetan government sponsored medical and astrological college or institution in Lhasa, was established in 1916 (Janes, 1995; Pordié, 2008). There is probably a disparity in theory and practice methods between Tibetan medicine in India and Tibet today (Janes, 1995), which was apparent in the literature review based on the various terminology used by researchers.

The Four Medical Tantras are categorized as follows: the first, Root Tantra, comprises six chapters that summarize and outline the basic principles of Tibetan medicine: the basis of disease, diagnosis, and treatments (Gonpo, 2011a). The Explanatory Tantra (the second) contains 31 chapters documenting human physiology, embryology, and anatomy' methods of healing; making medical compounds; causes of disorders; processes of birth and death; and the tenets and ethics of the physician (Gonpo, 2011a). The Oral Instruction or third Tantra, consisting of 92 chapters, outlines in-depth practical information about the causes, conditions, classifications, diagnosis, symptoms, and treatments of a range of specific diseases and pathological conditions (B. Clark, 1995). Finally, the fourth Subsequent Tantra has 25 chapters; the chapters describe how to diagnose through pulse and urine, make multiple medicinal compounds, and apply various external therapies and surgeries (Gonpo, 2011b). The English translation of the

first, second, and fourth tantra are based on the *Chagpori* printing block edition of 1892 (Gonpo, 2011a, 2011b).

### ***Individualized Care***

Tibetan medicine includes a paradigm of mind–body and preventive medicine, predictive diagnostics, and individualized medical treatments addressing the unique biology of the patient and shows promise as an excellent example of person-centered medicine for assessing and treating patients (Cameron et al., 2012; Bauer-Wu et al., 2014; P. R. di Sarsina et al., 2011; R. di Sarsina et al., 2012). The key to healing in the Tibetan medical systems’ long lineage of personalized medicine, person-centered, and preventive medicine (Bauer-Wu et al., 2014) may be found within the following three forces, factors, or phenomena as described in the root tantra: the three *nad* or *nyes pa*, the principle humoral energies of *rlung*, *mkhris pa*, and *bad kan nyas pa*; the seven *lus zungs bdun* or fundamental bodily tissues or constituents, i.e., digested foods and drinks, blood, flesh/muscle, fat, bone, bone and the three *dri ma* or waste products of urine, feces, and sweat (Gonpo, 2011a, p. 21). According to the root tantra, these three forces contribute to health when balanced and disease when imbalanced (Gonpo, 2011a). They are interdependent in their nature and act “as the base for birth, existence, and death” (Gonpo, 2011a, p. 69). Overall, the *nyes pa*, or humoral energies, are at the center of Tibetan medicine (Tokar, 2006). Tibetan philosophy posits that these principle humoral energies within the body are always in a state of imbalance or disturbance (Ergil, 2014; Jacobson, 2000).

### ***Theoretical Approach***

The *nyes pa* are used within the diagnostic process to aid in realigning the disturbances of homeostasis within the physiology of the bodily system as well as identifying the etiologies of conditions unique to the patient (Bauer-Wu et al., 2014). The unique characteristics of the *nyes pa* may be viewed as the physiological fingerprint of the individual, which may be used to access the individualized symptomatology of the patient. The three principle energies are the physiological, psychological, and subtle energetic processes of the human body within the Tibetan medical paradigm (Dakpa & Dodson-Lavelle, 2009a). The *nyes pa* plays a role in embryology (Gonpo, 2011a) driven by diet and behavior from the mother while in utero (P. R. di Sarsina et al., 2011) or by seasons, lifestyle, spirits, and diet after birth (Gonpo, 2011a).

There are three *nyes pa*: *rlung*, *mkhris pa*, and *bad kan* (Bauer-Wu et al., 2014; Gonpo, 2011a), which “are expressions of the elements that occur within our organism and determine the proper functioning of the body and mind” (Tokar, 2006, p. 307). Each of the three *nyes pa*, also known as humors, is associated with disorders, stage of life, emotions, environment, seasons, time of day, networks of energy channels, and the five elements (B. Clark, 1995; Gonpo, 2011a). There are five types of *rlung*, *mkhris pa*, and *bad kan*, respectively, equaling a total of 15-types of principle energies along with seven types of bodily constituents and three types of waste products (Gonpo, 2011a). Cameron et al. (2012), in an attempt to incorporate the *nyes pa* as part of integrative health validity, tested the constitutional self-assessment tool (CSAT) and lifestyle guidelines tool (LGT) to assist with scientifically assessing the validity of Tibetan medicine’s humoral theory.



The challenge with using a self-assessment is that the accuracy depends on the participants being knowledgeable enough to accurately evaluate themselves (Cameron et al., 2012). The authors acknowledged that the assessment tool is not intended to replace the experienced TMD but to provide a way to begin validating the theory. The intricate aspects of the *nyes pa* provide “a means to illuminate the pathologic trajectories for a given illness and its pathways for healing” (Bauer-Wu et al., 2014, p. 2).

### ***Integrative Aspects***

The physiological processes of the *nyes pa* govern the physiopathology, physiology, and psychology within the body (Rapgay, 2005). For example, *rlung* is associated with the nervous system, *mkhris pa* with the small intestine, vascular, endocrine, and secretory systems, and *bad kan* with the digestive and lymphatic systems (Rapgay, 2005). In addition, there are other bodily associations. For example, the ears, heart, joints, skin, and colon are linked to *rlung*, the liver, eyes, and gall bladder are linked to *mkhris pa*, and finally, *bad kan* is linked to the stomach, kidneys, pancreas, spleen, and urinary bladder (Rapgay, 2005). Yoeli-Tlalim (2010) suggests that the *nyes pa* are ideal as a foundational cross-cultural bridge to explore the mind-body dilemma. In addition, Tibetan medicine also addresses the energetic system interwoven within the psychosomatics and physiology of the human body and is also known as the subtle body (Dakpa & Dodson-Lavelle, 2009a).

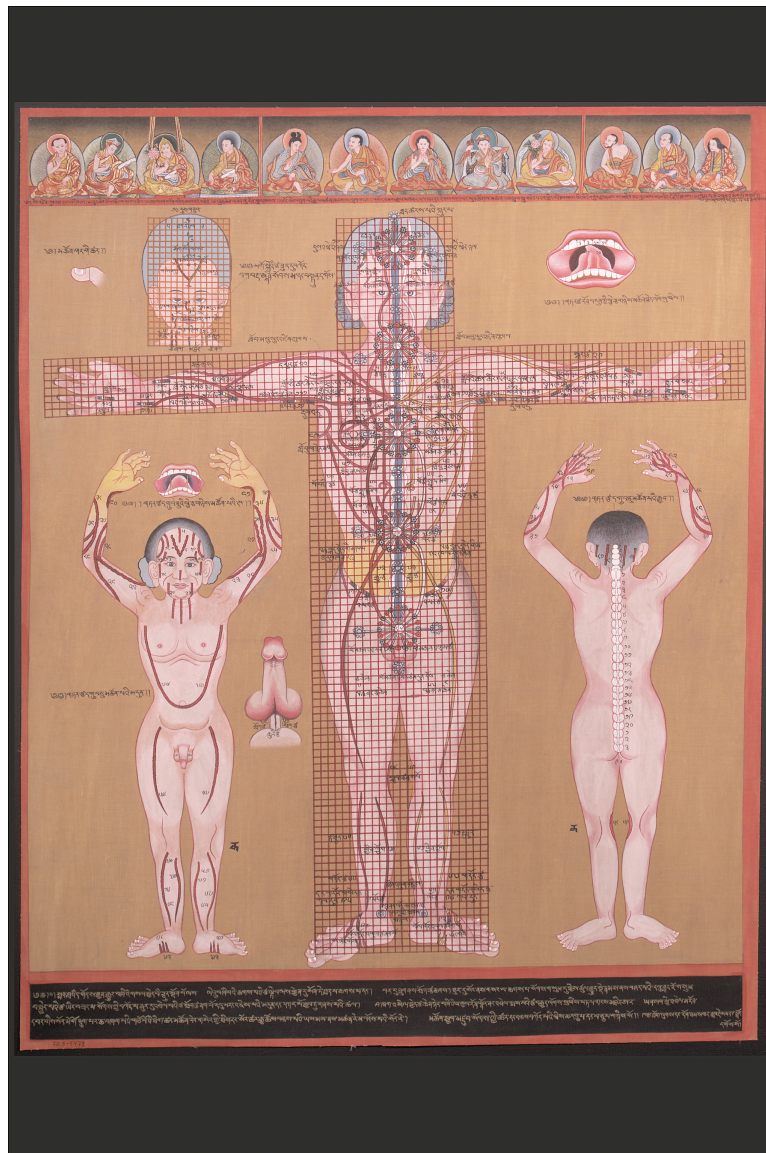
### ***Energetic Aspects***

The psychosomatic connection is based on an energetic concept of *channels (rtsa)*, which comprise the ‘subtle’ or ‘Vajra’ body, also known as subtle channels

(Dakpa & Dodson-Lavelle, 2009a). Subtle channels are critical to Tibetan medicine's theory, practice, and diagnosis (Dakpa & Dodson-Lavelle, 2009a; Ergil, 2014). While tantric/soteriological approaches to gross and subtle channels may overlap with medical ones, medical and tantric understandings of the channels also diverge (S. D. Gyatso, 2016). Tibetan systems for mapping, interpreting, and interfacing with networks of channels are too diverse and complex to discuss here. Still, in their most straightforward medical presentation, the *rtsa* or channels are grouped in the second Explanatory Tantra into four main categories: the formative channels, the channels of existence, the interconnecting channels, and the life channels (Gonpo, 2011a, p. 62). The channels (e.g., physical or biomedical vessels, veins, arteries, lymph tissues, nerves, or reproductive vesicles) form networks that are interconnected with various aspects of the physiology and anatomy of the human organism, including the *nyes pa* (Gonpo, 2011a). See Figure 1.

**Figure 1**

*Thangka, Interconnecting Blood Vessels, Front View*



*“Thangka, Interconnecting Blood Vessels, Front View”* American Museum of Natural History (AMNH) Anthropology catalog No: 70.3/ 5472; Courtesy of the Division of Anthropology, American Museum of Natural History.

In their discussion, Dakpa and Dodson-Lavelle (2009a) equated the subtle body to the central nervous system (CNS), although it is not a one-to-one relationship. The Explanatory Tantra [English translations] further specifies that *rlung* primarily resides in the “heart, brain, nerves, and blood vessels. This energy governs the functioning of the central nervous system, ...It is also responsible for all the functions of the mind and body that involves movement” (Gonpo, 2011a, p. 305). Brown’s (2009) research on the signaling system of the CNS as described in Western medicine presents some possible similarities or correspondences between biomedical concepts and terminology used in Tibetan medicine for describing the networks of channels and the subtle energies that flow through them.

D. Brown (2009) mentions two forms of signaling systems (e.g., biochemical and energetic) used by the CNS. D. Brown also references the existence of an energy-information relay system that is also part of the immune system. Tokar (2006) has queried whether the oversimplification of the term “energy” in an alternative healing context may be causing a language barrier between Western and traditional medicine. D. Brown’s discussion provides insight into the plausible connections between Tibetan medical concepts like *nyes pa* and channels and the complex communication system within the PNI framework. D. Brown posits that it is time for Western medicine to begin to acknowledge that the “parallel between the CNS and the immune system would predict an energy-information signaling system in the immune system as well as in the CNS” (p. 315), hence allowing dialogue and commensurability between Eastern medical systems and Western medicine. The three *nyes pa* and channel networks provide a vehicle for the

personalization of medications as well as a person-centered approach within the Tibetan medical system, thereby linking the mind, body, and spirit found in integrative medicine and wholism.

### ***Individualized Treatment***

Padma 28 is an example of personalized and multimodal medicine within the Tibetan medical system. Padma 28 is a Tibetan formula derived from an ancient Tibetan recipe for a multi-component herbal mixture distributed in the form of tablets (Aslam et al., 2010). Padma 28 has been used to treat peripheral arterial occlusive disease (PAOD) and circulatory disorders (Melzer et al., 2006). Melzer et al.'s (2006) meta-analysis of five trials of Padma 28 revealed a significant relief from associated PAOD symptoms with an increase in pain-free treadmill walking distance by 18% versus the 2% of patients that received a placebo. Moreover, Padma 28 is a nonaggressive medicine making it an ideal alternative for patients and physicians (Melzer et al., 2006). In addition, Padma 28 research on CNS disease may be helpful as a treatment for Alzheimer's disease (AD), Parkinson's disease (PD), and Huntington's disease (HD) based on Padma's 28 potent antioxidant effects (Ginsburg et al., 2011). Padma 28, which has been extensively researched, is an example of the multimodal effects of the treatments used in Tibetan medicine (Reuter et al., 2013). Yet, Reuter et al. (2013) posit that little research supports the efficacy of Tibetan medicine's individualized multimodal approach to healing.

### ***Tree of Medicine***

The Root Tantra is an overview of Tibetan medicine, making it the fundamental tantra in Tibetan medicine teachings (Y. Dhonden & Wallace, 2000). The Root Tantra (as

well as the other Medical Tantras) is represented using a tree motif. The Root Tantra, with its six chapters, “has three roots [or trees with], nine trunks, and 47 branches, 224 leaves, two flowers, and three fruits of which correspond to specific topics within the medical system” (Y. Dhonden & Wallace, 2000, p. 21). Eighty-eight of the leaves belong to the root of health and disease, 38 leaves correspond to the root of diagnosis, and 98 are from the root or tree of treatment (Gonpo, 2011a). The Tibetan medicine tree is best summarized by the three roots or trees of health and disease, diagnosis, and treatment. The health and disease tree has two trunks from left to right, health (balanced body) and disease (imbalanced or sick body). See Figure 2, tree of physiology and pathology. On the tree of diagnosis (see Figure 3), there are three trunks, observation, palpation, and medical history (Chenagtsang, 2018). The third root or tree is for treatment (see Appendix P) with four trunks diet, lifestyle, medicine, and external therapies (Chenagtsang, 2018).

**Figure 2***Thangka, Tree of Physiology and Pathology*

From “Tangka, Tree of Physiology and Pathology” by American Museum of Natural History, n.d., Anthropology catalog, No: 70.3/ 5465. Courtesy of the Division of Anthropology, American Museum of Natural History.

This first root or diagrammatic tree represents the body and deals with the physiology and causation of disease through the depiction of a healthy and sick body; the second root or tree diagram focuses on diagnosis; and the third represents the various forms of therapeutic methods used for treatment (Dönden & Hopkins, 1986; Y. Dhonden & Wallace, 2000). According to Y. Dhonden and Wallace (2000), the two flowers and three fruits that are the product of the first root or tree diagram represent the professional and spiritual qualities achieved when a physician of this tradition becomes proficient. Although, any person may attain these qualities when following the criteria for balanced health (Chenagtsang, 2018).

### ***Theory of Health and Disease***

In Tibetan medicine, there are 42 types of *rlung* disorders, 26 types of *mkhris pa* disorders, and 33 types of *bad kan* disorders, equating to a total of 101 diseases (Dönden & Hopkins, 1986, p. 55). Two factors are associated with disorders: causes and conditions, which enable the causes to manifest (Dönden & Hopkins, 1986). Causes are further broken down into two types: distant and proximate. The former is difficult to enumerate due to the Tibetan medical premise that all diseases and disorders originate in the mental environment from past and prior afflictive emotions (Clifford, 1984; Dönden & Hopkins, 1986). Dönden and Hopkins (1986) asserted that the cause of a disease could be present within the individual, but it will not manifest without the presence of the condition (Dönden & Hopkins, 1986). The terminology “cause” appears to equate to genetic biomarkers associated with a specific disease in the biomedical model where there is the potential for a disease to manifest.



According to Tibetan medicine, the distant causes, which are mental “afflictive states of mind” (desire, hatred, and obscuration), are also karmic in nature (Dönden & Hopkins, 1986, p. 55). The proximate causes, on the other hand, are the three *nyes pa*: *rlung* (wind; energy force), *mkhris pa* (bile), and *bad kan* (phlegm), corresponding to the above-noted afflictive emotions, respectively (Clifford, 1984; Dönden & Hopkins, 1986). The three humors also correspond to the subtle body – the essences, energies, and channels, respectively – and are not within the scope of this discussion (Clifford, 1984). The origins of illness within the Tibetan system are driven by afflictive emotions (84,000 types) that have corresponding effects on the physical body leading to numerous types (condensed into 404 types) of disorders (Dönden & Hopkins, 1986, p. 55). According to Tibetan medical theory, afflictive emotions cause imbalances within the three *nyes pa*. Burrow et al. (1978) posit that the “Tibetan approach to distant causes of disease is something the Western physician might do well to ponder, not for the *curing* but for the *caring* aspect” (p. 447).

### ***Diagnosis***

The literature detailing the methods of diagnosis is limited to the canonical text, i.e., the *rgyud bzhi* (Gonpo, 2011a, 2011b). Other researchers (Bauer-Wu et al., 2014; B. Clark, 1995; Dakpa, 2014; Dönden & Hopkins, 1986; Ergil, 2014; Tokar, 1999) have also provided insight into certain aspects of the diagnostic process. The process of examination, posited by B. Clark (1995), consists of identifying and understanding humoral imbalances and the etiology of symptoms and disease causation with the intent of curing the patient. Diet and behavior are key factors to include because they contribute

to symptoms and disorders. The following are four aspects the physician takes into account when assessing the presenting symptoms of a patient: “(1) the basis of examination, (2) the objects of examination, (3) the doors of examination, and (4) the methods of examination” (B. Clark, 1995, p. 197).

The *basis of examination* is where the *nyes pa* are explored to gain insight into the specific humoral diagnosis (B. Clark, 1995). The *objects of examination* consist of investigating the five sensory organs (e.g., ears, nose), their corresponding objects (e.g., sound, smell), as well as the five bodily excrements (e.g., mucus, blood, urine). The *doors of examination* are the aspects that include assessing the seasonal and environmental effects on the body that contribute to illness. According to B. Clark (1995), other factors within this form of examination are age, time of day, food intake, *nyes pa*, immediate causes of symptoms, and the nature of the patient. The following three noninvasive *methods of examination* have been used for centuries: visual observation (e.g., urine analysis, body shape, tongue), examination by feeling (e.g., pulse examination, temperature, and texture of the body), and interrogation (questioning the patient; Bauer-Wu et al., 2014; B. Clark, 1995; Dönden & Hopkins, 1986). These concepts are complex entities that take years to master, specifically pulse diagnosis, which is the most difficult to master (Ergil, 2014; Tokar, 1999). For example, the methods of examination entail an intricate assessment through the three humors that have been well documented (Dönden & Hopkins, 1986; B. Clark, 1995) and are depicted in the tree of diagnosis. See Figure 3. The tree of diagnosis is a pictorial representation of the three methods of examination, along with the eight branches and 38 leaves that guide the

physician toward the associated body parts that should be considered for each of the three methods of examination (Dönden & Hopkins, 1986). Further exploration of the three noninvasive examination methods, specifically from a Western perspective, may assist biomedicine practitioners in obtaining information on less costly approaches.

**Figure 3***Thangka, Tree of Diagnosis*

From "Tangka, Tree of Diagnosis" by American Museum of Natural History, n.d.,  
 Anthropology catalog, No: 70.3/ 5466. Courtesy of the Division of Anthropology,  
 American Museum of Natural History.

### ***Physician***

The traditional journey toward becoming a TMD starts with theoretical training as a teen through the memorization of The Four Tantras in their entirety over a six-to-eight-year period (B. Clark, 1995). The Tibetan medical paintings of the tree align with the format of the tantras and their corresponding chapters, allowing the physicians in training to make use of the tree as a mnemonic device (Ergil, 2014). In addition, the student must become fluent in identifying a substantial number of medicinal plants through their identification through taste while blindfolded (B. Clark, 1995). There are three classifications of a TMD in the *rgyud bzhi*: the unsurpassed, extraordinary, and the ordinary (Gonpo, 2011a, p. 290). An unsurpassed is the highest level. The extraordinary physician is clairvoyant, compassionate, and able to harmonize the imbalances within themselves and others (Gonpo, 2011a). The ordinary physician holds the title *Nangrig Menpa*, *Jejang Menpa*, and *Laegom Menpa* and is considered friends of the suffering (Gonpo, 2011a, p. 290). There are also several qualities required to hold the title of doctor and are considered prerequisites: intelligence, being compassionate, being committed, diligent, knowledgeable in practice, and socially ethical (e.g., in terms of spiritual matters and worldly and personal conduct; Gonpo, 2011a).

**Developmental Stages of the Physician.** There are various levels of sight and senses related to the development of the diagnostician explained by Tokar (1999). Tokar (1999) used the mountainous terrain as a metaphor to describe and assist with obtaining a visual depiction of the various levels. At the first level – the practitioner is on a mountaintop, unable to see what is on top of the opposite peak. In the second level - the

student can see that something is there. In the third level – the practitioner can see someone standing on the opposite peak but is unable to perceive anything about the person. The levels of sight continue until the student recognizes precisely who is standing on the opposite peak. However, as Tokar (1999) suggested, perception is subjective and is “inherent in the prejudices and limitations of any worldview” (p. 50). It is important to understand the technique and language of the medical system in which one practices (Tokar, 1999). However, as a TMD and any medical practitioner, one’s ability to effectively diagnose must be grounded in awareness, which leads to clear and precise perception (Tokar, 1999).

**Personal Development.** What is important to understand about the practice of Tibetan medicine is that the physician is continuously working toward spiritual development by becoming aware of their relationship to others and all existence. Hence, this is the reason for meditating on the Medicine Buddha as one practices Tibetan medicine. The medicine Buddha is the founder and healer of Tibetan medicine and is held in the same regard as Asclepius, who was considered the founder or deity of the medical traditions of Greece (Nutton, 2013; Vargas, 2008). The Asclepiad physicians, as well as TMDs, seek the help of whom they view as the authority or supreme healer of medicine to assist with healing their patients (Jacobson, 2000; Nutton, 2013; Vargas, 2008). Tokar’s (1999) experience with TMDs led the author to conclude that the foundation of a physician’s approach to diagnosis is within their spiritual practice. This provides insight into the possible reason for the various levels of practice and development among TMDs.

**Medicine Buddha.** The spiritual-medicine bridge may be found in the teachings of the medicine Buddha and is considered part of the medical training exhibited by physicians' meditation practice and medical treatments (Prost, 2008, p. 103). It is essential to note that Sowa Rigpa is not "Buddhist medicine" and is for Buddhists and non-Buddhists (Gonpo, 2011a). In the traditional practice of Tibetan medicine, the physician, during meditation, will visualize the "Buddha of Medicine," all beings and their particular sufferings and diseases, and wishes they become free of suffering (Tokar, 1999). As the meditation practice progresses, the TMD eventually merges themselves with the being of the Medicine Buddha, hence visualizing themselves as the Medicine Buddha with the aspiration to attain the same level of compassion, skillfulness, and wisdom (Tokar, 1999). This process is the foundation of diagnosis and is done before interacting with the first patient. The TMD is trained to emulate a spiritually evolved being, seeing all patients through the eyes of the *Bodhisattva*.

**Physician–Patient Relationship.** The traditional TMD relates to and treats all sentient beings as themselves, which includes patients (Tokar, 1999). This is a core principle from the teachings of Buddhism (Tokar, 1999), which is an aspect of the socially ethical quality noted in the prerequisites. These teachings are as follows: "(1) Understanding and discovering one's mind and thereby transcending ego; (2) developing a practice of compassion toward all other conscious beings; (3) developing a sense of equanimity" (Tokar, 1999, p.51). There is a conscious intent to identify with the patient through the understanding of "the basic nature of suffering - both the patient and the

doctor's" while also understanding that the doctor-patient relationship "has a professional and spiritual significance" (Tokar, 1999, p. 51).

### ***Benefits of Tibetan Medicine***

The person-centered and individualized approaches have been discussed; the following are additional areas specific to Tibetan medicine and may be of interest to Western medicine practitioners in palliative care, integrative medicine, and complementary medicine.

**Palliative Care.** Loizzo, Blackhall, & Rapgay (2009) asserted that Tibetan medicine has the most effective system of positive and palliative health care. The psychophysiological aspects of Tibetan medicine, which have remained unchanged, are what make Tibetan medicine ideal for chronic conditions (Loizzo, Blackhall, & Rapgay, 2009). The research in the field of Tibetan medicine on multiple sclerosis (Husted & Dhondup, 2009), regeneration (Dhondup & Husted, 2009), cognitive impairment and Alzheimer's disease (Crawford et al., 2006), peripheral arterial occlusive disease (Melzer et al., 2006), cancer (Bauer-Wu et al., 2014; Loizzo et al., 2010), and arthritis (Ryan, 1997) provides insight into the potentiality of managing chronic conditions and healthy older individuals. For example, in a randomized controlled trial using Western and Tibetan treatments for arthritis Ryan (1997) found that both treatments worked but relieved different symptoms. The patients receiving the Western treatment reported improved pain management through their ability to sleep at night (Ryan, 1977). However, the Tibetan medicine treatment was not as effective with pain management but provided improved limb mobility allowing a full range of motion (Ryan, 1977). Ryan's (1977)



findings suggested an integrative or complementary approach where both treatments may be advantageous.

Husted and Dhondup (2009), in their research on multiple sclerosis (MS), assessed the disruption found in the central nervous system of the myelin lipids in patients with MS through the lens of the three principle energies of the *nyes pa*. The authors concluded that there is a theoretical relationship between the characteristics of the imbalances of the three myelin lipids: phospholipids, sphingolipids, and cholesterol and the three *nyes pa*: *mkhris pa*, *rlung*, and *bad kan*, respectively. TMDs consider the patient's age, gender, the individual's *nyes pa*, the time of day, and seasonal variations to bring the body back to homeostasis (Husted & Dhondup, 2009). These factors are also applicable to MS and other chronic conditions (Husted & Dhondup, 2009). Dhondup and Husted (2009) suggested in their research on Tibetan medicine's concept of regeneration that the medical system emphasizes a preventive approach to older patients and longevity, making Tibetan medicine an effective method for healthy older adults and the management of chronic conditions.

**Ancient Treatments for Integrative Medicine.** Tibetan medicine “involves predictions and therapies shown to be more accurate and effective than those of modern medicine in fields from physiology and pharmacology to neuroscience, mind/body medicine, and positive health” (Loizzo, Blackhall, & Rapgay, 2009, p. 218). With the goal of integration into conventional Western medicine, these treatments and modalities have been scientifically studied (Horowitz, 2007). Treatments that have shown promise for chronic conditions are related to liver disease (Chen et al., 2011; He et al., 2012),

cancer (Bauer-Wu et al., 2014; Choedon et al., 2011; Choedon et al., 2014), lung injury (Horani et al., 2012), CNS disorders (Ginsburg et al., 2011), and inflammation (Eliaz, 2004; Yi et al., 2010; L. Zhang et al., 2009). He et al. (2012) concluded through the analysis of the ethanolic extract from *Meconopsis quintuplinervia* in vitro, which is used to treat hepatitis and is rich in antioxidants supporting its effectiveness as a treatment for liver disease. Chen et al. (2011) analyzed *Swertia chirayita*, also used for liver disorders, using in vitro methods and mice concluded that the medicinal herb supports effective use for curing liver diseases.

**Cancer.** Bauer-Wu et al. (2014), through the analysis of three (using Western standards of diagnosis) oncological case studies, found Tibetan medicine to be safe and effective, and patients exhibit an excellent quality of life. For example, in the case of Stage IIIA gastric carcinoma in a 47 year old man, after taking herbal compounds and *precious pills* for more than 20 months, computed tomography showed that 29 months (about 2 and one-half years) later, no cancerous cells were present (Bauer-Wu et al., 2014). Precious pills are known as *richen rilbu*, which are small pills that enhance vitality, contain a variety of herbal and mineral ingredients, and are blessed by Buddhist lamas (Prost, 2008). In the second case of a 27 year old man diagnosed with chronic myelogenous leukemia, his hemoglobin levels, and white blood cell count were normalized after three months of receiving a Tibetan medicine treatment. Finally, in the third case of red cell aplasia diagnosed in a 37 year old man, his hemoglobin levels were higher within two weeks of treatment than in the preceding three years with no need for a blood transfusion. Choedon et al. (2011) analyzed the pro-apoptotic and anti-tumorigenic

properties of the herbal compound *t'hapring* ([*rdo rje*] *khrab ring*). They found the medicinal effects triggered pro-apoptotic death in cell culture, growth arrest, and ameliorative effects in vivo, confirming its clinical application as an adjunct therapy for cancer.

Other treatment modalities showing promise are in research on diet and behavioral modification (von Haehling et al., 2013) and self-healing (Loizzo, Charlson, & Peterson, 2009; Loizzo et al., 2010). Biomedicine is impersonal, and the mind and body are not viewed as interrelated, so individuals seek alternative approaches (Millard, 2008). Millard's (2008) view that biomedicine assessments of Tibetan medicine may provide evidence that may lead to questioning the Western scientific paradigm, thereby directing scientists to a deeper understanding of the nature of health and disease.

**As a Complementary Medicine.** Loizzo, Blackhall, & Rapgay (2009) suggested that Tibetan medicine should be viewed as a complementary science of medicine. Tibetan medicine, as previously indicated, takes a comprehensive approach to treatment and diagnosis. In addition, the treatments are patient-specific (individualized), providing a synthesized approach to healing. The previously discussed and the following treatments might provide different techniques and therapies to healing for conventional medicine. For example, Padma 28 (Melzer et al., 2006), ethanol and aqueous extracts of *Pterocephalus hookeri* (L. Zhang et al., 2009), Reiki (Crawford et al., 2006), *thapring* (Choedon et al., 2011), dietary restrictions and behavioral adjustments (Ryan, 1977), and contemplative practices (Loizzo, Charlson, & Peterson, 2009; Loizzo et al., 2010; Pace et

al., 2009) have shown promise in the areas of cancer, inflammation and pain, arthritis, QOL and stress reduction, and behavioral health.

Crawford et al. (2006), in a quasi-experimental study using 24 participants (e.g., treatment and control), exposed the treatment group to 4 weeks of Reiki from master-level practitioners and found statistically significant increases in behavior and memory problems in patients exhibiting mild Alzheimer's disease and cognitive impairment. On the topic of longevity and optimal health, researchers have explored the Tibetan medical systems' subtle energy channels (Dakpa & Dodson-Lavelle, 2009a), dietary modifications (Dakpa & Dodson-Lavelle, 2009b), Tibetan contemplative practices (Tsondu & Dodson-Lavelle, 2009; Loizzo, Charlson, & Peterson, 2009; Loizzo et al., 2010), potential regenerative properties (Dhondup & Husted, 2009), and self-healing (Loizzo, Charlson, & Peterson, 2009; Loizzo et al., 2010). These areas, which have minimal exposure based on the review of the literature within the scientific community, may provide further insight into healing and living a healthier existence with any condition.

### **Healing Paradigm Shift**

With the growing usage of integrative approaches along with the need to better understand the physiological effects and outcomes of traditional medicines, researchers and organizations are shifting their initiatives toward bridging the gap between traditional medical systems, integrative approaches, and Western medicine (WHO, 2015; NCCIH, 2016). A shift in the treatment and perceptions of health, disease, and curing is occurring. There is also a potential shift as a result of the WHO (2015) and NCCIH (2016)

initiatives that may change the way conventional medicine is practiced (NCCIH, 2016). The mitigating factors contributing to the shift may be due to the potential benefits found by researchers in their studies on primary care services (Wang et al., 2015), diagnostic techniques (Niemi & Ståhle, 2016), global health care (WHO, 2015), and research on whole systems medicine (Luo et al., 2015) as well as disease management (Luo et al., 2015; Stanifer et al., 2015). For example, in Sweden, where there is an increased usage of Ayurveda medicine, diet modification, and other alternative medicines as treatment for respiratory conditions, tumors, musculoskeletal conditions, and other illnesses, patients reported improvement in symptoms related to their condition (Niemi & Ståhle, 2016).

There were two diagnostic techniques used by the physicians of Ayurvedic medicine (also based on humoral theory) in the Sweden study, one of which was the pulse diagnosis. The physicians' patients were impressed by the physicians' ability to treat accurately and diagnose illnesses and disorders (e.g., depression; heart-related problems) with the pulse diagnostic technique (Niemi & Ståhle, 2016). Patients reported positive experiences associated with the physicians' usage of pulse diagnostics. Niemi and Ståhle (2016) suggested continued exploration of the pulse diagnosis. Wang et al. (2015) conducted a pilot study in Tibet. They found that patients using traditional Tibetan medicine (TTM) primary care services reported having a better experience than those receiving the same services in Western Medicine hospitals. In China, TTM has a crucial role in China's health care system; therefore, their approach to clinical research is designed to take a whole systems medicine approach to analyze TTM (Luo et al., 2015). In a systematic review on TTM, Luo et al. (2015) reported that TTM might be beneficial

for managing many diseases, and additional clinical application research is warranted. Lou et al. also concluded that TTM, drug treatments (e.g., medications, medicated baths), and non-drug treatments (e.g., bloodletting, moxibustion) had a 93.8% superior effect in comparison to control interventions of the 149 studies reviewed.

Finally, Stanifer et al. (2015) conducted a study in Northern Tanzania. They found that usage of traditional medicines from traditional healers across all socioeconomic demographics was most common for chronic conditions (15%) and symptomatic ailments (42%). Patients (61.1%) reported increased usage of traditional medicines because they cost less, were more effective, and resulted in fewer side effects than biomedical treatments. Other reported issues were services and outcome related (e.g., medical non-compliance, low-quality of care, and worse medical outcomes). Communication was the main mitigating issue related to services and outcomes (Stanifer et al., 2015). However, the patients still noted the need for scientific validity, hence the transition between biomedical physicians and traditional healers. The authors recognized the need to understand traditional medicines usage within sub-Saharan Africa to aid in patient sensitivity and effective disease management programs within the health care system.

### **Next Steps Toward the Evolution of Biomedicine**

The growing movement toward integrative medicine, person-centered care, wholistic medicine, and interest in phenomenological research in medicine is an attempt to challenge medical orthodoxy by prioritizing the patient's subjective experience of illness and treatment (Gergel, 2013). Allopathic medicine is attempting to bring back

what was lost during allopathic medicine's transition from the pre-classical to the classical and from the classical to present-day biomedicine practices.

Ventegodt et al. (2007), through their research in wholistic scientific medicine, discovered that by considering the medical heritage from various cultures, there is a need to work on the body-mind connection when approaching treatment by working on the body, mind, and spirit simultaneously. Goddard (1995) suggested that "spirituality pervades, unites and directs all human dimensions and, therefore, constitutes the internal locus of natural health" (p. 810), thereby making it an integrative energy that is vital to healing. However, further research is warranted to explore the premise "that a person's spirit is the locus of healing" (Goddard, 1995, p. 814). Goddard's research and conclusions of the role of spirit and the use of the term integrative energy may provide additional insight into the *nyes pa* and Brown's (2009) discussion on the signaling systems of the CNS. Strandberg et al. (2007), in their research on the perception of a wholistic view among general practitioners and district nurses in Sweden, revealed that the biomedical model needed a multidimensional viewpoint to provide care to patients. The multifaceted view includes an overall medical picture and a wholistic picture of the patient, including the patient's social contexts, body, and soul (Strandberg et al., 2007).

Could there be some aspects of the Indigenous medical approach to healing practiced during the Asclepiad and Hippocrates era that we are missing today in modern medicine? With the increased interest in Indigenous approaches to medicine and the move toward a more integrative, wholistic, and person-centered approach to healing in Western medicine, are these new movements the attempt to recover what was lost or

ruled as unscientific? With advances in modern-day science and technology, taking a universal look into the spirit and its role in healing may be one step toward addressing what may have been viewed as a non-rational approach to medicine. The subtle body in Tibetan medicine may be one possible attempt.

### ***Spirit and Wholistic Medicine***

When looking at spirit through the lens of energy (life energy; subtle energy, energy body; biofield) as a component within wholistic medicine, as opposed to strictly religious, several authors have brought insight into the possible effects of subtle energies on health (D. Brown, 2009; Rein, 2004; Rosch, 2009; Rubik, 2002; Theise, 2009). D. Brown (2009) addressed the energy signaling systems' relationship between the energy body, immune system, and cell regeneration and longevity in their discussion. Rosch (2009) discussed subtle energy as a form of communication for living organisms by discussing the communication that exists within the organism as well as between the organism and its environment. Rosch (2009) outlined the role chemical/molecular communication, physical/atomic communication, and electromagnetic signaling plays in good health and preserving homeostasis. Rubik (2002) and Rein (2004) provided a scientific foundation of the biofield as a construct within medicine. Rein (2004) hypothesized that biofield is the body's innate self-healing mechanism. Through their discussions on the biofield, both authors brought scientific insight into the inner workings of energy medicine and the probable effects of specific CAM modalities (e.g., acupuncture, homeopathy) directly working with the subtle field interactions.



Theise's (2009) research on Western medicine's cell theory, the doctrine of medicine and biology, might be a way to begin a cross-cultural dialogue with other medical traditions, such as Tibetan medicine. Theise (2009) suggested that physicians and scientists of Western medicine focus on the cells within human anatomy as a model for addressing disease and disorder. Though phenomenally successful, it is still limiting because it does not address a complete model of the body. The exclusion of the body as a complex entity and restricting the treatment of disease using a cell theory hypothesis possibly prevents physicians from effectively treating some illnesses, organisms, or conditions that may be resistant to cell-based hypothesis research and testing (Theise, 2009). Through a change of perspective and viewing alternative medical models, scientists and physicians from various traditions may have a venue to explore medical theoretical views and practices, which may result in a "fruitful cross-cultural dialogue" within the scientific and medical arena (Theise, 2009, p. 268).

### ***Traditional Healing and Western Science***

The study aims to articulate and document holistic health from a traditional medical system within a modern clinical context (Nebelkopf & Wright, 2011). Nebelkopf and Wright (2011) assessed the Holistic System of Care (HSOC) model, a dynamic approach to healing for Native Americans, which integrated Western science with Indigenous cultural approaches to healing. Nebelkopf and Wright's research aimed to discuss the effectiveness of a model that deals with the whole person by linking treatment, prevention, and recovery through western science and culture. Nebelkopf and Wright's results supported the success of the HSOC as a model of effectiveness in

reducing substance use among adults, substance prevention among adolescence, and children's mental health, among urban Native Americans.

Yin and Ko (2014) reviewed the history of Korean medicine and its evidence-based approaches through the integration of western allopathic medicine and traditional holistic medicine. The author's concluded that Korean medicine had been successful in "implementing a national standard disease classification encompassing both allopathic and genuine traditional concepts" (p. 5). The practicing physicians in this medical system have available to their practice Korean diagnostic medical codes as well as Western medical codes to assist with developing a complete clinical picture of the patient's condition. The physician has an entire body of knowledge at their disposal, with the patient being the primary focus. Expanding research in the various areas of traditional medical systems may assist with developing a clinical picture of different methods of medicine, creating a global organization of health care conditions (Yin & Ko, 2014; Nebelkopf & Wright, 2011).

### Chapter 3: Research Method

The purpose of this study was to understand how physicians of Tibetan medicine practice wholistic medicine as this relates to the physician–patient relationship, diagnosis, and treatment of the patients in theory and practice within Tibetan medicine. This qualitative study addressed the approach to whole person care within the Tibetan medical system and how physicians apply this approach in patient care. By exploring TMDs’ experience and practice of wholism, my intent in the study was (a) to understand the contextual view of treating the whole person using Tibetan medicine (see Reuter et al., 2013), (b) to understand the perspective of the practice and diagnosis of Tibetan medicine from a wholistic framework in a way that Westerners in the United States could understand as well as show potential benefits (see Reuter et al., 2013), and (c) to provide an alternative narrative of a traditional medical system in a way that would enhance the understanding of health, illness, and disease, thereby allowing a cross-cultural perspective to be observed (see Yoeli-Tlalim, 2010).

The study was initially phenomenological. In Busetto et al.’s (2017) discussion on emergent design, the researchers suggested that including the original design and providing a detailed account of why changes were made are helpful, but rare. The initial approach was preserved to maintain research integrity, and an explanation for the modification in design was provided. See Chapter 4. The final study was a qualitative approach with an emergent design to explore the approach to whole person care within the Tibetan medical system. Otto and Knight’s (1977) wholistic healing, Merleau-Ponty’s (2012) concept of body subjects, and the integral model (Wilber, 2003/2004) provided a

lens for questioning and analytical thinking throughout the study. Sowa Rigpa's medical trees were the lens for data interpretation in addition to mind maps and artwork.

Chapter 3 begins with the selected tradition's research design and rationale and the associated concepts of wholism. The chapter continues with the role of the researcher, followed by the methodological approach, and ends with a discussion on issues of trustworthiness. I discuss participation recruitment, ethical procedures, and data collection and analysis.

### **Research Design and Rationale**

In exploring the TMDs' experience of a wholistic medical traditions approach to healing, the research question addressed was: How do physicians of Tibetan medicine view treating the whole person?

#### **Design**

A qualitative approach was used because it allowed me to understand TMDs' practices of wholistic care within their social-cultural reality of diagnosis and treatment of patients with illnesses (see Biggerstaff & Thompson, 2008). There were two research designs that I thought were suitable for the exploration, understanding, and practice of TMDs' wholistic approach to care, which were interpretive phenomenology (IPA; J. A. Smith et al., 2009) and grounded theory (Moustakas, 1994; Tracy et al., 2003). The study was intended to incorporate techniques from both traditions (see Koithan et al., 2007). Therefore, a qualitative approach with an emergent design was selected because the study required a responsive approach to information obtained throughout the research process (see Ravitch & Carl, 2019). The emergent design also encouraged the participants'

perspectives, participant engagement flexibility, and data collection and analysis flexibility (see Ravitch & Carl, 2019).

According to Merriam and Tisdell (2015), qualitative researchers are interested in how meaning is constructed and how people make sense of their lives and worlds. The primary goal of a qualitative study is to uncover and interpret these meanings (Merriam & Tisdell, 2015). Otto and Knight's (1977) wholistic principles were used as the form of inquiry in Phase I to create the interview guide for Phase II. Wilber (2005) and Merleau-Ponty (2012) informed my thinking for investigation and analysis. Because IPA is grounded in phenomenology and uses hermeneutics as the theory of interpretation, this design continued to inform my thinking and analysis in the interpretative process that was designed to capture the lived experience and perception of the population studied (see Biggerstaff & Thompson, 2008; J. A. Smith et al., 2009).

### ***IPA Approach to Inquiry***

The research question and subsequent interview questions in an IPA study are not necessarily theory-driven (J. A. Smith et al., 2009). However, J. A. Smith et al. (2009) suggested using theory-driven questions as second-tier questions because they are interpretive in nature, and there is no certainty that they will be answered. Otto and Knight's (1979a) wholistic healing theory, Merleau-Ponty's (2012) philosophy of perception, and Wilber's (2005) integral model were intended to be used to formulate second-tier questions. However, Otto and Knight's theory was used as a model for inquiry in Phase I to inform the interview guide in Phase II. Analytical thinking of all three theories informed Phase II's second-tier questions (interview guide). The integral

model (Wilber, 2005) and philosophy of perception (Merleau-Ponty, 2012) were also intended to be incorporated as part of the interpretive process to identify the factors and components of wholistic care from a TMD's perspective. Instead, the theories informed the mental analytical process. I used the Tibetan medicine philosophy as the framework for interpreting findings.

The IPA design provided a degree of open-mindedness, which required me to bracket preconceptions, knowledge, and experiences associated with the phenomenon in question. IPA allows an examination of the appearance of a phenomenon, and it is the role of the research analyst to facilitate and make sense of it (J. A. Smith et al., 2009). IPA provided an ideal framework of inquiry for interpreting a complex medical system using the TMDs' perspective on theory and practice, diagnosis, physician–patient relationship, and treatment.

### ***Empirical Research***

Orøy et al. (2011) used IPA to explore meaning in health professionals' experiences and interactions with families and critically ill or trauma patients with severe brain injuries. Lee et al. (2007) used the phenomenological approach to examine the phenomenon of depression using open-ended, in-depth ethnographic interviews because this method allowed the researchers to focus on a population with common characteristics (e.g., language, Indigenous practices). Researchers have used emergent design to study workforce changes (Busetto et al., 2017).

### **Role of the Researcher**

As the key instrument in this study, my role as a researcher was inquirer, observer, facilitator, transcriber, and analyst. These roles were applicable as they applied not only to the data but also to the double hermeneutic role of the IPA researcher. In this study, in the double hermeneutic role, I applied mental and personal skills to make sense of the physician, similar to the physician who is also trying to make sense of what is happening to them and the patient while the patient is attempting to understand what is happening as well (J. A. Smith et al., 2009). Merleau-Ponty's (2012) discussion on experience suggested there is a consistent exchange of information between the subject and the object where interpretation, perception, and experience are one during the exchange of information. Therefore, remaining vigilant, aware, and curious during the experiential exchange was paramount.

As the researcher, I may have interacted informally with some physicians, Tibetan scholars, and monks through preliminary exploration and understanding of Tibetan medicine and culture. However, personal relationships were always in the context of the researcher and/or student to the key informant and expert. To assist with minimizing potential experiential knowledge, the Husserlian phenomenological approach used by Lee et al. (2007) and recommended by Creswell (2007) was adopted as part of the research to avoid, as Lee et al. noted, "privileging my preexisting knowledge," (p. 2) meaning that my preexisting knowledge should not take precedence. Therefore, using bracketing, my subjective experiences were put aside to obtain a new perspective on the phenomenon from the physicians (Creswell, 2007; Lee et al., 2007).

## **Methodology**

### **Participant Selection Logic**

To explore whole person care and the philosophy of Tibetan medicine, key informants were knowledgeable in the field of Tibetan medicine (e.g., scholars, professors, TMDs). The intention was to use two to three participants; however, four were used to aid in developing the key informant participant interview guide, which was the interview protocol for the physicians in Phase II. Subsequently, two to three key informants were enough since three to six are acceptable sample sizes for IPA inquiry (R. C. Smith et al., 2009). On the other hand, six key informants were used in a study where researchers conducted key informant interviews and focus group interviews using 34 participants (Ashing et al., 2003).

### ***Physician Participant Sample***

To explore the wholistic approach of diagnosing and treating patients from a Tibetan perspective, the participants included in the study were Tibetan medically trained physicians. Due to IPA's detailed examination of a phenomenon and its focus on the view of particular people within a specific context, a small homogeneous, purposively selected sample size was used to assist with examining convergence and divergence in detail (R. C. Smith et al., 2009). Three to six participants were considered a reasonable sample size for IPA researchers (R. C. Smith et al., 2009). This study used seven participants. However, there were dissertation studies where the samples used were as little as three and as many as 12 (Gerish, 2014; Petruzzi, 2005; Schrader, 2014). Small samples are recommended because the underlying intent of the sampling population in



IPA is that “they represent a perspective, rather than a population” (J. A. Smith et al., 2009, p. 49).

There was a minimum of six physicians; however, seven participants participated. The inclusion criteria for the Phase II participants: Tibetan and non-Tibetan origin, may know about Western medicine, reside internationally or within the United States, and must have received training from an accredited Tibetan medicine institution (e.g., the Dharamsala Men-Tsee-Khang; Tibetan Medical University in Lhasa). Initially, the focus was on physicians of Tibetan medicine with knowledge of Western medicine or licensed MDs, with some of the demographics mentioned earlier residing in the United States or internationally and then Tibetan medically trained physicians. However, when recruitment presented an issue, TMDs living internationally without Western licensure credentialing were part of the inclusion criteria. In addition, demographic information such as gender, years of practice, geographic location, type of practice, and occupation (Tracy et al., 2003). To increase anonymity, the use of all said information was limited. Therefore, socioeconomic, spiritual, and religious criteria were excluded, allowing the inclusion of participants from various socioeconomic, spiritual, and religious backgrounds.

When using a phenomenological approach to inquiry, it is important to ensure minimal characteristic variances because it may be challenging to determine common themes (Creswell, 2007). Therefore, the purposeful sampling selection (e.g., TMDs and experts of Tibetan medicine), criterion sampling, and snowball sampling focusing on the phenomenon (e.g., wholistic care) minimized the variances (Mabood et al., 2013).

Creswell (2007) also noted that it is not necessary to use one site to select participants; sampling may occur from various locations (e.g., Universities, online forums, and Monasteries), allowing recruitment of participants from within the United States and internationally. Letters of cooperation were not necessary for this study.

### ***Selection of Participants***

After receiving approval from the IRB, the recruitment process of voluntary participants of key informants (e.g., experts of Tibetan medicine) and physicians holding the title TMD started. Participants were contacted via phone or Internet using an introduction phone script or email script to extend an invitation to participate as a key informant or recommend referrals to identify potential key informants or physicians using snowball sampling. This is an exceedingly small community, which requires a gatekeeper or formal introduction to any other form of recruitment would have reduced the number of participants (see Rubin & Rubin, 2012). The sampling criteria consisted of referrals (e.g., snowball sampling) from various gatekeepers; opportunities from personal contacts during field research; outreach to physicians residing in the United States and to Monasteries; direct contact via phone or internet using public information; or referrals from volunteered participants (See Mabood et al., 2013; J. A. Smith et al., 2009). A flyer and advertisement outlining the required demographics showed exclusion and inclusion criteria, and contact information was emailed or posted in online forums (e.g., Facebook) or handed to gatekeepers. However, when there was a recommended protocol for recruiting voluntary participants during the recruitment process, that procedure took precedence, and an IRB procedure change form was completed.

Once the participants started responding via phone or email, a phone call, a face-to-face appointment via videoconference, or an in-person meeting was set up for initial screening, which was held at a preferred location or via preferred communication per the participants' requests. The initial screening of potential participants was 30 min to 1 hr in duration. Full disclosure of the study was discussed with the potential participants (e.g., key informants or physicians) when all inclusion criteria (e.g., experts of Tibetan medicine, Tibetan medicine physician, Tibetan medicine physician knowledgeable of Western medicine) were met, and exclusion criteria were not applicable. When selected, the potential participant was given a consent form. The consent form's content (e.g., right to opt out, purpose and procedures, confidentiality, audio recordings, duration of the study, etc.) was reviewed and discussed with the participant; if terms were agreed upon, a signature was obtained. An electronic signature was accepted if both parties agreed to conduct the transaction electronically. A meeting (1–2 hr) was scheduled to conduct individual unstructured interviews (key informants), open-ended interviews (physicians) that were audiotaped if approval was provided, which was held electronically (e.g., phone, video conference), in a University, or at a location chosen by the participant (Section 8.03, Georgia Board of Psychology, 2011; Lee et al. 2007). Follow-up review sessions (1–2 hr) were held with key informants and participants to discuss data collected (e.g., interview transcripts, interview protocol, member check), where applicable, to ensure data accuracy.

**Instrumentation**

Otto and Knight's (1977) eight principles were used as a foundation of inquiry for Phase I (key informants; Appendix B). The interviews were unstructured and explorative. Open-ended, in-depth interviews were used for Phase II physicians using the interview guide I created based on the data analysis from Phase I. Phase I participants reviewed the interview guide for content, cultural and technical appropriateness and provided feedback. Recommendations were incorporated into the key informant physician interview guide for Phase II (Appendix A). The interviews allowed the Phase I key informants and Phase II physicians to provide their experience, perspective, and thoughts about Tibetan medicine's theory and practice, wholistic care, and health and curing (see Nastasi & Schensul, 2005). All interview questions related to the theoretical lens. See Appendix C. Interview notes and reflective journals provided moment-to-moment documentation of experiences, biases, and conversations (Nastasi & Schensul, 2005).

**Data Collection**

IRB approved the study (#07-10-17-0101287) on July 10, 2017. Data collection methods intended for this study: field notes, interviews, observations, audio or video recordings, and journals. However, the International Review Board (IRB) disapproved of using video recordings. There were two phases: Phase I consisted of key informants in the field of Tibetan medicine. Otto and Knight's (1979a) eight principles of wholistic healing were the instrument for the exploratory interview questions in Phase I. See Appendix B. Participation consisted of 1–2 hr interviews in an unstructured exploration format. The discussion focused on Tibetan medicine and whole person care to provide

context related to the research (See Ashing et al., 2003). The research question addressed: how do physicians of Tibetan medicine view treating the whole person? Phase I also helped in verifying methods and approaches to analysis. In Phase II, interviews were 1 hr in length using the key informant physician interview guide produced from information from Phase I. See Appendix A. Key informants reviewed Phase II questions to ensure questions were appropriate (See Yurkovich & Lattergrass, 2008). See Appendix A.

Interviews were scheduled upon receipt of the consent form. Participants and key informants could choose a location or an electronic method convenient and suitable to them. Natural settings are also essential during the interviewing and observation process because they provide a sense of comfort for the interviewee. Participants chose their location to provide flexibility and show respect for the participants and their time (See Ravitch & Carl, 2019). Phase I and Phase II participants were audio-taped to provide insight into the experience of the theory and practice of Tibetan medicine (Lee et al., 2007; Wittink et al., 2009). Otherwise, the interviews were hand transcribed when the participant or key informant declined the use of audio recordings. However, all participants consented to be audio-taped. If the participant could not meet for the full scheduled time or complete the questions on the interview instrument, a second or third appointment was made to complete the remaining questions on the interview guide.

The key informants and Phase II participants could keep journals of their experiences and notes of something they forgot to discuss, intending as additional input in the discovery process. None of the participants chose to use journals. This study did not use field notes; however, I captured notes while listening to the audio and kept

reflective notes during research to capture informal audio information and personal biases (See Creswell, 2007; Nastasi & Schensul, 2005). All notes were incorporated into the iterative process and analyzed for patterns, themes, and commonality.

### **Data Analysis**

LeCompte and Schensul (1999a) emphasized that the researcher has limited knowledge of the population under study when conducting qualitative research. Therefore, data analysis was more of a recursive process where I started analyzing data after the first set of initial interviews (Lee et al., 2007; Wittink et al., 2009). As data was collected, the data was organized, interpreted, classified, and coded (Creswell, 2007). It was important to identify themes and categories to understand better what is being observed (Creswell, 2007; LeCompte & Schensul, 1999a; Wittink et al., 2009).

While collecting data, the first set of procedural processes used were inscription, description, and transcription (See LeCompte & Schensul, 1999b). Inscription involves making mental notes during interviews and paying close attention to behavior and the surrounding environment. The behavior and environment became audio instead of visual, which needed finetuned attention. It was necessary, however, during the research process to document the key informant's and participant's perspectives of what was important, especially since there were cultural factors to consider. It was also essential to document the experience by describing and interpreting what transpired during the interview. The transcription process occurred through audio recordings or written dictation of the experience. Audio recordings were intended to be incorporated into transcription software (e.g., Express Scribe Transcription) that existed on a personal computer. Instead,

Temi.com was used to transcribe the audio recordings for Phase I and Phase II; all recordings were manually transcribed. See Chapter 4 for details. In some instances, there was a linear process. In others, it was circular. However, incorporating these procedures during and after the interview was critical to the data collection and analysis process.

LeCompte and Schensul (1999b) also mentioned a top-down approach that may prove beneficial with the spiral data analysis. As discussed by the authors, the primary concept suggests the importance of being mindful of the self and other people in relation to the environment. A bottom-up approach was incorporated into the procedural process as well, with the intent of using aspects of the six techniques identified because the premise of qualitative research is to understand the phenomenon (LeCompte & Schensul, 1999b; Merriam & Tisdell, 2015). Although, instead of the six techniques identified by LeCompte and Schensul (1999b), Phase I and Phase II used different approaches to analysis. The data analysis was intended to be consistent across techniques and was iterative to identify patterns and themes early in the process (Creswell, 2007; Lee et al., 2007). See Chapter 4 for more details.

Phase I used a preliminary analysis approach to obtain information for the Phase II interview guide. Phase II was an in-depth analysis using Braun and Clarke's (2006) thematic analysis instead of the six techniques identified by LeCompte and Schensul. Phase II also included trustworthiness in each thematic analysis phase (See Nowell et al., 2017). These techniques still supported the deep engagement and processing of the data. Pulling apart the data collected, categorizing, coding, comparing, identifying patterns, and organizing relevant information was key to making sense of the data. The analysis

was cognitive as well as technical (Creswell, 2007). The bottom-up process aided in refining the research process while also assisting in comprehending and effectively interpreting the information collected.

Audio recordings were reviewed and documented. Transcribed interviews were examined to isolate themes, identify common items and variables, and uncover patterns associated with behaviors, practices, and descriptive language (LeCompte & Schensul, 1999a; 1999b). The audio recordings' transcriptions were pulled apart using the same criteria. See Chapter 4 for details of the analysis process. Each method used underwent the same analysis process driven by the data collected and the defined phase, Phase I or Phase II. See Chapter 4. Information from all sources was integrated based on common themes, items, variables, and patterns, which were documented in tables allowing a story to emerge. Phase II was slightly different. See Chapter 4. The process was iterative, which required the data to be constantly compared and manipulated.

The data were also grouped and subcategorized based on the themes of the integral model (Wilber, 2000). However, this approach changed due to the complexity of the data, and it was best to analyze and interpret based on the *Sowa Rigpa* framework. The data were grouped and subcategorized inductively. The integral model (Wilber, 2000) themes were used, but not as designed. The integral model informed inquiry and analytical thinking. In addition, data was reviewed and manipulated continuously using item level, pattern level, and structural level analyses. Once the information was analyzed, it was intended to be entered into the HyperResearch program or NVivo



software. All analysis was designed to be semimanual to minimize the learning curve.

However, all analysis was done manually; see Chapter 4 changes.

### ***Data Interpretation***

LeCompte and Schensul (1999b) discussed several theoretical perspectives. The theoretical perspectives used to assist with interpreting the data were emancipatory (deductive) and building formative theory (inductive). Taking an emancipatory approach would provide the ability to analyze the data of the TMDs' experience of wholism (phenomenon) from the participants' and key informants' perspectives on understanding the meaning of treating the whole person within Tibetan medicine. Building formative theory from an inductive perspective would allow a story to emerge by identifying new domains, variables, patterns, and items.

Phase I used the inductive approach for a high-level interpretation of the data. Phase II used an inductive approach and attempted a deductive approach based on Western philosophies. The intent was to use both the inductive and deductive theories to provide the ability to determine how the data may support Merleau-Ponty's (2012) concept of embodied perception and Wilber's (2000) four-quadrant integral approach to healing. Merleau-Ponty's (2012) theory would allow a view into the potential intuitive aspects of the patient-physician relationship. Wilber's (2000) theory supports the humanistic perspective of treating the whole person. Their theoretical views stressed that healing needs to take a more integral approach by addressing the internal (individual) and external factors (individual behavior, cultural, and social) contributing to illness and associated with the healing process. However, it was necessary to think about the reader,

and using the integral model (2000) as a lens for interpretation required the reader to have prior knowledge of the theories. Using the integral model (2000) added a layer of complexity for the reader. Therefore, the theory and philosophy of Tibetan medicine were used as a foundation and framework for interpretation. Merleau-Ponty's theory also supported the intuitive aspects of doctor-patient engagement. See Chapter 5.

LeCompte and Schensul (1999) discussed various key points that addressed when to use existing research to inform interpretation. It was important to determine if the study enhances or supports the current body of research. If the study does not support or if it modifies the existing body of research, then maybe the research question needs to be altered or reformulated. For example, if the research question uncovered the importance of incorporating the integrative philosophy of Tibetan medicine into the practice and patient care within Western medicine, J. B. Brown et al. (1998) conclusions of their research findings might prove to be beneficial in supporting my research findings. Existing theories relevant to the uncovered findings were also addressed during interpretation (LeCompte & Schensul, 1999). The authors also note that analogies, metaphors, and relevancy (e.g., data, policy, program) relating to existing research or project expectations may also be used to interpret the data.

One way the participant's perspectives were appropriately reflected is by borrowing a narrative discussing the experience or view of the phenomenon (Wittink et al., 2009). Including direct quotes from audio recordings and written discussions is another way of reflecting the participants' perspectives. In addition, reviewing the findings with the participants to ensure the appropriate use of language would be

beneficial. Finally, tables and diagrams were used to provide a visual representation of the data, which will also be reviewed and discussed with the participants for accuracy (Creswell, 2007), see Chapter 4 modifications.

### ***Dissemination of Findings***

The research question explored whole person care and the TMDs' perspective of the physician-patient relationship, diagnosis, and treatment of patients. The research aimed to investigate the TMDs' experience of a wholistic medical traditions approach to healing and provide an understanding of how whole person care is practiced in Tibetan medicine. The goal was to understand Tibetan medicine and the physicians' approach to curing and healing while also increasing the knowledge exchange between Western and non-Western patient care practices.

Therefore, the audience of the research findings consisted of the community and those involved in the interviews, as well as researchers, practitioners, physicians, and educational program developers. An overall rhetorical structure was used as the foundation for discussing the results. Moustakas (1994) suggested using six chapters; however, the six chapters were condensed into five chapters to assist with providing form to the research manuscript. The chapters are presented in the following order and are entitled based on content: Introduction and statement of topic and outline; Review of the relevant literature and conceptual framework of the model; Methodology, Presentation of the data, and Summary; followed by research findings, and implications and outcomes. Figures and tables, where applicable, were included. This approach should sufficiently

address the needs of the academic community. After approval, the key informants and physicians were sent a one-page summary of the results.

Creswell (2007) discussed the importance of language to assist with targeting the audience. Since the audience is diverse, there was a need to ensure the language either met the needs of the global audience or the writings of certain sections were encoded for the interested parties. The latter would probably be more applicable because the dissertation focuses on academic publication. As noted in Creswell's (2007) discussion, it was important for the findings to be supported by credentials, references, a strong methods section, and the use of metaphors used in the academic community in which the research is directed.

However, it was also important to include aspects of the discussion in a language that the participants could understand to assist with the participant review process of the research findings (See Creswell, 2007; Lee et al., 2007). This portion of the data was encoded in a language the participants could understand and included in the dissertation as direct quotes (Creswell, 2007). Using the appropriate language for the targeted audience is important to ensuring data quality and verification/trustworthiness (See Lincoln & Guba, 1985). For accuracy and terminology consistency, Dr. Ben Joffe reviewed all information and terms related to Sowa Rigpa.

Another approach under the overall rhetorical structure is Polkinghorne's (1989) research report, which focuses on procedures for collecting raw data and documenting a description of the experience. The research report also includes a literature review, the theory associated with the research topic, implications for application, and psychological

theory (Creswell, 2007). This approach is not as structured as Moustakas's. Therefore, it would probably be best suited for the community, participants, and practitioners if they were the exclusive targeted audience. This approach aimed to discuss the findings in a way that provides a better understanding of the physicians' experience of whole person care when practicing Tibetan medicine. Therefore, to best satisfy a variety of audiences, there was a need to rewrite the findings to meet the needs of the targeted audiences (e.g., community, newspaper). The primary audience of this body of work is the academic community. Therefore, there is a need to present the data in a smaller context for another audience.

### **Issues of Trustworthiness**

Schensul et al. (1999), in their discussion, identified the traditional concepts of reliability and validity that may not be as relevant to qualitative research. There were two principles in ethnography that would be more of a threat in a quantitative environment, driven by control and structure but would not be in qualitative research (Schensul et al., 1999). The first is the researcher as an instrument. This role in ethnography is important in the development and outcome of the study. Observation is key in data collection because the premise behind qualitative research is exploration and understanding. The second is applying rigid controls in the studies conducted. Ethnographers, as observers, want to "focus on the natural flow of human events over time" (Schensul et al., 1999, p. 273).

When identifying the relevancy of validity in qualitative research, validity is a significant strength of ethnographical research (Schensul et al., 1999). The nature of the

researcher, which is to immerse themselves in the population of the study, helps align scientific categories with participant realities. However, according to the authors, the meaning of validity varies and depends upon the stage in which it is applied. Therefore, it is essential to understand the culture under study to ensure the proper application of questions and language within the research context, which enhances internal validity. There are internal threats that are applicable to validity. However, some threats depend on the design or type of research conducted. For example, maturation is not considered an internal threat when conducting exploratory research, but it is when “conducting semi-structured or definitional research and ethnographic surveys” (Schensul et al., 1999, p. 280). External validity may also be threatened through poor documentation (e.g., researcher-participant relationship, historical data) and inappropriate use of methods, concepts, and instruments on the population under study (Schensul et al., 1999).

To ensure data quality and verification/trustworthiness, qualitative researchers must consider credibility, transferability, dependability, and confirmability since these criteria are defined in qualitative analysis (See Lincoln & Guba, 1985). Respectively, those as mentioned above correspond to internal validity, external validity, reliability, and objectivity, which are criteria defined by quantitative analysis (See Nastasi & Schensul, 2005). There are 10 techniques that would ensure credibility: prolonged engagement, persistent observation, triangulation, member checking, peer debriefing, negative case analysis, reflexive journal, thick description, audit trail, and referential adequacy (Lincoln & Guba, 1985; Nastasi & Schensul, 2005). The authors also note that to access dependability or reliability, the following two techniques should be used: reflexive

journal and audit trail. The audit trail technique will aid in supporting confirmability or objectivity. Finally, a thick description will ensure transferability or external validity.

It was the intention to apply all the techniques outlined by Lincoln and Guba (1985) and Nastasi and Schensul (2005) in this study. However, there was no need to exclude a portion of the data for analysis later (referential adequacy; Lincoln & Guba, 1985). Therefore, this technique was omitted. Following is a discussion on the steps taken to support how the methods were applied. Also, Chapter 4 discusses how the use of trustworthiness was incorporated into the thematic analysis in Phase II (See Nowell et al., 2017)

For *credibility*, it was necessary to become immersed in the population interviewed to ensure a clear understanding of cultural language, spiritual views, and cultural beliefs (prolonged engagement). Detailed notes of the iterative process, as well as follow-up discussions with the participants (if necessary) related to interpretations and reflections assisted with credibility (Crist, 2005). For example, in a research study on the meaning of family care within gerontological nursing, the researcher included a step where the informants evaluated the researcher's interpretation by reflecting on the themes that surfaced through their personal analysis of their narratives (Crist, 2005). This step was to assess what Christ (2005) noted as external evidence.

See Chapter 4 for details on the steps taken during the course of the study related to credibility. The intention was to provide transparency of the study design and procedures, which are fully outlined in Chapter 4 to support trustworthiness. A journal was kept documenting my experiences, understandings, and personal biases to aid with

*confirmability* (reflexivity). To address *transferability*, gender variation in participation selection was used (Crist, 2005). Thick description was intended to be used within the context of Wilber's (2000) integral theory; see Chapter 4 for changes. The use of Husserlian phenomenology and reviewing research findings with participants will aid in improving data *dependability* by removing personal biases and cross-checking of results with participants (member checking; Lee et al., 2007; Lincoln & Guba, 1985); see Chapter 4 for modifications. Audio and video recordings and field notes assisted with providing an audit trail.

During the review session with key informants and participants, data, and research results, as previously noted, were reviewed to enforce member checking and triangulation of data; see Chapter 4 for modifications. The purpose of the review session was to include discussions on emerging interpretations to determine relevance (Crist, 2005). Due to the length of engagement required, this process was not used across all participants. According to Crist (2005), these periodic evaluations aid in identifying the practical implications of the research. Key informants were intended to be included for feedback on final interpretations, which was designed to assist with confirming the transferability of the physicians' perspective of curing and healing within the context of Tibetan medicine (Crist, 2005). However, a Tibetan interpreter was used instead. The interpretation of the data also went through a peer debriefing process. Based on the feedback received during the peer debriefing, the integral model (Wilber, 2000) was not ideal for interpreting this study. In addition, multiple data collection tools and sources (e.g., audio recordings, key informants, participants) were used to address triangulation.



All challenges with applying the techniques were documented in the limitation section in Chapter 5, noting which methods were less of a concern and why. A discussion on how future research could improve data quality and verify the findings based on the research findings was included. For example, Crist (2005) discovered that the sampling procedure might have prohibited a more robust interpretation of the data. To enrich data interpretation, the author suggested approaching participant selection by including “additional and different perspectives” of the experience of family care (Christ, 2005, p. 491). Crist recommended as an example of obtaining a unique perspective that it may have been beneficial to select participants with experience of family care but who had no prior experience of care in a community facility or home care services or participants currently in a community facility or receiving home care service and previously received family care.

### **Ethical Procedures**

The Georgia code of ethics 510-4-.02 section 3 on Human relations notes the importance of avoiding harm and exploiting participants (Georgia Board of Psychology, 2011). There was a need to recruit participants meeting the demographics outlined (e.g., physicians trained in Tibetan medicine) and key informants (e.g., knowledgeable individuals in Tibetan medicine, physicians, scholars of Tibetan medicine). The first step was to contact known general informants and publicly available individuals in the field of Tibetan medicine. In addition, I identified potential organizations with access to individuals knowledgeable of Tibetan medicine (e.g., Universities, organizations related to Tibetan medicine, Monasteries) via the Internet, email, or referrals from colleagues.

The potential Universities consisted of but were not limited to the following: Emory University: Emory-Tibet Partnership, Naropa University, University of Arizona, referrals from noted recruiting sites, and if recruitment was difficult, Men-Tsee-Khang in Dharamsala, India was also a recruitment resource. Other institutional resources within the United States are Shang Shung Institute of America and the Sorig Institute, which has four locations: Bay Area, Portland, Seattle, and New York. Other recruitment resources are clinics (e.g., Tibetan Medicine & Holistic Healing Clinic, Boulder, Colorado) and monasteries (e.g., Drepung Loseling Monastery, Brookhaven, Georgia). However, the most successful method of recruitment was snowball sampling.

Phone calls were made, and emails were sent to potential key informants and gatekeepers (e.g., referrals, Universities, Monasteries, and health facilities). Interested parties were contacted, and an appointment (30 min to 2 hr) was made to meet with the gatekeeper and or stakeholder where applicable or key informant to discuss the research proposal in person, via videoconference, or phone. It was essential to obtain approval (e.g., letter of authorization, IRB application, consent form) from the organizations (e.g., stakeholders, health facilities; and spiritual organizations) willing to participate in the research study where applicable, so a 1 hr meeting was intended to be scheduled to obtain such documents (Section 8.02, Georgia Board of Psychology, 2011). The documents mentioned above were sent electronically. A meeting was held with key informants to conduct unstructured interviews and physicians to conduct semi-structured interviews. To ensure the data accuracy of the information gathered, a follow-up session (1 hr) with key informants and physicians to review the material collected (e.g., interview transcripts,

key informant physician interview guide, final interpretations) was scheduled when applicable. All additional correspondence was conducted via phone or electronically (e.g., follow-up meetings, interview transcripts/member checking) or a preferred method convenient for the key informant or physician. All participants received a \$10 Starbucks thank you gift card, if desired, for their participation.

A coding system was used to maintain the confidentiality of the key informants and physicians (Creswell, 2007). A separate matrix was used to link the participants (e.g., key informants and physicians) with the codes and was kept in a locked cabinet. Participation was voluntary and only participants providing voluntary informed consent were used in the research study.

All participants could opt out of participating at any time during the study. If the participant needed to withdraw from the study, data collection ceased, and only demographic data collected was used for those participants. None of the participants requested to withdraw from the study. If a conflict of interest and a breach of confidentiality was raised, all parties (e.g., participant, chairperson, IRB) were informed and addressed immediately. If there was a need to re-assess risks and benefits, all affected parties were notified (e.g., participant, chairperson, IRB), and approvals were re-attained.

Exploring spiritual and cultural beliefs related to Tibetan medicine may reveal rituals or practices that were privileged information known only to the culture. Therefore, all information not associated with the study was not documented. All information was held confidential and coded to protect the identity of stakeholders and participants.

A translator must accompany TMDs who may not speak English, and inclusion was voluntary. IRB denied the use of a translator. See Chapter 4 for changes. Data collected during audio interviewing sessions (e.g., audio recordings, transcriptions, notes) were stored electronically (e.g., word processing software, mp3 files). All physical data (e.g., journals and jump drives) were kept in a locked cabinet (Creswell, 2007). Electronic data was password protected. Password-protected backup copies were made of all electronic media and stored in a separate locked cabinet. Names of the participants were masked on all data. A matrix was used to organize data to assist with easy retrieval, which was locked in a cabinet. After the five-year minimum, all data will be shredded, all electronic media will be destroyed, and all electronic files will be deleted (Creswell, 2007).

This chapter addressed the methodology, design, and role of the researcher, along with the population sample, data analysis, trustworthiness, and ethical procedures. The intent was to provide an understanding of the scientific approaches and protocols used to interview a small sample of the TMD population. The hope is that the information was disseminated in a way that aids research replication if desired. Chapter 4 presents the data collection procedures, analysis procedures, and research findings.

## Chapter 4: Results

Tibetan medicine is an ancient medical system integrated with science, art, and philosophy (Chenagstang, 2018; Gonpo, 2011a). Tibetan medicine has a systemic approach to viewing the body and has found a way to incorporate many aspects of living into healing and curing the whole person. Few researchers have conducted studies on whole person care. To my knowledge, there was no research addressing the subject of Tibetan medicine from the physician's perspective through an inquiry lens of Otto and Knight (1977), Wilber (2000), and Merleau-Ponty (2012) and an interpretive lens of Sowa Rigpa. The purpose of the current study was to gain insight into the phenomenon of the practice of whole systems medicine through a contextual view of Tibetan medicine.

I used the qualitative approach with an emergent design, incorporating multiple methods in the study to gain insight into this rich system of medicine. Aspects of ethnography allowed me to learn about the belief systems and culture through the canonical medical text, learn and experience the culture via lectures and teachings, and connect to the community. Whole person care or wholistic healing was the phenomenon I studied; phenomenology allowed me to understand the meaning of treating the whole person from a doctor of Tibetan medicine. IPA required a small-scale homogeneous criterion and a purposively selected sample. The emergent design allowed data from Phase I to generate the appropriate questions for Phase II while also providing participant, analysis, and interpretation flexibility as the study progressed (Busetto et al., 2017). I used a two-phased approach using semistructured interviews with a responsive method of inquiry. In Phase I, I used Otto and Knight's (1979a) concepts of wholistic

healing for key informant interviews. I used a key informant physician interview guide in Phase II based on the information obtained from the Phase I interviews.

To understand the factors needed in allopathic medicine for whole person care, I needed to assess a whole systems medicine approach to care. For that reason, initially, the current study addressed the following research question: How do physicians practicing Tibetan medicine view the theory and practice of this system of medicine with respect to the physician–patient relationship, diagnosis, and treatment of patients? To fine-tune the research question, I modified the question during the IRB process: How do physicians of Tibetan medicine view treating the whole person? The revised research question addressed understanding the contextual view of treating the whole person; understanding the perspective of the practice and diagnosis of Tibetan medicine from a wholistic framework; and gaining insight into how doctors of Tibetan medicine understand health, illness, and disease. The literature review in Chapter 2 of Western and Tibetan medicine provided a foundational lens from two complex medical traditions addressing the differences, commonalities, and philosophies. This study intended to find a common language using Western terminology for discourse between these two complex medical systems while presenting further insight into whole person care.

This chapter begins with an introduction and a preliminary setting explanation leading to the research. The discussion continues with the pilot study, which was not part of the initial design, participants' demographics (pilot, Phase I, and Phase II), data collection, and data analysis procedures. Chapter 4 concludes with the results and a summary.

### Setting

Due to the nature of the study (Pilot Study, Phase I, and Phase II), the complexity of Tibetan medicine, and the population studied, it took 4 months to obtain the initial approval for the study. I completed data collection in December 2019 before the COVID-19 global pandemic via Zoom, phone, or What's App. I used a nontraditional form of study due to the limited access to TMDs and knowledge experts. Taking advantage of the communication technology available provided me with more inclusive access to the limited number of scholars and skilled practitioners in Tibetan medicine. A remote interview approach offered practitioners in the United States and outside of the United States (e.g., Europe, Canada, and India) the opportunity to participate.

Because language (e.g., Tibetan medical terminology and Tibetan) was a factor, recruitment consisted of participants fluent in English (Phase I) and the ability to speak and read English (Phase II). To assist with the language challenges, I immersed myself in the culture, attended Tibet Week at Emory University, and designed Phase I interviews to provide insight into best practices when communicating with traditional TMDs. My foundational understanding of Tibetan medicine was through reading published literature and the Men-Tsee-Khang translations of the medical text. During the Phase I interview process, I discovered that my approach to questions required a specific direct approach to inquiry (e.g., slightly leading the participant to the topic of discussion). The method was different from a traditional form of investigation (i.e., an open-ended inquiry form). Most participants required specificity during the questioning, possibly due to the vastness or complex structure of medical disciplines. Also, I used Western terminology as a form of

inquiry, which did not translate, to gain insight into a non-Western medical tradition. I discovered I had to use Tibetan medical terminology as my form of investigation in Phase II.

I completed a year (2020–2021) of remote learning in Tibetan Medicine (Sowa Rigpa in Tibetan) offered by Dr. Nida Chenagtsang at the Sowa Rigpa Institute via Live Zoom lectures. The teachings provided a more profound lens to understand the philosophy, anatomy, diagnosis, and treatment within the Tibetan medicine framework. All my knowledge had been through reading articles and the Men-Tsee-Khang translations of the medical text. Most participants recommended learning Sowa Rigpa during Phase I and II data collection. The teachings aided in data analysis and interpretation of the Phase II transcriptions.

### **Pilot Study**

The intent of the pilot study was to evaluate scripts, electronic devices, procedures, key informant interview questions for Phase I, a demographic survey, follow-up interviews, and a manual transcription process. In addition, the pilot allowed me to gain clarity, time to completion, and virtual connections. As I was conducting the pilot study, three procedural changes were required. The participants consisted of two experts of holistic medicine. Both participants met the inclusion criteria (e.g., scholars, medical doctor (MD), or Doctor of Chiropractic [DC]). There were also two additional knowledge experts, an MD and a professor in the field of public health; both were not available to participate but were open to reviewing the interview questions for clarity and feedback.



I contacted all potential participants electronically and knew the pilot study participants. A pilot study consent form, demographic survey, and detailed description of the study, as well as the procedures, were sent by me via email and Facebook messenger. Once participants were contacted, I scheduled a 30 min initial screening interview for full disclosure to review the consent form and answer any questions. One participant wanted to meet face to face for the initial screening at their place of business. The other participant lived elsewhere, and I sent a follow-up email with a friendly check-in after 1–2 weeks to ensure the participant received the recruitment email. The initial screening took place over the phone. Both participants agreed to participate in the study and signed the consent form.

After the initial screening, I scheduled the interview date and time for 1–2 hr. One participant requested a copy of the interview questions; I granted the request and provided the questions for review before the interview. Both interviews were conducted using the key informant interview questions, see Appendix B, via telephone and audiotaped. I designed the questionnaire based on Otto and Knight's (1977) eight basic concepts of wholistic healing, which I explored to gain insight into whole person care and holistic healing. Since my participants were only knowledgeable of Western medicine modalities, the questions were flexible enough to allow them to answer based on their personal experience in their field of expertise. The terminology used during the pilot was relevant to the pilot participants' field of medicine where applicable in place of Tibetan medicine.

Once the interview portion concluded, I asked if any questions were vague or unclear, their thoughts on the length of time it took to complete the questions, and if there were any questions they wished I would have asked. Then I informed the participants that there would be a follow-up review meeting for another 1–2 hr, including fact-checking of transcripts and a debriefing statement and their thoughts regarding journaling or notetaking post-interview. The journaling intent, later removed from Phase I and Phase II, was to allow the participants to add additional information due to the complexity of the discussion. Participants did not make use of journaling or note-taking. I then concluded the research-participant relationship during the follow-up interview with a debriefing statement. One participant was available for a follow-up meeting lasting 1hr and 30 min to provide feedback on their experience and fact-check the transcript. Of the two participants, one completed the interview and the follow-up interview. The other pilot participant was only available for the initial consultation, and I received no response from the communications sent for scheduling a follow-up session. I offered both participants a \$10 Starbuck gift card.

Immediately after each interview, I reviewed my notes and noted any insights and thoughts I experienced during the interview process. I kept my notes in a file folder in a locked cabinet. Each participant had a folder, and that folder was also in a locked cabinet. There were no identifying labels to connect the participant's name with the file. A cross-reference sheet was used and kept in a separate folder in a locked cabinet. Recordings were reviewed and transcribed by me. I reviewed recordings several times during the

transcription process. Once I transcribed the interviews, I listened to the recordings again two or three times for accuracy.

Recruitment for my pilot study was challenging. Interviews depended upon physicians' responses to invitations, availability, and rescheduling cancellations. I had to submit an IRB change request form to accommodate the challenges and keep moving forward with the recruitment of my pilot participants. Changes to the original IRB application included the following:

1. I created an additional script when the electronic recruitment effort yielded no response. I designed and used a friendly follow-up script after 1–2 weeks when a potential participant did not respond electronically. I developed a follow-up script for the phone and a written script for face-to-face meetings based on possible responses. I also created a script for if I received a response of “no” from the potential participant to allow me to get a referral.
2. The second change was a procedural modification driven by a participant's request to review the interview questions before the interview. I modified the research procedures to send the interview questions after receiving a signed consent form. I submitted Copyright permission for the informant interview questions I used (Otto and Knight's eight principles and concepts) to IRB.
3. Finally, to conclude the researcher-participant relationship, I used a debriefing statement. The debriefing statement reinforced confidentiality and allowed the participant to provide contact information on where they would like the results

sent if they were interested in receiving a copy. I modified these changes for both phase one and phase two.

During the first year of recruitment, there were several IRB revisions during the pilot and post-pilot study. The pilot data collection took longer than anticipated due to Western physicians' availability. Scheduling interviews, the holiday season, vacations, and the reality that physicians (criteria: Western MDs or DCs or practitioners of holistic medicine) have full schedules, curtailed recruitment. There were also post-pilot study procedural modifications. I modified the recruitment flyer and the review transcription protocol because the pilot participants did not have time to review 30 pages or more of transcription or did not want to verify accuracy. I modified the procedures to include listening to the audio three times for accuracy. One of my CITI certifications expired, and I needed to take a refresher course for IRB submission. Finally, while testing my software options after data collection, I discovered that my computer did not meet the systems requirements for the applications chosen. I added Dedoose as an option for qualitative analysis but manually coded and analyzed the data.

The next step was to conduct my pilot data analysis to determine if this would be a lengthy process or if my procedures were acceptable and reasonable. During this process, I discovered that 1–2 hr interviews created long transcriptions with many relevant data. I decided to keep the length of time for the discussion and make no changes for Phase I.

## Demographics

### Pilot

Two participants had background knowledge in wholistic healing and incorporated the practice in their approach to care. One participant was an MD, and the other was a DC.

### Phase I

I used key informants who were researchers or formally trained in Tibetan medicine (e.g., scholars, professors, and non-traditional TMDs). There was a total of four participants, fluent in reading and writing English. Two held Ph.D.s., a researcher and professor who worked closely with a traditional TMD, and three were academically trained TMDs and recognized as TMDs as either *menpa* or *Kachūpa* level. Some participants were able to read, write, and speak Tibetan. Due to the small population of practitioners and researchers in this field, I removed all additional identifiable demographics in this chapter to maintain anonymity.

**Table 1**

#### *Phase I Demographics*

Participant	Training/education	Training years
KY001	TMD Xining, PRC; Diaspora/India	4+ medical 4+ clinical
KY002	Ph.D., RN	
KY003	TMD Xining, PRC	4+ Tibetan medicine
KY004	TMD Xining, PRC	

## Phase II

Participants consisted of seven volunteers, two females and five males. TMDs with years of experience ranging from 15+ years to 35+ years, where some communicated having clinical experience in Tibetan communities. Participants were academically trained from recognized and renowned Institutions of Tibetan medicine (Tibetan Medical University in Lhasa; Tibet, Men-Tsee-Khang, Tibetan Medical & Astro-science Institute in Dharamsala, India) or lineage trained and recognized by a renowned institution or both. Due to the small population of practitioners and researchers in this field, I excluded all identifiable demographics to maintain anonymity.

**Table 2**

*Phase II Demographics*

Participant	Training/education	Years in practice
PH001	Qingui province Diaspora/ India	25+
PH002	Medicine & Monastic Training Diaspora/ India	20+
PH003	Lhasa, Tibet	20+
PH004	Diaspora/ India	35+
PH005	Lhasa, Tibet	35+
PH006	Diaspora/ India	35+
PH007	Tibetan Monastery Tibetan Dharma Clinical experience with cancer patients	15+

## **Data Collection**

My study was global, which meant location was not relevant. Participants could either be located within the United States or outside of the United States. The study consisted of two phases plus a pilot. At the time of the interviews, in Phase I, out of the four participants, one participant was outside of the United States. In Phase II, out of the seven participants, three lived outside of the United States.

### **Phase I**

The purpose of Phase I was to explore the theory and practice of Tibetan medicine and whole-person care to provide context related to the research and aid in developing the interview protocol for the physicians in Phase II. Phase I was also used to aid in verifying the method and approach to analysis. I used Otto and Knight's (1977) eight principles and concepts of wholistic healing to inform my unstructured exploration interview to see if the approach to questioning would be appropriate for Phase II. As well as to inform the production of the key informant physician's interview guide used in Phase II. Additionally, Otto and Knight's (1977) eight principles used for inquiry and the Phase II interview questions were mapped into Wilber's (2000) integral framework to inform the interpretation process in Chapter 5. See Appendix C. The intended approach was to have a foundational thread using western philosophies to support the conceptual framework interpretation.

After completing my pilot, I sent a procedure change to the IRB. While waiting on the IRB to approve my requested changes for use in Phase I of my research study, I began outreach to potential participants via email for my Phase I study to start the

scheduling process. Phase I participants consisted of scholars, doctors of Tibetan medicine, and researchers in the field of Tibetan medicine. Four participants met the inclusion criteria for Phase I. Phase I participants were known as “key informants” and interviewed to ensure my approach to participants in Phase II was culturally and academically appropriate. The recruitment process used snowball and the internet (e.g., peer-reviewed articles, American Tibetan Medical Association, social media) to access scholars and professionals in Tibetan medicine.

When recruiting for Phase I, as of June 2018, three new interested potential participants met inclusion criteria (needed signed consent forms), and one participant was scheduled (rescheduled interview and waited on consent form). Even with gatekeepers, snowball sampling, and information from public sites, the number of people to commit varied depending upon the phase and availability, criteria for English-speaking participants, and personal perceptions. Each step relied on the completion of the previous step.

Three patterns or trends were found during the study’s first year. First, based on the pilot and progress on Phase I, the participants expressed a detailed amount of information on the subject matter, contributing to lengthy transcripts with relevant data. The second and third, from Phase I, there were many referrals, but the potential participants were interested in my knowledge base (e.g., books I have read), background, and known connections. Therefore, there was a need to stress the initial steps taken before I received IRB approval for the study in 2017. I discussed with potential participants how I immersed myself in the culture and read the books and articles



recommended by gatekeepers, TMDs, and scholars in Tibetan medicine. At this stage, it was necessary to gain credibility and respect from potential participants. One potential participant even expressed concerns about the study but admired my enthusiasm. The potential participant, during recruitment, described the challenges one would face when conducting a study on Tibetan medicine without having familiarity with an understanding of Tibetan medicine. It was not until later that I understood the scope of their statement. Due to these challenges, there was a need to request an IRB extension on 6/9/2018 to complete the data collection of Phase I. IRB granted the extension on 6/20/2018.

Recruitment during this phase was not without its challenges. Building my relationships within the Tibetan medicine community aided in the ability to obtain my four participants. I received many “no thank you” and many unanswered recruitment requests. Surprisingly, some gatekeepers who said they would assist me were unable to follow through with the commitment. My pilot study adequately prepared me for said challenges. I was grateful for the participants that said yes. The snowball technique was the most fruitful within the recruitment process. The participant seeing a referral within the recruitment request subject area prompted individuals or potential participants to respond either with yes, available or unavailable at that time. The snowball method was the most effective form of recruitment. The interviews were 1–2 hr long, and I used the key informant interview questions and demographic survey tested in the pilot study. All the participants were fluent in English.

I recorded all the interviews on my computer. After completing each interview, I submitted the audio file to temi.com, a computer-generated transcription service. While

listening to recordings and reading the transcriptions, I made notes on my interview skills and engagement practices with the participants and the participants' responses. I listened to each recording two or three times. In addition, I documented any nuances that I thought were important based on my prior readings on Tibetan medicine, my experience, and knowledge from a cultural standpoint that I thought might be important when conducting my analysis. I collected demographic data on each participant but decided not to include identifying information to protect anonymity.

While collecting data for my key informants, my chairperson became extremely ill and passed away several months after. I was appointed a new chairperson to assist me moving forward. By this time, I had completed Phase I data collection. However, preliminary analysis for Phase I was required before moving to Phase II. I conducted follow-up interviews with my key informants to better understand what my findings revealed during the analysis; see Phase I under data analysis. I only requested feedback on potential questions that I thought would help Phase II in the awareness of time. I derived 23 questions for the key informants to review but decreased the list to eight. Mourning the loss of my chairperson and moving through the requested changes to my initial design was a very frustrating time for me. After receiving feedback from three of the scheduled follow-up interviews conducted via email, I synthesized the information to create my key informant physician interview guide, which was my Phase II interview questions.

One of the four key informants was unavailable for a follow-up interview within the timeframe needed to keep my study moving forward. The fourth participant follow-up

interview took place at a much later date, and the feedback, based on the other suggested comments received, was minor and incorporated. After assessing all the nuances, challenges, and requested changes, I submitted my final IRB request for change within this study phase to obtain approval for the questions used to interview the participants in Phase II.

## **Phase II**

There was a total of seven participant interviews conducted using the semi-structured key informant physician interview guide. All discussions were via phone and sometimes the application WhatsApp for participants from outside the United States. I recorded all the data on my computer. The interviews were initially designed for 1–2 hr but revised to 1 hr. This process took longer than predicted because some gatekeepers originally agreed to assist but did not respond to my outreach. Therefore, patience, a more comprehensive network, and additional follow-ups to participants previously contacted were required. The other challenge was that some participants were willing to participate but needed a translator; IRB disapproved of a translator. English was a second language for all my Phase II participants. All information collected was via phone or in a follow-up email. Phone or WhatsApp was the best form of communication for Phase II.

As previously stated, the passing of my chairperson created a significant shift for me and my research. There were timing issues and approval steps for Phase I, language barriers, and availability for Phase II. The number of people to commit also varied depending on availability and criteria limitations (English-speaking participants). Due to

the limited number of exemplary TMDs meeting the criteria, scheduling was always a factor because of the high demand for their skills and knowledge.

For Phase II, three patterns emerged; there was a need for the participant to be comfortable with reading or speaking English. Some potential participants needed someone with them to clarify what was being said or to aid in replying. My inability to communicate in Tibetan impacted recruitment, and as previously mentioned, IRB did not approve the use of an interpreter. Some participants agreed to participate but later declined based on the consent form or lack of comfortability with the English language. The consent form and procedures were simplified and received IRB approval on 5/29/19.

The second pattern was availability, as previously noted. The third, as in Phase I, was the interest in knowing my knowledge base and background. Referrals from a well-known and respectable source were paramount in obtaining participants. Before getting some level of commitment, additional steps, at times, were taken to build a level of trust, even when there was a gatekeeper. There were some gatekeepers unable to assist with referrals, reasons unknown. Other challenges continued to occur; I sent another extension request on 6/8/2019. IRB granted the request for another extension based on the challenges mentioned above on 6/20/2019. I completed data collection in December 2019. Then COVID-19 Pandemic arrived in 2020. During this time, I was in the first year of the Foundations Program as part of the May 2020 Cohort at Sowa Rigpa Institute. I was grateful for the opportunity to participate in the training and teachings of *Sowa Rigpa*, instructed by Dr. Nida Chenagtsang.

## Data Analysis

### Phase I

After listening to each transcript three times, I started the initial coding process by taking an inductive approach using words from the participants. I continued to listen to the coding when needed. Each code was generated in a word document using the comment feature and assigned a number. Once the initial coding was complete, all codes were transferred to a word document by a participant. Every participant was color-coded. Creating new documents for each stage was essential to freeze the data in that state for verification purposes. Using a spreadsheet in excel, I made a color-coded column for all the participants and transferred the codes keeping the assigned number for each code from each participant. I read each code and selected a primary keyword that captured the essence of the code. I searched for the same patterns across all participants using the find feature.

A new keyword was created when an initial code could not be associated with a primary keyword. See Appendix E for the coding analysis process. Second level coding was generated based on one participant and patterns of the initial codes that resulted in 37 secondary level codes (e.g., nature, three poisons, wholistic, mind-body connection, biopsychosocial, *rlung*). I created themes based on the context of the 37 secondary-level codes. See Table 3. For example, the theme “there is an interconnected web affecting health and illness” was associated with the following codes “biopsychosocial,” “belief system/spiritual role,” and “mind-body connection.”

**Table 3***Phase I Secondary Codes Generated*

Secondary Codes	
Nature and health play a role in health	Holism/wholistic
Biopsychosocial	Culture
Family system	Self-Awareness/Physician/Patient/Physician-Patient relationship
Social	System factors of medicine
Patient feels supported	Method of assessment
Trust physician	Time with patient
Patient behavior	Three poisons
Symptoms	Bad kan
rlung	Treatment
Contextual experience influences health	Nyes pa (three humors)
Diagnosis	Effective communication and assessment
Energetic channels	Cultural traditions
Skills of the Physician	Adherence to treatment
Self-Care	Compassion
Testing (collapse or ignore)	Belief system/spiritual role
Role – Patient and Physician	Policy implications
Personalized medicine	East meets west
Healing components	Concept of illness and disease
Physician education training	Mind-Body connection

There were also subcategories under some secondary level codes. For example, “*loong/rlung*” was under *nyes pa* (three humors) due to its biological effect on the body. See Appendix F. Discrepant cases were coded and included under the proper theme. The participants used Western and Tibetan medicine terminology, which was helpful during analysis and contributed to triangulating the data when clarifying interpretations. Nine themes were identified with codes and subcodes or categories. Data chunks could have more than one code, and codes could be under various categories or themes. A hierarchical list was created to depict these findings. A preliminary themes diagram was also created, identifying the themes and relationships within the context of the data. See Appendix G.

**Phase II**

I used the six-phase approach to thematic analysis and incorporated trustworthiness in each phase (see Braun & Clarke, 2006; Nowell et al., 2017). First, I sent the first recording to temi.com, which is a computer-generated transcription service. The recorded audio presented challenges for the computer-generated service and interfered with producing an exact transcription. I then transcribed my recordings. Table 4 contains the six-phase approach, which includes in italics the description illustrated by Braun and Clarke (2006) required for each phase. Under each description are the steps I took within each stage. See Table 4 Familiarizing yourself with your data. I always found something I missed each time I listened. After getting the transcripts as clean as possible in a Word document, I started the initial coding process using an inductive approach. See Table 4 for steps used for analysis.

**Table 4***Phase II Data Analysis Process*

Six Stages of Thematic Analysis	Steps taken during analysis
Familiarizing yourself with your data	<p><i>Transcribing data, reading and re-reading the data, noting down initial ideas.</i></p> <ul style="list-style-type: none"> <li>• I transcribed my recordings.</li> <li>• I immersed myself in the data.</li> <li>• I listened to each transcription three times, correcting any errors and making comments for follow-up.</li> <li>• Stored raw data in an organized file</li> </ul>
Generating initial codes	<p><i>Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.</i></p> <ul style="list-style-type: none"> <li>• Initial coding process used an inductive approach in a semantic way using words from the participants.</li> <li>• I coded the entire transcript.</li> <li>• Listened to the recordings again when necessary, during the coding process</li> <li>• I coded each participant independently using the comments feature in Word.</li> <li>• Each code had a unique number in the comment box.</li> <li>• When appropriate, I recycled codes.</li> <li>• Participants and their data were uniquely color coded.</li> <li>• PDF files were created, one for the coded document and another with just the initial codes using the participant color.</li> <li>• I created a matrix in word to refine the data that included the participant ID #, the data, initial code, 2<sup>nd</sup> level codes, and refined code.</li> <li>• Data for all participants were merged (each participant had a different row)</li> <li>• The second round of coding was driven by interview questions; I refined the line-by-line codes by using a content and topic approach, again using a descriptive and interpreting coding approach.</li> <li>• I reused the refined codes when applicable within the interview question matrix and across interview question matrixes.</li> </ul>
Searching for themes	<p><i>Collating codes into potential themes, gathering all data relevant to each potential theme.</i></p> <ul style="list-style-type: none"> <li>• I created a document with the codes, then made a mind map.</li> <li>• Created a hierarchical code sheet for each question matrix to begin to see what categories/themes were emerging.</li> <li>• I used color markers and indexed cards.</li> <li>• Printed, cut, and pasted the 2<sup>nd</sup> level codes on index cards</li> <li>• Sorted based on subject content</li> <li>• Color-coded based on three high-level topics my research was trying to address</li> <li>• Started writing findings while searching for themes – the themes/categories continued to appear</li> </ul>
Reviewing themes	<p><i>Checking if the themes work in relation to the coded extracts (Stage 1) and the entire data set (Stage 2).</i></p> <ul style="list-style-type: none"> <li>• Merged the data one more time based on existing category and themes</li> <li>• I continued to write.</li> <li>• I removed all the relevant excerpts of data into a working document.</li> <li>• I saved and printed the documents with a date stamp for each significant shift in the process.</li> <li>• Returned to raw data for verification</li> <li>• Generated another thematic “map” of the analysis.</li> </ul>
Defining and naming themes	<p><i>Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.</i></p> <ul style="list-style-type: none"> <li>• Determine if my themes were codes or if my category/themes were genuinely valid.</li> <li>• Once I felt comfortable with the category/themes, I created subcategories based on the importance of the data extractions.</li> </ul>



Six Stages of Thematic Analysis	Steps taken during analysis
	<ul style="list-style-type: none"> <li>• Defining and renaming the themes was an ongoing process</li> <li>• I continued to write and merge while pulling the richest content that best described the existing category/themes.</li> </ul>
Producing the report	<p><i>The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.</i></p> <ul style="list-style-type: none"> <li>• I created another mind map of all the merged information and produced a hierarchical structure.</li> <li>• I was able to see everything on two pages in full color.</li> <li>• I then created individual mind maps for the 11 categories/themes that included all the sub-categories/themes.</li> <li>• To double-check my work – I took the initial codes for each participant (color-coded) and cut and paste them into a document with the 11 categories/themes. I discovered additional potential categories/themes and subcategories/themes.</li> <li>• One theme required revisiting, and most of the others were in alignment with minor adjustments.</li> <li>• I took a deeper look at my 11 themes and aligned them with my research question.</li> <li>• 11 themes were finalized into nine themes.</li> <li>• This process allowed me to fine-tune my findings and review the data again in preparation for refining the findings Chapter 4 and starting the Chapter 5 discussion.</li> <li>• Created diagrams for Chapter 5 that aligned with the narrative of the findings in Chapter 4.</li> <li>• Reported changes in the process and the reason for the changes in the use of methods and analysis.</li> </ul>

### ***Generating Initial Codes***

It was vital to keep the participants' meaning of the data content. In addition, some data had multiple codes, and I used interpretative comment codes. I took this approach because the participants provided a different lens to the same questions. The complexity of the data required descriptive initial codes to provide a trigger for me for the second round of coding. See Table 4 for more detail.

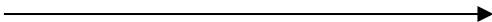
In the second round of coding, I again treated each participant independently. I needed to combine the codes in the second round because over 100 initial codes per participant were generated. To make the data more manageable. I used a new Word document. Because my interview format was semi-structured and responsive, my questions were a mixture of primary and follow-up questions driven by the conversation with each participant. Each participant's conversation was unique. Also, the participant's

answer to the question was sometimes discussed later in the conversation and not aligned with the initial question. I created another Word matrix document to keep track of each document, which included the file name.

I reused the refined codes when applicable within the interview question matrix and across interview question matrixes. Some of the amended codes used were “Implementing the TM Philosophy,” “Three Mental Poisons,” “Three Energies [*nyes pa*],” “Assessing the Patient,” and “Cause of Disorders.” My thought process was to remain close to the data while also considering how I needed to interpret the participant’s language using universal terminology. Refer to Table 5 for an example of the coding process for Phase II. At this point, I noticed there was still a need to review and refine codes. Also, I needed to merge all the data (unseparated by interview questions) to get a better picture of the categories and themes.

**Table 5***Phase II Example of Coding Process*

Inductive to deductive coding sample				
Initial code	2nd refined code	3 <sup>rd</sup> refined code	Theme	Subtheme
Tibetan medicine is very integrative	Tibetan medicine is a wholistic approach to health care	Philosophy	Applied Philosophy of Wholism	The Principles of Tibetan Medicine Define Wholism
Wholistic because it incorporates the science, art, and our philosophy				
Tibetan medicine understands integrative	The mind, body, and energy all work together			Approach to Care Is Wholistic
Do not address the body in a two-dimensional way				
Balance mind, body, energy, and emotion				
View the patient via the five elements lens or mind-body	View of the body	The body	Anatomy and Physiology of Wholism	Five Elements and Body Formation
Physical body is formed by five elements				

  
 From 3<sup>rd</sup> round of coding to theme to sub-themes

*Note:* High-Level Overview of Process Going from Initial Coding-inductive to deductive codes based on Tibetan medicine to Themes and Sub-themes

***Searching for Themes***

I needed to work offline in the third round of fine-tuning the codes and analyzing the data. It was time to start identifying categories/themes. I am a tactile and visual person, so I needed to feel the data and see colors. This approach allowed me to cross-check my colors for the 2<sup>nd</sup> level codes with the content and context of that code and apply the appropriate color. For the most extensive document of hierarchical codes (i.e., “the doctor,” “health and healing,” “five elements,” and “assessment and diagnosis”), I used index cards.

### ***Reviewing Themes***

By this point, to keep from getting deeper into analysis paralysis and the expectation of producing written content, I continued the writing process as I continued to refine codes and look for emerging themes. The three topics, whole person care, wholistic healing, and health and illness, made telling a coherent story challenging, so I merged the data one more time based on the existing category/themes. However, codes were applicable across themes to help tell the story and reinforce the concept of interconnectedness. I removed all the relevant excerpts of data into a working Word document. I saved and printed the documents with a date stamp for each significant shift in the process. See Table 4 for further details of the analysis.

### ***Defining and Renaming Themes***

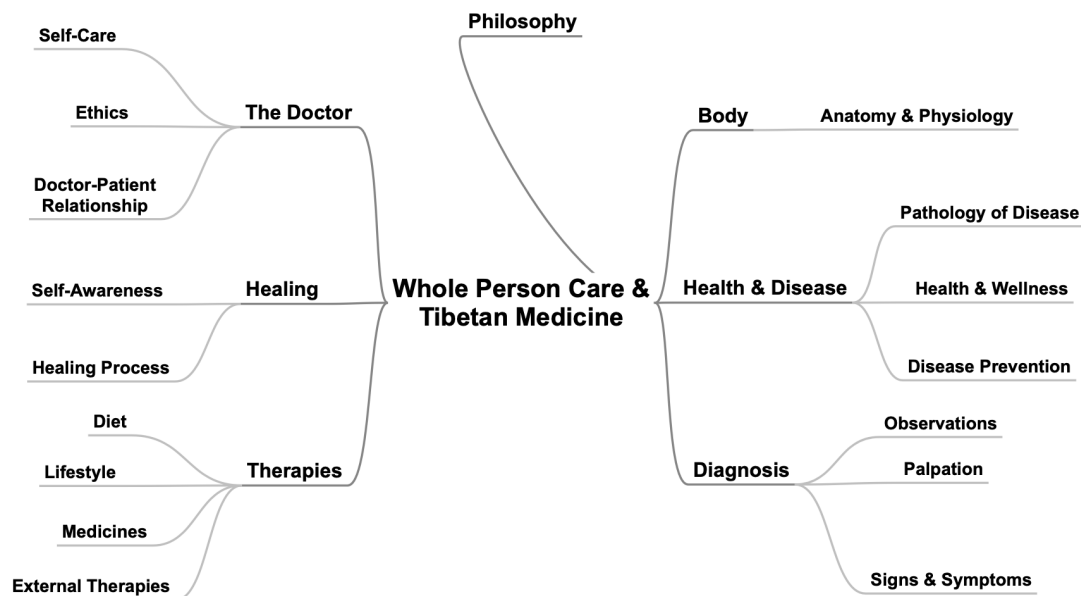
I then reviewed the category/themes and the associated content to determine if my themes were codes or if my category/themes were genuinely valid. Once I felt comfortable with the category/themes, I created subcategories based on the importance of the data extractions. See Table 4.

### ***Producing the Report***

After restructuring the data, I created another mind map of all the merged information and produced a hierarchical structure. This process allowed me to fine-tune my findings and review the data again in preparation for the last steps of the thematic analysis process, the interpretation section of Chapter 5. See Table 4 for details. See Figure 4 for an example of one of the mind maps created.

**Figure 4**

*Phase II Example of Themes Mind Mapped*



### **Evidence of Trustworthiness**

#### **Credibility**

I immersed myself in the culture of the studied population. I attended the yearly Tibet Week at Emory University and the teachings offered by Drepung Loseling Monastery. I interviewed Key Informants with a background in Tibetan medicine and knowledge of Tibetan medicine for my Phase I process. In addition, I completed a 1 year introduction to the foundations of Sowa Rigpa (Tibetan medicine) instructed by Dr. Nida Chenagtsang at the Sowa Rigpa Online Institute to assist with data analysis.

### **Confirmability**

I have double-checked my data and results with the knowledge acquired as a student in the *Sowa Rigpa* courses to ensure my understanding of the content spoken by my participants. I also had a Tibetan translator review information for terminology, cultural appropriateness, and Tibetan medicine content.

Additionally, when feeling the urge to double-check my analysis from a fresh perspective, I returned to the initial codes for all the participants' data, including comments. I sorted them based on the previously derived existing categories and subcategories. I discovered that most of the categories had minor discrepancies, and one did not align clearly with the subcategories, which required substantial revisions. My analysis and my data were a recursive process. As I wrote my findings and continuously reviewed my data, I was able to fine-tune my results. I read the relevant text to provide additional clarity from the English translation of the Four Tantras, also covered in my teachings of *Sowa Rigpa*. When further clarity was needed, I asked questions of my *Sowa Rigpa* contacts and reread the applicable section from the applicable Tantra.

### **Transferability**

I used purposeful sampling.

### **Dependability**

I kept an issue log during the analysis and writing up of findings. I created word documents of transcriptions. I coded transcriptions using the comment section of the word documents. Also, I kept contact logs during the recruitment process. As Nowell et

al. (2017) suggested, I incorporated trustworthiness within each phase of thematic analysis (Nowell et al., 2017); see Table 4.

## **Findings**

### **Phase I**

As previously mentioned, Phase I used Otto and Knight's (1977) eight principles and concepts of wholistic healing to explore the effectiveness of this form of questioning for Phase II. See Appendix B. Refined the approach to questioning for Phase II by creating a key informant physician interview guide. See Appendix A. Phase I knowledge provided insight into Phase II data collection and approach to inquiry. Again, I analyzed the data and created themes and subthemes. The findings offered additional insight into terminology that might be more beneficial when interviewing the participants in Phase II. Phase I findings revealed new areas of potential research. In addition, the results provided Western terminology that might assist in analyzing and categorizing data in Phase II. Following is a discussion of the themes and subthemes from a high-level lens. There were nine preliminary themes; these were preliminary because the data collected from the Key Informants were not the focus of the research.

#### ***Theme 1: Wholism Is Intrinsic to the System***

All four participants provided examples and stressed that Tibetan medicine embodies wholism through its diagnostic lens and practice. There is an understanding by the participants that everything is connected, mind and body are one, and the importance of looking at the whole, not symptoms or an organ, when it comes to diagnosis and treatment. I gained insight into wholism from the data through the lens of Tibetan

medicine. Wholism is personified in Tibetan medicine in the body's physiology and its relationship with nature, understanding symptomatology, illness, healing, and cultural traditions and practices. The essence of cause and effect and the interconnectedness of everything. A natural rhythm exists within all organisms and their connection to life on Earth. Self-awareness, physician-patient relationship, and approach to medicine were intrinsic factors in the phenomenon of wholism. These factors were in the education and training of TMDs. The theme made me more aware and inquisitive during the Phase II interviewing process to gain insight into how connections are made in Tibetan medicine.

***Theme 2: Nature Is Interconnected With the Physiology of the Body***

All four participants discussed how well-being, the human body, and the interconnectedness of the outside world played a role in health and disease. The participants stressed the importance of the region, environment, seasonal changes, and energetic influences within the body and the external world. These aspects are substantial in addressing the research question because they are part of understanding the phenomenon of wholism while also bringing into awareness what might be considered when addressing whole person care and wholistic healing.

***Theme 3: There Is an Interconnected Web Affecting Health and Illness***

This theme provided a biopsychosocial and psychoneuroimmunology lens to understand how the mind-body and physiological lenses used in Tibetan medicine connect. The anatomy in Tibetan medicine is the same as in Western medicine; the difference is in the philosophy of the lens. The second theme influences the biopsychosocial component within theme three. Belief systems, spirituality, and cultural



perceptions were also factors in health and illness. This theme provided a high-level lens into understanding and connecting the Tibetan medicine terminology used in Phase II. Therefore, reinforcing the participants' suggestions deepened my knowledge of Tibetan medicine terminology.

***Theme 4: There Are Many Influences of Symptomatology, Illness, and Healing***

All participants provided insights into the assessment of symptoms and the diagnostic lens used, along with the understanding that all signs are relevant, including one's behavior, lifestyle, and mental relationship to physical symptoms. This theme identifies the lens through which TMDs understand the concept of illness and disease and the components necessary for healing to occur. There is a one-to-one relationship between theme four and theme three due to the lens through which health and illness are viewed in Tibetan medicine. The link between the mind, the body, and the internal and external environment. The terminology was crucial here and assisted in my dialogue with the participants in Phase II.

***Theme 5: Self-Awareness Is Important in Healing and Physician–Patient***

***Relationships***

This theme stressed the importance of self-awareness within the physician, the patient, and the physician-patient relationship. The skills of the physician are associated with the physician's self-awareness. The physician's self-care, personal practices, health, emotions, and perceptions influence diagnostic outcomes because the physician's body is the diagnostic instrument. The treatments provided by the physician affect the patient's healing, driven by the intentions and present awareness of the practitioner. The patients'

self-awareness is through understanding their body and that nutritional intake and lifestyle affect the healing process. Treatment adherence is also crucial because of its association with the patient's behavior, reinforcing the patient-physician relationship. There is a one-to-one relationship between theme four and theme five because self-awareness influences healing.

***Theme 6: Interpersonal skills and Time Are Important in Physician–Patient Relationships***

There were several subthemes that all participants discussed, summarizing the need to meet patients through compassion, which assisted in building trust within the doctor-patient relationship. Spending time with the patient and the need for the patient to feel supported were also key factors. In addition, how adherence is related to physician trust and participatory engagement by the patient identified a one-to-one relationship between theme four and theme six.

***Theme 7: Approach to Practice/Medicine***

The participants provided additional context to the methods used in the diagnostic process, treatment, and the perception of disease in a way that I could comprehend. They stressed the importance of lineage training and self-awareness in the diagnostic process. Participants discussed the personalization aspects of the treatments within the Tibetan medicine system. I was able to grasp a fundamental understanding of wholism within the Tibetan medicine framework. The doctors' approach and practice of Tibetan medicine are interwoven with Tibetan culture. The lens used within the Tibetan medicine paradigm is fully reflected in the doctors' process and practice of Tibetan medicine.

***Theme 8: Physician Education/Training Is Important***

Here training is just as necessary in the Tibetan Medical system as in the Western medical system. Traditional doctors are extensively trained in Tibetan medicine, and it takes decades of training, practice, self-care, and self-awareness to become extraordinary. Training is key to the philosophy of wholism. One participant expressed the importance of reading and understanding Tibetan, just as one must understand English to become a Western medical doctor.

***Theme 9: Western and Tibetan Cultural Factors of Medicine***

All participants provided insight into the importance of culture and the challenges of practicing Tibetan medicine in some Western cultures, specifically the United States. Tibetan cultural understanding is key to grasping and seeing through the lens of Tibetan medicine. Personal spiritual practices and cosmology are also part of the interconnected web of Tibetan medicine. Contemplative practices, karmic understanding, and the traditional lineage path are interwoven in diagnostics, treatment, and becoming a Tibetan medical doctor. The Tibetan cultural factors of medicine and the Western policies provided insight into my recruitment process and my interaction with the participants in Phase II.

In conclusion, the interviews with the participants in Phase I helped me understand the importance of using the terminology known to the participants in Phase II. The set of questions and dialogue was appropriate for Phase I participants only. The questions for Phase II were modified to hold the context of the questions in Phase I. However, it was necessary to use Tibetan medicine terminology, not Western. I hoped to

continue with the same inquiry format, but a new list of questions was created and identified as the key informant physician interview guide. See Appendix A. Phase I provided a more profound understanding of how to use Tibetan medicine terminology to gain insight into the phenomenon of wholism.

## **Phase II**

The Canonical text consists of four tantras: detailed instructions explaining the theory, practice, diagnosis, and treatment of Tibetan medicine. It is the foundation from which Tibetan medical physicians derive their knowledge and embody the information to assist with Tibetan medical practice.

The text was a central theme when interviewing the TMDs. The *rgyud bzhi* or Four Tantras played a significant role during interviews. Some participants would recite information from the text in Tibetan during the discussion before responding to a question (to aid in accurate explanation). In addition, participants frequently directed me to the canonical texts to derive the information, answer my question, or get clarification. At times there was an expectation that I had read and had knowledge of the canonical texts. Five out of seven participants referenced the canonical text as previously mentioned. This study required a less-traditional, inter-textual and inter-discursive approach since information did not simply come directly from participants but from participants' ongoing engagements with authoritative written sources. While their essential Tibetan medical knowledge coverage is not exhaustive, the Four Medical Tantras are undeniable foundational touchstones for all formally trained TMDs. The practitioner embodies this foundational information. Therefore, I used the text to clarify

analysis or to enhance or make sense of a participant's contextualizing comments, citations, or feedback when needed.

***Theme 1: Applied Philosophy of Wholism***

The philosophy of Tibetan medicine is wholism which came through in all the participants' discourse. There is a systematic, scientific, and synergistic way in which this interconnectedness is defined within the whole person care of the Tibetan medicine paradigm. There is an invisible and, at times, concrete thread that connects the macrocosmic world to the microcosmic world (e.g., the body) and environment. The philosophy and the lens through which the doctors view the world, the systematic and scientific web, makes treating the whole person possible.

To include all the interview excerpts that support this theme under "wholism" would be limiting. Therefore, the following themes are an expansion of this knowledge that provides for all the philosophies and interconnections within each defined scope. The present theme is a contextual view and perspective.

**The Principles of Tibetan Medicine Define Wholism.** Participant PH001 clearly defined the basic principles of Tibetan medicine: "Tibetan medicine is a wholistic approach to health care, and focuses on the mind, body, and spirit... incorporated in Tibetan medicine [are] science, art, and our philosophy that provides a holistic approach to health care." Art, science, and philosophy are not only exhibited in the practice of Tibetan medicine, but the principles are embodied in the canonical text, teachings, and medical paintings. Participant PH001 continued by providing additional insights into these three principles and how they are applied:

It is a science because its principles are demonstrated in a systematic and logical framework based on [the] understanding of the body and its relationship to the environment.... It is an art because the diagnostic technique is based on the medical practitioner's insight, skills, and compassion. It is a philosophy because it includes Buddhist principles of altruism, karma, and ethics.

PH005 affirmed the importance of the philosophy and art principles: "if one is to become a good doctor, a medicine doctor without knowing [their] dharma system, cannot go too far. You are [a] medicine doctor but not knowing the art, you cannot go too far."

**Approach to Care Is Wholistic.** During the interview, it was clear that the physicians embodied wholism in their approach to care. The lens through which the doctors view their approach to health care understands that every aspect of the human experience interacts and engages in everything externally, even beyond our planetary existence. Cause and effect permeate within the interconnected web. All participants expressed similar words for wholism throughout the discussions. The participants provided examples to further clarify the meaning of wholistic and wholism from the perspective of TMDs.

[Tibetan medicine] is a very integrative healing system. And when we are treating a patient or person, it is a very wholistic treatment. ... The protocol or methods we are going to offer to the person are very wholistic; the medicine we offer is very wholistic. Tibetan medicine [doctors] understand that there are certain things like interconnectedness. The body itself is very connected ... the body itself is very wholistic, and the body itself is very integrated (PH005).

PH003 and PH006 expressed the wholistic thought process of the physician when a patient presents with an illness and when considering treatment:

So, if someone comes to you with an insomnia issue, you do not just give them medicine for insomnia because you do not really know what is causing [the] insomnia. It is very important to consider the person's wellness through the ...wholistic perspective (PH003).

You know you are not treating the patient as a whole [person] when you as a doctor when you start to [view] individual cases, individual diseases, or signs and symptoms. Then you are not really able to treat the patient as a whole. I tell my patient that if you start to look at the small issues, then we will miss the main bus... this is one example of how Tibetan doctors are taught to look at [their] patients through the wholistic paradigm (PH006).

### ***Theme 2 The Anatomy and Physiology of Wholism***

The participants provided detailed insights into the physiological wholistic lens through which the physician viewed the body. Through this lens, the scientific principles and philosophy of Tibetan medicine begin to take shape within the practice of medicine. The lens is an intricate web connecting the external and cosmic world to the body's anatomy and the energetic system. It is here where psychoneuroimmunology comes to life through the practice of Tibetan medicine. The terminology used by the participants is different but more inclusive to connecting the external and cosmic world to the energetic and physiological systems. The language used by the participants is either defined in Chapter 2 or explained in the excerpts provided.

**Cosmology, Channels, and Body Formation.** Here, the participants poetically described the formation of the bodily energies and the interconnectedness between the body and the Universe. The discussions provided a foundational understanding of the interconnected thread from the external world that moves through the body's physiology, diagnosis, and treatment. Two of the seven participants mentioned cosmology. However, the following is a description of one participant's excerpt; PH006 spoke on these themes very directly:

Tibetan medicine teaches us that we enjoy a direct relationship with our Mother Nature. And our mother nature is a form of a Universe, and our Universe is sustained by this birth energy, solar energy, lunar energy, and without which, the Universe goes into chaos...Similarly, our body system is kind of a microcosmic world, [the] Universe has a macrocosmic world, and we enjoy the direct kind of interrelationship.

...from the very beginning of the formation ..., you have the consciousness that comes into being. Then you have the karmic kind of influence that comes into being. Then you have the most important influences from the quiet cosmic systems physical elements we call (speaking Tibetan) *joongwa nga* ('*byung ba lnga*) ...and from all these very subtle, very powerful energies, then in the body especially at the navel, there are two branches; actually, we call the branches, the central channel which is called (speaking Tibetan) *dbu ma*.



**The Central Channel Is an Energetic System.** Based on my coursework and understanding, it is like the central nervous system but not a one-to-one relationship.

Participant PH006 further explained the role of the central channel at a general level:

That imaginary, the central channel that is, there is *very, very, very, very highly important, very highly, highly powerful* [emphasis added], but you don't see it; it is more imaginary. *But from that central channel* [said with emphasis], there is the right side ...we call *ro ma*, it carries the solar energy, which is like heat in the body system. From the left, the lunar energy is the cold element of the body system, with the central chakra.... Then finally, our body forms.

... Then, slowly, steadily, the physical bodily constitutions come into play. It is very important to look upon your patient [as] a universe type. And you should try to see how best you can balance these two very hearted, very important dual-energy systems. Because then we believe that you will be able to restore the balance. And balance is health. This is one ... example of how the Tibetan doctors are taught to look upon your patients ... through the Wholistic paradigm.

**Five Elements and Body Formation.** All participants mentioned the five elements. There is an energetic system interconnecting physiology to diet and lifestyle, the planetary system, and all interactions. The internal and external energies of the five elements are considered “the bridge between (PH003)” the microcosmic body and the macrocosmic world previously discussed by PH006. Participant PH001 provided a detailed account of the relationship between the five elements and the formation of the

body, giving insight into the intricate and invisible thread that exists between living organisms and the macrocosm:

At the moment of conception, when the fetus is formed in the womb, so are the five elements, which are also responsible for forming the bitters. Let's say Earth is responsible for, master of tissue and bone and sense of smell, ... and the Water element is responsible for fluid, like blood. And other fluids in the body, and the tongue, and the sense of taste. The Fire element is responsible for the body temperature, digestion and complexion and eye, and vision. And the air is possible for expression, breathing skin, and a sense of touch. You know space is responsible for the vitality of the earth, and the five elements also act as its foundation of forming the body.

**Physiology, Emotions, and Energetic Systems Interrelationships.** All the participants expressed how theory and philosophy interconnect with the physiological aspects of the human body. The participants introduced another energetic system that linked the five elements to emotions and physical body functions. In the following excerpt, PH001 discusses the three principle humoral energies (*nyes pa*; see Chapter 2) while also addressing the science and philosophy principles. PH001 is the only participant that identified the three humoral energies (*rlung*, *mkhris pa*, and *bad kan*) as a spiritual phenomenon.

There are three principle energies which are important; wind energy in Tibetan is *rlung*, it is the air principle that is responsible for circulation, breathing, and sensory organs and movement, and elimination, most importantly, psychological,

neurological function. The second energy is called bile or *trīpa*, which is associated with the fire element and is responsible for metabolic function, temperature, complexion, and digestion. Most importantly, the mental aspect, determination, and understanding. The third energy is called *bad kan*. *Bad kan* is also the earth and water element responsible for forming the physical structure, maintaining mental stability and sleep, and weight management. The Attachment [*rlung*] also you will see is a kind of desire. And hatred, and anger [*mkhris pa*], and delusion is kind of ignorance [*bad kan*], and in that connection; These are the spiritual aspects that are very important.

The medical connection made to the spiritual aspects by PH001 is a standard principle in *Sowa Rigpa*. Although other participants did not discuss the link, the fundamental teaching in *Sowa Rigpa* correlates the emotional states (desire/attachment; anger/hatred; ignorance-delusion) with the three *nyes pa*.

**Nondualistic View of Mind and Body.** The mind plays an essential role in the healing and manifestation of disorders. The energetic systems previously described provided some insights into the cause-and-effect relationship in the presentation of conditions. All participants expressed a belief in/confidence in the non-dualistic nature of mind and body in the approach and practice of *Sowa Rigpa*. Participant PH001 stated, “when I see a patient, I treat a whole person. Not a partial [part] of the body or not dividing the mind and the body separately....” Energy is also part of the mind and body connection. According to PH004, “We in Tibetan medicine see that the human body is

not just the body. It is the combination of mind and energy ... mind and energy and the body, work together, survive together.”

Two participants provided excellent analogies on the body within the context of non-dualism and health:

Like body-mind, the body is like the house, and the mind is like the guest. ... So, between both, there is an interdependent relationship; they are not separate. If the body is not happy, the mind is not happy. If the mind is not happy, it can affect the body (PH005).

Because we are guests, tenants, and our bodies [like] a house, and, if you get good tenants in your body..., your house is kept clean, and your house is nice, you keep it longer. If you have bad tenants, then your house is destroyed very fast (PH002).

### ***Theme 3: Pathology of Disease***

All participants discussed disease pathology and the concepts underlying the cause of disorders. Identifying imbalances within the patient’s physiology requires an in-depth inquiry into every aspect of the patient’s existence. An in-depth investigation is needed to get to the root of the problem, so everything is significant during diagnosis. Various lenses are used to discover the root cause of the imbalances that connect the external world with the inner world. The physicians at this stage attempted to identify the imbalances in order “to restore the balance and balance is health,” as previously expressed by PH006. Through this understanding, the appropriate treatment applied assists in restoring homeostasis or balancing the physiological system.

**Cause of Illness and Disorder.** Imbalances within the energetic systems are presented as the cause of conditions and are expressed by participants using various terminology. PH007 suggested the “distance cause is our ignorance. Ignorance causes the three mental poisons. And the three mental poisons cause the three humors. That is why Tibetan medicine always considers the cause of the disease is our mental affliction.” Psychological effects on health are “95%,” according to PH002. Therefore, linking the three mental poisons and the spiritual aspects, as previously mentioned by PH001, provides additional insight into the principle of philosophy. Adding to the discussion of causation is PH001, at the “Immediate level are the four causative factors such as diet, lifestyle, season, and evil spirit.”

[The energetic system of the five elements contributes to causation because] the five elements are the mental and bodybuilding elements. So, each of them has their own function on mental health and physical health. And when disturbed or become excess or deficient, we start to have a clinical condition (PH003).

Participant PH002 adds to the discussion by stating: All these illnesses come from air [i.e., *rlung*], phlegm, and bile, also five elements. That’s why we have, actually, two diseases. Excess and deficient, so very important in treating, to balance the body...And why Tibetan [medicine] doctors have to also do astrology is because we believe there are three causes of disease, karma disease, obstacle disease, and natural disease, so we do astrology to determine what kind of disease you have.

PH006 asserted that the cause can also be connected to the solar and lunar energies because “there are no diseases on this earth, which doesn’t come under the category of either hot disease or cold disease.”

**Example of Disorders as It Relates to the Cause.** Here, the participants applied the Tibetan medicine terminology to familiar illnesses to provide a clearer understanding of the disease or disorder’s root cause from the physician’s assessment lens. For example, PH004 used the terms primary and secondary to isolate the causes of tuberculosis. The “Primary cause of tuberculosis is the bacteria; the secondary cause may be their poor nutrition, of course, sanitation and hygiene” (PH004).

PH006 reinforced the emotional connection through the lens of thyroid conditions: if you look at the emotion, like in hypothyroid conditions. I think I would say almost 99% of hypothyroid patients have emotional issues. Disease stems from emotions. And it is not an aggressive emotion; it is more of a passive emotion. Aggressive emotion doesn’t give rise to a hypothyroid condition; it may give rise to something like more of a hyperthyroid condition, which is ... comparatively less. But the majority of people have this hypothyroid condition. And if you look at the trend of the disease, more females have hypothyroid conditions because we believe that females the women are more emotional.

***Physical Disorders: Lifestyle and Diet.*** Previously PH001 identified lifestyle and diet as a cause of disorders. PH006 discussed the manifestation of diabetes as an example:

For instance, you can say diabetes is more of a food and lifestyle... the vegetables, like mostly potatoes, and you know radish, and beans are starchier and sugar-based foods ... sugar, butter, and milk, ... physically activity is coming [slower]. People are hooked more on their chairs and their computers, you know, ..., not much physical exercise this moment.

***Digestion.*** How the body processes, food is another cause of illness and was discussed by participants.

If the digestive system or digestive biome becomes disordered or deficient, millions of malaises are probably literally saturated and cause a problem; internal health conditions will rise from there... Diabetic condition, cholesterol, weight gain, all are coming from digestive fire deficiency, including kidney (PH003).

“Diabetes.... low metabolic activation starts in the body system. Your whole digestive system especially, you know in the liver, pancreas, and stomach they become um very, very, very, slow” (PH006). PH005 provided a case example of arthritis:

When we are looking at arthritis, its focus is on the bones, not inside the stomach, not on the liver, but we are looking at why this joint is operating this way. There are several causes or condition factors, but the root goes back to why it is not working, which is indigestion ... then it’s the digestive system. ...the arthritis joint is the symptom, not the problem, not the disease.

***Psychological Illness.*** PH002 provided an example from the assessment perspective reinforcing the cause of mental imbalances from their viewpoint.

You have a patient psychologically ill ... they always have an excess of air [rlung]; then we interview them, we can find out the logic of the mental illness, then physically, basically we can then check the proper organs and then which ones have excess and which ones are deficient. And then we check air [rlung], phlegm [bad kan], and bile [mkhris pa].

***The Use of Astrology Aids in Pinpointing the Root Cause.*** Participants PH005 and PH002 provided additional information on the topic of astrology.

I think the liver is the problem and treat it, but the liver is not getting better. So, then we do astrology, to bring something that is invisible, that is beyond the doctors' concept, beyond the doctors' concept is like hidden information by astrology ... In Tibetan medicine, ...want to be a good doctor, you need to learn astrology (PH005).

First, my patients come in, and I provide them with herbs or acupuncture, massage, [etc.]. I think that is the best for them and provide that, but if [the treatment does] not help them, then I just do astrology and take my astrology as part of my log/learning, I took in the office with the patient, so I check them.

What kind of disease is it, is that karma disease? Or natural disease or obstacle disease (PH002).

#### ***Theme 4: Health and Wellness***

Maintaining health requires constantly balancing the body's physiology, which is driven by internal and external factors. All participants addressed the importance of balance in maintaining health and preventing disorders. The lenses used to balance the



body in treatment and maintain health are the five elements and humoral and astrological energies. However, only one discussed the role cosmological energies play in restoring homeostasis. Following is a discussion by participant PH006 explaining how to balance the body for health while expressing that the individual or patient is also responsible for maintaining the balance. Maintaining the body's homeostasis is through knowing and understanding one's body:

You would say my kind of body comes with an energetic disposition that is more of a lunar one, so now I should balance it by avoiding all these cold conditions, and cold effect. ... Therefore, this is a fundamental issue. If you understand this dual energetical kind of function in your body system, then you really know how to balance your body. And you know how to select your food also. If you have more of a lunar energetical disposition and want to balance it, you should try to select foods that are more heating, like more warm soups, foods that improve your body heat condition.

On the other hand, if you have more of a solar energy type of feeling, like high blood pressure or an infection in the liver, where your body tends to be physically a little hot; and your eyes tend to have a little reddishness, you have a headache, you are sweating, you feel your body is very hot, you say, oh my body has more of a solar impact. So, therefore I should cool down my body system, try to balance it by resting myself in cooler climate conditions, taking some more chilling, more cooling kind of foods and drinks. That is why we say know your body system, manage your health.

Participant PH004 reinforced that it is the individual's responsibility to become aware that there is "a subtle energy that always connects our body and mind ... we have to consider working at trying to balance our mind, body, energy, and emotion."

***Theme 5: Disease Prevention***

Five out of seven participants specifically mentioned prevention and health; however, it was implied throughout all the interviews when discussing Tibetan medicine. As previously discussed, health is a state of balance between the mind, body, and energetic system. And there is an understanding that there is cause and effect, constantly interacting and engaging with the external world. The participants affirmed that prevention helps maintain balance within the intricate web between the body and the macrocosmic world. Health and prevention are essential within the whole person care phenomenon and the Tibetan medicine paradigm.

Overall, Tibetan medicine starts with prevention using herbs and pulse and urine diagnosis to detect imbalances. It is the belief that treatment is prevention (PH007, paraphrased). Mental health is vital for general well-being along with diet, lifestyle, and seasonal and regional effects. Public health awareness and education are also effective ways to aid in disease prevention. Four participants discussed in length various aspects of prevention. Following are two participants' comments on disease prevention, the four factors.

**Prevention Begins with the Patient.** According to PH006, people don't really take much care in prevention and how to understand the different types of diseases, like Hepatitis B and Tuberculosis [This speaks to the importance of

public health awareness as a preventative measure]. People should really take an interest, not only in taking medicines, especially disease prevention first. Because it is important that, you know, the first kind of step toward ... disease prevention starts from you.

**Four Important Components of Disease Prevention.** The participants mentioned that diet, lifestyle, mental aspects, and seasons and regions are associated with disease prevention. These are some of the factors PH001 noted as causation; hence logically, they would be components for prevention. Participant PH006 shared

diet in Tibetan medicine is *very, very*, important because selection of the proper diet, helps you to balance, aggravation of *nyes pa*, *rlung*, *mkhris pa*, and *bad kan* in your body systems. Where you can have more *rlung*, ... Then what kind of food do you select to pacify the *rlung*? To balance the *rlung*. ... These teachings are very, very rich in our medical text! The ancient, old, the classical medical text. And then lifestyle. These two are the most important factors, most important. Food and lifestyle are very important.

Participant PH003 also contributed to the diet and lifestyle discussion:

Prevention is built from diet, lifestyle, and nutrition. Treatment from all those methods, plus you actually give medicine, which are the herbs for us. Then you do rituals, you do some different healing systems. Like some people do sound healing, some people do meditation, some people do yoga, some people do, like rituals, like a chanting, mantra kind of thing.

The mental aspects of prevention are discussed by PH006 when describing the effects words and thoughts have on health.

[The mental aspects are the] third one. We say mental, how you really look at things, your mental aspects, your psychological aspects. These things act according to the Tibetan medical system, what we call mind, body, and speech. How the mind plays a part ... every time, when you talk, when you gossip, ... how it really plays a role in spreading the positivity, ...spreading the negativity. And how your own speech, how your own communication, in your own life, [affects] health.

Seasons and Region are the final discussion points on prevention provided by PH006, and here is where cosmology plays a role in health:

And the fourth, is seasonal factors. Seasonal factors are a very big, big subject! It is not only the season; it is also the cosmology that comes into being. ... And each season brings up different changes in biodiversity—your own kind of, you know, flora and fauna. And the lives, the animals, the insects, the vegetation...we follow this dynamic interrelationship in the microcosmic world and the macrocosmic world. So, based on that, you need your body system; you need to adjust your own kind of diet and lifestyle and where you stay according to the changing seasons. Part of the bigger aspects is to keep yourself healthy and in harmony with your mother nature. So, these are the four things that we generally follow as part of the traditional Tibetan medical systems in the way of the preventative health education and preventive health approach.

***Theme 6: Patient Assessment and Diagnostics***

TMDs diagnose and assess disorders without the use of technical instruments. In Tibetan medicine, when meeting with a patient, all information is relative and provides a clue into the patient's present state. The physician's approach to diagnosis, with the doctor's body being the instrument, requires a firm grounding presence and intuitive component that flows fluidly through the engaged interaction between the doctor and patient. Here, the doctor's self-care practices, the wholistic lens of the body, and the scientific web interconnect to support the doctor's diagnostic process. The principles of philosophy, science, and art are applied.

Doctors use observation, the pulse, health history, and inquiry. All "symptoms are very important for the clinician to identify the problem. So, if [the patient] is taking medication, that means we don't have the data" (PH005). What PH005 is inferring is that medication, for example, biomedicines, does not allow an accurate data reading because the medication minimizes or relieves the symptoms. The physicians' considered other factors when diagnosing and assessing the patient, as previously mentioned, which are astrology, seasonal conditions, regional conditions, the time-of-day symptoms manifest, diet, and lifestyle. All participants discussed assessing the patient.

**The Use of the Senses.** The physician must be alert, fully present, and engaged with the patient when using the body as a diagnostic tool. Participants expressed how they engage with their patients using their diagnostic tools. Participant PH002 described their experience of reading the pulse and how they use their fingers to sense the *nyes pa* energies and state of the imbalances to assess the health of the patient:

The pulse reading, under your fingers, three fingers, like air, phlegm, and bile.

Then we have like a heart, lung, and liver. Like those come from under your fingers. Then you have the pulse. So that's mostly a feeling that I cannot explain.

You check, which one is excess, and which one is deficient ... each finger represents the three air [*rlung*], phlegm [*bad kan*], bile [*mkhris pa*], and the different elements. Each finger represents the organs, like heart, lungs, liver. And then you have a feeling. That's a feeling and that [as they chuckle] I cannot explain that to you. It's uh, feeling. You have to experience it. Because the urine check is just visible, you know. But to check, the pulse is invisible.

Participant PH007 expressed why they find the pulse diagnosis indispensable for collecting vitals.

[Suppose] I ask questions before the pulse diagnosis and urine analysis, which doesn't help; that's why I don't like to do that. *Rlung* covers a lot of information.

That's just keeping with the way an ordinary traditional Tibetan Doctor of Medicine diagnoses. Other doctors have a list of questions to give to the patient and wait for the patient to answer the questions. I focus on reading the pulse ...

The pulse and urine diagnosis together give a lot of questions [and answers] regarding the pulse and urine. Then I ask the questions to the patient.

Participant PH001 provided insight into their diagnostic approach using sight and auditory skills:

So, when I see a patient, I observe from the start, when the patient enters the room, their walking, body built, and appearance. And their presentation and the

energy; how the person engages or speaks. Visually, I mostly look at the tongue; I look at the urine sample; I look at the abnormalities and the body appearances ... the color of the skin, all of that, and if they laugh or not. And if some people seem to really be sad and happy and low energy all that (PH001).

Participant PH006 described an experience of an assessment using the sense of touch, sight, and hearing:

Of course, another way is also, through looking at the physical characteristics, you know. And which is very important, which is also so very, very, very important. When touching your hand, I could feel your hand was very rough, an element of roughness all over your skin. Very dry, very rough. And then the nails, look at your nails earlier it was like more bluish, there's no color. Now you can see the changes. Earlier, even your breathing ... And the way you walk, the way you talk, the way you express your thinking, the sensory functions of the movements, every activity, every movement the patient is making in front of you. It is your ... way of data mining things. So, this is the traditional way of doing things. But now, it is easy; we can at least measure things.

**Need to Spend Time Talking With the Patient.** Most doctors implied that the quality of the information the doctors gathered was from the time spent with patients.

However, PH003 stressed the importance of taking the time to collect data:

Then if you have someone [come in], I give [them] medicine or that herb, or eat this or eat that it won't work because sometimes they are malnourished and you won't find out in five minutes you have to have a longer conversation to find their

lifestyle, what is their routine, how they cook. ... So, you do need to spend time talking to [the] patient.

**Example of the Diagnostic Process During Assessments.** Participant PH005 provided an in-depth description of the diagnostic process. The participant described the interrelationship between diet, behavior, symptoms, physiology, and elements and how they related to the assessments.

[Diet and behavior] for example, if someone is drinking, say, alcohol and then somehow has heavy problem with pain and discomfort under the ribs on the right side of the body, maybe the liver function is not doing well. Then liver is his organ or fire element or the heat nature. Then maybe there is something that is not doing well. ... These are the kind of things we can connect; you know. For the behavior, if you are running every day for five miles back and forth, then you have insomnia; maybe your wind element went up ... Also, ... there are a lot of things that connect to your job and your condition. If you are more of an angry person and more like deluded, that also connects to the disease. So, for that reason, it is important to understand your behavior part. It is very important.

[The regions, elements, and time of day affect the outcome of disorders/conditions. For example,] for females, understanding your menstruation cycle condition, and then where you live in the region because different regions have different elements—then asking if the wind gets worse or better or has four seasons? Because four seasons have different elements. Or within the 24 hr, which part of the day it gets worse, or sicker because the day and the night are



different elements. Morning, noonday, evening [are] different conditions, different elements, different circumstances, plus of course your age.

PH005 continued the discussion by stating with a health history, “also, we are asking did you go to see a previous doctor? If yes, what did they say, and then if they have certain conditions, we ask them their genetic family and family conditions.”

**Mental Health Is Assessed During Intake.** TMDs assess mental imbalances during intake sessions, which was evident in their non-dualistic way of viewing the body. “In Tibetan medicine, in general, the mental health is a part of, your general well-being. [The physician] performs healthy mind, healthy body (PH003).” PH003 expressed in length mental health, the importance of awareness, signs, and symptoms:

When we have a mental imbalance or have anxiety issues, we don’t even recognize it until we get to that point. We just keep going; we drink coffee, ah, until we burn out. When you are burned out, that means you are exhausted, that you have used up what you have. So, then you must put in fire; it takes a long time to put in or out fire. So, that is one of the ways to recognize it.

So, the sign of yawning is one of mind and body imbalances. So, yawning, we normally neglect that sign. Then you feel empty, feel unwanted, and your sleep is not good. You wake up many times at night and ask for food and cannot shut your mind down. All these things are the starting point of mental imbalances. And when you sleep, you are not well-rested in the morning ... you are sleepy.

[Meaning] one of your elements is not working well; they are out of balance.

[Other symptoms] the patient ... feels pain ... The pain is unlocalized; it goes everywhere, it can be more bile, it doesn't focus in one place—unspecified pain and aches. There is sometimes shortness of breath, ... tightness in the chest, upper back, and mid back. A lot of times, they tell you, I thought I had a heart attack. I have chest pain, but I have passed all my check-ups through the doctor, EKGs ... nothing was found unhealthy according to the medical report, but they still have the pain. In ... just two patients this week, their consult was healthy with their doctor's checkup.

Participant PH003 discussed their analysis technique to assess further the type of cause of the patient's condition. Urinalysis and astrology determine which spirit provocation affects the illness or influences the patient.

We implement astrology to see what kind of spirit is being resolved. And then I have another Tibetan doctor friend who is really good at looking at urine to see what kind of spiritual component is influencing the patient. ... you check the bubble of urine; you check the sediment of the urine in that area to see which area it's [spirit] being located. Then you divide, and then the doctor will start questioning the patient.

### ***Theme 7: Treatment***

Tibetan medicine has a deep connection with interconnectedness, cause, and effect, which is interwoven in the practice of medicine. The medicine, the patient, the treatment, and the doctor-patient relationship are interconnected and interdependent, including the external environment, nature, and cosmology. Therefore, the intention

behind the medicine is always to heal. Natural treatment is often associated with being less harmful. Some people are under the impression that natural medicine is better for you because they believe there are no side effects. However, PH002 explained that “all medicines are the same. After excess, then always the side effect. The wrong medicine also has side effects. For example, you have a kidney problem. I give you liver medicine, also make you sick regardless of natural or chemical.” Participant PH007 explained further that “scientifically there is a side effect ... but [in] comparison to others [medicines], light side effect.”

Treatment is personalized, synergistic, and focuses on the root cause of the illness. Through case examples, participants explained how to view the concept of treating the root cause. PH001 provided an analogy for treating the root cause, not the symptom.

[For example,] like in the kitchen, there is a stove, and the water is boiling, but it spills over from the pan, so we are trained to add the cold water onto the pain and to reduce the splash. In Tibetan medicine, we try to reduce the fire [that caused the water to boil]. And to look at the root problem and symptom.

Participant PH003 provided an insomnia case example where the family received the treatment:

I have treated many patients when they come to see me with insomnia, but I was treating their sons or their daughters or their parents because those are the root causes of their insomnia ... So, I will provide something for the daughter or give

some advice for them. Then I do not need to do much treatment for the mother because once that issue has been resolved, then they start sleeping better.

Another example provided by PH003 on coping with imbalances affecting mental health: The basic thing we need to take care of is your eating, meaning your nutrition, diet, your lifestyle, your sleeping patterns, and your exercise. So basically, meditation, physical exercise, mind and mental exercise, breathing exercise type of thing. So those are the methods to cope with it.

**Treatments Are Based on the Type of disorder.** Recall that the types of causes of disease were natural, karma, and obstacle. Participant PH002 described these classifications and shared the treatment or remedies used based on these classifications. These classifications are important because it brings to one's awareness that all diseases and treatments are personalized, and personalization is based on the type of disorder and patient's physiological imbalances. Treatment is also personalized based on disease classification and physiological imbalances. Therefore, if the cause is known, then the form of therapy to apply is known. Following PH002 discusses the types of disorders and their associated remedies:

All diseases have medicine but different medicine. *Natural* is your lifestyle, and the food and cold or hot, then the medicine is herbs. [Then there is] ..., the massage, acupuncture, and cupping, so many different treatments. Treatments are only for natural, but natural diseases are like 75%. So, the *karma* disease is your past life. You do some bad thing, and you get a result, consequence in this life and deserved. *Karma* disease, we just ask the person clean up your karma by yourself.

I ask my patients to do meditation and pray. Also, Tibetan tradition is to do prostration because a karma disease, nobody can help you. For example, yesterday I am fighting with you, and I just did a really bad thing to you. Then tomorrow I send my brother to you to apologize. Do you forgive me? I don't think so. *Obstacles* we just visit with monks and have the spiritual ceremony and then ... get rid of your bad obstacle and evil spirits and treat that.

**The Effects of Health Information on Well-Being.** PH004 described a cancer patient case example where a patient received treatment and felt better. However, after the patient received progress results, the numbers were not in the normal range but had decreased. The patient was unable to focus on the improved health that they were experiencing. Their attention was on the test results, which caused a shift in well-being.

We also take the health of all these biomarkers, whatever they bring to the pulse. So, to see if there is a change. I had a patient; ... The patient called me and was so thankful that they were almost 98% cured. They were so happy. Terribly happy, and I was so happy to know that! But then, after some days, ... a report ... was about 500 and something, which means it's too high. But compared to ... previous situation, it was more than 900, and it was less. ... with this report, they felt rejected! ... they were not able to go to work, but now they are going to work and sleeping well; everything was going well. But after this report, they were morally very down. Then I have to provide support; then, I have to give the patient solid advice. ..., to make them emotionally well. The patient said thank you, and then they were again happy. All these reports that we get from the

hospitals are useful and important, but they are not the solution. That is the problem, you know [“you know” was softly said].

**Accessing the Progress of a Treatment Application and Terminal Conditions.**

The diagnostic measures used to assess the patient also validate the success of applied treatments and physiological imbalances. “Blood pressure pulse characteristics (BPP)” are assessed through the pulse and urine (PH006). The pulse or pulse rate can inform the outcome of a surgery. “If a surgery was successful...the pulse will be restored ... [if] the pulse gets weak ... [then it] was not a good surgery procedure (PH004).” PH004 continued the discussion and identified indicators to assess treatment progress or lack of progress:

The *external indicator* is the body weight. If the patient starts to gain weight, like in the case of a very terminal state ... that’s a good indicator ...an excellent indicator. The *internal indicator* is the diet. If the patient starts to get an appetite and starts to eat, that means the patient is responding and will survive. *The pulse indicator*, if the pulse has changed from weak and irregular to a regular and strong pulse, that means the patient will survive, that means the patient has changed by taking Tibetan medicine. If there is a complete change of pulse to regular, you know, a strong pulse, that is what you call a secret indicator. So, these three indicators are very important whether a person *survives or not*. And if after taking Tibetan medicine, if there are these things going on, we can say that, yes, Tibetan medicine has definitely an effect.

***Theme 8: Self-Awareness and Healing***

All the participants mentioned the various aspects of healing. Support systems, the patient's active role, and the energetic systems create a healthy healing environment. The patient must be an active participant in the healing process and tentative to any symptoms that arise. Symptoms are the body's form of communication. Symptoms are clues and provide insight into physiological and energetic imbalances. Self-awareness applies to both the patient and physician because the doctor and the patient are interconnected through karma, and knowing one's own body is critical. The doctor's health and perceptions related to healing the patient plays a key role in the healing process. This karmic relationship is discussed further under the doctor and doctor-patient relationship.

**The Interconnective Aspects to the Healing Process.** Here the factors that contributed to healing were linked, creating an interconnected web for recovery. None appeared to exist in isolation. TMDs "believe that the physician, the patient, the medicine, the support the patient gets from his family and friends, all work together to heal somebody (PH004)." It is also critical to be self-aware and knowledgeable of your body. "You should know how to look inside; how you feel in your body system, which is more important, much more important than that laboratory, the hematological, radiological parameters (PH006)." Self-awareness was also noted earlier by PH006 in the discussion on the cosmological effects on the body under health. PH006 posited understanding the lunar and solar energies; whether one was hot-natured or cold-natured, health could be maintained through diet and lifestyle (paraphrased).

Participant PH001 explained the patient, doctor, disease, and treatment relationship.

One thing you see that Tibetan medicine explains is that the physical body is formed by five elements; the medicines are formed by five elements; the disease is also imbalanced due to the imbalance of those five elements. So, the patient, the doctor, and the disease itself, they are all Interrelated (PH001).

**Energetic System and the Motivation to Heal.** The channels discussed by PH006 under body formation were reintroduced here as part of the healing process. “The three main channels, white is right, center one is blue, and left one is red... The healing process is very important here (PH002).” However, there is a slight discrepancy here compared to PH006’s discussion on channels; they described the right as holding the fire element, which would make it red, and the left as having the lunar energy and cold-natured, which would make it white. PH002 reversed the colors. The right is red, and the left is white. Participant PH004 discussed the energies that the clinician and the patient manipulate:

What we are trying to manage is the gross mind, the gross body, and the gross *rlung*. You see, so from that gross *rlung* we are dealing with the most gross aspect ... we have to take each person [as] somebody who wants to heal, who wants to get better with their physical illnesses ...when you speak of the subtle *rlung*, it is more connected with the energy where anyone [for example] can manipulate with yoga. And the most subtle lung is the thing that when the body and mind separate, that is very, very subtle *rlung*, which is different.



**The Role of the Mind in the Healing Process.** Here PH002 explained how thoughts affect healing and control the healing process.

If you are a happy person, no anger and no attachment, no hatred, then your body heals quite easily and is very healthy. But if you have all this anger and stress, are depressed, then it's difficult for your body [to heal]. Another example is if you buy a beautiful vehicle ... you just have an accident, and everywhere your vehicle is gutted no matter how expensive it is. Our minds are the driver, and the body is the vehicle. You can say we are the guests, and our body is a guest house.

Another example is where the patient's mind is not focused on the healing, causing the patient to distance themselves from "their natural understanding of their natural health (PH006)."

[The patient] becomes more focused on the numbers, "earlier it was four now, doctor, it has become 4.5!" I said, are you okay? Are you feeling comfortable? "Yes, I am good. I feel comfortable, my urine and everything ... But it is 4.5."

This doesn't make any sense to me (PH006).

PH006 patient case example is like PH004 case example of their patient under the effects of health information on wellbeing. The similarities stress the importance of self-awareness of one's body and natural health. They also bring attention to the personalized nature of the patient's physiology.

**Difference Between Healing and Curing: The Role of the Patient.** Participant PH006 asserted that the patient is the key to either being healed or cured of their illness. Here the concept of healing and curing can also be viewed from the lens of health and

wellness, where balance is critical—in addition to understanding the nature of the disease and the root cause (e.g., excess, deficient, karma, or natural). Even with these understandings, the patient must actively participate in the healing process.

[What] I am trying to explain to you is much more important than the treatment and the medicine which I am prescribing. My medicine, which I am prescribing, may definitely help, but the nature of your disease is much more important in the healing process. And if you don't know the nature of your disease, and if you don't participate from your side, then there will be no healing ... [you are] in for lifelong tablets, drugs, drugs, drugs, lifelong [with sadness and emphasis]. But for us, for the Wholistic System, people who believe in the wholistic kind of natural treatment, there is nothing like a *lifelong treatment*. ... every treatment, every disease can be cured, but it may be duration dependent. But for that patient who participates, a patient who understands their kind of nature of the disease, energetical dispositions, natural body constitution ... there is a 100% chance that you will become completely cured. And if you don't care, you bother only about the medicines; then there is no cure—only medicine, medicine, medicine.

***Theme 9: Doctor and Doctor–Patient Relationship***

This lens reinforced the interconnectedness within the doctor–patient relationship and the doctors' relationship with oneself, the medicines, the healing process, the internal and external elements, and the essence of the practicing physician. A karmic connection reinforces the interconnectedness within this whole-person care paradigm, a spiritual component driving the doctor-patient relationship. The doctor and the patient had an

equal part to play. The doctors' level of altruism and compassion expressed when engaging with the patient, which I experienced during our discussions, were heartwarming.

**Physician Self-Care.** All the participants mention that the practice of self-awareness, personal health, and the state of one's mind and energy are essential for the practicing physician of Tibetan medicine. To effectively treat and diagnose patients, the physician must have self-awareness because the physician's body is the instrument used to assess, analyze, and derive a treatment. Meditation and prayers are daily practices to benefit the doctor and their patient.

***Diet and Lifestyle Are Important.*** In previous discussions, diet and lifestyle were critical components for health, treatment, and disease. All aspects affiliated with the patient are relevant to the doctor.

Participant PH004 perspective: First, we have to be strong enough, physically strong, and healthy enough to treat somebody's condition. Because you know it's a lot of exchange of energy between the patient and the doctor. If the patient sees that we are not feeling well, then they won't feel comfortable ... we have to prepare ourselves with a good breakfast. Because we say, if you don't, then this will drain your energy right from the beginning of the day... emotionally, and mentally we must be strong ... too much stress, or emotionally you are not feeling good, then, that day may not be good to start with the patient. We have to take rest.

Participant PH007: For medical control. If you want to help other people if you want to heal or give treatment to them, be patient. You have to learn to keep healthy. For example, a doctor who consumes alcohol is a problem; it messes with pulse diagnoses. If you always drink alcohol every night, your mind is not so clear for diagnosis.

***Meditation and Spiritual Practices.*** Here the participants shared their personal daily practices. PH002 expressed the importance of “awareness ... I have to pray and meditate for awareness in Tibetan medicine.”

So, the physician must be emotionally strong, start the day with prayers and dedicate the whole day for the sake of the people who need your help. So, start the day with the rituals. And we always keep some kind of an energy string, or amulets or something with us so that energy, the *bla* [*a type of subtle vital force*], can stay inside our physical body and help us control everything (PH004).

Prayer for the patient...clear my mind, attention, and awareness to bring to the patient... tuning into any practice of diet, lifestyle, whatever form of medicine...I set up the intention before I start ... and ... do a little prayer to close the day (PH003).

Participant PH006: Trying to seek the blessings of the Medicine Buddha, ... to carry out his Divine wishes. Buddha’s Divine blessing is easing the suffering of sentient beings. It’s like taking the permission from the Buddha of the medicine who has given you such a wonderful extraordinary, healing knowledge ... because of his teachings.

**Doctor–Patient Relationship Expressed Through Conduct and Behavior.** All participants stressed the importance of one’s conduct and behavior in treating the patient and building trust. Grounded in the philosophy of Tibetan Medicine, the doctors were servants of humanity, exhibited compassion and altruism, and had respect for all sentient beings.

***Duty Is to be Servants of Humanity.*** PH005 provided an analogy reflecting the mindset of the physicians as the servants of humanity:

Like the father, seeing your own child as sick, the “father says, okay, I will do something for you tomorrow.” They will do everything now, or he will not say, “oh, this is expensive, I will treat you with the cheaper one” No. Or we will not say your condition is dirty, So the father is willing to touch, willing to do anything he can. I train as a physician, so now my duty is to serve humanity; it does not matter which groups or which types of age or gender. ... person material space is clean, is important [too].

“... in Tibetan medicine, we treat everyone, just like yourself and even an insect (PH001).”

***First, Do No Harm.*** Here the participants discussed what was important to honor their roles as physicians. When the physician is unable to assess the disorder, other practitioners are consulted. The Tibetan medicine model’s natural design is an integrative treatment approach. PH005 stressed the importance of doing what is best for the patient and necessary while also seeking assistance from other colleagues or traditions:

Certain conditions, like acute disease or need to have surgery... more chronic means it is harder to treat ... There is a saying in Tibetan medicine we have, like if you really know what is the cause, what is the condition, where is the problem now? How can you treat, how to treat, how long will it take the time to really treat? What would be the final result? If you know those kinds of things, then you can tell the patient the disease and work [the case] ... If not, until you understand the disease, you treat gently... if you don't know what the problem is, then it is better to send to someone ... always sending to someone who has more experience, or you discuss with someone who has experience. Or you send them to either Western medicine, or Traditional Chinese medicine, or Ayurvedic, so this is also part of the treatment. Part of your honor.

PH007 stressed the importance of treating patients from all economic backgrounds: "I treat the patient without money. They come to see me; I am okay, and I offer free treatment. That is my main purpose, just to help people."

**Doctor–Patient Relationship Is Important.** Participants shared their views and the role of cosmic forces in the relationship. Participant PH005 emphasized trust. "Between the physician and patient, trust is very important. Because if you are not trusting me and if I have very special medicine, I offer to you for free, you will not take it ..." PH001 explained a preexisting relationship between the patient and doctor exists before the first interaction occurs in the following excerpt.

... there is a karmic relationship between the physician and the patient. ...the doctor has a goal to relieve the pain of the patient and eliminate the suffering of

the patient...the patient has a goal to be free from the illness, to be healthy.... the patient, they come in to see the doctor into the office requesting help. So that kind of relationship ... for both the patient and the physician, already built. That's also based on the karmic relationship too. There's a wind energy pushing the patient needed to ... seek help. And there is a wind energy pushing the action of the karma or the doctor to see the patient ... And also, our previous karma ... our previous life karma. Or this life karma. So, there's a force, an unseen force pushing to have this relationship.

Another participant, PH002 viewed the doctor-patient relationship from a different lens: "A relationship with patients is not important ... Like me or don't like me, patients that trust me or don't trust me, that's not important, but it's important they follow the treatment."

**Compassion.** Throughout the discussion with the participants, there was a level of tenderheartedness. The participants provided detailed accounts of tenderness exhibited in doctor-patient relationships. The participants also demonstrated a level of intuition and engagement with sensory perception.

PH005 discusses the essential attributes: ... your welcome and warm heart is very important. Because the people when we see each other we can feel the other, how you are feeling to me, you know? That does not mean I am 100% understanding how you are reliable; it may be conduct, it may not. But I can tell that you are welcoming or not. So, for the patient, it is very important you welcome your warm heart because they are already suffering ..., no matter how much

experience you have, and then what you are feeling toward the person, your honesty, warm heart, your willingness, your kindness, your compassionate; those are the very important attributions.

***Role of the Doctor.*** The medical text clearly mentioned that a doctor's job was not just to give medicine. The doctor's job is to let the patient understand the nature of their disease. And together ... both doctor and patient should work together (pause) to achieve a behavioral solution (PH006, paraphrased).

**Communication Is Important.** Effective communication aids in building connections were a vital component expressed by the participants. Communication allows the physician to embody the narrative and the patient's emotions. PH003 believed "if there is a communication blockage, the patient will not understand what I am talking about, I won't understand what they are talking about, I will be unable to explain things to the patient." PH001 says to "have patience and know how to listen to the patient ... even if it takes a long time. So just discussion of conversations. So very important ... to feel the pain of the patient."

**Doctor–Patient Relationship Affects Treatment Outcome.** Here participants reinforced prior discussions expressed in the findings showing the interconnectedness within the Tibetan medicine paradigm. Participant PH004 emphasized the physician's role in healing: "We have to take each person first of all, as somebody who wants to heal, who wants to get better with their basic problem, physical illness." Participant PH001 reiterates the interconnective aspects of healing that flows over into treatment outcomes and reinforced here: "The doctor and patient have the same nature [cause and effect]"



driven by the previous life karma. ... the disease of the patient and the application of the treatment, there is a ... cause and effect relationship.” PH005 expresses other factors affecting treatment outcomes:

[The patient] comes to see you for help, and you are a little cold, then that doesn't help. If you are not welcoming and they are not trusting you, no matter how much knowledge you have or no matter what treatment you have to offer, it is not working.

### Summary

The purpose of the study was to understand the phenomenon of the practice of whole person care through the lens of a physician of Tibetan medicine. Chapter 4 presented the two phases of my data collection process. I reviewed how the data was analyzed and managed. I presented themes I believed were essential to capture the essence of how physicians of Tibetan medicine practice whole person care. The participants in Phase I, four individuals, and in Phase II, seven individuals, understood the consent form. Participants voluntarily agreed to participate in the study before the interview, either verbally or with electronic signatures. Phase I interview responses explored and assessed the language needed to comprehend Tibetan medicine and created an interview guide for Phase II participants. The responses from Phase II were examined to understand the theoretical foundation of whole systems medicine through the lens of *Sowa Rigpa*. The analysis also included assessing the participants' experiences and practices as they expressed their approach to the diagnosis and treatment of patients. The

study used a qualitative approach with an emergent design incorporating components of ethnography and phenomenology.

Participants' responses to the research question resulted in nine themes that allowed an understanding of whole person care from the lens of Tibetan medicine. The participants expressed how the principles of art, science, and philosophy are interwoven and interconnected in their practice of whole person care. Their discussions made it easy to see the web of healing in their approach to care. The participants, through many examples, specified a clear roadmap of their approach to whole person care.

The scientific principles and philosophies mentioned provided a lens to view the body, where the external world and the inner world were interconnected, allowing the assessment of many factors (e.g., seasons, social, diet) that affect health and illness. In the practice of *Sowa Rigpa*, the key to health is balancing the three humors. The three humors are where physiology, philosophy, and science meet. The three humors are the foundational thread allowing physicians to diagnose and treat disorders; health occurs when the body moves from imbalanced to balanced. The physician returns the body to a balanced state through various therapeutic approaches (e.g., herbal pharmacology, compresses, decoctions), where diet and lifestyle are the primary steps in treating the patient.

Furthermore, the participants named many assessment techniques where pulse diagnosis, observation, inquiry, and urine analysis were the primary diagnostic techniques. All four are essential. Yet the pulse diagnosis supplies a vast amount of patient health data. The principle of art is in this diagnostic technique. There is a need for

heightened awareness in the diagnostic process; therefore, the physician's self-care and self-awareness are vital to Tibetan medicine's pulse diagnosis and practice.

Additionally, in *Sowa Rigpa*, the patient has a participatory and active role in their health. Moreover, the doctor-patient relationship is key to the patient's health outcomes. The patient, doctor, and treatment are interconnected. In addition, the internal (physiology) and external environment are interdependent, including cosmology, creating a sacredness that flows throughout the practice of Sowa Rigpa. Chapter 5 will conclude with the interpretations of the findings and continue with the limitations, recommendations, and implications of this study.

## Chapter 5: Discussion, Conclusions, and Recommendations

This study was conducted to gain insight into the phenomenon of the practice of whole person care by taking a contextual view of the Tibetan medical system from physicians' perspectives related to the theory and practice of Tibetan medicine. I conducted this study to understand the components involved in treating the whole person, the interconnectedness existing in health and healing, and aspects included in a wholistic form of health care. Based on the theories and practices of Hippocrates (Lloyd, 2005), allopathic and Sowa Rigpa medicine historically share common ideals and perspectives. Allopathic medicine later diverged based on the philosophy of Descartes. Therefore, to gain insight into the phenomenon of whole person care, I chose to look through the lens of a traditional wholistic medical system. Holism and wholistic are two separate paradigms. In addition, the goal was to extend the knowledge of Tibetan medicine's doctor-patient relationship and possibly provide language to assist with understanding Tibetan medicine among Western medical practitioners and nonprofessionals. Also, I sought to provide insight into how a wholistic approach to medicine benefits both the practitioner and the patient.

Western professionals may expand their curiosity in Sowa Rigpa through increased dialogue on the treatment of chronic conditions, the mind-body relationship, potentially cost-effective clinical techniques, and methods for enhancing doctor-patient trust and relationships. Western medicine research articles were used as a bridge for a common language and to find potential mutual interest for further discourse, one of the goals of this study. The discussion intends to inform while exploring similarities and

slight differences with the hopes of finding a safe space for open exploration between the two disciplines of medicine (see Bodh et al., 2017; Samuel, 2019; Uher et al., 2020).

I completed the study using a qualitative approach with an emergent design incorporating knowledge from grounded theory, ethnography, and IPA to answer one research question: How do physicians of Tibetan medicine view treating the whole person? From a big-picture perspective, the research question addressed the critical aspects of treating the whole person. The participants provided data on Tibetan medical practices from a wholistic framework and furnished insight into how doctors of Tibetan medicine understand health, illness, and disease. I used a two-phased approach. In Phase I, I explored how knowledgeable individuals in the field discussed and addressed whole person care. I used the preliminary analysis and information from Phase I to develop the interview protocol (i.e., key informant physician interview guide) for the study's second phase (Phase II).

In Phase I, I used purposive sampling to recruit four participants as Tibetan medicine knowledge experts (e.g., scholars, professors, and trained TMDs) who were also knowledgeable in Western medicine, fluent in English, and renowned in the field of Tibetan medicine. In Phase II, I used purposive and snowball sampling to recruit seven exemplary TMDs for whom English was a second language. I used the IRB-approved protocol for my study. Phase I consisted of in-depth unstructured virtual interviews using Otto and Knight's (1977) eight principles and concepts (copyright approved) as questions. Phase II included in-depth semistructured virtual interviews using the key informant physician interview guide. Through the interviews, I collected 8 hr of data-rich

audio recordings for Phase I and 7 hr for Phase II from my four and seven participants, respectively.

### **Summary of Key Findings**

Nine themes emerged from Phase I and nine from Phase II. Table 6 provides Phase I themes and a summary of findings. Table 7 includes Phase II themes, subthemes, and an overview of the results.

**Table 6***Phase I Themes and Summary of Findings*

Theme	Summary
Wholism is intrinsic to the system	There is an understanding that everything is interconnected, mind and body are one, and the importance of looking at the whole, not just an organ or symptom, when it comes to diagnosis and treatment. The personification of wholism is in the body's physiology and its relationship with the ecological and external environment, and the understanding of symptomatology, illness, healing, and cultural traditions and practices.
The natural world is interconnected with the physiology of the body	Addressed what was important in understanding the phenomenon of wholism while also bringing aspects of whole-person care and wholistic healing into awareness. The region, the environment, the seasonal changes, and the energetic influences existing within the body and the external world were significant.
There is an interconnected web affecting health and illness	This theme presented a biopsychosocial and psychoneuroimmunology lens into understanding how the mind-body connection and the physiological lens used in Tibetan medicine connect. The physical anatomy in Tibetan medicine is the same as Western medicine; the difference is the lens used, wholistic vs. a dichotomy of mind and body, respectively.
There are many influences affecting symptomatology, illness, and healing	This theme addressed the assessment of symptoms and the understanding that all signs are relevant, including one's behavior, lifestyle, and mental relationship to physical symptoms. This theme explored the lens through which TMDs understand the concept of illness and disease and the components necessary for healing to occur.
Self-Awareness is Important in Healing and in the Physician-Patient Relationship.	This theme stressed the importance of the self-awareness of the physician, the patient, and the physician-patient relationship. The skills of the physician were associated with the physicians' self-awareness. The physician's self-care, personal practices, health, emotions, and consciousness influenced diagnostic outcomes because the body is the instrument.
Interpersonal skills and time are important in physician-patient relationships	This theme summarized the need to meet patients where they are through compassion, which aided in building trust within the doctor-patient relationship. Spending time with the patient and the need for the patient to feel supported were also key factors. In addition, participants mentioned adherence appeared to be related to physician trust as well as participatory engagement by the patient.
Approach to practice/medicine	Here the participants expressed how Tibetan culture and the lens used within the Tibetan medicine paradigm was fully reflected in the doctor's approach and practice of Tibetan medicine. Participants supplied context around the methods used in the diagnostic process, treatment, and disease causes. The participants discussed the importance of lineage training and self-awareness in the diagnostic process. Participants discussed the personalization aspects of the treatments within the Tibetan medicine system.
Physician education/training is important	Here training was just as essential in the Tibetan medical system as in the Western medical system. The traditional doctors of Tibetan medicine are extensively trained, and to become extraordinary takes years of training, practice, and self-care and self-awareness. Training was key to the philosophy of wholism.
Western and Tibetan cultural factors of medicine	This theme highlighted the importance of culture, and the challenges of practicing Tibetan medicine in some Western cultures, specifically the United States. Contemplative practices, cosmology, karmic understanding, and the traditional lineage path were interwoven in diagnosis, treatment, and becoming a TMD were addressed by the participants. The Tibetan cultural factors of medicine and the Western policies provided insight into the recruitment process for Phase II.

**Table 7***Phase II Themes, Subthemes, and Summary of Findings*

Theme	Subtheme	Summary
Applied Philosophy of Wholism	<ul style="list-style-type: none"> <li>• The Principles of Tibetan Medicine Define Wholism</li> <li>• Approach to Care is Wholistic</li> </ul>	There was a systematic, scientific, and synergistic way in which the interconnectedness was defined by participants within the whole person care Tibetan medicine paradigm. Interviewees alluded explicitly and implicitly to an invisible and, at times, concrete thread that connects the macrocosmic world to the microcosmic world (e.g., the body) and environment. This was the philosophy and the lens through which the doctors viewed the world, the systematic and scientific web, which makes treating the whole person possible.
The Anatomy and Physiology of Wholism	<ul style="list-style-type: none"> <li>• Cosmology, channels, and body formation</li> <li>• The central channel is an energetic system</li> <li>• Five elements and body formation</li> <li>• Physiology, emotions, and energetic systems interrelationships</li> <li>• Nondualistic view of mind and body</li> </ul>	Through this lens, the scientific principles and philosophy of Tibetan medicine begin to take shape within the practice of medicine. The lens is an intricate web connecting the external and cosmic world to the body's anatomy and the energetic system. It is here where the psychoneuroimmunology model of Western Medicine and discussed by Tibetan medical practitioners comes to life through the practice of Tibetan medicine.
Pathology of Disease	<ul style="list-style-type: none"> <li>• Cause of illness and disorder</li> <li>• Example of disorders as it relates to the cause</li> </ul>	Understanding the root cause was key to diagnosis and treatment. There are emotional influences and energetic imbalances impacting physiology. There are diet and lifestyle changes as well environmental and astrological implications. All might contribute to the root cause of illnesses or disorders. Participants discussed root causes contained a primary and secondary cause. And noted there are also types of causes: natural, karmic, and obstacle. To obtain insight into the physiological and energetic imbalances within the patient's physiology required an in-depth inquiry into every aspect of the patient's existence. An in-depth investigation is needed to get to the root of the problem, so everything is relevant during diagnosis. Through this understanding, the physician can apply the appropriate treatment to aid in regaining homeostasis or rebalancing the physiological system.
Health and Wellness		This theme addressed that health is a state of balance between the mind, body, and energetic system with the understanding that there is cause and effect constantly interacting and engaging with the external world
Disease Prevention	<ul style="list-style-type: none"> <li>• Prevention begins with the patient</li> <li>• There are four important components of disease</li> <li>• Prevention</li> </ul>	It showed the concept of prevention and ways to support health.
Patient Assessment and Diagnostics	<ul style="list-style-type: none"> <li>• The use of the Senses</li> <li>• Need to spend time talking with the patient</li> <li>• Example of the diagnostic process during assessments</li> <li>• Mental health is assessed during intake</li> </ul>	This theme addressed how Tibetan medicine doctors traditionally diagnosed and assessed disorders without the use of modern technical instruments. Tibetan medical practitioners use traditional and modern biomedical tests in diagnoses today. The physician's approach to diagnosis with the doctor's body being the instrument requires a firm grounding presence and intuitive component that flows fluidly through the engaged interaction between the doctor and patient. Here, the doctor's self-care practices, and the wholistic lens of the body aid the doctor's diagnostic process
Treatment	<ul style="list-style-type: none"> <li>• Treatments are based on the type of disorder</li> <li>• The effects of health information on well-being</li> </ul>	Discussed how the doctors' applied treatments and assessed the progress. The theme also addressed the effects of patient's beliefs during the healing process. This theme showed how Tibetan medicine has a deep connection with the sacred, which is interwoven in the practice of



Theme	Subtheme	Summary
	<ul style="list-style-type: none"> <li>• Accessing the progress of a treatment application and terminal conditions</li> </ul>	medicine. The intention behind the therapy is always to heal. Here the causes of diseases are treated based on the classification of illnesses where therapeutic treatments are reserved for natural causes. Karmic and obstacle causes use other methods (e.g., prayer, mantra, meditation, yoga). Treatments are personalized and work synergistically based on the patients' constitution, the individual physiological assessment, and imbalances.
Self-Awareness and Healing	<ul style="list-style-type: none"> <li>• The interconnective aspects to the healing process</li> </ul>	This theme revealed how support systems (family, spiritual, social), the patient's active role, and energetic systems were influential factors in creating a healthy healing environment.
The Doctor and Doctor-Patient Relationship	<ul style="list-style-type: none"> <li>• Physician Self-Care</li> <li>• Doctor-Patient relationship expressed through conduct &amp; behavior</li> <li>• Doctor-Patient relationship is important</li> <li>• Communication is important</li> <li>• Doctor-Patient relationship affects treatment outcome</li> </ul>	Discussed the role of the doctor and the importance of the doctor's self-care. The important components within the doctor-patient relationship are identified. This lens reinforced the interconnectedness existing in this paradigm within the doctor-patient relationship and the doctors' relationship with oneself, the medicines, the healing process, the internal and external elements, and the essence of the practicing physician.

In summary, the findings from Phase I served as a foundational bridge for recruitment and understanding of Tibetan medicine from researchers, scholars, and recent graduates holding the title of *smān pa (menpa)* or *bka' bcu pa (kachūpa)* in the field. Phase I presented insights as intended, leading to the key informant physician interview guide. Only a preliminary analysis of the data was necessary. The next section contains the in-depth interpretation and discussion of the Phase II findings. The discussion continues with the study's limitations, recommendations, and implications.

### Interpretation of the Findings

The research question in this study focused on whole person care as experienced by formally and traditionally trained TMDs. The seven participants in this study discussed the philosophy, diagnosis, treatment, and practice from their individual perspectives and experiences. The interpretation and discussion of the findings are based on insights and understandings from interviewing the participants. The interpretations are merely a high-level view in its most simplistic form.

The traditional Tibetan medicine framework informed the interpretations (Chenagstang, 2018; Gonpo, 2011a). I used the tree of *health and disease*, *the tree of diagnosis*, and *the tree of treatment* to aid in interpreting the findings in this study to extend the knowledge of the discipline discussed in Chapter 2. Engil (2014) discussion on the use of trees as a mnemonic device aligns with this approach. According to Sabernig's (2020) discussion in "The Trees of Nosology in Tibetan Medicine," mapping or trees allows the learner to understand and explain "the content of the teachings" (p. 241). In the discussion on traditional ecological knowledge (TEK), Indigenous teachings such as Tibetan medicine are best described using the framework in which they are taught (Berkes, 1993). Therefore, replicated pencil hand drawings (see Chenagstang, 2018; Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort) provide insight into the complex associations that make whole person care possible.

Chapter 2 included authentic tree and channel drawings used in *Sowa Rigpa*. The trees in this section are used to discuss the findings of this study. The trees and images discussed are visual representations displaying medical information, as mentioned by Chenagtsang (2018), derived from the medical instructions in the *rgyud bzhi*. Traditionally the medical information is mapped on trunks, branches, and leaves, as described by Tidwell (2017). The trees display physiology, diagnostic processes, illness, and treatment based on the medical knowledge and teachings from the *rgyud bzhi*. Participants, in their discussions, noted many of the concepts shown on the trees. The participants also often referenced (i.e., spoke in Tibetan) the *rgyud bzhi*, recommended as suggested reading or recited information from this canonical text to aid with recall.

### **Philosophy of Whole Person Care**

Throughout the discourse with the participants, whole person care included a collective of factors as inputs to view the patient through the lens of wholeness. Participants expressed the interconnected and integrated aspects existing within the body, including its connection to the surrounding environment (e.g., social, cultural) and outer world (e.g., astrological influences). These findings align with Thomas et al.'s (2020b) study, where Australian general practitioners stressed the importance of viewing the patient through a multidimensional lens. The Australian general practitioners emphasized whole person care goes beyond the biomedical lens where the following were essential inclusions to treatment: team-based care (e.g., collaborative care), family, psychological and emotional health, culture, worldview, spirituality, health attitudes, stage within the development lifespan, and social determinants. Those results support many views and practices of the participants in the present study. In addition, participants in the present study discussed collaborating with other physicians and including family as a potential factor in symptomatology. Thomas et al.'s research also support these findings.

The participants expressed that Tibetan medicine embodies wholism and whole person care, which is also exhibited in all the themes. The present study found, throughout all nine themes, wholism in the practice of *Sowa Rigpa* encompasses understanding the oneness and connection that exist with the common physiological nature, natural environment, earth and cosmology, plants and trees, and all sentient beings. The participants in this study noted how these factors affected health and disease and incorporated them in their discussion on philosophy, anatomy, diagnostics, and

treatment in their patient care. The findings in this study are supported by Sturmberg et al.'s (2019) research on the interactions and interdependencies between health and disease. These authors discussed the complex network existing between the external (socio-cultural, environment, political) and internal (physiological, psychological) factors where the internal factors are constantly communicating within a psychophysiological network at the cell and organ level. The complex systems approach identified by the researchers supports the philosophy of wholism as described by the participants of *Sowa Rigpa* in the present study.

Participants also discussed the energetic systems (e.g., nyes pa, five elements) of *Sowa Rigpa*. Participants stressed the importance of balancing the mind, energy, and body. In their discussions, energy permeates everything, and the participants expressed through their explanations of the energetic systems how physicians incorporate their understanding of energy in the practice of *Sowa Rigpa*. These findings support the seminal work of Otto and Knight (1977), where the basic principles of wholistic healing address the human body as a complex electrochemical subsystem where imbalances within these systems contribute to the cause of disease. Throughout the discussions with the participants, there appeared to be a sense that sacredness also exists between all living organisms and the ecological systems in which they live. There was an understanding by the participants that nothing exists in isolation; all things are interconnected and interdependent, further supporting Sturmberg et al.'s (2019) work.

The participants in this study view the approach to care through a wholistic lens, whereas the philosophy of allopathic medicine uses a reductionistic lens in its approach

to treating illnesses (Godman & Kingma, 2013; Cassell, 2012; Leder, 1992;). Theise's (2009) research on cell biology and Tibetan medicine suggests that allopathic medicine and biology use cell theory to address disease in the anatomy and physiology in the Western medical model. Cell theory requires a limited lens where "some bodily phenomena may remain resistant to cell-based hypothesis formation and testing" (p. 268). However, the three approaches within the Western medical model that expand the non-dualistic way of thinking and appear to align with and support the philosophy of Sowa Rigpa are the practice of naturopathy (Fleming & Gutknecht, 2010), the biopsychosocial model (Engel, 1977), and psychoneuroimmunology—inflammation in mental illness (Lee & Giuliani, 2019), immune system and homeostasis (Soria et al., 2018), and chronic stress (Straub & Cutolo, 2018). One participant specifically associated the lens of Sowa Rigpa with psychoneuroimmunology.

### ***Incorporating Whole Person Care***

Thomas et al. (2020c) found several factors affected the practitioners' ability to apply whole person care: time investment, interpersonal doctor-patient relationship, the perceived value of whole person care, the funding structure of whole person care within the health care system, the relationship between care providers, and the structure of the practice. Those factors were not concerns of participants in the present study. Participants discussed the systems in place for prevention and ethical practices, including the doctor-patient relationship. The participants also expressed that their practice of care embodied wholism, they invested time in patient care, and collaboration was part of the practice.

One participant stated that collaboration with practitioners of other medical traditions or referring the patient is part of the TMDs' honor.

Thomas et al. (2020c) suggested offsetting the challenges found in their study with increased access to care (e.g., home visits; co-location providers), longer intake sessions, and multiple visits. Furthermore, including family members as part of the care team and increasing education on whole person care to the general population. Those suggestions are most relevant and align with the approaches used and discussed by participants in the present study that exist within their practice. In addition, the authors noted that patients need to be open to whole person care and prevention. Moreover, for the doctor to develop communication skills and the doctor–patient relationship while also practicing self-awareness were essential in the practice of whole person care. Participants' medical practice in this study naturally incorporated Thomas et al.'s suggestions.

The study supports the theoretical approach of a non-dualistic approach to whole person care. The participants mentioned that physicians do not consider the mind and body as separate entities within the philosophy of Sowa Rigpa. They noted through their discussion of the connection between physiology, emotions, and the energetic systems under the anatomy and physiology theme that these connections aid in linking the mind and body. The participants also reported that the mind is the primary cause of illness, thereby supporting the seminal work by Adler and Cohen (1993). In addition, appearing to support the fourth principle of TEK defined by Berkes (1993), “that mind and matter are one” (p. 4).

Moreover, the literature supports a standardized and organized approach to assessing the mind-body connection and ecological interactions within the patient via the *nyes pa* (Dakpa & Dodson-Lavelle, 2009a; Ergil, 2014; Dönden & Hopkins, 1986). The discussion of the findings continues by providing insight into the systematically organized lens used by participants, *Sowa Rigpa* medical practitioners. The participants' discussion on the foundational philosophy of *Sowa Rigpa* opens the door for continued debate on the Cartesian way of thinking within Western medicine.

### ***The Body***

The findings under the theme of the *anatomy and physiology of wholism* are vital because they provide a glimpse into how physicians diagnose and practice using a wholistic lens when caring for the patient. Participants provided descriptions and explained the role of the *nyes pa* (or three humors) in their discussions on the role and functions of *rlung* (e.g., circulation, elimination, psychology), *mkhris pa* (e.g., metabolic function), and *bad kan* (e.g., mental stability). Historically, similarly supporting these findings is Hippocrates's use of the four humors (e.g., phlegm, yellow bile, blood, and black bile) as part of the theory and practice of Western medicine (Lloyd, 2005).

Another participant detailed the active role of the *five elements*, for example, in *bodily fluid, tissue and bone, and temperature regulation*. Hippocrates used similar terminology (e.g., taste, hot and cold) and categorizations (e.g., elements, seasons) to corresponding humors as a lens to view anatomy and physiology (Lloyd, 2005). Through the description of the *five elements* (internal and external) and the linkage to the three humors by participants in the present study, it was clear that these energies played an

active and significant role in anatomy and physiology. These findings are consistent with the discussion on the physiological processes of the *nyes pa* by Rapgay (2005), where the *nyes pa* govern physiology, psychology, and physiopathology. For example, *rlung* with the nervous system and heart, *mkhris pa* with the endocrine system and liver, and *bad kan* with the lymphatic systems and stomach.

Samuel's (2019) discussion on mental illnesses and the subtle body links Western medical concepts with Tibetan medical concepts. The researcher dialogues on the similarities between the subtle body and allopathic medicine's neurophysiology of the autonomic nervous systems. Similar findings were found in the present study, where participants noted that *rlung* was associated with psychological and neurological functioning. One participant reported that patients with psychological disorders tend to have an excess of *rlung* energy. Samuel continued the discussion, asserting further linkages between *rlung* energy and the concept of consciousness within the endocrine and autonomic nervous systems. Yet, the author understands that it is difficult to ensure an absolute relationship due to the complexities within the allopathic and Tibetan medical systems. Therefore, the present study concluded that these are areas where the assertions offer language that might encourage dialogue and expand the knowledge within both medical disciplines with the hopes of additional research on these topics.

Yoeli-Tlalim (2010) suggested the *nyes pa* might be the cross-cultural bridge between mind and body. The participants in the present study consistently mentioned the *three humors* as the connection between the mind (e.g., emotions) and the body (e.g., physiology, organs), thus supporting this cross-cultural bridge. One participant, however,



identified the *five elements* as the bridge connecting the microcosm (e.g., body) to the macrocosm (e.g., universe), where physiology, diet and lifestyle, the planetary system, and all interactions are interconnected.

Table 8 represents the data discussed by participants. The table provides insight and supports why the *nyes pa* and the *five elements* might be viewed as a bridge. Additionally, as described by participants and supported by medical teachings (Gonpo, 2011a, 2011b; Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort), these energies manifest in various parts of the body. Moreover, they control multiple physiological functions and appear to have commonalities with the principles of the psychoneuroimmunology model. The connection between physiology, emotions, and the energetic systems discussed by participants reinforces the mind-body connection. A Western perspective might view these connections through the lens of relevant research in psychoneuroimmunology (PNI).

On the role of PNI in mental illness, the authors address the importance of the immune system's response in the body's attempt to support homeostasis (Soria et al., 2018). The mind-body connection in an article on inflammation in mental illness (Lee & Giuliani, 2019), where researchers examined the effects of targeting the immune system as a pathway for treatment by hypothesizing the interconnection between depression, fatigue, and the immune system. Finally, in a review on chronic stress (Straub & Cutolo, 2018), the authors discuss the physiological systems of the psychoneuroimmunology pathways affected by stress. These articles provide a communication pathway from an allopathic lens of the mind-body connection, which might provide a bridge for

collaboration or discussion on energy, anatomy, and physiology between physicians of *Sowa Rigpa* and Western medicine. These are potential areas where common philosophy and language may encourage or spark discussion between physicians and researchers of these two complex medical traditions.

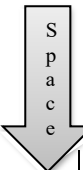
**The Relationships Between Energetic Systems.** Participants in the present study mainly reported the linkage between the *humoral energies*, the *external* and *internal five elements*, *three mental poisons*, and the physiological processes to identify the energetic relationships. The *central channel* also influences physiological functions through its connection with the *three humoral energies*. See Table 8. One participant discussed the *central channel* and its relationship to *hot* (i.e., solar energy) and *cold* (i.e., lunar energy) conditions that are part of medical philosophy and identifiable in anatomy and physiology, food, and treatments. Roodaki et al.'s (2018) work support the hot and cold theory used in all traditional medicine through its role in immunity. The role of hot genes is found in chemotactic and inflammatory processes, while the role of cold genes is in inherent immunity. Understanding the *central channel* is not common knowledge discussed or included in medical practice. The information was included due to its relationship to hot and cold when explaining physiology, food, and treatments. These findings reported by the participants align with Jones et al. (2016) examination of historical Western medicine's interconnections of the humoral temperaments, humoral and elemental theory, including the hot and cold conditions mentioned.

To clarify these energetic connections, see Table 8. To further connect the seasons and physiology, see Appendix L (Sowa Rigpa Institute, Year 1, Foundations Program,

May 2020 Cohort). Both are essential links to understand the wholistic thread further. Table 8 represents the interactions and connections between the energetic systems, psychological associations, and the nature of *hot* and *cold*. The table reads from left to right, starting with the *five external elements* that interact and, sometimes, merge to represent their corresponding humoral energies and psychological affiliations. Table 8 shows how these energetic systems interact or transition from one to another and how the physician detects and assesses this essential information through the *three humoral energies* to diagnose appropriately (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort). Clifford (1984) and Jones et al. (2016) discussed the interactions in Table 8 in terms of the microcosm body and macrocosm universe, where the two are in constant motion as if in a dance. The *three humors* and *five internal elements* are the bridge described by participants between the microcosm and macrocosm.

**Table 8**

*Astrological Influences and Corresponding Internal Energies*

External elements	Seasons	Internal elements	Three humoral energies	Three mental poisons	The central channel	Hot and cold conditions	
Wood	Spring	Space (exists in all)					
Fire	Summer	Fire		Bile ( <i>mkhris pa</i> )	Anger/hatred	<i>ro ma</i>	Hot
Metal	Autumn	Wind		Wind ( <i>rlung</i> )	Attachment/desire	<i>dbu ma</i>	Cold
Earth	Transitional phase between each season	Earth		Phlegm ( <i>bad kan</i> )	Ignorance/confusion	<i>rkyang ma</i>	
Water	Winter	Water					

The participants expressed that the doctor and the patient contain the exact nature, meaning the body includes these energetic influences or dispositions. The participants noted that the universe, planetary system, Earth, and all organisms are made of these

components and are influenced by the associated energies depicted in the table, creating an interdependent and interconnected relationship between the doctor and patient. The participants discussed how energetic imbalances manifest disease through the terms excess and deficient. These findings align with Clifford's (1984) assertion that when these interactions are out of step or out of tune with the sacred reality existing in all things that put them into motion, imbalances occur, and disease results. Participants also reported that astrological influences and internal energies contribute to the body's ability to maintain homeostasis. The findings affirmed that the body and the treatments are made of and influenced by the same energies. Therefore, furthering the understanding that the astrological influences and internal energies also contribute to the synergistic aspects of the applied treatments that contain these properties.

Table 8 provides insight into the bridge between the macrocosmic world and the microcosmic world mentioned in the findings by one participant, also supported by Jones et al. (2016). This insight is important in this diagram because the three humors are the gross subtle energies, which appear to be the foundational lens described by the participants; physicians use these energies to measure or detect imbalances while diagnosing and treating disorders. These findings reaffirmed Yoeli-Tlalim's (2010) suggestion that the three humors might be a cross-cultural bridge and the center of Tibetan medicine (Tokar, 2006). The humoral energies are associated with a unique personalized diet, lifestyle, herbal pharmacological remedies, and external treatments (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort). For a more in-

depth discussion, see treatments, which further clarify the participants' discussions on the synergistic treatments working with the body.

The humoral energies are the foundation of diagnostic criteria, described by the participants and found on *the tree of diagnosis*. Each energy corresponds to unique identifications during observation, palpation, and signs and symptoms within the diagnostic process (Chenagtsang, 2018). In addition, the humoral energies have unique identifiers to assist with classifying the types of imbalances that affect *bodily functions and disease pathways, entry and location points, pathology causation, seasonal occurrences, lifespan development*, etc. These factors affect health and illness, which is part of the discussion on the *tree of health and disease*. The humoral energies *rlung* (wind), *mkhris pa* (bile), and *bad kan* (phlegm) link the *five elemental* external and internal energies and become the vehicle for *Sowa Rigpa* to embody wholism, consequently providing a lens for the physician to treat the whole person.

The energetic systems (*three humors*, five elements, and *channels*), detailed by the participants under the theme of *anatomy and physiology of wholism*, possibly make available a common language for viewing the body through the complex lens that Theise (2009) alluded to in their discourse on cell theory and Tibetan medicine. Hopefully, scientists and physicians might take an interest and explore further. Theise's (2009) discussion on how various traditions of medicine view the lens of the body suggests there are deeper complex understandings of traditional medicines that might not be understood through the allopathic lens of cell theory, for example. Theise (2009) acknowledges that there are alternate models to view the human anatomy, which impart an opportunity for

scientists and physicians from various medical traditions and disciplines to engage in discourse and discovery by exploring philosophies and practices from multiple medical traditions. The findings in this study might contribute to a “fruitful cross-cultural dialogue” (Theise, 2009, p. 268) which means a cross-cultural dialogue between multidisciplinary colleagues and other specialists in the field from various medical traditions (Sullivan et al., 2020). Although the humoral energies addressed in this study are not a one-to-one correlation to Hippocrates’s humoral theoretical foundation (Falagas et al., 2006; Tidwell, 2017), the findings possibly bring awareness to and reintroduce Hippocrates’s work for further exploration or open discussion on similar philosophies.

Additionally, the humoral and five element philosophy presented by the participants practicing *Sowa Rigpa* embraces a theoretical lens that appears to reinforce the existence of a scientific and standardized lens of a traditional medical system (Berkes, 1993). In addition to previously discussed authors’ perspectives of humoral energies, Clifford (1984) related the humoral energies and Western physiological functions: *rlung* the vital force was in the nucleus controlling metabolic functioning; *mkhris pa* was associated with vital energy and the “catabolic activity of enzymes”; and *bad kan* was the “anabolic force which synthesizes new protoplasm” (p. 91, paraphrased). Clifford’s (1984) work transfers the theoretical lens of *Sowa Rigpa* to the cell level. These energetic correlations were noted by one participant when discussing the formation of the body in utero. Researchers Rosch (2009) and Brown (2009) also discussed the possible energetic communication pathways existing in living organisms using an allopathic lens, which may offer one perspective into the energetic lens discussed by participants. See Table 8.

Researchers' (Brown, 2009; Picard & McEwin, 2018) work on the biological energetic signaling system also appears to support the energetic theoretical systems of *Sowa Rigpa* and is promising.

**Effects of the Five Elements.** Energies influence organs and body parts differently (Chenagtsang, 2018). As expressed by the participants, these interactions cause imbalances creating conditions for the manifestation of illnesses. As noted, under the subthemes, *five elements and body formation* and *physiology, emotions, and energetic systems interrelationships*, a participant discussed that each element is associated with an organ and functional aspect of the physical body. Participants noted that regions, elements, and seasons play a role in health conditions. An example of these relationships is a rendition of the turtle diagram that draws upon the astrological association connected to the Tibetan medical system. See Appendix L. The drawing illustrates how the five astrological elements in Tibetan medicine relate to the organs and seasons (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort). The system presented in this diagram originates from Chinese medicine and co-exists with the five *joongwa nga* element system, India-Greek-Persian. The artwork is a simplified representation of the complexities of the influential relationship between the macrocosmic energies (universe) and the microcosmic energies (body) expressed by the participants in this study. The drawing also provides a glimpse into how the artwork is an instructional tool used to aid in providing knowledge and understanding of the theoretical lens of the body.

Additionally, Appendix L shows how the seasons are associated with specific organs, which participants discussed under the theme's *disease prevention* and *patient*

*assessment and diagnosis* correspond to the external elements. There is also a transitional state (i.e., 18 days) depicted standing for the adjustment period required by the body as one season (i.e., 72 days) changes to another (Chenagtsang, 2018). This picture represents the interconnectedness between the body, the Earth, nature, the ecological system, and the universe discussed by participants under the *theme: applied philosophy of wholism*.

These findings align with Jones et al. (2016) discussion on elemental and humoral theory. The researchers expressed how those theories guided farming, diet, the human life cycle, cosmologies, and medicine. This traditional standardized way of viewing the body and its relationship to the astrological elements (five external elements; Chenagtsang, 2018) provided valuable information when diagnosing, assessing, and treating a patient. It is an artistic pictorial view of a natural way to mentally comprehend how the astrological elements connect to the body to aid in diagnosis and patient treatment. Jones et al. (2016) support the present study's findings. Still, their work included additional factors (i.e., temperaments, life stage, and cardinal points) interconnecting the body (i.e., humors) with the astrological elements not mentioned by participants. The drawings in the appendices (Appendix J, K, L, and M) provide insights into participants' discussion on the principles of art, science (i.e., technique and standards), and philosophy and how the physicians use these principles in a way that synergistically works together to view the complexity of the body.



## Understanding Health, Prevention, and Disease

Throughout the study, participants stressed the importance of balancing the energetic systems and how to sustain health. Participants provided examples to help understand the bodily symptoms and their energetic correlates. The findings revealed that balancing the energetic systems, physiology, and emotional states is key to health. The teachings of Dr. Nida Chenagtsang affirmed these findings (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort). *Sowa Rigpa* captures the emotional states under the *Dharma (Trunk of Health)*, which is associated with the mind and the *primary causes* branch (*Trunk of Disease*). The *tree of health and disease*, see Appendix J. The *Sowa Rigpa* framework interconnects mind and body with the humoral philosophy. The three humors bridge the connection between the mind, external factors (e.g., seasons, lifestyle), and the body. Physicians use the theory of the three humoral energies to balance the body's physical energies, physiology, and emotions to return the body to homeostasis, thereby affirming Ergil's (2014) and Jacobson's (2000) assertion on the three humors being in a constant state of imbalance. Research in psychoneuroimmunology on stress (Straub & Cutolo, 2018) and mental illness (Lee & Giuliani, 2019; Soria et al., 2018) are examples of the communication pathways and subsystem interactions when the body is out of balance from an allopathic perspective. The immune system plays a vital role in these examples.

The *tree of health and disease* depicts the components contributing to maintaining health. See Figure 2 in Chapter 2. The color of each leaf is associated with a specific humoral energy. For a more detailed representation in English, see Appendix J. The tree

provides insight into the findings in this study under the themes of *physiology and anatomy of wholism, health and wellness, disease prevention, pathology of the disease, and treatment*, where participants noted aspects from both trees. In Greek mythology, there is also the Tree of Life bearing the gift (fruit) of eternal life, which is protected by a snake, where both trees symbolize “rejuvenation and eternity” (Antoniou et al., 2011, p. 218). The *tree of health and disease* in *Sowa Rigpa* offers similar symbolism within the medical paradigm. Both trees within each corresponding historical philosophy stand for wisdom, rejuvenation, and life (Antoniou et al., 2011). Historical symbolisms continue to provide a lens as a bridge for common discourse and exploration between allopathic and *Sowa Rigpa* traditions.

### ***Prevention***

The participants specifically stressed the importance of diet, digestive biome, excretions, and digestive processes. One participant offered arthritis as an example where the digestive system was the root cause; see the theme *pathology of disease*. In alignment with these findings, Dourado et al. (2020) found a significant relationship that necessitates further investigation between Rheumatoid Arthritis (RA) and gut microbiota. Dourado et al. (2020) suggested a dietary treatment to manage RA. Although, noting diet as a treatment is not presently considered in the allopathic treatment plan due to the limited available evidence-based research.

Participants explained the connection between the foods consumed and the elimination process and the role of these factors in health and disease. Participants also reported that health conditions (e.g., diabetes, cholesterol, weight) arise from imbalances

in the digestive system: excess or deficient heat (fire element) or low metabolic activation. The *trunk of health* (see Figure 2 and Appendix J) shows the *three humors*, the *bodily constituents*, and *excretions* as the critical physiological aspects in maintaining health and homeostasis within the body described by participants. These findings provide further clarification and understanding of the key to healing discussed by Bauer-Wu et al. (2014) and the *trunk of health* outlined in the *rgyud bzhi* (Gonpo, 2011a, p. 21). The digestive process begins with the *bodily constituents*, where dietary or nutrient intake starts and ends when the body eliminates waste via the *excretions* branch. The *three humors*, the *body constituents*, and the *excretions* noted by the participants and located on the *trunk of health* might be the “good communication” and “good health” Rosch (2009) frequently discussed.

Rosch’s (2009) discussion on the electromagnetic communication that occurs within and between the organism and the organism’s environment as the body attempts to maintain health appears to relate to the dynamics found within the *tree of health and disease*. The terminology used by participants, also found on the *trunk of disease*, might represent an example of electromagnetic communication in *Sowa Rigpa*. The external factors such as environment and the seasons (*arising of humors*; the fourth branch from the bottom on the right), diet or lifestyle (*secondary causes*; second branch on the left) or internal disturbances expressed through the body’s response to the stressors or psychological states (*primary causes*; first branch on the left) could expand the understanding of the communication occurring between the external environment and the body. One participant provided tuberculosis as an example, where the primary cause is

bacteria, and the secondary cause is sanitation and poor nutrition. Based on the literature and the findings in this study, the *tree of health and disease* is the communication highway where the body attempts to maintain homeostasis.

The *tree of health and disease* also informs the patient and the doctor about the imbalances in the form of the manifestations found on the branch of *incurable diseases*. In addition, the *tree of health and disease* provides information on when the mind or treatments are causing complications as shown on the branch of the *side effects of treatment*, which was discussed under the theme *treatment* and subtheme *assessing the progress of a treatment application and terminal conditions*. The participants noted using indicators as an assessment measure: external (e.g., weight), pulse, and internal (e.g., appetite) or as a treatment outcome measure.

### ***Pathology***

When assessing the pathology of a disease, another finding in this study revealed that the *primary cause* of the disease is emotions, as identified on the first branch on the left of the *trunk of disease*. See Appendix J. Participants suggested a one-to-one relationship between emotions and humoral energies and an interdependent relationship between the mind and the body. One participant provided thyroid conditions as an example where emotions are the primary cause, specifically passive emotions. These concepts introduced by participants are not new to allopathic medicine. Research on similar forms of mind-body communication appears promising as it relates to the stress response and mitochondria, where physiology interacts with energetic communication systems (Picard & McEwen, 2018). Scholarly literature also supports the mind-body

connection with studies on attachment (Plasencia et al., 2019) and anger (Lupis et al., 2014; Moons et al., 2010). Also supporting the mind-body link, Davis et al. (2017) found that repetitive thoughts directly impact health and well-being in their investigation of the connection between health and work-family conflict. The *tree of health and disease* is where the linkage between emotional states and physiology occurs in *Sowa Rigpa*. Research on health and disease (Sturmberg et al., 2019) supports participants' philosophy of interdependence.

The *tree of health and disease* appears to be where psychoneuroimmunology, biopsychosocial, and *Sowa Rigpa* merge or can be a tool for translation and collaboration. The patient's self-awareness, discussed under the theme of *self-awareness and healing*, also seems to be a relative part of self-regulating the body's internal systems. Participants stressed that it was important for the patient to know their body and pay attention to how their body communicates imbalances. The findings suggest that if the patient understands whether they are *hot* or *cold*-natured, it helps them maintain health through diet. Research supporting the hot and cold diet theory are studies investigating food composition and hot-cold qualities (Xie et al., 2020), the hot-cold potential relationship in nutrients (Liu et al., 2012), and the hot-cold theory's role in immunity (Roodaki et al., 2018). Patient participation also plays a significant role in supporting their health and wellness and was emphasized by many participants. These findings are consistent with Otto and Knight's (1977) work. The authors view the doctor as more of a facilitator in the healing process. Participants in this study stressed the importance of active participation by patients. The

patient's self-awareness also supports personal growth by working toward healing and by correcting imbalances.

Participants also mentioned speech, emotions, and thoughts as contributing factors to health and well-being. In a recent literature review, J. D. Creswell et al. (2019) suggested a need to increase randomized control trials (RCT) to investigate contemplative practices and the psychosomatic implications in health and disease. Nevertheless, researchers have found promising outcomes with mindful eating (Mason et al., 2016), pain management (Morone et al., 2016), and acceptance and stress reactivity (Lindsey et al., 2018). From the findings in the present study, there is an immediate cause and effect to health because speech, emotions, and thoughts manifest through humoral energies, which have an associated physiological effect as depicted in the *tree of health and disease*. Participants discussed training the mind through meditation, which might assist with the cultivation of mindful speech, emotions, and thoughts, thereby providing a pathway to balancing their anatomy and physiology. Through the cultivation of mindfulness (i.e., mindful diet, speech, emotions, thoughts, and social support systems), the patient might become more aware of their body, aiding in healing and prevention.

Participants discussed the link between organs and humors and how this information informs diagnosis and assists with identifying disorders. See Appendix M. The flower drawing illustrates the interconnectedness between three classifications of organs (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort). The flower drawing is a common metaphor used as a visualization of the connection between the *solid organs* (roots), *hollow organs* (stems), and the *sense organs* (flowers).

Participants addressed these connections under the themes *the anatomy and physiology of wholism* and *patient assessment and diagnosis*. The sense, solid, and hollow organs are located on the branch of *entrances and pathways of humors* found on the *trunk of disease* on the *tree of health and disease*; see Appendix J.

The flower image is important to the findings in the present study because it provides insight into the wholistic lens presented by the participants. See Appendix M. Additionally, it offers another systematic way to glimpse the physiological relationships between the astrological elemental energies and derive a diagnosis. The flowers are interdependent yet interconnected. The inner organs work together to maintain balance within the body, filter waste, digest food, and transmit nutrients; they are the keys to the body's survival. The following allopathic studies provide a common language for discussion and exploration between physicians and researchers of allopathic and *Sowa Rigpa* medicine with the hopes of strengthening the desire for increased research and collaboration between the two medical disciplines. Both Liu et al.'s (2020) and Ma et al.'s (2018) research on non-alcoholic fatty liver disease (NAFLD) appear to link diet, NAFLD, and coronary heart disease (CHD). The findings from these two studies seem to support these root organs' (i.e., heart and liver) interdependence while reinforcing the significance of diet in the *Sowa Rigpa* treatment process and maintaining health. Ma et al. (2018), in their study on the effects of diet on non-alcoholic fatty liver disease (NAFLD), concluded that a quality diet reduces fat accumulation in the liver, thereby providing further insight into *Sowa Rigpa*'s dietary approach to treatment.

Liu et al. (2020) concluded that a relationship exists between NAFLD and coronary heart disease (CHD) in their study on NAFLD and CHD. The authors also believe NAFLD may even be a predictor of CHD. The researchers used ultrasonography as a diagnostic tool instead of the recommended standard biopsy for NAFLD. Although their research is promising in these connections, the authors agreed that continued research is needed to support their claims.

The flowers are another standardized depiction of how to begin to train the mind to connect the energies, understand the relationship between organs, and how one organ might provide information about another organ based on these relationships. The flowers are also a symbol that reminds the physician of the interconnection between the elemental energies, the body, disease, and the natural environment. Therefore, allowing the collection of parts to provide insight as it relates to the patient and the outer world in whole person care.

### **Practice, Diagnosis, and Treatment Within Whole Person Care**

Frey et al.'s (2013) discussion on the biopsychosocial model and the physician's role within this model appears to support some aspects of the practice of the *Sowa Rigpa* physician in the present study. The physician sees the patient as a human being under the biopsychosocial model (Frey et al., 2013), thereby supporting the findings under the subtheme *doctor–patient relationship expressed through conduct and behavior*.

According to the ethical practices described by the participants in the present study, physicians accept and treat all patients equally as members of their families. Treating the patient as a family member means from a place of concern and compassion where the



physician's level of care equals the level of care they would provide for a family member. Participants in the present study affirmed that doctors are trained to be servants of humanity and show compassion, altruism, and respect for all sentient beings. Frey et al.'s (2013) discussion on the biopsychosocial model also supports these qualities where the physician practices empathy and compassion while remaining open to all the phenomena presented by the patient associated with the illness. The doctor's role, skills, and ethics are significant findings in the present study.

Thomas et al. (2020a) noted that Australian general practitioners reported that empathy and unconditional acceptance were relevant in whole person care. Thomas et al.'s findings support what participants in the present study said. The ethics reported by participants in the present study include the ethical practices required to be a physician and extend to the care of the patient and approach to treatment. The findings suggest that the physician's primary goal is to be a humble servant, grateful for the gift of healing, and to share their knowledge with others. Compassion and communication were relevant amongst the participants in the doctor-patient relationship because it builds trust while enhancing treatment adherence.

Consistent with the findings in the present study, Hesse and Rausher (2018) found that affectionate communication was an important predictor of patient-perceived confidence in doctor-patient relationships and patient satisfaction. Moreover, perceived negative satisfaction with the doctor-patient relationship and lack of knowledge of illness were associated with low-medication adherence (Venkatesan et al., 2018). Yet, in Berger et al.'s (2020) study, physicians stressed knowledge, competence, and expertise over

interpersonal aspects (i.e., empathy) when interacting with patients. These findings were inconsistent with the participants' views in the present study. Participants reported affectionate communication as part of the doctor's ethical behavior. The participants' perceptions and beliefs align with Georgopoulou et al. (2020) findings that trust and understanding the patient illness improves adherence and the doctor-patient relationship. In addition, consistent with the views of the present study, were Blödt et al. (2020) findings that patients with cancer preferred a knowledgeable and competent doctor with humane qualities and interpersonal trust in the doctor-patient relationship. Participants in the present study believed skills and affectionate patient treatment build trust; humane qualities were paramount when discussing their patients.

Participants stressed the importance of the doctor-patient relationship, which was a major finding in Thomas et al.'s (2020a) study. The researchers suggest a healthy relationship is a fundamental key in the practice of whole person care. The main findings of their research expressed by the Australian general practitioners on patient care were fostering trust and the need for in-depth diagnostics to get to the root cause by going beyond the initial complaint. These findings were consistent with the present study, where intake sessions were in-depth and the diagnostic process aimed to get to the root cause. Only one participant appeared to support the hierarchical structure of the doctor-patient relationship.

Thomas et al. (2020a) also expressed the importance of considering other factors (e.g., personal) that might affect health and treatment, incorporating multiple visits into the patient's care, and continuity of care over the individual's lifespan. Also mentioned in

their findings were collaborative care and the inclusion of preventative care, which participants in the present study found equally important in whole person care. In some instances, Thomas et al. identified that expressing empathy, offering encouragement, kindness, and acceptance allows the patient to see the doctor's humanity. These insights align with the findings in the present study, based on the participants' discussion of how they engaged with their patients.

### *Self-Care*

Participants reported contemplative practices as part of their self-care practices for overall health and well-being. The promising benefits of meditative practices are evident in a literature review focused on communication outcomes between healthcare professionals and patients using mindfulness and compassion-based approaches as an intervention for healthcare professionals (Amutio-Kareaga et al., 2017). The authors suggest that compassion-based and mindfulness programs enhance doctor-patient communication, self-awareness, and improve the quality of care and empathy within the doctor-patient relationship. According to the researchers, the study intended to bring insight into programs that cultivate these qualities and increase patient awareness with the hopes of increased usage in universities and medical schools.

Tidwell's (2017) work dissertates the physician's skill cultivated to use the body as a diagnostic instrument. The findings in the present study support that a keen sense of knowing or intuition is a prerequisite, along with a keen sense of awareness or a higher level of consciousness. The embodiment of knowledge is vital for the *Sowa Rigpa* doctor (see Tidwell, 2017). The level of awareness described by the participants for exchanging

sensory information between the doctor (the diagnostic instrument) and the patient aligns with Merleau-Ponty's (2012) perspective of perception. Tokar (1999) believed it is essential that all physicians of medicine should possess these skills to diagnose effectively. Researchers studying intuitive knowledge and the perceived value and usage in the diagnostic reasoning process found that practitioners used intuition. Still, they unanimously agreed that analytical reasoning needs to factor into the results (Van den Brink et al., 2019). However, others believe intuition is invalid in the diagnostic reasoning process (Van den Brink et al., 2019). The dual-process theory supports the inclusion of intuition in the diagnostic process (Van den Brink et al., 2019), and continued research on intuition and diagnosis is suggested. Participants mentioned that the cultivation of the level of diagnostic awareness embodied by the *Sowa Rigpa* physicians takes years. Training begins with contemplative practices, which participants noted were part of their medical training.

The findings in this study also included insight into the significance of self-care practices, as previously discussed above. Picton (2021) concluded that developing work-life balance and self-care are essential skills for doctors and medical students. Researchers recognized that understanding that the disease and symptoms were only a part of whole person care (Cassell, 2011; Engel, 1977; Micozzi, 2014a). The findings reported by the participants suggest that physicians are exceptionally disciplined practitioners with daily contemplative practices, *the four immeasurables*, and *mantras*. Some practices described by the participants also extend to the treatments; the participants imbued treatments and care with a strong intent to heal to achieve the best

outcome for the patient. Researchers' assertion of the interconnectedness between the physician's practice of medicine and compassion (Dakpa, 2014; Ergil, 2014) supports the present study's findings.

### ***Karmic Relationship***

Participants addressed the karmic relationship under the subthemes *treatments are based on the type of disorders*, and *the doctor-patient relationship is important*. The manifestation of the karmic force, as described by Clifford (1984), is driven by the mental confusion manifesting during the origination of the three humoral energies on the spiritual plane, creating a subject-object dualism. The formation of the karmic force described by Clifford during body formation is somewhat similar to one participant's explanation. Another participant explained the distinct types of karma and the cause-and-effect relationship. The same participant also described the interdependent relationship between the doctor and patient generated by the karmic force. The karmic energy creates life and the universe (Clifford, 1984), thereby orchestrating the music in the ballroom for the dance of interconnectedness and interdependence to commence. The active karmic energies in the doctor-patient relationship support and reinforce the lens used to view the patients. The interdependence of the doctor-patient relationship described by the participant might be viewed through Jain's (2007) understanding of the doctor-patient relationship. The author describes the doctor-patient relationship as a sacred bond in which the patient and doctor are allies, not a commercial transaction. There is a deep interdependent bond. Researchers have yet to explore these deeper connections, including the theoretical karmic concept.

### ***Health and Well-Being***

Melnyk et al. (2020) evaluated interventions that assisted in improving the overall health of physicians and nurses. The researchers acknowledge the importance of the practitioners' well-being and the need to improve the health of physicians and nurses in the health care system, which will also enhance the quality of care. The findings in the present study also suggest the importance of the physicians' overall health with the need for them to be physically and mentally strong. Participants noted that their energetic systems, diet, and lifestyle are crucial to their ability to be a physician because their body, as previously mentioned, is the instrument for diagnosis and treatment. The participants reported that it is essential that the physicians are attuned to the patient and in tune with their awareness to make the proper assessment, diagnosis, and treatment plan. This level of awareness described by the participants aligns with Merleau-Ponty's (2012) philosophy. The disciplinary practices discussed by the participants also revealed that the care and treatment of the patients are the physician's priority. The participants noted that they understand the interconnection and interdependence in the doctor-patient relationship and embody this understanding in their self-care practices. Supporting these findings, Vigier et al. (2021) examined the physiological linkage within the doctor-patient relationship and whether they influenced each other. The researchers found that with increased time spent together, doctors' physiological responses were significantly linked to patients' physiological responses. The findings in this study suggest a sacredness exists throughout the medical practice of *Sowa Rigpa*.

## ***Diagnosis***

The findings provided insight into the physician's diagnostic processes and perceptions of the pathology of the disease. Participants mentioned that diagnosis is not disease or organ centered within the Sowa Rigpa framework. According to all the participants, the physicians' intent within the diagnostic process is to understand and treat the root cause of the disease. The foundational premise in Tibetan medicine and a common finding amongst all the participants was to treat the whole person by considering the full dimension of the patient. To view the patient as a whole person, the physician investigates the patient's psychological, physiological, cultural, and social aspects during the patient assessment and diagnostics. This finding aligns with the factors expressed in the seminal work by Engel (1977) on the biopsychosocial model. As described by participants in this study, Tibetan medicine also considers cosmological and environmental factors during an assessment. Mori et al.'s (2019) findings on seasonal changes and rheumatoid arthritis and Zilli Vieira et al.'s (2019) findings on short-term geometric disturbances and cardiovascular disease and myocardial infarction (MI) support the need to assess and research the effects of cosmology and environmental implications on health and illness.

The cosmological and environmental implications mentioned by participants are present through all the themes; however, emphasis and understanding are placed under *the anatomy and physiology of wholism*. There appears to be an invisible thread or an energetic thread interconnecting all aspects of existence, creating a cause-and-effect relationship or rippling effect reinforcing the concept of interdependence or

interconnectedness. Based on the findings in this study and the context of this discussion, that invisible thread appears to be the *three humoral energies* and *karmic forces*. As previously made known, the three humoral energies emerge on the spiritual plane born from the *karmic* force (Clifford, 1984); here is the interconnecting thread connecting all existence.

From Hutchinson's (2011a) perspective, the scope of including all aspects of a patient was not necessary, and the author believed it to be an impossible task. It was not the physician's responsibility to consider these complex dimensions in the assessment and diagnosis (Hutchinson, 2011a; Carruthers, 2013). The findings from the present study under the theme of *patient assessment and diagnosis* and *applied philosophy of wholism* appear to dispute these perspectives. Moreover, in alignment with the present study, Kusnanto et al. (2018) addressed the benefits of incorporating a complex model into primary care: improved clinical outcomes through the increased awareness of the factors (e.g., social, cultural, environmental, behavioral) possibly contributing to or that might support a patients' illness. There is also the benefit through this awareness of enhanced management of a condition by the patient and improved doctor-patient relationship while supporting a multidimensional approach to care. Table 8 and Figures 2 (see also Appendix J [English]) through the colored humoral leaves, once committed to memory, allow the physician to identify direct relationships aligned with the three humors within the complex dimensions of the body as it relates to health and disease.

Expanding upon the knowledge of modern medicine, two participants also discussed the inclusion of astrology as a tool to aid in diagnosis. Although not new to



traditional medicine, this finding should be of interest. Aligning with these findings, the use of astrology is present in Ayurveda to identify the nature or cause of disease and the most effective treatments (Anigol et al., 2020; Shastri, 2021) and the best time to apply the treatment (Anigol et al.). In Ayurvedic medicine, the physician uses astrology to gain insight into six factors when assessing a patient: diagnosis, prevention, the time of disease occurrence, health care, disease severity, and the appropriate treatment.

Those factors align with *Sowa Rigpa* and why one participant stressed that all physicians must have a foundational knowledge of astrology. Supporting these findings, early European medical universities also used astrology as a method for systematically documenting patient medical records (Kassel, 2014). Astrology is not new to the medical field, but there is minimal research on its usage within traditional medical systems. Following is a deeper look into how physicians can treat the whole person using Tibetan medicine's traditional tools for diagnosing and assessing the patient.

The theme *patient assessment and diagnosis* findings are represented in *the tree of diagnosis*. See Appendix K. Thomas et al.'s (2020a) study found that Australian general practitioners view patients not from a disease perspective but as a person. Participants in this study affirmed that diagnosis is not disease focused; diagnosis focuses on the cause of the imbalance, and that disease occurs when either the humors are in excess or deficient. The three humors allow the physician to assess the patient by checking the state of the humors and identifying three key points: excess – too much, deficient – not enough; disorder – mixed up (Sowa Rigpa Institute, Year 1, Foundations program, May Cohort, 2020). Through this lens, the findings align with other researchers' assertions that

a multitude of etiologies are treatable using the same treatment method (Tokar, 1999; Yoeli-Tlalim, 2010). These findings are inconsistent with allopathic medicine. According to Frey et al. (2013), the physician aligns the treatment with the symptoms and disease in allopathic medicine. However, in the present study, participants reported that physicians view symptoms as data to help identify imbalances, and the physicians align them with the three humors. Supporting this finding, Dhondrup et al. (2020) present detailed graphic representations of illnesses through the *Sowa Rigpa* lens created from data that physicians and scientists could potentially use for disease comparative and pharmacological analysis. Understanding diseases' various categorizations (e.g., *rlung*, *bad kan*) and their etiological relationships might be advantageous in collaborative research between *Sowa Rigpa* and allopathic medicine.

**Observation.** The *tree of diagnosis* (see Appendix K) does not include all the information gathered about the patient (e.g., posture, how they walk and speak, mental and physical conditions) that physicians in this study deemed important when observing a patient during their assessment. Conversely, that does not mean the information is irrelevant; participants noted that all information is essential. Additionally, questioning the patient is part of the assessment process. These findings are consistent with Thomas et al.'s (2020b) research. Thomas et al. (2020b) found that viewing the patient through a multidimensional lens (e.g., biopsychosocial, family, culture, etc.) was an important outcome in their study. They support that all factors affecting the patient's health and treatment are relevant. Also consistent with Thomas et al.'s (2020a) findings, the participants in the present study emphasized the importance of gathering a health history

and spending time with the patient. Spending time with patients in Thomas et al. (2020b) study also entailed cradle-to-grave care from in utero to death, where care may continue post-death via counseling. Understanding the patients through individualized care (i.e., life expectations, attitudes, and beliefs) was expressed, supporting the findings in the present study.

One participant focused on the tongue; another focused on the pulse to retrieve the bulk of their information. The participants noted that the intent of the assessment is to identify the imbalance, which is observable using the physicians' senses (i.e., site, auditory, smell) through *observation* (first trunk from left) of the *tongue* and *urine*, and intuitively through the pulse (middle trunk). For example, the tongue and urine provide information on which of the three humors are presently dominant based on the characteristics of the humor identified on *the leaves* on the branch of *the tongue* and urine found on *the trunk of observation* (Chenagtsang, 2018). The tongue can also provide information on the solid and hollow organs; see Appendix M. This finding is consistent with Tania et al.'s (2019) discussion on the use of tongue diagnosis as noninvasive and trends associated with automated tongue diagnostics where specific sections of the tongue are related to various organs (i.e., liver, gall bladder, heart, lung, stomach, and spleen).

One participant noted that mental health is part of health, and in *Sowa Rigpa*, the mind is the *Dharma* on the *trunk of health*; see Appendix J. The participant reported the ability to combine astrology and urinalysis to obtain additional information related to a patient's mental health and assessed when meeting with the patient. The process is visual

without technological devices; participants also reported using modern medical diagnostic tests during the assessment. In alignment with these findings, Zheng et al. (2013) identified five urinary metabolite biomarkers to assist with identifying major depressive disorder in a urine-based diagnostic test. Even though Zheng et al. suggested caution when interpreting their findings, the potential is promising for future research. Guerreiro Costa et al. (2022) affirm that further research on metabolite markers is needed.

Assessing mental health (e.g., well-being) during patient assessment by physicians is also consistent with Thomas et al. (2020b) findings. Their findings suggest, as previously mentioned, a multidisciplinary approach without limitations with collaboration, when necessary; collaboration is also in alignment with participants' reports in the present study. Participants in the present study repeatedly discussed the linkage between emotions and the three humors, allowing physicians to assess mental health during diagnostic intake and urine analysis. The findings link the mind (i.e., emotions) to the humoral thread existing throughout the *Sowa Rigpa* framework (Chenagtsang, 2018), which applies to both the doctor and the patient, as previously noted by one participant.

**Palpation.** The findings in the present study revealed the importance of pulse analysis in *Sowa Rigpa*. The physician's body as a diagnostic instrument is applicable here (Tidwell, 2017). Merleau-Ponty's (2012) sensory experience of subject and object addresses the physician's experience of the patient's body, where the physician gathers sensory information to learn and understand the patient's physiology. One participant

primarily focused on the pulse as their source of information. The participant noted that the pulse contained the most data and informed the physician's interrogation portion of the diagnosis.

The participants also noted that the pulse comprises information about the humoral energies, organs, heart rate, and vital information related to the physiology of the body (see Chenagtsang, 2018). See Appendix N for more details. Supporting the findings in this study on the importance of the pulse diagnosis is the work by Bodh et al. (2017). Bodh et al. (2017) examined the Ayurveda and Tibetan medicine pulse techniques to share and expand the knowledge of the pulse diagnosis technique. The authors present detailed information affirming a systematic approach to the *Sowa Rigpa* pulse diagnostic technique that allows the physician to access a vast amount of data during the examination. According to Clifford (1984), the pulse aligns with the Chinese system, takes years to master, and is incredibly important.

Based on participants' discussions, the doctors can identify the dominant humor based on what they feel with their first three fingers (index, middle, and ring) based on the characteristics found on the three leaves on the branch of *the pulse* on the *trunk of palpation*. See Appendix K. One participant in the present study could detect the absence of the patient's gall bladder during the pulse reading. Reading the pulse is also very intuitive. Another participant, when asked to describe the pulse process, was unable to; they expressed that it is more of a feeling. Here is where the doctor's self-awareness and self-care are most relative to the outcome of their diagnosis.

Additionally, it is essential to understand how the information from Table 8 (external five elements), Appendix L, and Appendix J are interconnected and related to the data received from the pulse reading, making the information extremely important for physicians to comprehend (Chenagtsang, 2018). Once the physician detects the imbalance and the root cause, the physician can use the trunk of *signs and symptoms* to balance the humoral energies by determining the treatment type that would respond positively to the cause and symptoms. The *tree of health and disease* are also relative in this process because the participants in this study stressed that region, seasons, and time of day affect the patient's condition.

Using the tradition's authoritative mapping of trees, Sowa Rigpa appears to offer a framework that supports the need for a systematic framework for complex systems. Complex systems require systemic frameworks, transdisciplinary perspectives, and medical approaches that operate from a comprehensive systems perspective to address the multifaceted lens needed to sustain health and reduce the occurrence of disease (Picard et al., 2013). The well-being of the patient and treating the whole person should be the goal (Cassell, 2011).

### ***Treatment***

Participants mentioned three classifications of disease: natural, karmic, and obstacle, where the treatments are only applicable for natural conditions. Obstacle and karmic diseases require different treatment methods, which are not part of this discussion. The findings in this study on treatment and whole person care found that treatments work with the physiology of the body by using the philosophy of the three humoral energies.

Participants emphasized the importance of diet and lifestyle to prevent and treat conditions. These findings align with recent research on diet and rheumatoid arthritis. Researchers suggest that diet might aid in treating rheumatoid arthritis due to the disease's connection with intestinal microbiota (Dourado et al., 2020). Dourado et al. (2020) findings support participants' assertions in the current study that digestion is the root cause of arthritis and other illnesses. Participants consistently mentioned that diet and lifestyle are fundamental to health; still, both can heal and cause harm.

Vandebroek and Balick (2014) support the concept of food as medicine. The researchers stress that common foods in the human diet can be viewed outside of a cultural context but globally and play a role in non-communicable diseases. Food is medicine in *Sowa Rigpa*; some foods precisely correspond to each humoral energy (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort). Participants also mention a 24 hr humoral clock when discussing diagnosis and treatment, which is used for the time of day when humors are most active (Chenagstang, 2018). This clock aids in providing information on the best time to consume an oral treatment and the best time to eat certain foods.

Potter et al. (2016) posited that understanding the relationship between nutrition and the human circadian system may reduce chronic conditions. Participants also consider the time of day that symptoms occur during the assessment process. Bouchaala et al. (2020) support these findings where there was a time-of-day effect related to balance performance, range of motion, and inflammation in women with rheumatoid arthritis. The time-of-day effect also applies to lifestyle, with recommendations on the

appropriate number of hours for work, sleep, behavior (individual), spiritual practices (spiritual), and socializing and support systems (social; Chenagtsang, 2018). Participants emphasized that maintaining balance is key where diet or lifestyle might be in excess or become deficient disrupting humoral balance. Patient self-awareness and active participation in lifestyle and diet are crucial to prevention and healing.

Participants reported that they wholistically integrate diet and lifestyle as part of treatment. Smirmaul et al. (2020) assertion that lifestyle modifications promote health and become relevant evidence in the COVID-19 pandemic aligns with these findings. Furthermore, the authors suggest it is also vital to incorporate a planetary health point of view, which would globally benefit humanity and the ecosystem. Those factors support the participants' approach to health, prevention, and treatment for treating the whole person.

Other remedies mentioned by participants were herbal medicines and external remedies. One participant stressed that herbal remedies are natural and organic. The ingredients are from the natural habitat where the plant growth thrives under the right conditions (e.g., region, environment, soil). Another participant also explained that natural does not mean the remedy does not cause harm. The participant expressed that all medicines are harmful and provide risks. This finding aligns with Bauer-Wu et al. (2014) assertion that overconsumption leads to humoral imbalances manifesting disorders, whereas proper intake aids in healing and well-being. Based on the findings and reported research, the present study concludes that the remedies are beneficial when the substances are appropriately combined, administered using the correct dosage, given at



the appropriate time and length, and given for the right disorder (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort). The indication of a successful application, reported by participants as external and internal indicators, is through the *tree of diagnosis* using the diagnostic methods and assessing the response on the *trunk of signs and symptoms*. See Appendix K.

Participants noted that the medicines and patients were formed by the five elements, and treatments work synergistically with the whole body. To better understand the wholistic aspects of the treatments as well as treating the root cause expressed by the participants, the tree of therapies further detailed the meaning behind these findings (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort). The tree has four trunks: *dietary food*, *lifestyle*, *medicines*, and *external therapies*. This discussion briefly addresses how medicines and therapies rebalance the three humoral energies. The tree of treatments is not shown here. See Appendix P (original Thangka Painting). However, as shown in the other trees (Appendix J and Appendix K), each branch on the four trunks corresponds to a specific humoral energy. The *dietary food trunk* is comprised of two branches for each humor: *rlung* (wind foods and wind drinks), *mkhris pa* (bile foods and bile drinks), and *bad kan* (phlegm foods and phlegm drinks). The acceptable foods and beverages are specific for each humoral energy (see Chenagtsang, 2018). The same standardization applies to the trunks of *lifestyle*, *external therapies*, and *medicines*. The three *nyes pa* divisions represented in the Trees of the Root Tantra seem to contribute to the synergistic effects. The divisions correspond to what foods, symptoms, and treatments apply to each *nyes pa*, which means what taste, nutrition, and medicines

or therapies would rebalance or calm a specific *nyes pa* or what symptoms or signs represent a disorder of a particular *nyes pa*.

Research on medicinal substances has only touched the surface and appears promising as a treatment for cancer (Tang et al., 2020). Aligned with the findings in the present study is the research by Bauer-Wu et al. (2014) discussing the synergistic effects of herbal formulas. The key to the synergistic effects appears to be in the theoretical approach to compounding the medicinal substances, see Appendix O. The medicines are compounded based on the branches of taste and potency specific to each humoral energy (see Chenagtsang, 2018; Gonpo 2011a). The components of taste, potency, and humors work in unison to create a synergistic effect allowing the formula to work with multiple physiological pathways that provide the ability to treat numerous diseases (Tang et al., 2020) by rebalancing the humoral energies. Tidwell and Nettles (2020) provide further clarification and insight into the synergistic effects mentioned by participants in the present study. The researchers suggest maintaining the purity of the compounds when conducting empirical pharmacology studies based on their assessment of the allopathic pharmacology research processes and the theoretical framework used in compounding *Sowa Rigpa* medicines (see Tidwell & Nettle, 2020). Schwabl and Vennos (2017) discuss the “multi-level mode of action” of the complex formulas (Padma Nervotonin and Padma Digestin), offering insight into the synergistic aspect that aids in restoring homeostasis, specifically in the treatment of menopause, stress, and indigestion (p. 16). Continued research in Tibetan medicine’s pharmacology to comprehend the formulas, the minerals

used, and their therapeutic indications and contraindications (Yeshe et al., 2018) would collectively benefit allopathic and *Sowa Rigpa* medicine.

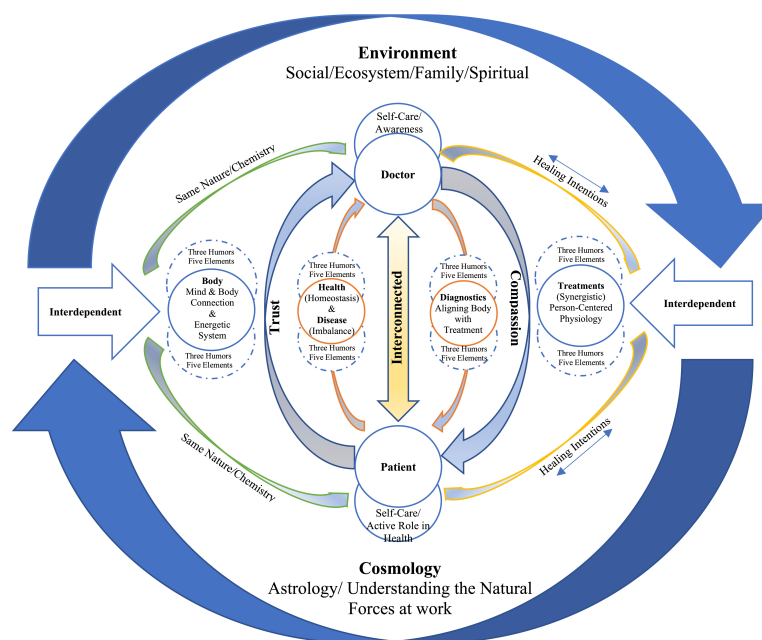
The application of *taste* and *potency* are part of the preparation of distinct types of medicines (e.g., butters, powders, decoctions, pills, soups, etc.; see Chenagtsang, 2018). The treatments have two broad categories: *pacification and cleansing* (emetics, enemas, purgatives). All medicines in the *Sowa Rigpa* system are uniquely classified by humoral type: *wind* (soups, butters, and enemas), *bile* (decoctions, powders, purgatives), and *phlegm* (pills, ash, and emetics). The herbs also have categories: *hot* (south), *cold* (north), and *neutral* (east and west). The herbs' seasonal directions correspond to Appendix L. The hot and cold theory aligns with Liu et al. (2012) findings, where twelve nutrients were associated with hot and cold properties in food. Their results suggest that nutrients in foods may be used to identify the hot and cold nature of foods. Yu et al. (2020) focused on cellular temperature to determine the effects of hot and cold properties of compounds and suggest continued research in this area. Vandebroek and Balick (2014), in their discussion on food as medicine in the Dominican community, addressed the use of bitter taste in healing. The findings in the present study revealed that the three humors continue to be the consistent thread connecting the body, diagnosis, and treatment. Clifford (1984) purported that the humoral energies “are the principal triad in Tibetan somatic medicine” (p. 90) and are consistent with the conclusions in the present study.

The standardized approach to treatment aligns with the anatomy and physiology, health and disease, and diagnostic lens, thereby creating a wholistic approach to care and healing. The *Sowa Rigpa* medical system and physicians' approach to care acknowledges

the complex interconnected systems affecting health and disease while also providing a standardized systematic and traditional scientific (i.e., technique and standards) approach for diagnosis and treatment. Moreover, the treatments have synergistic effects based on the standardized framework used to compound the medicines and select the proper therapies for pacifying the humors or cleansing the body.

### ***Whole Person Care and Sowa Rigpa***

Figure 5 provides additional insight into the interactions and relationships of the main aspects of whole person care from the present study's findings. Figure 5 depicts the interactions and interdependence between the environmental and cosmological factors as a continuous flow that feeds into and affects the body, doctor, patient, and treatment. The three humors and the five elements are represented based on my interpretation and understanding of the participants' explanations. The three humors appear to be the common thread connecting all the components, represented by a circle with broken lines. The properties of the body flow out to both the doctor and patient, reflecting that both contain the same chemistry and nature. Compassionate care during the patient's diagnostic exchange cultivates trust from the patient to the doctor. Here is where ethics and communication build trust within the doctor-patient relationship. During the diagnostic exchange within the doctor-patient relationship, information flows from the patient to the doctor, providing data for assessing imbalances within the body.

**Figure 5***Whole Person Care and Sowa Rigpa*

The healing intentions flow from the doctor to the medicines, which flow from the treatment to the patient creating a sacred essence influencing the connection between the doctor, patient, and treatment. The healing intention flows both ways at a subtle level. As the good intentions flow into the treatment, the patient receives the healing objective through the medicine. The doctor is also the receiver of healing by sharing their gifts, creating a bidirectional healing exchange. There is an interconnectedness between the doctor, patient, and treatment. Finally, self-care was essential for both the doctor and the

patient. While self-awareness plays a significant role for the doctor, active patient participation is vital for the patient to heal.

*Sowa Rigpa*'s approach to treatment aligns with the anatomy and physiological lens, health and disease lens, and diagnostic lens used by physicians, thereby creating a holistic approach to care and healing. Energetic systems are essential components in their model of health and disease. The *Sowa Rigpa* medical system and physicians' approach to care acknowledges the complex interconnected systems affecting health and illness. *Sowa Rigpa* is a standardized, systematic, and scientific approach to diagnosis and treatment. The treatments have synergistic effects based on the standardized framework used to compound the medicines and select suitable therapies for pacifying the humors or cleansing the body.

### **Limitations of the Study**

The qualitative study explored the perspectives of seven exemplary TMDs on whole-person care. The population of key informants and accredited and recognized TMDs were small. Therefore, generalizability is only limited to the context of the tradition of Tibetan medicine and the volunteers. The population studied for Phase I was limited to scholars, professors, and TMDs recently trained that volunteered based on referrals. The population studied in Phase II was limited to TMDs, either lineage trained or university-trained at Men-Tsee-Khan, Tibetan medicine and Astro-science Institute in India, the Tibetan Medical University in Lhasa, or both. Practice experience of the Phase II population spanned from 15 years to over 30 years, with some providing extensive care to Tibetan settlements in India.

The English language was a limitation. Phase II participants' criteria excluded non-English speaking TMDs because English was the only language of the investigator. Language prevented the inclusion of potential participants eager to contribute and limited accessibility to others. IRB did not approve a translator. Speaking Tibetan would have provided a richer exchange because the participants frequently recited Tibetan excerpts written in Tibetan, the language of the medical text. In another area where the language was restrictive were articles researched on the topic of Tibetan medicine. The Tibetan medical system is used and practiced by doctors in other countries, and I excluded research from where the written primary language was other than English.

There were a minimal number of trained TMDs, based on the accessibility. Participation was voluntary in this research. The small sample size of participants in the design corresponded to the small overall population size and factored in the accessibility to the group. The population within the field of Tibetan medicine and the TMDs were, in a sense, a closed group, meaning access must be granted by someone from inside the group or intricately connected to the group. The recruitment process relied on the compassion of the key informants, gatekeepers, and networks to gain referrals and the participant's willingness to volunteer and feel comfortable.

There was a need to navigate from the role of an outsider without fully being an insider (e.g., a recognized scholar of Tibetan medicine or Tibetan medicine physician). "Researchers can only ever occupy the space between, as we cannot fully occupy one or the other of those positions" (Dwyer & Buckle, 2018, p. 1). This study required an understanding of the culture, Tibetan medical terminology, and practices to gain

credibility and confirmability to have the means to obtain respect from the Tibetan medicine community, and to analyze and interpret the data, respectively. During my immersion in the cultural experience, I needed to manage my personal biases during analysis. There was a constant battle between neutrality and biases (Dwyer & Buckle, 2009). According to Dwyer and Buckle, the principal investigator's role, personhood, and role within the relationship of the studied population "is an essential and ever-present aspect of the investigation" (p.55).

The methods used were snowball sampling and direct email using published information on the internet to aid recruitment and credibility. However, snowball sampling yielded the most participants. Snowball sampling also presented challenges. As an outsider, depending on whom I spoke with, there was an expectation that I was well-read on the topic of Tibetan medicine, knew the terminology, and held a certain level of knowledge.

Additionally, I experienced several significant life changes during this dissertation process, two being the loss of my mother and my chairperson and mentor 4 years later. There were also two computer crashes. These factors and others affected my ability to navigate the complexities, where some processes took longer than expected.

### **Recommendations**

Whole person care involves many complex components depending on the lens used for assessment. Based on the findings of this study, whole person care entails environmental elements, astrology, the energetic systems, the patient's active participation, the doctor's role, treatments, and diagnosis. The present study showed



interconnection and interdependence of all these components are essential in understanding health and disease. The study's findings were presented to increase the understanding of how Sowa Rigpa physicians view whole person care and opened the door a little wider for discussions to continue related to philosophy and practice. The findings showed that the physician of Sowa Rigpa postulates a whole person care theoretical lens and an approach and treatment lens that other researchers believed impossible or unwarranted due to the necessity to consider all complex dimensions (Carruthers, 2013; Hutchinson, 2011a). The present study does not dispute the complexity involved in evaluating all components required to treat the whole person.

On the contrary, the present study addresses the complexities and offers recommendations based on existing literature. Future research should continue to explore whole person care from traditional medical systems and ways allopathic medicine might continue to use the broader concepts of these complex dimensions, including the doctor-patient relationship, which will only enhance treating the whole person within all medical traditions. The following are specific recommendations based on other researchers' findings as well as the conclusions of the present study.

Thomas et al. (2020c) found several factors that affected the practitioners' ability to apply whole person care within allopathic medicine in Australia. Thomas et al. suggest offsetting the challenges with increased access to care (e.g., home visits; co-location providers), longer intake sessions, multiple visits, including family members as part of the care team, and increased education on whole person care to the general population. The present study revealed that participants incorporated these factors in their practice of

*Sowa Rigpa*, hence supporting the need for additional research within allopathic medicine in the United States.

Additionally, Jonas and Rosenbaum's (2021) assessments of the use of whole person care models within the United States asserted that the usage in general primary care had achieved positive outcomes (e.g., clinical, decreased cost, and patient experience). Yet the authors concluded there were still challenges with continuity of content with the approach within the often-used models assessed. Further research in these areas is needed.

Based on the findings in this study, the critical lens that might be helpful for future researchers to continue to explore is the interdependence between health and disease. There are multiple energetic, biopsychosocial systems, and environmental systems interconnected that contribute to the health and wellness of an individual. Continued research in these areas is suggested. Sturmberg et al.'s (2019) discussion on health and disease imparts insights into the whole person care phenomenon and its complexity. The researchers assert that subjective experiences and personal illness are interdependent and are part of the "single whole person phenomenon" (p. 4), which supports the findings in the present study on the physician's lens within *Sowa Rigpa*.

The present study found that physicians in *Sowa Rigpa*, through their keen use of sense and ability to use their body as a diagnostic tool, incorporate a high level of intuition and awareness into their diagnostic process. Recent literature supports intuition as an "undeniable part of diagnostic reasoning of physicians" (Van den Brink et al., 2019, p. 7). Continuing research and finding ways to explore and finetune the intuitive skills of

the allopathic physician, as Van den Brink et al. (2019) suggested, would only help the practitioner and patient. Also, exploring diagnostic techniques such as the pulse, there appears to be a great deal of information to obtain during the intake session.

The present study found that *Sowa Rigpa* physicians' self-care practices, intentions for healing during treatments, and deep understanding of interdependence and interconnectedness bestow insight into the significant role of the doctor-patient relationship. Researchers have discovered that a potential physiological effect occurs between doctors and their patients (Vigier, 2021). Further research in allopathic medicine on compassion, time spent with a patient, or perceived interactions with the patient related to the patient's physiological response, might be helpful. In addition, further research on physicians' self-care practices might also be beneficial. Self-care might improve intuition, cognition, and physical health (Pipas, 2020). Sturmberg (2020) asserts that the use of complex-based interventions that address these complex dimensions in health and disease helps the physician become more efficient and increases empathy.

Continued research on the energetic pathways, subtle energies, and environmental effects, including cosmology, would be beneficial in understanding these complex dimensions' effects on health and disease. Furthermore, future research on *Sowa Rigpa* and psychoneuroimmunology, along with understanding the *Sowa Rigpa* energetic systems and their physiological relationships, could help *Sowa Rigpa* to become common knowledge amongst all physicians. Researchers have discussed the possible energetic effects on health (Brown, 2009; Rein, 2004; Rosch, 2009; Rubik, 2002; Theise, 2009).

Research around psychoneuroimmunology is ongoing and continues to be promising (Picard & McEwin, 2018). Picard and McEwin's (2018) framework for evaluating mitochondria and the stress response appears to support the theory and philosophy of *Sowa Rigpa*. Continued research in psychoneuroimmunology will strengthen the mind-body connection and provide additional insight into the energetic pathways (Brown, 2009; Picard & McEwin; Rosch, 2009) existing in the body. There is an opportunity to exchange knowledge based on the concepts used in traditional medical systems. Continued research in *Sowa Rigpa* and allopathic medicine is needed.

Finally, further research to explore ways allopathic medicine physicians could collaborate with *Sowa Rigpa* physicians or explore the medical concepts to broaden the lens through which to view health and disease would be helpful. Traditional medical systems have so much to offer the modern medical physician. With an open mind and a compassionate heart, traditional medical theory and practices and allopathic medicine might be an ideal way to solve health care socioeconomic issues and chronic health conditions. Based on the findings from the present study, four questions come to mind for future exploration: What is the common thread or theme in allopathic medicine that could bridge the mind-body, diagnosis, and treatment? How can the relationship between allopathic medicine and traditional medical systems be strengthened? What is required to continue the exploration of the energetic interactions that exist and affect physiology? And where does the theory and practice of *Sowa Rigpa* correspond with the allopathic medical model?

## Implications

The present study provides insight using everyday language to assist individuals unfamiliar with *Sowa Rigpa* with understanding whole person care from the physician's lens. The intent is to increase awareness and spark interest with practitioners, patients, and researchers of allopathic medicine to see whole person care through a whole medical system approach to care. The study might help patients seeking an alternative care approach obtain foundational knowledge of *Sowa Rigpa*.

Implications for practice in Western medicine: The present study provides an opportunity to explore ways to expand the training and knowledge of treating the whole person. The present study may affect social change through continued exploration into traditional medical systems globally and specifically within the United States, particularly Tibetan medicine, which may decrease the prevalence and costs associated with chronic conditions. The present study provided potential common language and understanding of concepts used in *Sowa Rigpa* to encourage researchers and medical practitioners to explore theory and practices in *Sowa Rigpa*. By exploring a traditional medical system's approach to treating the whole person, Western professionals may further explore treating chronic diseases, the mind-body relationship, and using strategies that may be cost-effective and enhance doctor-patient relationships from other researchers in the field of traditional medicines (Bauer-Wu et al., 2014; Luo et al., 2015; Niemi & Ståhle, 2016; Ozawa-De Silva & Ozawa-De Silva, 2011; Stanifer, 2015; Wang et al., 2015).

By increasing research in the Tibetan medical tradition, the additional research may also guide research design for future studies in the West on Tibetan medicine and the mind-body connection. Future development around complementary and integrative health depends upon researchers' understanding of traditional medical system practices and the complexities of the properties and active elements involved in the treatment modalities (e.g., botanicals; NCCIH, 2016). It is essential for both systems of medicine to share and engage in approaches to understanding diseases (Dhondrup et al., 2020) and pathogens like sars-CoV-2, which gave rise to the COVID-19 pandemic (Tidwell & Gyamtso, 2021). The knowledge exchange could benefit and expand modern medicine through collaborative research and open discourse on philosophy and theoretical approaches (Bodh et al., 2017). Comparing and contrasting systems and collaborative research are the analytical processes at the foundation of exploration and discovery. Approaching the field of medicine from this lens, studied medical traditions would benefit the collective expansion of knowledge and patient care.

Potential implications for universities teaching Western medicine: The present study provided an alternative lens to view whole person care to encourage and increase curiosity in medical students. The present study offers an opportunity for medical students to explore different practices and see the practice of medicine through a different lens. In addition, medical students and physicians could examine ways to strengthen their intuitive diagnostic skills and treatment applications through the lens of traditional medicine practices. The continued exploration and understanding of the physician's role in the doctor-patient relationship and ways to strengthen the healing implications within

the relationship. Another takeaway is to continue to enhance the student's knowledge of self-care as a physician. Western medical practitioners, through engaged inquiry, might explore being open to other medical traditions, practices, and ways of thinking. The practice of medicine should encompass understanding and engage with all medical traditions for the discipline's collective and inclusive growth. The COVID-19 pandemic is one example where cooperation benefited everyone.

### **Conclusion**

“Everybody can heal. Everybody can become happy. But to heal from a serious disease, we need to change from a very deep place within ourselves” (Ventegodt, 2016, p. 452).

The present study addressed whole person care and what it means to treat the patient wholistically. Tibetan medicine was the lens of the present study to view the practice of whole person care used in a traditional medical system. The present study found Sowa Rigpa to be rich with a sacred essence and lens through which to view health and disease. The discussions with the participants revealed that physicians of *Sowa Rigpa* see a sacredness existing within all living organisms and the interconnectedness between the environment and the earth. Everything consists of the internal and external five elements and three humors. Nothing exists in isolation, and everything is interdependent. Suppose the health care system embraces this level of sacredness and understanding. In that case, practitioners and patients can become more aware of the inner workings of the individual body and become more mindful of self-care. Increased awareness within the

health care system and the delivery of care promotes empathy, compassion, and quality of care in a healing space.

Recent research on whole person care, under the allopathic umbrella, has addressed whole person care terminology (Thomas et al., 2018), the doctor-patient relationship (Thomas et al., 2020a), the challenges in applying whole person care (Thomas et al., 2020c), and the various models of whole person care (Jonas & Rosenbaum, 2021). The researchers identified the need for continued research on whole person care to streamline terminology, create a unified theoretical approach to whole person care, obtain the physician's perspective, and study outcomes of applying a whole system approach to patient care. Based on those suggestions, the research, and the findings in the present study, exploring these areas would be beneficial.

It is also important to note that incorporating whole person care within the Western paradigm is not without challenges. The biopsychosocial model is also a critical part of whole person care. The biopsychosocial model, which blends the psychosocial and biological within allopathic medicine, is known for its positive effects and is commonly used when addressing chronic conditions (Kusnanto et al., 2018). Research in this area is abundant, yet there are still challenges with going beyond biomedical thinking to include these broader concepts in patient care (Thomas et al., 2020b).

Based on the findings in the present study, continued research on whole system medical approaches might provide insight into the various components needed in the practice of whole person care. This dissertation study will hopefully continue to foster the discussion on whole person care as an approach to continuity of care through the



individual's lifespan and increase collaboration between physicians of *Sowa Rigpa* and allopathic medicine within the United States and others interested in traditional medical systems.

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## Appendix A: Phase II Interview Questions

### 1. *What does it mean to you to treat the whole person as a Tibetan Medicine Doctor?*

- *How do you see these elements/dimensions relating to the presenting disease or symptoms?*

#### Clarification

In Tibetan Medicine, the body is viewed as a microcosm of the natural world. The theory and practice of Tibetan Medicine considers astrology, the five elements, karma, the three nyés pa, the seasons, the seven bodily constituents, the three excrements, as well as many other factors I have not mentioned.

Why are these components important when treating a patient?

How do you implement the guidelines associated with these aspects when working with a patient?

### **Potential additional questions and topics**

#### ***Health***

What are the assumptions about the etiology of the disease?

Can you describe health prevention measures to assist in preventing the manifestation of disease?

#### ***As a Physician***

What are your criteria for accepting to treat a patient? What are your criteria for deciding not to take on a patient or to refer?

What do you do to prepare yourself prior to a consultation?

#### ***About the Patient***

During your consultations, what is important for you to know before diagnosing and treating a patient? *What do you require/expectations from your patient?*

#### ***Diagnosis***

- Thinking about a patient, can you provide an example where behavior was a major part of the presenting illness? How do you make that evaluation?

#### Clarification

The nyés pa are the key to the psychophysiological balance within the body.

Thinking about a patient and an illness, how do you implement the guidelines associated with the theory of the nyés pa?

What is your thought process on how you think through a diagnosis? Is it based on the human experience? How do you validate the illness?

- The subtle physiology appears to be the key to healing due to the interconnectivity of the mind, physical body, and the subtle. How do you implement these aspects in your pulse diagnostics?
- How do you know how a person is doing psychologically or spiritually? How do you make that evaluation?

*Clarification*

Of the three nyés pa, loong appears to be an important indicator along with other factors when assessing the mental aspects of a patient.

In your practice, how do you assess your patient's psychological state?

What other factors must be considered when making a psychological assessment?

- *Thought process on how you think through a treatment.* How do you know if the treatment was successful?

***Physician-Patient Relationship***

- *What is important to you within the physician-patient relationship?*

2. Thinking about the physician as the healer, what training approaches are applicable to physicians of other traditions? What suggestions do you have for physicians of other traditions to develop their diagnostic and therapeutic sharpness of thought, hearing, and vision?

***Closing Question***

3. Is there anything that you think I should have asked?

**Probing Questions**

Can you tell me more?

Why is that important?

Can you describe the process?

## Appendix B: Phase I Key Informant Interview Questions

How do physicians of Tibetan medicine view treating the whole person?

- A. Thinking about the definition of wholistic or wholistic healing, what would you say about the theory and practice of Tibetan Medicine?

Read definition: Wholistic: “Wholistic healing deals with the totality of a person’s being...means treating the whole person, helping the person to bring the mental/emotional, physical, social, and spiritual dimensions of their being into greater harmony using the basic principles and elements of wholistic healing and, as much as possible, placing reliance on treatment modalities that foster the self-regenerative and self-reparatory processes of natural healing” (Otto & Knight, 1977, p.3).

BREAK

- B. Otto & Knight’s (1977) eight basic concepts of wholistic healing will be explored, and the experts will be asked to give their thoughts on each point:
- a. “Recognition that every human being has vast untapped potentials, resources, and powers is inherent in wholistic healing.
  - b. The fostering of self-awareness and self-understanding can play a vital role in the healing process.
  - c. Placing reliance on the capacities and resources of the person seeking health is a key factor in mobilizing the healing process.
  - d. The interpersonal relationship environment is an integral part of the treatment program and is of outstanding importance throughout the period of healing.
  - e. Maximal use needs to be made of self-regulating processes and therapies within the dynamics of a disease process before that process reaches the point where major chemotherapy or surgical treatment is required.
  - f. Wholistic healing makes optimum use of the dynamic and therapeutic forces inherent in group interaction and group work.
  - g. Recognizing the integrative aspect of life, wholistic healing also addresses itself to the quality of a person’s life by fostering exploration of the personal lifestyle, to bring values, goals, aspirations, and personal functioning into increased harmony.
  - h. Utilization of a person’s spiritual resources or belief structure is an important aspect of the wholistic healing process” (Otto & Knight, p. 8 - 13).

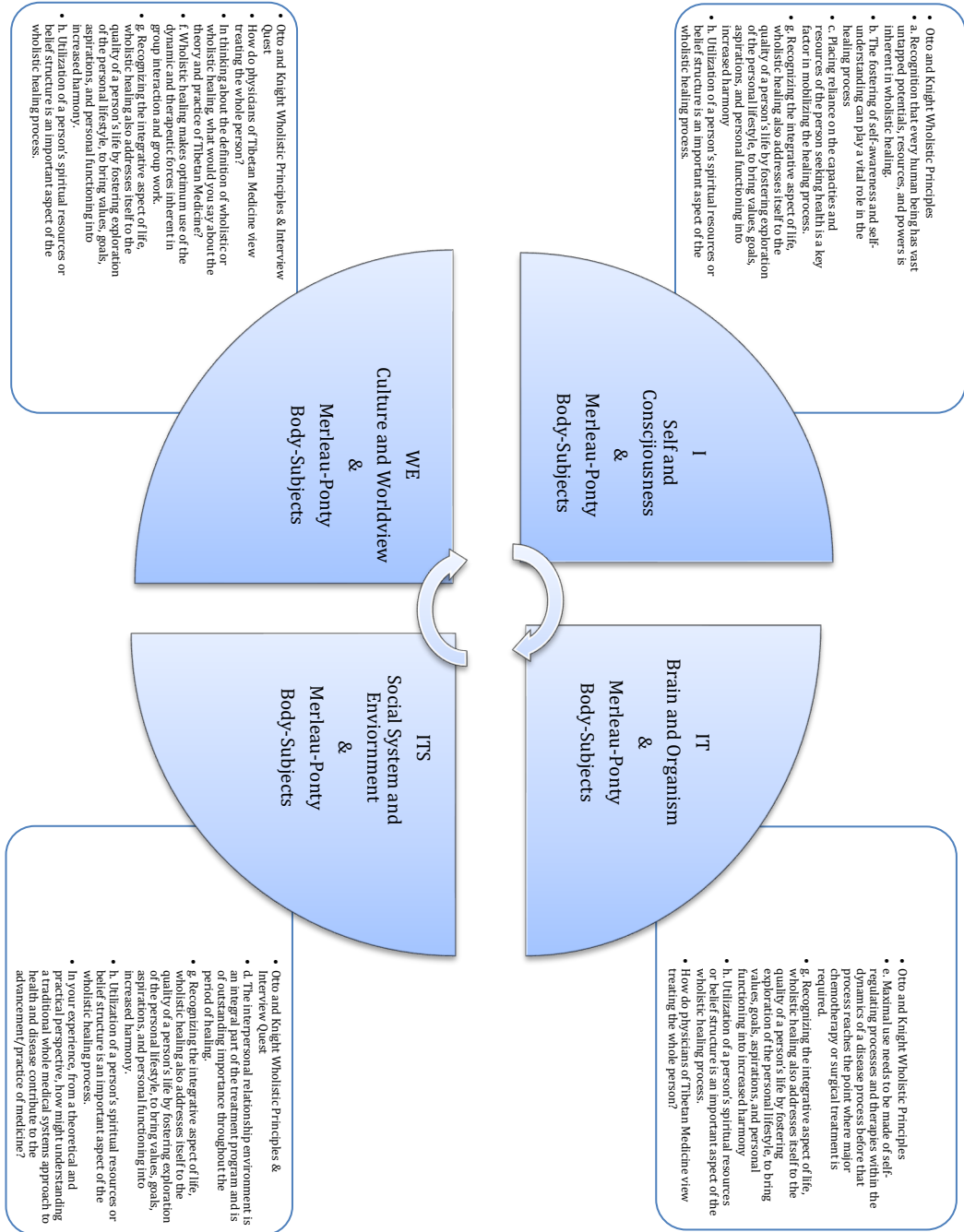
BREAK

- C. From a theory and practice perspective, in your experience, how might understanding a traditional whole medical systems approach to health and disease contribute to the advance/practice of medicine?

Potential Clarifying questions:

1. How might understanding Tibetan Medicine's approach to health and disease contribute to Western medicine?
2. From your perspective, what areas related to the theory and practice of Tibetan Medicine might be worth exploring from a Western medicine perspective?
3. In your view, what does Tibetan medicine look like in the Western world? What challenges does it face?

Appendix C: Conceptual Framework Informing Phase I and Phase II Questions



## Appendix D: Debriefing Statement

Thank you so much for participating in this study! I will use the information from all the interviews for my doctoral dissertation research study. Again, I want to make it clear that I will never use any unique identifiers that will divulge your identities, such as your name or any of your personal information. Your information will be compiled with that of all of my other participants for my dissertation research study. If, for any, reason I may need to directly quote you in writing within my dissertation, I will never use your real name, I will always assign a random letter or number, and any additional information that may directly identify you will be excluded.

Would you like a copy of the results of the study?

YES

NO

If yes, please print name and where you would like the information sent below:

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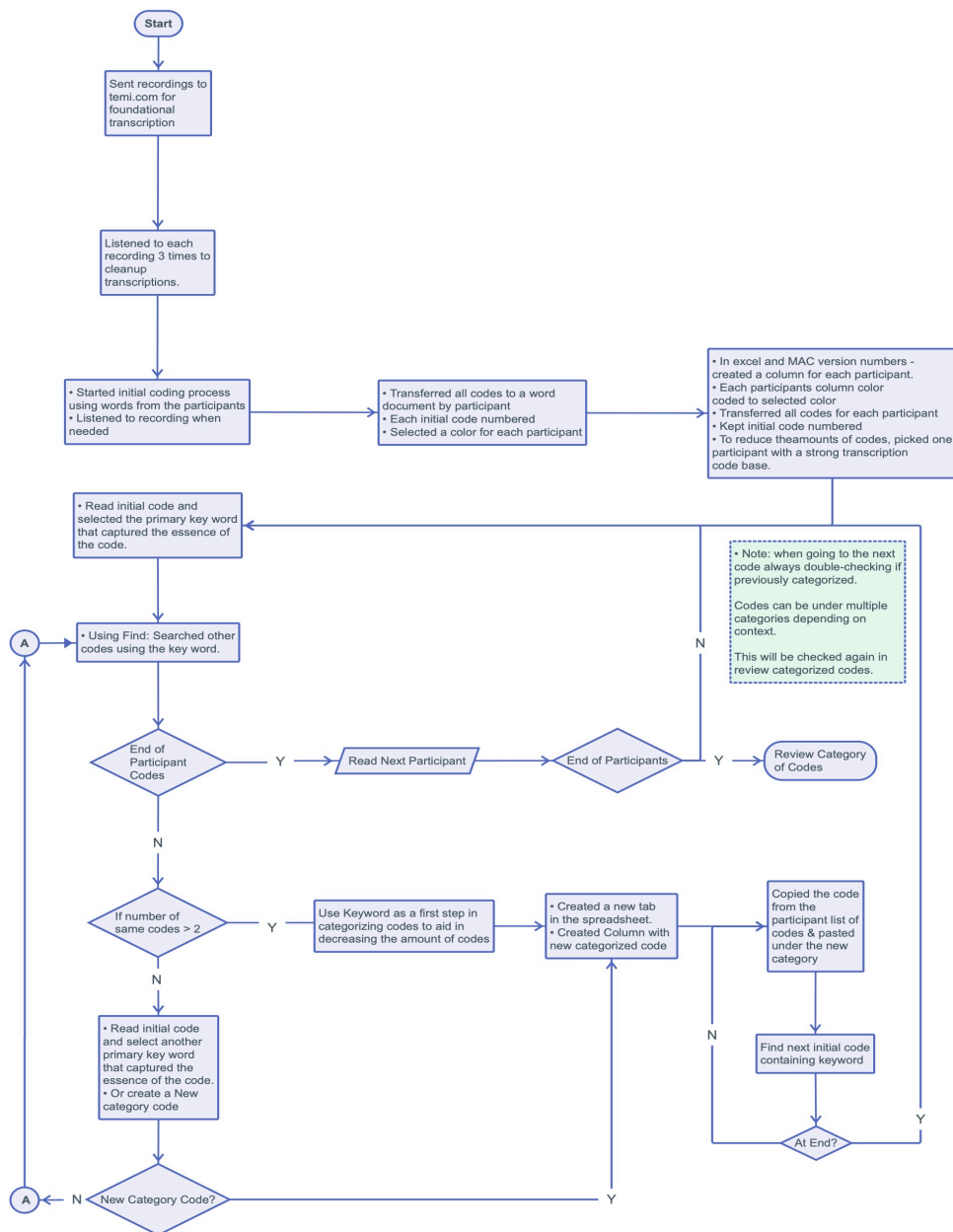
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**Please realize it may be a year before all the analyses are complete.**

## Appendix E: Phase 1: First and Second Coding Iteration

Phase I: First and Second Iteration of Coding Analysis





## Appendix F: Phase I Preliminary Themes

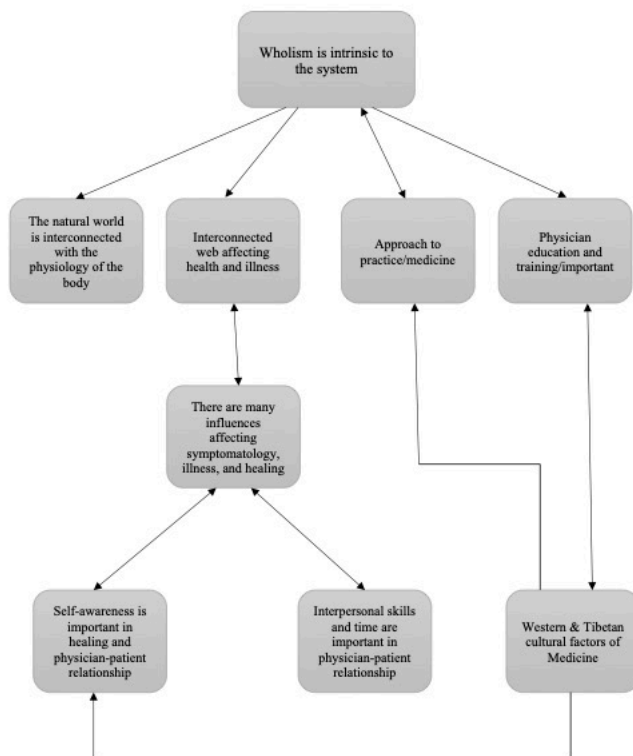
Nine Preliminary Themes with codes and subcodes or categories – *Second Level codes are Italicized and bolded.*

1. The natural world is interconnected with the physiology of the body
  - a. Nature and health play a role in health***
2. Wholism is intrinsic to the system
  - a. Holism/wholistic***
3. There are many influences affecting symptomatology, illness, and healing
  - a. Symptoms***
  - b. Concept of Illness and Disease***
  - c. Healing components***
4. Interconnected web affecting health and illness
  - a. Mind-Body Connection***
  - b. Biopsychosocial***
    - i. Biological
      1. ***Nyes pa (Three Humors)***
        - a. Bad kan***
        - b. Rlung***
        - c. Trīpa
      2. ***Energetic Channels***
        - a. Subtle
        - b. Gross
      3. Measures/testing
      4. ***Nature and health play a role in health***
    - ii. Psychological
      1. ***Three Poisons***
      2. ***Patient Behavior***
    - iii. Social
      1. ***Culture***
      2. ***Family System***
      3. ***Social***
  - c. Belief System/Spiritual role***
    - i. Role in healing
    - ii. Spiritual Practices
  - d. Contextual experience influences health***
    - i. Social
    - ii. Family system and biopsychosocial spiritual
    - iii. Karma
    - iv. Cultural East vs. West
5. Western & Tibetan Cultural factors of Medicine
  - a. Cultural Traditions***
    - i. Astrology

- ii. Spiritual Practices
  - iii. Karma
  - iv. Intuitive aspects
- b. Systemic Factors of Medicine**
- c. Policy implications**
- d. Skills of physician**
- e. East Meets West**
- 6. Self-awareness is important to healing and the physician-patient relationship.
  - a. Self-awareness/Physician/Patient/Physician-Patient relationship**
    - i. Physician Self-awareness
      - 1. Diagnosis, treatment, and healing
      - 2. Self-Care**
      - 3. Skills of the Physician**
    - ii. Patient Self-awareness
      - 1. Healing
    - iii. Physician-patient relationship
      - 1. Healing
- 7. Interpersonal skills and Time are important in the physician-patient relationship.
  - a. Patient feels supported**
  - b. Trust Physician**
  - c. Time with Patient**
  - d. Effective communication and assessment**
  - e. Compassion**
  - f. Adherence to Treatment**
  - g. Role – Patient and Physician**
    - i. Physician
    - ii. Patient
  - h. Testing (collapse or ignore)**
- 8. Approach to Practice/Medicine
  - a. Methods of assessment**
  - b. Diagnosis**
  - c. Perception of disease
    - i. Symptoms**
    - ii. Concept of Illness and Disease**
  - d. Healing Component**
  - e. Treatment**
  - f. Personalized medicine**
  - g. Role – Patient and Physician**
- 9. Physician Education/Training is important

## Appendix G: Phase 1 Preliminary Findings


Phase I Preliminary Themes and Relationships



## Appendix H: The Principles and Concepts of Wholistic Healing Copyright Clearance

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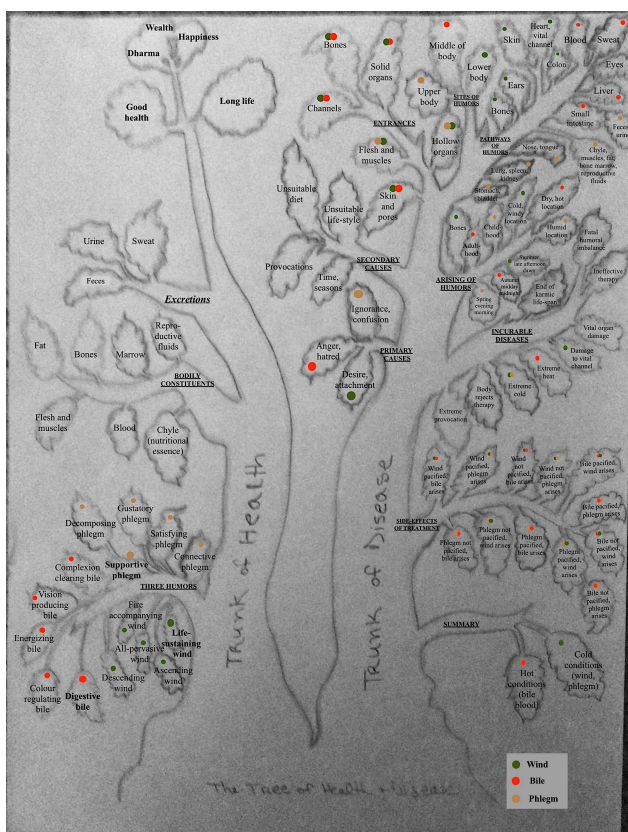
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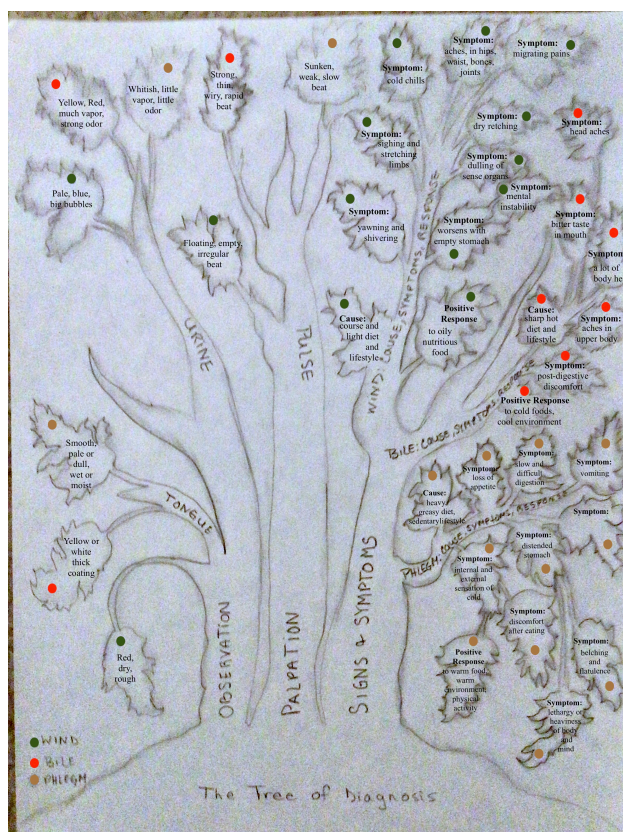
## Appendix J: Hand Drawn Tree of Health and Disease



Note: Hand-drawn rendition by Emma Brooks (9 in. W x 12 in. L; mixed media pencil and graphics) of The Tree of Health and Disease. Adapted from *The Tibetan Book of Health* (p. 60) by Chenagtsang, 2018 (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort) and reprinted with permission.

Homework assignments, as a student of Sowa Rigpa, consisted of making copies of the medical trees to aid in internalizing the material and the connections involved. A hand-drawn copy with embedded graphics took hours to recreate. This diagram is based on information outlined within the *rgyud bzhi* (Root Tantra; see also Figure 2 and Figure 3) of Tibetan medicine, thereby representing the tradition's authoritative mapping of how medical information should be synthesized and studied.

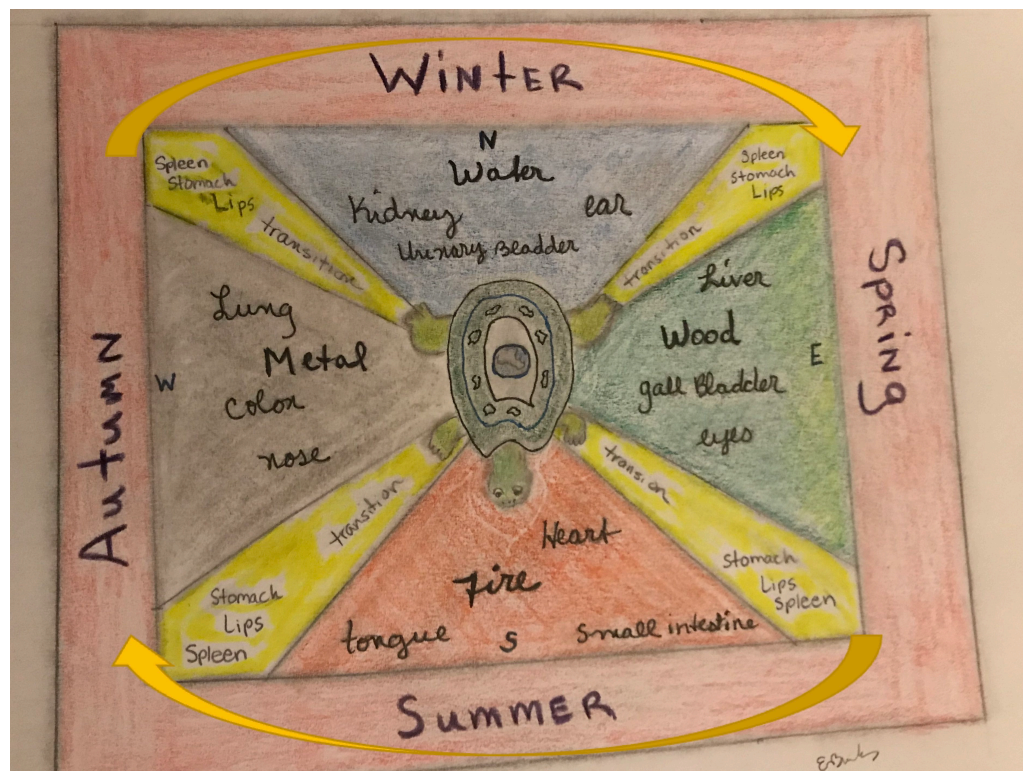
## Appendix K: Hand Drawn Tree of Diagnosis



*Note:* Hand-drawn rendition (9 in.W x 12 in. L; mixed media pencil and graphics) by Emma Brooks of The Tree of Diagnosis. Adapted from *The Tibetan Book of Health* (p. 71) by Chenagtsang, 2018 (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort) and reprinted with permission.

As a student of Sowa Rigpa, I was required to make copies of the medical tree diagrams to aid in internalizing the material and the connections involved. This diagram is a hand-drawn copy with embedded graphics and took hours to create. This diagram is based on information outlined within the *rgyud bzhi* (see Figure 2 and Figure 3), thereby representing the tradition's authoritative mapping of how medical information should be synthesized and studied.

Appendix L: Relationship Between the External Elemental Influences, Seasons, and  
Organs

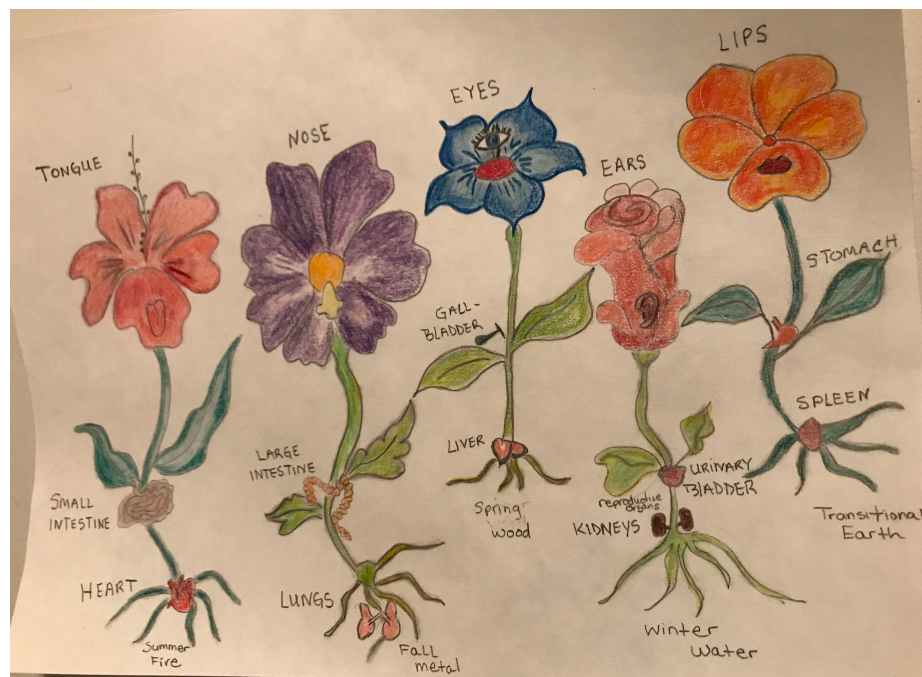


Note: A hand-drawn rendition (12 in. W x 9 in. L; mixed media pencil and graphics) by Emma Brooks of The Turtle and five external elements. Adapted from *The Tibetan Book of Health* (p. 24) by Chenagtsang, 2018 (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort) and reprinted with permission.

As a student of Sowa Rigpa, I was required to make copies of these diagrams to aid in internalizing the material and the connections involved. I produced this using drawing pencils and colored pencils with embedded graphics. This diagram is based on information outlined within the *rgyud bzhi* of Tibetan medical theory and practice, thereby representing the tradition's authoritative mapping of how medical information should be synthesized and studied.



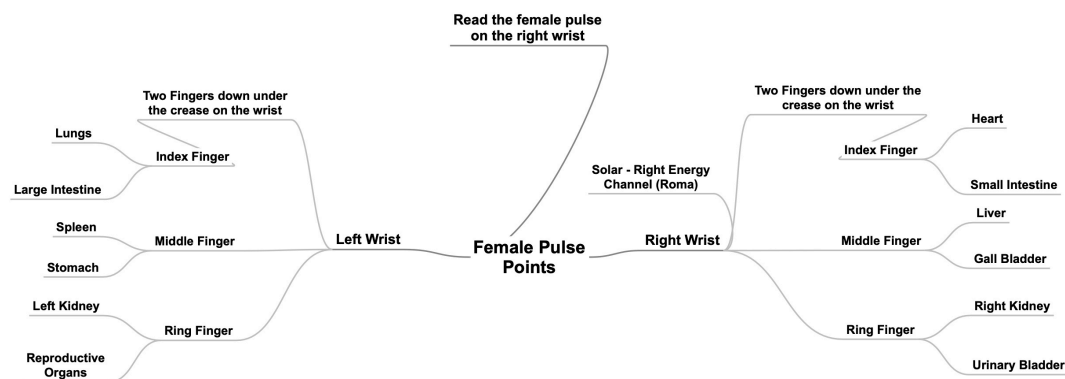
Appendix M: Flower, Stem, and Root Organs' Interconnections and Corresponding  
Seasons and Elements



*Note:* A hand-drawn rendition (9 in. W x 12 in. L; mixed media pencil) by Emma Brooks of the interconnectedness of the solid organs, hollow organs, and sense organs. Adapted from *The Tibetan Book of Health* (p. 30) by Chenagtsang, 2018 (Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort), reprinted with permission.

A homework assignment. Hand drawn using drawing pencils and colored pencils took hours to recreate. The flower diagram illustrates a traditional metaphor that explains how the solid, hollow, and sensory organs are all interconnected, especially for diagnostic purposes. This diagram is based on information outlined within the *rgyud bzhi* of Tibetan medical theory and practice, thereby representing the tradition's authoritative mapping of medical information that should be synthesized and studied.

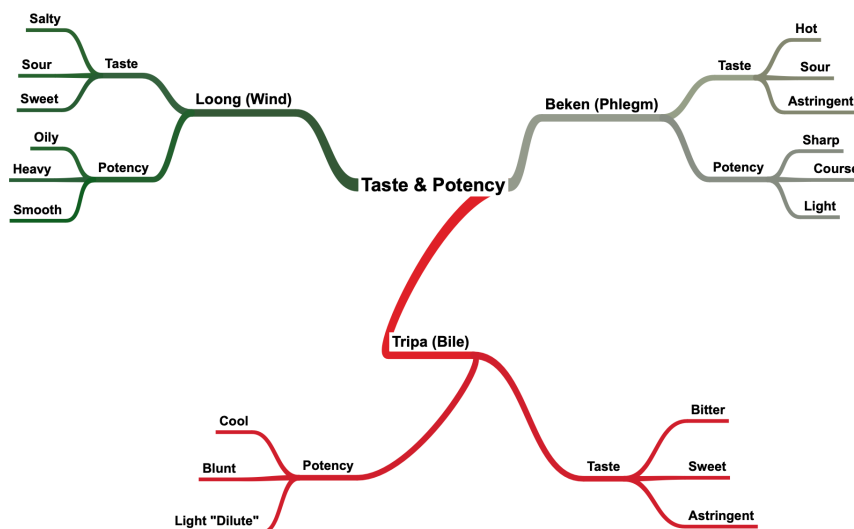
## Appendix N: Example of the Female Pulse



*Note:* Mapping tool. As a student of Sowa Rigpa, I was also required to create diagrams or drawings of new information to aid in internalizing the material and the connections involved. Also, based on information outlined within the *rgyud bzhi*.

The participants in this study repeatedly reference the use of the pulse technique. Some participants described the connections between the fingers and organs. The diagram provides a glimpse into the patient's health data retrieved from the pulse reading relayed through the fingertips of the physician. Pulse diagnosis is an essential diagnostic technique (see Chenagtsang, 2018). When reading the male pulse, the index fingers identified on the female pulse are swapped, i.e., the lungs and large intestines are monitored on the right wrist. The physician checks the lunar-left energy on the left wrist in place of the solar (Chenagtsang, 2018; Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort).

## Appendix O: Taste and Potency Based on Humoral Energies for Making Medicines



*Note:* Created using a mapping tool.

Many hand-drawn diagrams were created as a student of Sowa Rigpa for taste and potency. This is a simple creation to aid in internalizing the material and the connections involved. This diagram provides a visual of the humoral energies and their corresponding tastes and potencies in treatments, herbal substances and compounds, and foods based on information outlined within the *rgyud bzhi* (also see Chenagtsang, 2018; Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort).

## Appendix P: Thangka, Tree of Healing Therapies and Treatment



*Note:* From “Tangka, Tree of Healing Therapies and Treatment” by American Museum of Natural History, n.d., Anthropology catalog, No: 70.3/ 5467. Courtesy of the Division of Anthropology, American Museum of Natural History.

Here is the tree of therapies and treatments. The three distinct colors of the leaves represent the three humors, with the leaves at the bottom left representing the color for *rlung*, the next color, yellow, *mkhris pa*, and green *bad kan*. The hand-drawn rendition was through a mapping tool. The root from left to right is the dietary food, lifestyle, medicines, and external therapies (see Chenagtsang, 2018, p. 88; Sowa Rigpa Institute, Year 1, Foundations Program, May 2020 Cohort).