

The Holistic Alternative to Scientific Medicine History and Analysis

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The resurgence of the holistic health movement in the US in the 1970s can in part be attributed to increasing consumer dissatisfaction with the present system of medical care delivery. This article traces the rise and decline of modern medicine and the concept of public health by analysing the assumption of hegemony by scientific medicine and its practitioners. Then it describes the challenges that holistic medicine's theories and therapies currently pose to scientific medicine's organisational form and practical content. Holistic medicine is assessed in terms of its organisational and conceptual basis, and the relationship between holistic medicine and the needs of advanced capitalist society is discussed. The article is reprinted in a slightly edited form from the International Journal of Health Services, 10: 1, 1980.

IN an era of concern over the costs of medical care and disarray in the health-care delivery system, the rise of a countertendency centering on a quest for health deserves attention. A resurgence in the healing arts, manifested through a diverse collection of "holistic health practices," is underway in the United States and Western Europe (1). Movements and theories such as humanistic medicine, transpersonal psychology, parapsychology, folk medicine, herbalism, nutritional therapies, homeopathy, yoga, massage, meditation, and the martial arts have spread widely over the last five years (see for example, reference 2-6). (See also reference 7 and 8).

To grasp the complexity of the emergence of this movement as a social phenomenon today, it is necessary to explore the historical and theoretical dimensions of both the holistic tradition itself as well as the tradition to which it is now in opposition. We begin by describing how the rise of scientific medicine in the late 19th century led to the demise of a prior holistic understanding of health and medicine. Next, we relate the re-emergence of holistic health thought to the broader economic crisis that currently confronts technologically based forms of medicine, as well as to the inability of Western medicine to adequately address the health problems of advanced societies (see refs 9, 10, 11).

Medical Theories and the Rise of Capitalism

In early to mid-19th century Europe, two different theories arose to explain the nature of origin of disease. The first, known as contagionism, postulated that some disease were contagious, spreading via commerce and population migration. The strategic consequence was the quarantine, and the system of quarantine enforcement was intended to shut down commerce and trade to keep disease away from non-infected areas. The second theory, known as anticontagionism, postulated that disease instead resulted from local sources and arose out of "miasmas" — clouds of rotting matter and filth activated by certain meteorological conditions. The practical outcome of this story was to leave ports and commerce alone, and to eliminate filth and swamps in the disease-laden areas. What makes these previous medical theories of more than marginal interest is their direct association with distinct political perspectives. As Ackerknecht point out (12):

Contagionism was not a mere theoretical or even medical problem. Contagionism had found its material expression in the quarantines and their bureaucracy, and the whole discussion was thus never a discussion on contagion alone, but always on contagion and quarantines. Quarantines meant, to the rapidly growing class of merchants

and industrialists, a source of losses, a limitation to expansion, a weapon of bureaucratic control that it was no longer willing to tolerate, and this class was quite naturally with its press and deputies, its material, moral, and political resources behind those who showed that the scientific foundations of quarantine were naught, and who anyhow were usually sons of this class. Contagionism would, through its associations with the old bureaucratic powers, be suspect to all liberals, trying to reduce state interference to a minimum. Anticontagionists were thus not simply scientists, they were reformers, fighting for the freedom of the individual and commerce against the shackles of despotism and reaction.

The high point of anticontagionism occurred just before the political revolutions of 1848. It lost its strength in the wake of the subsequent reaction, while contagionism remained dominant until its reformation into germ theory in the 1870s.

The leaders of the contagionist movement, primarily high-ranking royal military or naval physicians, were politically unified. The anticontagionists were split between liberals and radicals. Opposing quarantine and state bureaucracy, the liberals favoured sanitary reform by cleaning up filth, purifying drinking water, and controlling refuse disposal as solutions to disease eradication. This position attributed disease to a primarily biological condition: the miasma. The radicals instead saw disease (and the miasma) as arising from broader social conditions: the poverty, filth, malnutrition, and oppression bred by nascent capitalism. The liberal position, typified in Britain by Edwin Chadwick's report of 1842, recommended environmental and sanitary reforms that left untouched the production system and its social relations (13-15). On the other hand, the radical position, as typified by Friedrich Engels's *The Condition of the Working Class in England in 1844* (16), fully implicated the developing capitalist system and its class relations for disease, as well as for the class-related incidence and distribution of morbidity (17).

In France and Germany, radical anticontagionists formulated "social medicine", the core of which maintained that resistance to disease was not purely biological but depended on class and social position (18, 19). This orientation implied that the human body could resist or become more susceptible to disease, and that prevention of disease was possible through adjustments or change in the social structure. Thus, in reporting on a typhus epidemic in 1848, Rudolf Virchow, a social medicine physician (and founder of pathology in his later years), called for measures such as free public education, separation of church and state, higher wages, progressive taxation, cultural autonomy for national minorities, agricultural collectives, and full employment (20). With the defeat of the

revolutions of 1848 in Europe, social medicine was virtually obliterated. As the anticontagionists lost power and prestige, contagionism was revived as the leading medical theory.

Nevertheless, anticontagionism had left its mark, and the movement of sanitary reform went forward from England to other European countries and America. Between the late 1840s and the 1880s, centralised water supplies, sewage systems, ventilated housing, and improvements in factory construction were all introduced (21). Health standards began to improve. Better transportation between town and country enabled larger quantities of fresh food to reach people. Improved standards of living resulted from successful efforts to gain higher wages and from the general deflation in Europe due to lower production costs (22). Death rates began to plummet. Not only did sanitary reform improve health status, but it had secondary benefits for capital as well. Centralised water supplies, for instance, removed locational dependence upon rivers, fostering industrialisation. Moreover, water supplies allowed for the design of effective fire-fighting techniques that could reduce the unplanned destruction of capital and lower fire insurance costs. The sanitary movement also assisted in the creation of new industries such as refuse disposal; by the end of the 19th century, trash had become private property—and was collected only when one paid (23). That sanitary reform was controlled by the bourgeoisie meant that it emphasised benefits to capital more than to other social groups. Although far removed from revolutionary class struggles, it was nonetheless progressive.

While the sanitary revolution, as it is called, was proceeding, medical theory was being greatly influenced by technical developments which allowed the visualisation of bacteria. The germ theory of disease emerged in France and Germany during the 1870s and 1880s and became the means for constructing new conceptions of disease and health—conceptions that are still maintained with slight alterations today under the rubric of “scientific medicine.” (22)

Germ theory and the theory of specific etiology (single cause of disease) served as the basis for a total transformation of medicine. When germ theory produced its first practical success (vaccines for cholera, rabies, diphtheria, anthrax), popular acclaim mounted. As these discoveries were being made, death rates throughout Europe were falling dramatically, to an extent that was publicly noticeable. Yet, ironically, this decline in death rates was erroneously attributed to germ theory advances, rather than to the sanitary reforms and higher living standards that had actually caused the decline. Studies of death rates for virtually all infectious diseases show them declining precipitously after the introduction of sanitary measures, and well before specific therapeutic interventions occurred (25). Nevertheless, scientific medicine took the credit. The end result was the reification of germ theory, which came to be employed as a total expansion, rather than as a theory that could explain *some* things—but not everything—about disease. Environmental and social factors were no longer considered very relevant to the understanding or causation of disease.

Implications of the Imposition of Germ Theory

Germ theory and the concept of specific etiology were tremendously progressive steps for the development of medicine. Although scientists at the time exaggerated the im-

portance of specific etiology and neglected much previous knowledge about infectious diseases, the importance of these advances cannot be doubted. Germ theory was deeply influenced by the social context in which it developed. The growing strength of the labour movement in Europe, as well as in America, had helped to focus attention on health hazards in the workplace, but germ theory's placement of blame for most sickness and disease on microorganisms served to exculpate industry for responsibility. Scientific medicine, as opposed to the social medicine of the 1840s tended to focus on the biological problems of the individual in order to understand and treat most diseases. The diagnosis of illness was made on an individual basis and treatment or therapy was also individually prescribed.

There are serious problems with this approach, which still dominates contemporary medicine. The physician deals with an individual patient (already a socially determined process) (27). The patient is not an abstract being, but of a certain age, sex, race, and class, and has internalised a specific historical experience from childhood to adulthood (28, 29). The taking of a purely medical history individuates the patient; however the disease or injury from which the patient is suffering is received as part of a collective experience in a particular historical, cultural, and social setting. These latter circumstances are as much a part of the cause, and *should be* part of the treatment, as are purely medical facts. (The medical facts themselves are social-historical facts.) Thus the essence of scientific medicine's treatment of disease discourages a proper understanding of disease by excluding from consideration the most relevant internalisation of the external world by the patient. As Wartofsky (30) puts it: “Human ontology cannot be reduced to an asocial or ahistorical biology without doing violence to the very specificity of human biological structure and function itself.”

By abstracting disease from its social framework and reducing it to the biological sphere, social conditions could be and were ignored. Scientific medicine became consistent with, and indeed legitimated, capitalist development by integrating a model of healing with the social structure; in so doing, scientific medicine has obscured the relationship between disease and the form of social development. Today heart disease, cancer, and auto accidents are posited as “diseases of civilisation.” (31). They are conceived of as necessary consequence of economic growth and industrialism, when it is uncertain that this is so (32).

The greatest decline in the death rate has come from the reduction in infant mortality, attributable mostly to public health measures and not to medical advances. Life expectancy has increased in the United States only when the reduction of infant mortality is included in the statistics—in other words, a man of 60 in 1900 had virtually the same remaining life expectancy as a man of 60 today (33). Despite the fact the expenditures for medical care now constitute almost 10 per cent of the Gross National Product in the United States and are growing at a rate almost twice that of the rest of the economy, it is not at all clear that *health* is improving. Medicine is largely ineffective against the leading causes of death for those under 45 (accident, suicide, and homicide) as well as those over 45 (heart disease, cancer, and stroke) not so much because the biological origin (if any) of these problems is misunderstood as that their social aspects have

been relatively unexplored and unincorporated into medical practice.

Success in finding specific causative agents for infectious diseases led to a particular understanding of causation: the view that a specific biological agent was responsible for a specific disease. This assumption remains at the heart of modern epidemiology, even for the study of chronic diseases.

Epidemiological research, especially after World War II in the United States and Europe, has attempted to link social and economic factors to morbidity and mortality distribution. Social epidemiology, as this type of research is called, received emphasis during the War on Poverty programmes of the early 1960s and, at the same time, gave some scientific justification for their inauguration and continuance (34, 35). Studies indicated differences in occurrence, severity, and length of specific illnesses based upon a person's income, race, age, and especially class. While these findings became widely accepted within the discipline of epidemiology, they never had a substantial impact on medical education. (In fact, most health workers, including physicians, are not taught epidemiology.) Yet, just *associating* a relationship between social characteristics, disease incidence, and health status does not fully explain the totality of that relationship. To the extent that social epidemiology was content to remain on a descriptive level, it became merely a form of demography (36). While social epidemiology allows for the use of "multifactorial" explanations for disease occurrence, it still tends to rely upon a notion of specific etiology and sees social and economic factors as contributive rather than causative.

The search for a specific cause tends to preclude a thorough and exact analysis of the particular societal context. This problem can be illustrated by the relation between smoking and lung cancer. While smoking is clearly *related* to lung cancer and people who smoke are far more susceptible, there is no *known* agent transmitted from the cigarette into the lungs which can be said to specifically cause the disease. It cannot be maintained by remaining within acceptable grounds of epidemiological thought that cigarette smoking *causes* cancer, although a high correlation between smoking and lung cancer incidence exists. In other words, where causality is multiple and/or approximate, no firm conclusions can be drawn that are generally acceptable within the scientific community.

If this is true of cigarette smoking, where the effects are relatively apparent, imagine the difficulty in trying to establish the causative nature of industrial pollutants, occupational chemicals, or excessive noise—all of which clearly fall outside the notion of cause that is accepted by classical epidemiology. Consider the difficulty in firmly establishing the causative nature of specific social, economic or political factors, given these limitations! The methodological emphasis on determining a direct causative link limits the study of many of the more pressing problems of illness in advanced Western society by its reductionist orientation. Moreover, research scientists, as opposed to epidemiologists, often try *not* to think in terms of multiple causation. The following quote (cited in reference 37, p 29) from Lewis Thomas, M.D., president of the Memorial Sloan-Kettering Cancer Center in New York, is indicative:

It has become something of a popular notion to say that the diseases we are left with, now that we have got rid of the major infections,

are in some sense so complicated and so multifactorial, as the term goes, that they have something to do with the stress and pace of modern living—that we can't do anything about them until society itself is remade... I simply can't take that point of view very seriously—not as long as we are as ignorant about the mechanisms of those diseases as we are. We really don't know anything at a dog's level about the mechanism of heart disease, or cancer, or stroke, or rheumatoid arthritis. We can make up stories about them and it could be, I suppose, that they do have multiple causes, and are due to things we can't control in the environment. If that's true—if that should turn out to be true—that would be quite a piece of news. Because it has never happened before. Every disease that we do not know about, and for which we have really settled the issue, so that we can either turn it off, switch it off or prevent it once and for all—every such disease turns out to be a disease in which there is one central mechanism... In the case of pneumonia, it's the pneumococcus, and in the case of tuberculosis, it's the tubercle bacillus, and in pellagra, it's a single vitamin deficiency, and I have a hunch, of course, I can't prove it, that it will turn out to be that way for cancer.

For all the billions that have gone into cancer research, no single etiological agent has been found. But the WHO claims that 80-90 per cent of all cancer is environmental or occupational in origin, hence preventable in some way (38). Although there are constant pronouncements on the cause of heart disease (e.g. highfat diet, excessive sodium intake), none appears to be specifically responsible. The most fruitful approach to the control of heart disease may be the alteration of the social environment (i.e. stress reduction) (39). Suicide and homicide are obviously not amenable to biological answers, despite the protestations of the socio-biologists (40).

Therefore, the present understanding of medicine and disease spread is most valuable for infectious diseases—ones that have largely been brought under control in the advanced capitalist world. For diseases that are not infectious, there does not seem to be specific etiology, or a single cure; it is these diseases that constitute most of the morbidity and mortality in the United States.

Popular Disaffection with Scientific Medicine

It is through the study of chronic diseases, the so-called diseases of civilisation, that one confronts the ineffectiveness of scientific medicine. It was not until the discovery of sulphur drugs and antibiotics in the 1930s and 1940s that modern medicine could intervene in the disease process in a specific way with a relatively guaranteed result (excluding surgery, of course). However, this seeming success with infectious disease both increased the expectation of medicine's capabilities and, at the same time, wreaked havoc with the demographic profile of the Western world by increasing longevity. Thus, millions of cases of chronic degenerative disease resulted in people who would not previously have lived past childhood.

Since the 1960s, a growing disaffection regarding medicine has been noticeable. There are several compounding facets to this: (a) doubts regarding the value of a medicine which prolongs life to old age, but often in hospital or nursing home settings and in a manner which tends to deprive people of their human dignity; (b) ethical questions arising from the inequitable access to and allocation of extremely scarce medical resources, e.g. artificial organs, dialysis machines, and certain surgical procedures; (c) an awareness that modern medicine has been unable to cure and reduce the number of cases of certain diseases, despite the large sums of money

spent on research; (d) the realisation that much disease results directly from the degradation of the physical environment, the workplace, and the individual, coupled with a sense that medicine does not adequately address prevention on either the social or the individual level; and (e) the explosion in the costs of the provision of medical care to individuals, the government, and employers. This section will expand on these points and relate them to an explanation of the rise of holistic medicine in the 1970s.

While there has been relatively little change in life expectancy rates for those already over 50 in the United States since the turn of the century, there has been a significant increase in the number of people, and the percentage of the population, living to an older age. In 1900 there were only 3.1 million people 65 years and older, but by 1975 there were 22.4 million, with a population projection of 3.18 million aged by the year 2000—perhaps a conservative estimate (33). This will create a pool of largely unemployed elderly, dependent on a social security system warred with financial dilemmas and a private pension system unable to maintain parity with inflation. Needless to say, the economic plight of the elderly adversely affects their health status. Given that the elderly consume more health resources than other segments of the population, this demographic change implies greatly expanded medical care costs. Currently, 68 per cent of the care for the aged is financed by public monies through legislatively guaranteed benefit packages (41). Medicare has continually had the most inflationary outlays due to current hospital behaviour and failings in the largely proprietary nursing home industry. It is not difficult to grasp why the issue of passive and active euthanasia is now under discussion and why a concern over dignity in dying (and even a life after death) is being promoted in this decade (42, 43).

A somewhat related problem stems from the ethics of allocating scarce medical resources in a democratic society. As sophisticated medical technology becomes evermore expensive, the question of how to decide who should have access to that technology and on what basis allocative decisions should be made pose a series of critical bioethical issues. A whole set of dilemmas have arisen to further complicate this problem. For example, in the United States today all people with kidney disease can get their treatment reimbursed through the end-stage and renal dialysis programme of Medicare, yet poor women have been denied access to legal abortions through Medicaid.

A third facet of the growing dissatisfaction with medicine comes from the ineffectiveness of medical research in adequately answering the most pressing disease problems today. Results of a curative nature from cancer and heart disease research have been negligible, let alone significant in alleviating these problems. While there have been advances on an individual clinical level (44), the morbidity-mortality data demonstrate how limited these have been. In the face of a population apparently not getting healthier, palliative therapies abound for a wide gamut of current disease conditions. For example, the huge consumption of psychoactive drugs in the United States has been given wide attention. One can only speculate on the numbers of people who use some form of medication or drug (e.g. alcohol) to get them through the day (45).

Another facet of the overall problem results from the

mounting evidence that much disease, especially heart disease and cancer, results from the degradation of the physical and social environment. Air and water pollution, radiation exposure, and additives to food substances have all been implicated in the disease process and clearly must be addressed if social prevention strategies are desired. Further, occupational stress and health hazards in the workplace reveal additional social origins of disease (38, 46-49). Millions of workers have been exposed to chemicals whose long-term effects on health were previously considered inconsequential (or in some case known to be hazardous but used anyway). Greatly increased cancer death rates among certain categories of workers will emerge over the next two decades. Moreover, the degradation of the individual citizen through lack of exercise, inadequate or inappropriate diet, heightened anxiety and chronic social stress, and other aspects of alienation from labour and life adversely affect health status indicators and drive up the utilisation of health services. What is of special importance about all these factors is that, by definition, they are preventable. Yet, medicine, medical research, and the medical care system continue to ignore the possibility of prevention by not addressing the social occupational, and environmental origins of our current disease structure.

Each of the above points has an underlying economic aspect. The cost explosion in medical care today has established cost containment as the overriding priority in most decisions. With the US economy facing severe problems of inflation and intermittent recession, both corporations (who purchase the bulk of health insurance for their employees) and the Federal Government (which funds services for the poor and aged) are calling into question the amount of money being spent on medical care services (50). The cost of medical care and other associated health services (such as environmental and workplace clean-up requirements) has increased at an exponential rate over the last three decades, making the health sector a leading growth industry. From the corporate perspective, these health benefit costs might have their own justification if the present array of services returned an even larger increase in the labour force productivity via improved health. But the past two decades have brought significant change in health status, despite this escalation of expenditure. Complicating this problem is the fact that the major portion of health expenditures flows out of the corporate sector and State into the hands of professionals and hospitals. Thus health care expenditure appears unequivocally as a major factor limiting capital accumulation, and a corporate strategy to reduce inflation in health costs is currently becoming evident (51). Replacement of costly, high-technology medicine with cheaper, non-technological therapies is a major redirection advocated by proliferating medical-care evaluation studies (52, 53). Corporations have developed an interest in holistic health as *Forbes magazine* notes, "because it emphasises more money-saving prevention and patient responsibility" (54).

In addition, to the extent that the provision of successful medical care has become a source of legitimacy in advanced capitalism, increasing popular dissatisfaction with current medical practice will become a chief focus of the State (It has become clear for instance, that right-wing political groups have latched on to the public disaffections with medicine through the promotion of anti-abortion crusades, laetrile

legalisation campaigns, etc.).

All of these problems have led to a heightened concern with health in recent years. The holistic health movement has arisen in part out of this concern and in part has helped to generate it.

Holistic Health Movement

There are problems in defining the holistic health movement beyond grouping together all practitioners who place themselves against or outside the mainstream of modern medicine. Further, it is difficult to distill commonalities from the potpourri of alternative therapies, since such a diversity has been linked as a movement by its organisational advocates (1,57-59).

The positive health orientation of holistic therapy has two separate components. The first is the perception of health as a value in and of itself; the second is the notion of health as a praxis—the active participation of the individual in the ongoing maintenance of his/her own health. Holistic therapies also assume a unity between mind, body, and spirit, the major implication of which is that illness is regarded as more than just physical disease and is assumed to have causes and dimensions beyond the purely biological. The separation of mind and body has long been a philosophical issue in Western thought, and the elimination or downplaying of the mind as a component of the disease process has been considered as of the cardinal success of scientific medicine. The critique of the mind-body duality and the reintroduction of elements of spirituality in holistic medicine form a strong counter to the crude materialism of scientific medicine in its narrow emphasis on what it takes to be the physical and biological source of disease.

The holistic health movement has philosophically set itself in direct opposition to some of the basic tenets of scientific medicine. The potential power of the "mind" over the "body" is being tested in the treatment of various diseases as practices such as meditation, biofeedback, autogenic training, and hypnosis become quite popular. The exploration of psychic phenomenon (e.g. clairvoyance, telepathy, precognition, psychokinesis, and extrasensory perception) may encourage a new understanding of pathophysiology and ongoing health maintenance. Other practices (such as yoga and the various forms of martial arts) are promoted as aids in forming an integrated view of the individual's health and a greater consciousness of health.

Although it is challenging the taboos of scientific medicine, holistic medicine has not yet established itself as scientific. Holistic therapies primarily have relied upon anecdotal evidence, with "proof" of efficacy to be found in individual testimony. Since scientific theory prides itself on repeatability and universality medicine orientations easily fall prey to charges of quackery and hucksterism. Several factors, however, complicate the picture. For one thing, a number of scientifically established medical procedures and therapies have been found in many cases to be no more effective than treatment by a placebo. This applies not only to certain drugs, but also to various surgical and medical treatments. Indeed, several recent Government reports have criticised the scientific medical establishment for choosing many of its practices more by intuition than by science or study. Most notable is the recent survey by the Office of Technology Assessment,

an agency of the US Congress on the safety and efficacy of 17 common medical practices (52). The implication of this orientation is apparent: if scientific medicine were to subject itself to the same rigorous testing that it demands for holistic medicine, many of its forms of intervention would not fare too well either! One may conclude that science, as we presently know it, is insufficiently developed to properly understand the interactions of body, mind, and spirit over the course of the disease process. At the same time, this line of reasoning should not suggest immediate acceptance of holistic medicine and its various therapies without some proof of efficacy.

By concentrating on individuals and tailoring therapies to individual needs and desire, holistic medicine achieves a great degree of client satisfaction. Interpersonal sensitivity and responsiveness to patient's needs and values which are generally operationalised in the holistic practitioner-patient interface. Since the patient is held responsible for his/her own health (and in many cases, the results of therapy), people are loathe to blame failure of the intervention or the therapy itself. Rather, it is usually assumed that the patient has not tried hard enough, "it's not the time yet," or that the search must continue for the real root-cause of the illness. Often, the power of suggestion and belief plays a dominant role in therapy. For the most part, then practitioners of holistic medicine tend to generate loyal followings for their particular theory and therapy among their clientele. In an era of growing disenchantment with modern medicine, one finds in holistic therapy a popular modality upon which to center one's hope for alleviation, if not elimination, of a plaguing health problem. It is less invasive and dangerous than scientific medicine; it tends to use natural or symbolically ritual medicines or drugs; and because it employs more intimate forms of treatment such as touching, holistic medicine is usually enjoyable and pleasant.

As public support wavers for the scientific establishment, various forms of holistic health care are generating attention and hope from both those suffering from maladies and those wishing to grow in new dimensions of their lives. Nevertheless one finds in the holistic health movement many of the same organisational and social patterns that predominate in the present health care system: solo, fee-for-service entrepreneurial practice; knowledge or skill sold to "consumers" in commodity forms elitist and sexist behaviour on the part of the practitioners; a concentration of availability of services to middle-class, white people able to pay; and a clear separation between practitioners and those who are served. Most practices also tend to be focussed on the individual, as in scientific medicine, and lack virtually any focus on the larger social grouping.

In the midst of the growing narcissism in the United States today, holistic health practices are being explored as part of strivings toward self-growth and self-actualisation (60). In addition, some corporations are beginning to seek increased employee productivity by offering training in practices such as mediation for stress reduction (61-63). While taking a positive step by including the mind as a causative as well as a healing agent, most holistic practices continue to exclude the external social world from their attempts at healing, failing to provide strategies for changing economic and social relations. Some practices are serving to further commodify

alienation "personal" problems are temporarily relieved as a particular practice tends to adjust the individual to the society from which the pathology has arisen. Thus, this adjustment of the individual may become a prominent tendency (64).

Most holistic practices contain heavy doses of mysticism and charismatic elitism. Their Eastern (and precapitalist) origin often results in an authoritarian elitism that has taken interesting—and—disturbing—forms as these age-old practices have been transplanted into America. The most glaring deficiencies of holistic practices, as they currently exist, arise out of their intense individualism and limited notion of totality. Most assume that they are totalistic by stressing the unity of the body, mind, and spirit. However, this ignores the larger social world outside the body from which much of disease originates. Meditation, for instance, can relieve the effects of stress on an individual, but it does not remove the stress source. When one stops meditating, the social stress is still there. A readily apparent weakness of many of the holistic medicine practices is that they ignore politics, declining to connect disease to existing social relations. When these connections are made, the problem is often defined in terms so general—"the West," "modern society"—as to suggest that the only sensible course is exclusive concentration on healing the individual in a chaotic and brutal world. The philosophical thrust of holistic medicine assumes emotional and spiritual dimensions of the individual transcending the physical body. Yet even this expansion still centers on the internal dynamics of the individual to the exclusions of external reality. This, of course, differs from the social medicine of the 19th century, which defined the totality to include the physical and social environment as well as the human organism.

Conclusions

Various holistic medicine therapies are rapidly becoming popular alternatives to scientific medicine. In just a few years, holistic medicine has been able to achieve significant public support in the Western world, as well as the nascent support of both corporations and the Federal Government. It is imperative that health policy analysts and health practitioners understand the nature and content of holistic medicine and the social dynamics out of which it arises.

That holistic medicine poses challenges to the hegemony of scientific medicine cannot be denied. One example is the pressure for the National Cancer Institute in the United States to hold controlled clinical trials to test the alleged efficacy of laetrile in cancer treatment. Some 17 state legislatures have legalised the prescription and sale of laetrile within their borders, a decision made in spite of the almost unanimous opposition of the medical profession. Chiropractic therapy now receives reimbursement from several Medicaid plans and from Medicare. Court cases regarding the rights of people to choose a holistic therapy (i.e. nutritional therapy or laetrile) against the wishes of their physicians, who advocate either chemotherapy or some invasive treatment, have been heard with mixed results to date (see, for example, reference 65). It seems apparent, though, that many more such issues will be fought out in the legal arena. Meanwhile, a groundswell of investigation into alternatives to scientific medicine has been occurring as patients

seek out therapies suggested by the multiplicity of articles in the popular press. Bookstores have been devoting higher and higher percentages of shelf space to sections on health, psychology, and the occult; many of the ideas gleaned from this recent explosion in publishing are used by people as supplements—it not direct alternatives—to what scientific medicine-oriented physicians suggest.

Its nontechnological nature and extreme emphasis on individual responsibility for health are aspects of holistic medicine that imply cheaper modalities of care than the present medical care system offers. Those social groups advocating cost containment in health care have an obvious interest, then, in the explosion, growth, and spread of holistic health care. As noted earlier, medical care inflation has been running at a rate almost twice that of the rest of the economy, and the likelihood of its being slowed down dramatically is quite limited in the absence of major cutbacks in care, which seem politically infeasible at this time. Given this reality, there is a definite political and economic necessity for new approaches to health and health care problems. Holistic medicine just may fill that need.

Similarly, a changing ideological focus is being promoted in health today. A medical care system emphasising the individual's role in maintaining his/her own health and promoting a significant lessening of absenteeism among employees would be of considerable value to the corporate sector. If the infusion of holistic medicine modalities into the workplace could keep people on the job and improve their individual productivity by making them either objectively healthier or at least believing they are healthier, it would serve to address one of the most pressing problems in America today (as defined by corporations): low productivity due to worker alienation. Thus holistic medicine could be of great utility to our present malfunctioning system of economic production.

Finally, if holistic medicine should succeed in giving people a sense of caring for themselves and being the decision-making subject in their lives rather than just an object; if it should succeed in promoting dramatic changes in current, unhealthy lifestyles; if it does provide a more meaningful justification for living in a relatively unpleasant world; then it most certainly will be utilised by greater numbers of people in our society. Yet, by achieving such results, holistic medicine may then become a part of corporate and state strategies for cost containment in health care. Also holistic medicine could easily be formulated into a social mechanism for allaying criticism of present inadequacies in health care delivery and the social production of disease (66).

We have attempted to demonstrate that the resurgence of the holistic health movement in this decade is no social accident, but clearly arose in response to degenerative social and psychological conditions of the day. Holistic therapies are addressing some of the crises that have been created by the ongoing demise of scientific medicine. It should be noted that scientific medicine is far from dead at the moment, however, and may, with some propitious discoveries, regain its hegemony. At the same time, we have tried to indicate that holistic medicine, to the extent that it focuses solely on the individual and ignores political and social dimensions, is not the entire answer for health either. Nevertheless, holistic medicine is an up-and-coming social movement gaining wide

popular support, and as such, demands attention from all health workers and policy analysts (67-69). This attention should, hopefully, be directed toward uniting people in the transformation of their social conditions necessary for improved health (70).

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