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Journal

Institute of Urban and Regional Development

Author

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Publication Date

1984-11-01

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MYTH AND REALITY**

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Working Paper No. 436

November 1984

with the assistance of
Roger Coleman, M.D.**

INSTITUTE OF URBAN AND REGIONAL DEVELOPMENT

University of California, Berkeley

Should medicine ever fulfill its great
ends, it must enter into the larger
political and social life of our time;
it must indicate the barriers which
obstruct the normal completion of the
life cycle and remove them.

Rudolf Virchow
(1821-1902)

THE PROMOTION AND MAINTENANCE OF HEALTH: MYTH AND REALITY

Leonard J. Duhl, M.D.* with the assistance of Roger Coleman, M.D.**

INTRODUCTION

I was brought up in the center of one of the largest cities in the world. When growing up, I had not the slightest question about whether that environment was better or worse than any other. I lived in the streets, went to the schools, and got to know the community in an unusual way. From the time I was very young, my dad took my brother and me to every corner of the city, to all of its resources--its museums, its schools, its business districts, its ethnic neighborhoods, as well as its parks, the shores, its beaches, and to pockets of country nearby.

I had no notion that it was bad. The noise was accepted as part of living, for the "El" rumbled by our home in Brooklyn. The crossing of streets became a game as one dodged cars. The pattern of response to one's neighbors was to take and to give, to participate in the hustle and bustle. I found that the world of barter and exchange was part of my life. I worked hard; learning was a part of the experience of growing up.

I look back now to that environment and realize that much of what I am was shaped by the total environment which I experienced from adolescence on from my family and school environment. In the values, the patterns of behavior, and the style of response a hidden curriculum was subtly learned that went way beyond the outline of my courses in school.

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There was a piece of my family life which I took as the gospel of the right life, because it was part of the doxology of the family: going to the country in the summer. The streets in the city were too hot, and one needed the fresh air of either the mountains or the seashore. The sun was important and it was good to have a holiday or vacation. I can remember with vivid expectations the hot, late spring days and the beginning of summer as school was just about to be let out. I looked forward to the summer vacation in the country, and each summer since birth that country was part of my life. There, too, I was in touch with the whole of that world. It was not as familiar, and it was a little more fearsome. The midst of the woods in the middle of the night was worse to me at the beginning than a ghetto of foreigners in a central city. I did not know the meaning of the noises of the night--the screech of the owls, the chatter of the crickets--nor the uncertainty of direction, unguided by the grid-like streets of the city.

It took little longer to learn than city living; but I slowly found myself in touch with the world of the country that I used to wander in alone. I remember an early morning, watching some recently-hatched turtles crawl across a sandtrap as the dew began to fade away and the sun began to rise. I can remember a night at age eleven, sleeping outdoors and waking up and seeing the stars in such vivid brilliance that each one in the Milky Way firmly implanted its image in my head. I had not seen those stars before, nor had I seen the turtles or the birds, but I slowly learned about them in the country.

Nobody needed to prove to me that this world was good. Even though it was frightening, it was something I had to face. Nobody suggested that it had anything to do specifically with my health though subtly I heard, primarily through the family mythology, that open air and smelling the flowers was somehow good for my growing up. Eating fresh produce, drinking warm milk

fresh from a cow, and working in a garden digging up potatoes also was somehow good.

Over the years since then, as I began to get deeper into the concern both with illness and health, I found it impossible to separate the world of the ill or the world of a growing person from the environment. On the surface I was part of an intellectual discourse in college and university about the battles of nature vs. nurture, arguments about the natural life of Rousseauian thought vs. the scientific explanation of Descartes. I began to hear of genetics and its control over our development in life, and I began to focus as a physician on the problems of illness.

Yet somehow the hidden curriculum of my past led me more and more to the continued interplay between humans and their environment. I knew deep in my heart that it was tremendously important, and yet also knew how little we preoccupy ourselves with it or knew any of the answers.

I remember once a discussion with Abel Wolman, the professor at Johns Hopkins School of Public Health, who said that, though we do not know why grass in open space is important, it is still important to yell and scream for it, whether or not we have answers.

It is my purpose now to begin to focus on the issues of health and environment. I recognize that the questions being posed are a result of both knowledge and analytic thought and some deep, almost instinctual awareness as well--an awareness that our environment is somehow insulting us in a way which we do not fully understand, yet we believe to be important.

The character of the environment that we now know is becoming more and more clear to us in a way that is not just educational, but which is having a tremendous impact on our lives. Like Rene Dubos, I am a "despairing optimist" in the sense that what is going on in terms of the environment and the human

being's health brings me to the point of great despair, while at the same time I see particular people and programs working extremely hard on the issue which brings over me a sense of great optimism about our ability to cope.

THE PROMOTION OF HEALTH AND ILLNESS

One must, if one were concerned as we are with the question of health, look at what we mean by that word. It may not be enough for me to state my meaning, because the word itself is used quite freely to convey so many different ideas. Perhaps the best definition of health is one that my mother used when as a child I asked her how one stays healthy. She replied that you pick the right parents, eat the right food, and get plenty of rest. Somehow it was implied that one needed to be loved in order to be healthy.

Health, however, has many definitions. Its most common usage is the absence of illness. Most people, when asked if they are healthy, would say, "I am sleeping well. I am not tired. I am feeling pretty good." Yet, when those words are reflected upon, though they are related to a general sense of well-being, the more common utilization of the word "health" seems to convey the sense that there is an absence of sickness. People are doing what they want to be doing, uninhibited by changes that have taken place within their organism which might prevent them from doing what they wish. In recent years, as we have become more sophisticated about environmental insults to ourselves, we would say that, as long as the environment does not inhibit us through smog or other pollutants, or from being the kinds of people that we would like to be, we are healthy. It may very well be important, also, to be aware that the reality of the specific insults is not as important as whether people perceive themselves as being insulted, assaulted, or hindered from being what they wish to be.

It is easy for us who are analytical to state that there is no basis in reality for some of these perceptions, and yet the perceptions of internal insult or external ones may be enough to make any one of us feel unhealthy. This leads to the awareness that there may be some external things that insult us which may, indeed, insult all beings; but there are some that insult specifically us as individuals because we are unique, whether it be by our culture or experience.

A city-born person spending a first night in the country can complain bitterly about the noises of the night causing sleeplessness and pain, leading to ill health. The death of a spouse, who slept in one's bed for many years, leads to an absence which is as great as the removal of an organ, involving all the pain in the sense of the lack of well-being. Both are changes of environment.

Health, then, is a very relative issue. I would like to suggest that health depends particularly on the question of where one is, which is dependent upon one's own physiological state, one's psychological and social experiences, or one's subtle learning through the hidden curriculum of culture or pattern of living as it relates to a specific disability which has occurred.

Health directly relates to the statement of "I hurt." If I am hurting, by whatever definition, I *may* state that I am not healthy. I say *may* state because that very environment may define the hurt in languages that do not consider the health as the issue, but call it financial loss, power battles, or bring in some other question--spiritual, social, political, or what have you. Health, then, for me is a synthesis of one's internal and external environment, a direct relationship to all our experiences of being, our values and our perceptions. Within a society as pluralized as Canada or the rest of North America, or even the world, the question of what health is, therefore, open to the gravest of disagreements.

Before leaving the subject I would add that even the qualitative nature of the hurt may determine the definition for, if one is so hurt that all of one's life

focuses around that central hurt, if one's very being is preoccupied with one's disability, health may be colored by that perception and nothing else has any relevance. This may hold true for death or *dying*, or the severely ill. At the same time, if the insult is only part of a larger experience, health may be the absence of illness and permission to go on doing all the other things, including things which cause difficulty, but one not defined as health-impairing.

I do not want to leave the discussion of health without focusing on the people who Maslow¹ has called "self actualizers." Williamson and Pearse² call them the living or "*the alive*." These people have, as Maslow has suggested, dealt with some of the basic issues of survival, and can go on to a sense of aliveness in which they are not concerned with stability, but rather with increased opportunity for new experiences in a wide variety of arenas. Where the standard "*survivor*" concerns one's self with the returning to a homeostatic state free of pain, hurt, or illness, "the alive" person is interested in the homeostatic state as a temporary plateau before one moves onward. They are open, as are people in all creative processes, to a variety of inputs which would lead to new levels of experience and existence. These people who are alive and living do not even use the words of health. Though they reflect the WHO definition, their concerns are with their experiences of living and the total quality of their life; and though they may become ill, they bounce back from their illness into a continued life of creativity and experience. Many of us know people quite old chronologically who have lived through many careers and experiences, and are continuing to find opportunities for their own participation. They see insults not as pain or hurt but, in the language of the Chinese characters for the word "crisis," as an opportunity. Crisis is both a danger and an opportunity and "the alive" people take advantage of crises for growth.

HUMAN DEVELOPMENT

With the concept of crisis, we begin to open up a set of issues about the meaning of illness. Certainly, the notion that crisis is both a danger and an opportunity suggests the relationship between development and disease. Hans Selye³ has said better than I what some important questions are in the relationship between stress and the way the body reacts. He has further related those concepts of stress to the ultimate breakdown of the organism leading to a variety of illness patterns.

What is most clear from almost all the work on stress, especially Holmes's⁴ development of a stress test or measure, is that the body is an adaptive organism which has a capacity to cope, up to a particular point. It is clear that the capacity to cope is based on past history, including primarily the genetic predispositions upon which all further experience is built.

The learning patterns that take place within the organism from the moment of conception on through the environmental processes of nurturance and through overt learning, set the patterns for future response. Learning takes place both within the uterine environment, and subsequently, through the birth process and all subsequent experiences. It is clear that, if basic nurturance does not occur and a variety of basic needs are not met, the individual's subsequent capacity to respond to crisis, stress, and opportunity becomes limited. Similarly, learning or the opportunity to learn, which can take place through stress and crisis, sometimes locks us into a repetitive pattern which cuts down on the range of options that we have through our biological and social inheritance. Thus, during our lifetime the environment teaches us the extent of our organic adaptability and the limits within which we must operate.

One must have a view of the human organism that is akin to those of the philosophers, Comenius⁵ and Rousseau,⁶ who basically believed in the capacity of the human organism. For if one has that belief, one looks at the environment in terms of what it does over time through learning and nurturance to maintain, encourage, and create alternative adaptive responses which serve the individual. Our society tends, more often than not, to limit this capacity through the environmental institutions, organizations, and relationships. Indeed, the environment, through its social, political, educational, and physical institutions, attempts to mold an individual into currently perceived adaptive responses which are capable of coping with expectable current realities, rather than leaving learning to become open-ended.

Thus, when responses are no longer capable of dealing with crisis by the existing learned techniques, the organism, both in its biological and psychosocial responses, breaks down at its weakest points. The lesson, therefore, suggested by the work of Thomas Holmes⁷ is that, when crises rise above a particular threshold where the individual cannot successfully respond, they invariably lead to breakdown. However, if one person's stress is not perceived by another as a crisis, the other would not necessarily break down. Our learned coping devices and perceptions are such that we define the very crises and stresses which cause difficulty for us. In fact, many of Holmes's stress items may not be stress for people who have learned other kinds of adaptive patterns.

All of this leads to some very serious questions about the institutions that are involved in the developmental process. We must ask questions about whether, indeed, we believe in this limitless capacity of the organism from conception on, or conversely take the opposite view. This view implies that the human is an empty vessel which needs to be filled, that the environment's responsibility is to teach, and that the empty organism must learn from the

outside what it has to know in order to cope with the situation (cf. Skinner).⁸

Obviously, the central values of our society are critical to our observations. If, for example, the values of the society are such that monetary returns are more important than optimal development of health, the choices made in the environment may limit the adaptive potential rather than expanding it.

In all societies which must survive--and if their concern is purely one of survival--they must "brainwash" their children to cut down their creative potential for true aliveness and health. Thus, if the mentality of the environment is that it *must survive*, true health may no longer be possible except for the rare person.

This extremely strong statement suggests that our society cannot--and I underscore *cannot*--accept too much aliveness, because aliveness implies breaking down systems of rigidity, structure, and bureaucracy. Creativity requires openness. Survival requires not "rocking the boat."

Aliveness and health as learned through the developmental cycle can be hindered by the structures of our society. The basic political and social question must be, then, whether the society values issues which we relate to health more than survival itself. This is not to state that survival needs must not be met, because basic needs must be met as we reach toward aliveness and health.

Think, though, what the external society believes about the creative person. Creative children have been shown to be too disruptive because they do not fit into the organized curriculum of classrooms. Rather than being locked into concrete educational patterns, people would need to be freed to adapt on an individual--as well as institutional--basis if they are to survive and fulfill their potentials as members of a society in a state of flux. The way of life that has heretofore been only for the alive and the healthy must begin to be developed across the board, even if it appears that survival itself is the goal. To

conserve what we really have requires adaptive potential by individuals and society.

I will return later to the questions of what can be done in dealing with our environment. For the moment, we must take a further look at the physical, social, and political structures of our society in order to see whether, indeed, they fit into the developmental health process.

We have observed that questions which are asked about the way we govern and the way we live affect the development of people. Because of the massiveness of our cities and institutions, we no longer can get in touch with existence that makes up human life. It is suggested that we live in smaller communities in order to be in touch again with nature, to remove ourselves from the insults of the external environment, and to permit ourselves to get in touch with both our internal being and the external worlds. This may occur through non-natural as well as natural means--touch, smell, hearing, and sight--to enable this communication to become a part of our daily existence.

In these remarks, concepts of human development may be as vague as health. I have also suggested that *development*⁹ may be critically important to understanding our institutions. Any predetermined notion of development which insults a form of uniqueness--and in so doing that uniqueness becomes labeled as illness and ill-health--prevents the aliveness our society requires. By labeling uniqueness as illness through a self-fulfilling prophecy, the potentially alive behave as if ill.

ILLNESS

If, indeed, illness is caused by the inability of an organism to synthesize all its external and internal environments in order to cope with crisis or stress, it is important to understand how we currently respond to the cry of "I hurt." Our response is to treat people by locking them into the patient-dependent role, which results in an inability to achieve health.

I have no question that the serious illnesses and hurts resulting from breakdowns of the system can be coped with by our formal health care institutions. What I am unsure of, at the onset of illness--at the crisis point--when individuals are learning if their body can adapt to the crisis or stress, is whether iatrogenic processes cause a perpetuation of illness rather than its alleviance, which could be used as a crisis/learning opportunity to move toward health.

In looking at the institutions that deal with the disease cycle, it is clear that almost all of these institutions tend to lock people into the disease model. However, current trends are opening up the possibility that the perpetuated dependent situation of the ill might not occur. These trends include the ability to respond to crisis at the moment of occurrence, the development of primary care programs by the medical profession, and the creation of alternative pathways for people who hurt to be responded to quickly and fairly.

Thus, the more a person is informed about his or her own body, about the processes of development of the illness, and the more they are connected to the structure of the broader environment, through relatives, friends, tribe or network, without being locked into the illness system, the greater is the chance that they will stay healthy and will not be locked into the illness or dying model. Self-healing through personal responsibility can occur.

Therefore, it is important to look at our health-related institutions carefully. For example, so much of what we do, through insurance or the use of high technology, leads to disconnecting the individual from the sense of their ability "to command the events that affect their lives." The sense of power over one's own destiny becomes lessened. The sense of helplessness, the sense of not knowing, the fright, the confusion, the notion that there's a "juggernaut," or "combine," makes it extremely difficult for one to develop one's own innate capacity for growth for self-healing. Survival becomes the goal, not aliveness.

Though our institutions are modeled to cope with and yet maximize the illness process, it is equally clear that the patient's model of self collaborates with models of dependency. Their images of illness, of external threats, and of danger being external leaving one without internal power, contribute to their own destiny. Clearly, all the techniques that we can use, from education and learning to the use of the body, and the various tools we have available (spiritual, physical, biological, social, touching, relationships as well as the medical tools) will be to the individual's benefit. It is important, therefore, that all activities which contribute to this sense of personal confidence and self-will be built in, both in personal learning through natural growth and developmental process, and in institutions that are responding to "I hurt."

Recently, Rene Dubos¹⁰ told a story about La Fontaine, the author of *Aesop's Fables*, whose French country environment was critical. He suggests that the particular environment led La Fontaine to produce his fables. If he had been born in Russia, perhaps he would have written other fables or he would have utilized his own skills in a different way. La Fontaine was lucky, because he had this ability to turn his own internal processes into productive capacities. It would be my suggestion that his environment taught him through its hidden curriculum that he had those capabilities, and the fables were

produced.

Many of us are more or less educated. But most learn, through either the conscious or unconscious environmental social processes of our society, only about their impotence and inability to cope. A biologically deprived organism with no food input quickly learns how to adapt to low input in much the same way as natives of high altitudes learn how to produce more red blood cells to compensate for low oxygen. Biological coupled with psychosocial learning teach us both our capacities and our incapacities. And thus, our society trains most of us to be survivors, some to be ill, and discourages all but a few--the lucky and the rare--from achieving opportunities for health.

John Seeley¹¹ some years ago suggested that our society is based upon a model in which some people are "*haves*" and some are "*have nots*" and some are thus "better than others." To attain health means a value system which no longer requires rich or poor, healthy or ill for its survival. If our society requires some ill to survive, it cannot encourage the ill to attain health. If my hypothesis is right, that our survival requires aliveness, the old techniques of locking people into survival and illness are no longer valid.

Jonas Salk, in his recent work on *The Survival of the Wisest*,¹² has pointed out that our globe is moving into a new epoch (Epoch B), the second half of the "S" curve, in which the techniques and the values which heretofore worked (competition, putting people down, suppressing capacities), must be replaced by healthy, openness, cooperation, autonomousness, and wholeness.

I cannot leave either development or illness without noting that basic needs must be met if one is to cope with the external environment. These basic needs are not only involved in the learned capacity of the ability to respond, but they are associated with food, love, tenderness, caring, and the other qualities which maximize growth. As I have indicated, this basic security does not

result from the "absence of stress," but rather stress and crisis can, in the right environments, lead to growth through learning.

I have emphasized the notion of *connectedness*, as well as the ability to command events. It seems to me that difficulties result from any environment that disconnects people from the external world of reality, that places between people and the world secondary sources of knowledge and information and does not permit the direct relationship of the individual to things around him or her. Connectedness, as Rene Dubos pointed out, may very well be the ability of the individual to be in touch with the environment with all their senses and with all aspects of primitive experience. Thus, being brought up on the farm permitted him to be in touch with the rational and non-rational parts of his being, with the experience of death, growth, birth, and illness in such a way as to make none of them foreign. Healing may very well be the process of reopening all these avenues of experience involved in holistic development, thereby integrating and synthesizing the internal and external environment.

HEALTH AND THE PROCESSES OF GOVERNANCE

In all my previous remarks, I have laid the groundwork for looking at the way our society allocates its resources, to deal with our own growth development, and to deal with illness and the cry of "I hurt." It is my hypothesis that, despite the tremendous amount of money going into medical care, very little is being allocated to health and aliveness. Similarly, very little is going to aid the understanding of growth and development or to dealing with the early "I hurt" phenomenon. Why is this so?

I have suggested, as one divides our society into the living, surviving, and dying, that the living make up less than 10 percent, the dying fill 20 to 30

percent, leaving the bulk of our society in the hands of the survivors. The survivors by their very presence and number set the values and the criteria against which all programs are defined. Since survivors define health as the absence of illness, and the ability to turn from a state of boat-rocking to one of stability, the survivors expend most of their health energy in those arenas which will return the people who are ill to survival states and returning to living and working activities in existing institutions. Indeed, the current rebellions by the have-nots and the ill are forcing a reallocation of these funds, so that those funds that have gone primarily to survivors or to survivors who get ill can now be reallocated to the have-nots and to the ill and dying.

We have seen over and over again by reallocating these resources it means a bigger "hunk of the pie" going to those people to deal with their illnesses or to raise their developmental level.

This reallocation by itself does not lead to health. It is only when the healthy and alive align themselves with the ill and dying do we get innovative changes that permit moves towards health for the total society, because both sense a crisis in the existing systems for dealing with health and illness. These alliances as yet are not firmly made. Our personal health may also be related to this alliance.

It means that on the deepest level we may have to change our perceptual model and consciousness about the governing processes. In order to survive, it has seemed important to allocate resources under the existing models to those perceived economic and military institutions which preserve our status. Therefore, our notions of survival demand a new aliveness in Epoch B¹³ (using Salk's terms), meaning that those survival institutions to which we have previously allocated our resources may not assist us to survive. The only institutions which will permit us to survive are those which maximize the individual's

potential for his or her own growth as they define it, *as well as* maximizing the health of even the sickest members of our society.

I am suggesting, therefore, something that has not been well accepted in the medical literature: we can indeed have healthy sick people, that there is such a thing as a healthy schizophrenic, or a healthy poverty victim because health is a phenomenon above and beyond the illness response.

The models of health and governance that we use come from the broader value systems "in good currency." These may, indeed, be outdated given the changing issues and problems we are currently facing.

To briefly sketch out some of the current problems means we have to face the transition of hierarchical power structures to newly emerging ones. Historically, royal power became elected power. Both models are hierarchical with the ruler maintaining power either by birth, military strength, or election. With power the ruler is given the license to propose and dispose, and to be fair in dealing with all of the community.

It is interesting to note that many of the biological and psychological models currently used even by the non-scientists of how the human organism works parallel those socio-political governance models. They assume that the brain is the furthest developed of any organ within the human body and that with its rational ability can control all that is within the rest of the organism.

Slowly, almost non-consciously, notions of political structure and governance has been shifting to non-hierarchical and more horizontal arrangements. As John Rawls¹⁴ in his book on justice has pointed out, current statements of equality are that "every person is equal." This notion is one that is being striven for politically and yet we know that it is not working. Another view of equality is that each is uniquely different and in their difference they are equal. The concepts of equality and of justice is applicable to health. If all people are to be

treated the same, the sense of individual uniqueness is gone. Slowly we are shifting to a more biological concept that the organism is made up of unequal parts, an equality among unequals.

In Rawls' language on the theory of justice applied to health, justice when it is used in a hierarchical model leads to a "noblesse oblige," or a "white man's burden" helping those who are lower down on the pyramid. Justice in the equal model--all are the same--means that everybody has to be treated the same. As one gets to equality among unequals justice and health shifts. Those who are more equal than others in certain areas have the *responsibility* to assist others in the process of development toward higher states, and at the same time respecting the uniqueness of each individual. Thus, justice in health is the responsibility of assisting others in the processes of growth.

If our concern with organization for health (justice) shifts in part from the individual we must begin to focus on the relationship of people within a given community. Since each segment of the community has its own personal uniqueness and development they are as equal as anyone else to define their perceptions of and needs in health. By focusing on only special groups needs what we have had is a fragmentation and splitting apart rather than a health program for the larger community. How to get both is our problem: local uniqueness as part of a larger system.

But does this concept of governance relate to the health of the biological organism itself? We have redefined the foci for health to include not just the individual but the community. If, as Louis Thomas¹⁵ points out, the organism is not the ant but the colony, the health of the family, colony, community, or tribe becomes the foci of our concerns for health care. The specific point of health intervention may be the individual or family, but the overall frame of reference must be the community as a whole.

The human organism is a prototype of this model of organization. Each organ is uniquely itself. The liver is the liver, and yet each organ plays a role in the totality of existence. The question is never which organ is in charge. The body is in charge. The body, or the tribe, becomes *the* mind (not the brain); the whole is more than the sum of the parts. In the human body each organ assumes shifting "leadership"; the need and the situation determine the appropriate leader.

What then is leadership? Leadership, in the language of Robert Biller,¹⁶ may be providing a steering mechanism, or the performance of *education-therapeutic* function that permits the total organism to grow and to learn. Justice, health, and healing become the assisting of the total organism both to be unique and part of a whole at the same time.

The process that is involved is that the individual has its uniqueness, but each time it makes a choice it recognizes that by doing so limits its potential. At the time of human conception, the single cell has multiple choices available to it and its development. Thus, the genetic DNA template provides a range of options. It is the environment that limits the choices, which can have both positive and negative aspects to it. Governance of the whole body becomes a governance of unequals who are equal, who have to learn all about themselves, their potential, and the parts.

The concepts of Don Michael¹⁷ suggest that health is institutional, societal, or tribal learning. The total organism--individual, family organization, and community--must learn to be unique and whole. Health then is a constant dialectic (C. West Churchman) between the parts and the whole, between differences or uniqueness on one hand, and holding together on the other.

In the language of *living*, *surviving*, and *dying* there are two conflicting forces: one towards survival, and one towards aliveness, growth, and creativity.

The process of dialectic is to preserve and conserve at the same time as there is a move toward openness and creativity.

The question then comes up about how one can learn these processes and create the suitable governance model. Only when one goes through experiences where one learns about life in its totality, and connecting all levels of existence by sensing through primary sources of information, can one move towards this conceptualization of governance and health. If one gets stuck in a lockstep of discipline, concept, bureaucracy, orientation, survival, status, or illness, one is unable to deal with the phenomena of health.

Our responsibility for societal learning and change by which these new forms of equality are recognized, requires experiences on the non-conscious hidden curriculum level where concerns exist for wholeness and uniqueness. It means emphasizing the grounding in both the specific and in the abstract, and being able to continue in the dialectic between all aspects of one's own organism and with one's environment. Its dimensions are physical, psychological, social, spiritual, and communal. One way to achieve this end is the tribe with its culture, non-verbalized mythology and ritual that permits the process to occur unconsciously.

In our current individual-oriented society, by avoiding the tribal and a common philosophy to which other things can be referred in the Western world, puts increasingly more and more responsibility on the individual or a relationship. By putting the tremendous responsibility on this small segment of the total organism, we create tremendous stress to the total organism of the whole, and we doom ourselves to failure and illness. Illness and breakdown can only be avoided if the responsibility for coping with health and governance is shared by the tribe specifically, by the family, and by encouraging the individual's development.

Wholeness can be achieved in many ways. For some it can occur by focusing consciously on health. For others, focusing on work or play may perform the same function if the need or wholeness can continue to be maintained. In Alex Micklejohn's work with the experimental college and the Great Books program, come the same concepts--a community around understanding and participating fully in the issues of our age can lead to a healthy response. In his book on the Experimental College,¹⁸ he points out that one does not need a psychiatrist to deal with mental health if there is a *community of learning*. Thus, our concerns are not the concerns with health alone but rather with wholeness, by whatever route.

I was once told as I moved my focus of professional concern from area to area as I have done often in my life that I was really in the same business but in a new location. The reason that I moved my focus was that I reached the momentary limits of coping and societal learning, and had to move to another arena to continue the process of wholeness with the environment. Some might say this is being "one step ahead of the law" if the notion of law is that it is designed to maintain the status quo and the *survival* status, rather than to encourage *aliveness* and growth. To be the Protean Man, according to Bob Lifton,¹⁹ may be the only way of truly surviving, if there is at the same time a dialogue with the "job specific" aspect of the person.

SOCIAL CHANGE

One of the basic reasons for our concerns with the physical and social environment and its relationship to health is our desire to make a change for the better. For whatever reason, a vast number of people are concerned about what is happening to the health dollar. How we allocate our resources, and

whether indeed people are getting what they want, need, or others say they should have.

Social change then becomes a critical issue in any discussion of health. To me social change can occur through many processes ranging from direct action to legislation or to the changing of perceptions and values inside one's self.

There is the concept of creeping incrementalism, which in part is "the art of muddling through"; by which the many processes of society continue their independent existence, interacting with problem areas, and precipitating minor changes, which leads gradually to the total system adapting. Thus, as science moves forward the tremendous influx of research money pressed on the system and made many direct and indirect changes. In part then social change can be considered a continuing ecological process within a series of open and living systems.

There are some, however, who believe that social change can be accomplished by a master plan--a blueprint. I hope that, by my remarks up to now, I have given enough reasons as to why such a master plan alone cannot lead to major and significant change, and at the same time please all the people involved.

For me, "master planning" is a combination of two kinds of processes: on one hand it is something like presenting the results of a psychological test to a patient and asking the person on the basis of it to change; or on the other hand, it is the perception that the rational understanding of issues will deal with the whole of the problem, and therefore rationality itself can effect change. In this latter concept, the planner perceives that he or she has or can get all the available data. It is my hypothesis that this is not so.

But what, then, is social change? I believe that social change is in part the ecological process previously mentioned. It goes on constantly without

leadership, and can lead to incrementalism, muddling through, and a symptom-by-symptom technique of dealing with things. On the other hand, social change is a process of social learning, as pointed out by Don Michael.²⁰ Such a process, with or without a leader, is a dialogue--a dialectic between all the parties, human and institutional, by which a more complete understanding unfolds as to the issues. Change and learning occur on all levels. They occur through day-by-day actions as well as through longer-range proposals.

Indeed, the model of social learning is similar to individual development. The society and its institutions have the capabilities and potentials to be alive, ever-changing and responsive to the situations as they come up. This can happen only if its own leadership is open to changing paradigms and perceptions, and the leader performs an educating, steering role.

Just as easily as with individuals, institutions can get to the point where they are not alive but surviving. They become sclerosed, rigid, and incapable of responding to the new kinds of demands. Thus, institutions, like individuals, can get locked into survival, or sometimes dying, roles.

It is the surviving capacity of institutions which concerns me at the moment, because social change, then, becomes an attempt to "rock the boat" of the survivors and move them to aliveness. To do so often becomes a battle and a competition between the various survivors. On the other hand, some institutions have an ability to maintain their flexibility over time. (Some say that the survival of the Catholic Church over thousands of years has been because of its ability to bend in the wind, and to continually adapt itself to the various modalities and cultures in which it was located. Surely, Vatican II showed that temporary ability through the leadership of Pope John and with the assistance of Cardinal Bea where a major institution was modified.)

The dilemma is that social change becomes more and more difficult the larger the system is and the less connected individuals are to it. Thus, we have to have a reorganization of both governance and technology, so that our concerns can be cut down to a scale that can be handled by humans.

It is not my belief that one can fully detechnologize society, as Ivan Illich²¹ suggests. Rather, one may be able to shift to a level that Schumacher²² calls mid-technology, whose scale permits technological use for human ends, connectedness and relationship of the decisions to the people affected. Thus, the ability to command events that affect one's life is directly related to size and to the processes in governance.

It has been said that crowding causes disease. However, we know that crowding in cultures where their governance permits coping and adapting does not necessarily lead to the same pathology as does crowding in populations which have no skills or coping ability. The process of governance becomes central to the issue of dealing with the promotion of health. It is for that reason that I make a modest proposal to assist in the process of change towards health.

A MODEST PROPOSAL

If change is related to societal learning, and social change requires a new way of conceptualizing, the development of new images and, at times, the changing of an institution's constituency, it is important for us to look at what can assist the social learning process in the health field. In so doing, when decisions are made about the design of the environment of health and non-health-related facilities and resources, we can determine what effect it would have on health.

What I propose is indeed a *modest proposal*, although it is difficult to see how it will work. In part, it is based upon work done in the ecological and environmental fields. Through the use of environmental impact reports new questions can be raised, problems can be redefined, and the various parties involved in the community from the planners to the potential consumers can be involved. Surely, environmental impact reports have gotten bogged down in bureaucracies. They have taken endless time. People have not had an opportunity to read them. New professionals were created who merely prepared these reports. Real change, it is said, did not occur. Yet I believe that the concept of the reports would be extremely useful to the social and institutional learning process.

In order to promote the most effective policy-making possible, we want a meaningful dialogue between those affected by decisions and those making them. For this reason, it seems to me that we must go beyond the usual report sequence in which one expert, or a team of experts, reports to another group of experts. What is needed is a mechanism to assure community involvement within the process of decision-making. This involvement is in itself health-building, and is a necessary step to improve the probability that the disparate health needs of many peoples and individuals will be met.

A procedure may be developed which requires that the experts making impact reports be closely involved with the communities to be affected by the reports. Some possibilities are as follows:

1. Expert report be in conjunction with meaningful meetings with community committees.
2. Expert to actually be a worker in the community to be affected. This will improve his ability to act as a successful mediator between needs of community and possibilities of policy. (This was the procedure followed in

Roger Coleman's²³ work with Alaskan Natives, which was funded by the Indian Health Service; but his office was in the Native Community Center and thus was responsible directly to the Native community. This enabled him to more deeply understand both sides of issues and be effective in assisting meaningful dialogue between Native People and government.) This is almost an ambassador role, and makes reporting and communicative processes more meaningful.

Though basic human needs may be universal, these needs must be met in a plurality of ways and in a multiplicity of environments in accordance with the varieties of human preference. So we are faced with a two-level problem: at the deeper level are the universal human needs as a necessary requisite for health; on the more superficial level is the multiplicity of ways people experience the meeting of these needs. Thus, the way to promote the meeting of underlying human needs is to foster the expression of individual preferences in meeting these needs.

In order to base policy upon human preferential variables which are underlined by universal needs, it is necessary to understand these variables from the perspective of the people involved. This is a complex problem. In order to gain a deep understanding of a person's values one must go well beyond asking a few standard questions. Getting to know the people who will be affected by policy is necessary if this policy is to have an effect that is truly conducive to their health and well-being.

Developing a procedure for the understanding of the environmental needs of people as experienced from their point of view is certainly a more complex task than that of instituting policy based primarily on the knowledge and concepts of experts.

Involving the people in the planning of their own environmental health programs would serve a two-fold purpose: it would assist people in gaining a meaningful connection to their government, which in itself is conducive to health and well-being. It would also help to assure that the decisions ultimately made would meet the universal needs of people as they are variously expressed.

What I propose is the requirement of *Health Impact Statements* for every proposed project within and outside the health field to see how it would affect the health of people. First, these reports should be prepared within the relevant human-scale community in which all the people involved could participate. Secondly, each report should involve two processes and, in fact, two reports: one prepared by the proposer, and one by the adversary. Similarly, in order to obviate difficulties, it would be important to maintain a short work-time sequence. The report and a decision on the report should be completed within within a ninety-day period, so that no pile-up develops.

A health impact statement should include three parts, such as:

1. The specific impact of the proposed activity on the health of the relevant population;
2. An analysis of the relationship of the proposal to the surrounding physical and social environment and the quality of life; and
3. The implications of this proposal for processes of governance.

The report, prepared in two versions, would be available to all members of the community, the basic decisionmakers, and to those people in related programs which might be affected by the activity. The short work time of the report would lead to a need for the various people involved to participate fairly rapidly in the processes involved.

As one can see, my main concern is to raise a series of questions, and to assist the various involved people in a large complex health system in ascertaining exactly what the issues are, and in learning in a specific way what may be the range of concerns included in the concept of health. This does not mean that all must accept the same definitions. In fact, one of the more important issues will be for each report to state its specific definitions of health. There are obviously alternative definitions.

Within the total report, it would be important to include the items listed below. This is not meant to be an all-inclusive checklist, but to suggest some issues that might be involved, for example:

1. An Environmental Impact Statement should raise questions about *what* the effects of any new project would be upon the total environment. As part of this concern, it would be worth exploring the impact of the project on:
 - the "health" of the community;
 - the "health" of extended families;
 - the "health" of nuclear families;
 - the "health" of individuals;
 - the ability of individuals to cope with "I hurt independently;
 - the ability of families to respond to an individual's cry of "I hurt";
 - the ability of the community to cope with and respond to cries of "I hurt" by individuals and groups.
2. The measures of the health impact statement would be *economic* and non-monetary terms, the impact of a project on human, social, physical, and environmental resources, and the criteria being:
 - to increase an *individual's ability to cope* with his or her own health and response to "I hurt," e.g., maximizing personal physical, social, psychological development, and ability to deal with simple cases of "I hurt";
 - to detechnologize responses to health and "I hurt" needs, e.g., less specialized manpower; general well-being; lowered costs of labor, equipment, and facilities;
 - an early response to "I hurt": access; speed; competence, using all tools available, e.g., communication, crisis, and emergency clinics;

- a whole response to "I hurt"--contextual basis of problem;
- a non-labeling of illness, unless there is no other choice of response, e.g., issues can be dealt with by job, housing, etc., before being dealt with as illness;
- construction and finance; are these the most critical issues?
- staffing; is the ability of the facility to serve people and to be adequately staffed as, or more important than, the physical criteria?
- the relationship to other facilities, programs, and activities; how does this institution or facility relate to transportation, other resources, etc.?
- the development of individuals; does the program change the way individuals develop? What is the relationship to families? extended families? support groups?
- exclusivity; does it assist some people and not others?
- holistic health; does it deal with health as a "whole," or does it segment it? Perhaps segmenting is important because one wants to deal with a highly important technical matter. Does it deal with a technical issue or a particular disorder, or with the needs of people, e.g., families and community?
- connectedness; is this proposal connected to the broader environment? Is there a way it can be connected with people? Are people part of it, or are they put on a technological assembly line? Is it connected physically, aesthetically, socially? How about connectedness in terms of a governance process? Ability to "touch," to be in personal contact, etc.?
- early care; how does it relate to getting care early enough after the response of "I hurt"?
- a non-lockstep; does the proposal lock people into a model of behavior that cannot change over time; create environments that do not lock people into "illness" states, but encourage growth and development? Does the physical design prevent us from adapting to new kinds of techniques in medical care? Does it lock people into passive relationships? Does it allow people to participate? Does it allow a change in our notions so that parents can stay in with children in the hospital, and change the concept of who is in charge?
- consumer control; what does it do to people's ability to command the events that affect their lives? Does it diminish it or does it aid it?
- change; can the organization and facility build change over time as the foci of problems change?
- multi-generational issues; does it separate the generations or not?
- connectedness to the environment: social, physical, family, etc.;
- "permission" to respond on both cognitive and analytic levels as well as non-rational, emotional, spiritual, and unique social-cultural/personal responses;
- connectedness to resources where high technology and skilled labor are available for serious illness;
- humanness;
- tribal questions; does it meet the values of some of our subtribes which exist in any country? Does it allow them to have links and ties

to their own tribe? Does it also not lock them in so that they can go elsewhere?

In all of the above, I have tried to indicate that I am not expecting my views to hold for anyone else. Rather, these questions plus many others are questions that must be raised, discussed and then worked out. But they cannot be discussed if people involved are not informed as to the issues involved in health, and especially if the questions are not clearly presented. Thus, what is proposed is an educational learning experience for the community about health, relating it to surrounding issues so that problems in the health systems are connected to other relevant areas.

Though it is clear that there are no answers to these questions, I personally believe that the following several principles must be dealt with:

- "community"-based response to health where local mid-level technology (Schumacher)²⁴ can be created;
- responses to groups/cultures must be unique, responding in ways conducive to their own ways but meeting criteria for health of the community as a whole;
- mechanism for creating performance specifications by the community as a whole (feeding in data by individuals and groups) to which all will abide; and
- governance systems to make this work;

Much of our communities' responses to health are a result of "hidden curricula" that "teach" what health is. Is there a way to look at overt as well as covert curricula? The following questions could be asked:

- If outdoor hiking and walking is as health-producing as calisthenics, why is it not communicated?

- If knowledge of the body, mind and soul is part of one's own health, why is it not so communicated?
- If connectedness is related to health, why do we have such large, complex systems which de-humanize, rather than those of human scale which connect?
- If continued growth at all ages is related to health, why do we lock people into "good student and parent" roles?
- If the family and community networks are related to health, why are our policies and programs geared to breaking up these networks?
- If health is related to utilizing those resources we have, why are all products and programs replaceable rather than recyclable?
- If nutrition is the core of a health program, why not give policymakers the benefit of a nutrition program before it is made available to consumers in the field?
- If learning how to cope with stress is like a vaccination, why are programs not geared to stress learning part of our health programs? Why are there no re-creation centers rather than just treatment programs?
- Since parenting is important, why not educate people for parenting?

Facilities, buildings, and equipment are tools to achieve healthy goals. Why are they ultimately ends in themselves, forcing programs to conform to them rather than being used? Since health programs will change, multi-use facilities must be created.

We need to take another look at all our institutions and their relationship to health, such as:

- the role of hospitals and clinics;
- the schools and universities;
- sports and recreation programs;
- housing, urban/rural facilities; and
- neighborhood centers, "Y's," "settlement houses."

We need to consider experiments in health in a community setting, such as:

- the use of alternative non-academic programs as models of health with less structured activities;
- studies of natural experiments now going on in health; and
- better methods of learning about nutrition such as through camping trips rather than with a nutrition course.

For the physical planner who is concerned primarily with dealing with the physical environment, it raises an especially important point because suddenly the physical planner must be aware that the physical by itself has never had a direct impact on health. We have thought that crowding by itself was important, and yet we now know that the physical environment and the social environment together deal with the health aspects of the crowding problem. Thus, we are forcing people through a health impact study to perceive of the soft issues that are not measurable in the usual ways of evaluating things and looking at those soft issues in order to fully understand what really may be the impact of their actions.

Health *cannot* be experienced second-hand. Connectedness is important for the healing process. It is equally important for the decision-makers. We dare not permit policy to be determined by those who do not have first-hand knowledge of being healed and healing. Thus, all policy-makers (bureaucrats and consumers) should have direct experience in the line of working with

others in a healing and team role.

SOME EXAMPLES

Let me just state briefly that there are five examples of areas in which these kinds of questions can be raised. In each of these five there is a usual perception of what the issue is and at the same time issues that go way beyond our current concept. The five areas are:

1. the construction of a new coronary care unit;
2. the development of a sports movement program facility;
3. the creation of a non-public school;
4. the development of a clinic; and
5. the building of a re-creation center.

In the construction of new *coronary care unit*, the usual concern is whether this new hospital or facility needs that kind of unit in order to deal with the acute problems that come to it. However, even though one looks at the coronary care unit from that point of view, it is important to know whether there are other facilities giving the same kind of service and, indeed, that is part of our current concept of planning. Yet, we have not faced the questions as to whether the unit itself, which puts people into a very dependent situation and disconnects people from the broader community environment, may be perpetuating the potential for coronaries, though dealing with the immediate impact of a threatened coronary occlusion. What I mean here is that it may be important to talk about coronaries, potential coronaries as a comprehensive system dealing with people's lifestyles, their different personality patterns, their relationships in the home, their concerns with stress, the need to have a response to people under stress and tension. Those programs may have higher

priorities for health than a care unit which deals with the problem when the illness is well-advanced. Again, I am not proposing the abolition of coronary care units. I am asking only for the raising of questions.

Regarding a *sports movement program*, the questions may be whether the sports program locks people into an outdated concept of the body and movement; whether it is used to obtain health; whether movement can have other meanings; whether we can connect movement to imagery, symbol, and ritual; and whether movement can be the leverage point to which health can be developed. Indeed, can the promotions of health be built around new concepts of movement? For example, looking at George Leonard's book, *The Ultimate Athlete*,²⁵ one might suggest that physical movement permits one to deal with psychological, spiritual, physical, dietary, nutritional, and other aspects of preventive and promotional concerns. It may suggest that a sports and movement program be the core of personal re-creation. How does one deal with a conventional program as against a medical program? How does one deal with a changed concept of a sports program against a conventional secondary-care medical program?

A *non-public school* needs to be considered that is concerned with issues of human development, with integrating the social, physical, psychological, and spiritual issues. Such a school is one called Magic Mountain in Oakland²⁶, California. This school is viewed as a place where one can begin to deal with holistic issues, have regular meetings with families, focus on body awareness, on the children's physical, psychological, and cognitive development, as well as participating in learning about the process of self-government. These concerns have more to do with health than do those of most of our medical facilities. That kind of school, as compared to the standard school dealing purely with cognitive knowledge, may very well be a place to be supported when one is promoting

concepts of health. Indeed, we have schools like this for the mentally retarded where we have defined the need for the school as a place for handling a health problem, but we have not, except in rhetoric, created schools in terms of the general promotion of development and the health of normal children. Thus, the school is not the place where one finds disease early, but rather the place where one participates in the learning about wholeness, connectedness, relationship, aliveness, and governance.

Consider a proposal to *develop a new clinic*. Should that clinic be for primary care; should it be staffed by non-professional manpower; should it have outreach; should it be concerned with all kinds of issues of "I hurt?" Does it have an available crisis response? How does it participate with the caretakers of the community who already exist? Do we need professionals for the bulk of care? Do we change our licensing procedures, or our certifications as to who can give care? How do we define what is good primary care for different subsections of our population?

The development of a *re-creation center*²⁷ could be crucial to a community. In another context I have proposed the development of centers for re-creation for people who are in transition. In this center people faced by a crisis can begin to look at their own need for personal change. The availability of a resource for dealing with many issues without actually creating a standard medical care facility permits one to explore one's self in the fullest dimensions. The Re-Creation Center could also set the stage to deal with personal mythologies and symbolism, to assist them to go through rites of passage; to participate in learning about one's self, one's body, one's psychological state, one's relationships and, further, as a base for social change. Again, like the non-public school it may be an institution that has health potential without actually being a health organization. Such an organization could be modeled in part on the

Peckham Health Center²⁸ which was a facility--a settlement house made of glass--available to the population, to use while their health was studied. Though no medical care was given, the amount of illness diminished and a number of people moving towards aliveness from health and survival was increased. *Though no direct service was given the health improved.* These were, indeed, all lessons for us regarding the physical environment.

A BRIEF CONCLUSION

Very clearly, the organizing principle of my concepts of wholeness is not the physical environment. The environment is a tool for dealing with the concerns of human beings because human development, their life and their relationships, are the cornerstones (the organizing concepts) of the kind of life that I believe is central. It requires hard decisions. It is our responsibility to come to one. Through our policies and actions, we want to maximize the potential of the individual for aliveness, their development, and the quality of life over the other values that exist in our society. You will be told that these values *are* utilized in all decisions. That is only partially true; what is different is that the priorities and hierarchy of values have changed. Our awareness of the wholeness of our society may now be more important than any achievement or creation of the parts (Salk's Epoch B).²⁹

The processes of healing involve not only the individual, but the community, tribe, and family as part of the larger social and physical environment. Though we have a responsibility for optimizing the development of individuals toward attaining their health, we have an equal one to look at the healthy development of the environment. To do so requires all our being, from science to art, from the rational to the ambiguous and emotional. Health tests our

limits as human beings. As W. H. Auden³⁰ has said,

*Healing, Papa would tell me,
Is not a science,
But the intuitive art
of wooing Nature.*

The promotion and maintenance of health is not a myth; however, since it is so important, to be a reality it cannot be left just in the hands of the medical profession.

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