Scientific and Social Problems and Perspectives of Alternative Medicine: Analysis of a Dutch Controversy

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Introduction

Ever since the mid-1970s, the Western world has seen growing public and political interest in alternative medicine. The main reason has been a feeling of dissatisfaction with regular, science-based medicine, which gained a monopoly position for itself in the course of the last century. The feeling of dissatisfaction is caused by a number of mutually reinforcing developments, the most important of which we should like to outline here.

First, a shift has taken place in current mortality and morbidity patterns. As a result of the rising average age of the population, urbanisation and the tendency to overfeed in most Western countries, the morbidity pattern is at present dominated there by chronic-degenerative afflictions, functional disorders and psycho-social complaints. On the whole, the way in which diseases are handled in regular medical science is still based on the way in which in the past infective diseases such as cholera, smallpox, typoid and diphtheria were conquered. This approach has not proved very successful in combating the complaints and diseases that prevail in modern morbidity patterns.

Secondly, as a result of technological developments and increased specialisation, there is a considerable stress in the interhuman relationship between physician and patient, especially where semi- and intra-mural care are concerned. An impersonal approach is used in which the attention is mainly focused on somatic aspects and symptom fighting by means of surgical and chemical methods. The contact between physician and patient is also made more difficult by the bureaucratic methods that result from the growing influence of the state on the health services which occupy an ever more important place in the national economies of the West.

Thirdly, the importance of liberation and democratisation movements of the '60s and '70s should be pointed out. The self-image of these movements can be explained in terms of the need for self-determination and self-realisation, for involvement and participation, for a mimetic contact with nature (both internal and external) and a loyal attitude towards others. Within the new health movements, such as the self-help movement, the psycho-therapeutic movement, the psychiatric counter-movement and the movement in favour of alternative therapies, this re-orientation leads to a different angle on views concerning health and morbidity, diagnosis and therapy, as well as the physician-patient relationship.

The three developments mentioned above are interlocked and culminate in heated debates on the scientific and social problems and perspectives of alternative therapies in the press, political parties and national parliaments.

Within the framework of the discussion of holism and the movement for holistic health care, there have been repeated discussions of alternative therapies in the United States in recent years. The interest taken in different therapies and new approaches in health care came to the fore, for instance, during a congress of the National Institute for Mental Health, as well as at a congress of the American Medical Students' Association, in 1977. Another proof of interest is the foundation of the American Holistic Medical Association in 1978, and the widespread establishment of new holistic health centres and clinics (1). In Australia and New Zealand a parliamentary and ministerial committee respectively, have investigated alternative therapies, and chiropractic in particular. In 1977, the Australian committee published a voluminous report (2): the New Zealand committee followed in 1979 (3).

In Great Britain attempts are being made at establishing a lobby in parliament in favour of natural therapies (the so-called 'Action for Natural Therapies'). In 1980, a number of scientists were invited to investigate the status, quality and remedies of alternative therapies in the United Kingdom, as well as the need felt by the British people for alternative medicine (4). In Belgium an 'Action Committee for Therapy Freedom' has been in existence for some time; its aim is to establish the patients' right to choose the therapy or therapies of their preference.

In the Netherlands a similar committee exists, 'Equal Rights for All Therapies'. In January 1977, this committee organised a congress in Amsterdam, attended by 1500 people, which sent a request to the then government, asking, on behalf of the medical consumer, to be given the freedom to choose one's own therapy and therapist, and the right to obtain alternative care on the same conditions as regular medical care. In May, 1977, the government instituted the Commissie Alternative Geneeswijzen (CAG) ('Commission for Alternative Therapies'), the Chairman of which was P. Muntendam. In January 1981, the Commission submitted a report (5). When the report came under discussion on 5 September 1983, a comfortable majority in parliament expressed the wish to have alternative therapies included in the services offered by the Dutch National Health Service. The right-of-centre Lubbers government adopted an extremely cautious attitude, being afraid that official recognition of alternative medicine would lead to rising costs.

The CAG - a body of experts in the field of both regular and alternative medicine - limited itself in its work to those branches of medicine in which there is most interest in the Netherlands, i.e. acupuncture, therapies involving extra-sensory perception, natural therapy, anthroposophical therapy, homoeopathy and manual therapy.

The summary of the reports submitted by working groups constitutes the main body of the CAG report. It is preceded by a short historical-philosophical exposition and definitions of the concepts 'alternative' and 'therapy', as well as a discussion of matters such as reductionism and holism, quacks and quack methods, suggestion and placebo in therapy, and the differences and similarities between regular and alternative medicine. Using the CAG report as our guideline, we intend to investigate in this article the scientific and social aspects connected with an official approval of alternative medicine.

The CAG report does not contain any concrete scientific analyses or evaluations of the various alternative therapies in the Netherlands. This does not mean, however, that the scientific aspects are not considered. As we shall see, the CAG did pay a good deal of attention to the question whether or not alternative medicine has, generally speaking, a scientific basis. In fact, the very strategy of the CAG rests on the assumption that the problem of the official

approval of alternative medicine is essentially of a scientific nature. Social factors and priorities play negative parts only, preventing a thorough scientific evaluation of alternative medicine from being started at all.

With regard to the social aspects, the CAG limited itself mainly to establishing the social relevance of alternative therapies in terms of the number of contacts between patients and alternative therapists, the motives for consulting an alternative therapist, etc. In doing so, it reached the not very surprising conclusion that public interest in alternative medicine can hardly be overestimated, and that, therefore, the authorities cannot afford to ignore the alternative group any longer. However, this approach implies an obvious limitation of the problem. The CAG devotes no more than five pages out of a total of approximately three hundred to the general problem of the relevance of alternative medicine seen in the light of more general social developments. It is not surprising, therefore, that the CAG does little more in those few pages than circumspectly offering a brief outline of the problem: 'One might, perhaps, say that the rise of (at least some) alternative therapies should be regarded as an attempt on the part of (a section of) the community to look for, and sometimes even find, better ways of dealing with health care' ((5), p. 169). Unfortunately, the CAG fails to elaborate this point, which is central to the issue: 'Time will show whether the interest in alternative medicine is a passing phenomenon or whether alternative medicine will be the starting-point for the development of a new kind of health care' ((5), p. 170). Answering these crucial questions would, it is said, necessitate an extensive sociological anslysis which the Commission did not consider itself capable of making, partly as a result of the lack of research data. However, unless the phenomenon of alternative medicine is explicitly placed in a wider social perspective, it is impossible, for us at any rate, to endorse the plea in favour of alternative medicine, which is what the CAG report does, after all.

Part I: Scientific Aspects

1 The CAG's scientific strategy

In the CAG report, the problem of the (non)scientific basis of regular and alternative medicine plays an important part. The CAG's opinions on this score may be summarised in three points.

First, the CAG assumes that there is only one form of medicine, and only one medical science: 'Naturally many diverse views can exist within science, but there can be no question of alternative conceptions of science outside the one medical science' ((5), p. 22; see also (5), appendix H, p. 6 and pp. 12-14).

Medicine, it is stated, owes its unity to the existence of an unambiguous scientific method: rational discussion and evaluation within the so-called 'forum' (6). This forum is not a concrete social institution, but an abstract body to which in principle every scientist belongs. Ideally it shuld apply a number of impersonal, objective methodological rules which make it possible, in the course of time, to separate true from untrue statements, or, to put it somewhat more carefully, statements that are more true from those that are less true. One example is the rule that scientific discourse should be consistent. From a forum-view of science the gap caused by the differences between regular and alternative medicine which, according to the Commission, are often exaggerated, is not unbridgeable. After all, to the realm of science belong all those forms of knowledge that can be subjected for discussion and evaluation to the universal rules of the forum. There is nothing to indicate a priori why alternative medical knowledge should be downright unacceptable in all cases as a result of these rules. The CAG expects that, in fact, the contrary will prove to be the case.

Secondly, the notion of the forum offers the CAG a formal and procedural criterion for separating science from non- or pseudo-science. However, as to the content of regular and alternative medicine, fundamental differences may occur, since 'each form of medicine can offer only a limited view of reality as a result of its epistemological principles. Within different forms of medicine, different lines of thought can be detected, which depart from different paradigms' ((5), p. 27). In this context the CAG differentiates between two types of approach: the analytical and the contextual ((5), pp. 231-232). These can be roughly characterised as follows. In the analytical approach human beings, organs etc. are first divided into their separate components - whether literally or conceptually - and next an effort is made to understand how these entities function in terms of the action of, and the interaction between, their components. The contextual approach, on the other hand, departs from the idea of the entity as a whole and tries to explain occurring phenomena with the help of factors from the wider social and environmental context in which this entity has been placed. According to the CAG, the two views, the analytical and the contextual, are complementary. It is precisely because of their differences that they are both needed to provide an adequate and satisfactory view of the reality of illness and health.

A third important point in the CAG's opinion is that the scientific community of (regular) medical practitioners does not exercise as it should its forum function with respect to alternative medicine. The fact is that really very little good research has been done into the scientific tenability of alternative therapies. Instead of a dogmatic denunciation of alternative therapies, a (real) scientific approach is called for, in the form of a differentiated and finely graded 'evaluation of their truth content measured by objective standards' ((5), p. 238; cf. p. 20).

The fact that this kind of scientifically justified evaluation has not, or not sufficiently, taken place is due not so much to any unscientific qualities of alternative therapies, as to 'interfering' factors within the scientific community of regular physicians, such as influence by pressure groups, personal interest, availability of funds, status of alternative medicine, etc. The Commission assumes that this is, in fact, an anomalous situation which can and should be ended. The only legitimate conditions for an official approval of alternative medicine are to be found, according to the Commission, through scientific justification: 'In general the process of argumentation and counter-argumentation will be the most important: he who has the best argument shall win' ((5), p. 276).

Criticism

There is one thing that strikes one immediately in this vision of science as it is propounded by the CAG. It is that the forum-view on which the CAG bases its theoretical expositions in fact dates back to 1971 (6). And the problem is that since at that time stormy developments in the theory of science have led to completely new ideas on the sciences <1>. It stands to reason that these developments have not bypassed the CAG altogether. However, the way in which it tries to combine or even reconcile the new ideas with a forum-view is nothing less than shabby. We shall try to prove our point by offering comments on the CAG standpoints outlined in the previous section, from the point of view of modern theory of science.

The problem with the scientific forum is that it does not exist. This problem is admitted as such by the CAG when it states that the notion of a forum is an idealisation which never has been completely realised and which, in practice, it will never be possible to realise. The point is, however, that introducing and working with idealisations of this kind is useful only when real scientific communities satisfy the demands that are made of a scientific forum to some degree at least. However, this is not the case by a long chalk. Wishing to be brief, we shall limit ourselves here to one example, viz. the rule that a newly proposed idea or fact

'should not be incompatible with other already accepted or simultaneously offered claims, unless accompanied by arguments which would make the new claim considerably more true than the existing one' ((5), p. 236). If this kind of rule were heeded, scientific innovation would soon come to an end. After all, as was shown by Kuhn in particular, in scientific innovations (revolutions) a new theory or a new paradigm generally merely holds the promise of finding 'greater truth'; first the new paradigm must be accepted before the 'greater truth' can possibly be found. Therefore we may say that an evaluation of alternative medicine on the basis of a forum-view is impossible. There is, however, another objection to the notion of a forum. It is this: even if a forum existed in medical science (whether or not approximately), the forum-view would still offer a demarcation criterion for marking the territories of science and non- or pseudo-science that is far too broad. In fact it would cover all so-called rational argumentation (such as jurisdiction, but also less formal forms occurring in everyday discourse). It is hardly surprising, therefore, that from this point of view the differences between regular and alternative medicine seem relatively small.

This leads us to criticism of the second point, concerning a difference in content between alternative and regular medicine. We feel that a combination or a peaceful co-existence of different approaches to illness and health (such as the analytical and the contextual approaches) will be far more difficult than the CAG thinks it is, for the following reason. Fundamental differences in therapies (as regards underlying concepts of illness, for instance; cf. (12), Chapter 1), generally speaking imply different methods of testing the efficacy of these therapies (by means of an experimental rather than a casuistic test, for example: we shall come back to this later). The CAG report contains a long list of specific difficulties that may arise in effect research with regard to alternative therapies. It is remarkable, however, that the Commission does not go on to mention that the problem of the acceptability of arguments raised in the forum concerning the efficacy of therapies is largely dependent on the acceptability of the testing methods for that particular therapy. Determining the correctness of scientific arguments is not a matter of formal logic. Specific theoretical considerations, in particular with regard to the question 'what counts as sound evidence?', play an important part. The considerable fundamental differences throughout the wide range of regular and alternative therapies necessarily make a scientific evaluation in the way envisaged by the CAG highly problematic. All this criticism leads, in fact, directly to the conclusion that the idea of the truth value of alternative therapies being determined by a forum using objective standards is very dubious. To say the least, it defies comprehension that the CAG should use notions that are highly disputed in the modern theory of science, such as 'objectivity' and 'truth', completely gratuitously (13), (14). However, the CAG really goes too far when it argues at the same time in terms of Kuhnian paradigms - which, after all, are incommensurable according to Kuhn - and in terms of universal criteria in order to test the truth of all existing paradigms by applying objective criteria from the point of view of one all-encompassing standpoint (the 'one and only' medical science)! ((5), appendix H, pp. 34-35).

According to the CAG, the only really true conditions for official approval concern the matter of the scientific basis of alternative medicine. Socio-historical aspects are regarded as no more than inconvenient obstacles hindering the process of official approval ((5), pp. 243-244). In the modern theory of science, howeve,r the socio-historical context of science is frequently - and rightly - considered one of its essential and inseparable aspects. Socio-historical influences are not simply deemed 'deviations' from the ideal or 'wants' of rationality. The CAG expresses the opposite opinion: 'These forum rules are not, however, always applied in the proper way as a result of fundamental human shortcomings and voluntary (sic!) limitations in the minds of some or several forum members' ((5), p. 25). We feel that in this way, as is clear from the CAG report, the full social significance of the current debate between regular and alternative therapists is bound to stay in the dark. As a result, the usefulness of the report for progressive perspectives and actions in the field of health and politics remains very vague.

2 The strategy of the 'regulars'

The 'Royal Dutch Society for the Advancement of Medicine (KNMG) represented 'regular medicine's' point of view. The scientific strategy of the KNMG physicians and their philosophers can also be classified in a number of sections according to main lines of thought. In doing so, we shall base ourselves mainly on the 'Commentary of the working group for the preparation of the KNMG reaction to the CAG report in the Netherlands', which we shall refer to as 'the KNMG working group' (15).

First, it is assumed that an explicitly acceptable criterion for separating science from non- or pseudo-science exists. The CAG is reproached for not distinguishing 'between science and pseudo-science. The two can be separated, however, for two reasons, viz. (1) that scientific theories and hypotheses can be tested, and (2) that science has a cumulative character' ((15), pp. 1676-1677; cf. also (16), pp. 1629-1630). However, it appears that the second criterion - the accumulation claim - does not play an independent part. The idea behind it is that only accumulation of knowledge that has been tested and found correct is acceptable. To this way of thinking accumulation is, therefore, the consequence of testing: knowledge that has once been tested and found correct will be valid forever, so that testing will automatically lead to accumulation ((16), p. 1630).

Secondly, the KNMG, like the CAG, holds the opinion that there is, and can be, only one medical science. Unlike the CAG, however, this one medical science is associated a priori with regular medical science. The KNMG working group considers the growing interest in alternative therapies as a sign that there are lacunae in regular medicine, and makes recommendations to eliminate the origins of this interest. This optimistic way of reasoning is in sharp contrast with the idea of the CAG which points out the fundamental nature of the problems with which regular medicine has to deal, particularly with regard to the chronic-degenerative diseases.

As a consequence, the KNMG loses no time in expressing rejection of alternative therapies: 'a large part of the alternative therapies must ... be characterised as pseudo-science' ((15), p. 1677; cf. also (16), p. 1630). On the other hand, the scientific character of regular medicine is strongly emphasised. Medicine is an applied empirical science that uses the results of many other sciences (biology, chemistry, physics, mathematics, sociology, psychology). According to the KNMG, it is possible as a result of its scientific character, 'to draw up a long list of investigations which irrefutably prove the usefulness of particular regular therapies' ((15), p. 1676).

Criticism

It is remarkable to see in the KNMG standpoint a striking resemblance with the CAG: both emphasise the crucial role that is, or should be, played by science when evaluating (regular and alternative) therapies. More particularly they both assume the postulate of the unity of (medical) science. Part of the conflict, then, is caused by the fact that the content of the postulate means different things to the two groups. In this section we shall consider the KNMG's criticism of the CAG report point for point.

First of all there is the idea that a practically applicable, general criterion exists (testability), by means of which science may be separated from pseudo-science, as the corn is separated from the chaff. This is the notorious problem of demarcation. It is a fact, however, that for contemporary

theory of science the demarcation problem is an unsolved, or even an unsolvable, problem. At the moment there is no such thing as a generally accepted and universally applicable demarcation criterion (see (17), for example). What we do have are numerous proposals, but all of those are arguable, and in any case they are not generally applicable, as becomes clear when testing with the help of historical and sociological case studies. That is why, particularly in the modern sociology of science, the demarcation problem of science and pseudo-science is often considered unsolvable or is disregarded as being a pseudo-problem (for an example, see (18)). Naturally, this can be regarded as arguable. It is not possible, however, to ignore all these views and to give the impression, by carelessly dropping a term like testability without further explanation, that the whole problem is simple and has already been solved.

On the other hand, we feel that the idea of testability, so long as it is not regarded as an unambiguous demarcation criterion, does underline an important fundamental aspect of the matter, which should most certainly not be left out of the discussion.

All this automatically leads us to a criticism of the second point, viz. the idea of the unity of the (medical) scientific method on the basis of notions such as testability and testing. We do not wish to invent the wheel all over again and shall limit ourselves to presenting KNMG advisor, Mellenbergh's curious standpoint. He quotes Suppe's book, The Structure of Scientific Theories, for 'a survey of the current state of affairs' ((16), p. 1630), but he 'forgets' to mention that this current state of affairs in the theory of science, as it is presented in Suppe's book, is in sharp contrast with his own ideas!

The third point in the KNMG's evaluation concerns the rejection of the major part of alternative therapies and the defence of the 'irrefutably useful' regular medicine. Measured by the KNMG's own standards, their opinion on alternative medicine is, to say the least, 'unscientific', as it is not the result of thorough testing of this branch of medicine. Mellenbergh even mentions having 'the impression' that many alternative therapies are pseudo-scientific ((16), p. 1632). On this point there is more to be said for the CAG's opinion that it is time that a systematic evaluation of alternative therapies should be undertaken, although we feel that what such an evaluation should be like is still a point for discussion.

3 Testability and testing

As we have seen, the general strategy of both the CAG and the KNMG is aimed at proving the (un)scientific basis of alternative medicine. In doing so, however, an important aspect of the matter is ignored or incorrectly represented. That is, that the aim of therapy is 'curing' rather than the acquisition of theoretical-scientific knowledge. Naturally, knowledge is used in every branch of medicine in some form or other. The KNMG, and to a lesser extent the CAG also, harbours the - unexpressed - presupposition that scientific knowledge which has been produced under specific conditions, is 'simply' applicable in actual therapeutic practice. Of course, subsidiary problems will have to be dealt with, but they do not detract from the usefulness of the necessary medical-scientific knowledge as such, nor do they make it superfluous. This way of thinking ignores an important aspect, however, something which every general practitioner will have experienced. This is the fact that the conditions under which scientific knowledge is produced can be radically different from the situations in which this knowledge would have to be used. Thus the whole notion of the 'application' of scientific knowledge in actual therapeutic practice becomes doubtful (and it is the practices that concern us in this debate, after all). One example is the discovery of the antibiotic effect of penicillin on a colony of bacteria in a petri-dish. In this environment the situation can be kept completely under control, but in using penicillin to fight infectious diseases new problems arise, such as the growing resistance of the bacteria. In view of this consideration, it would seem to us much more useful when evaluating alternative (and regular) medicine, not to make a 'detour' by way of medical science, but to try and develop concepts of testability and ways of testing that are directly applicable to these practical situations.

Testing and control

One problem to be explored can be stated as follows. In any test, the tester should be acquainted with the relevant conditions which make possible a particular treatment and be able to control them. This holds good for both regular and alternative therapies. If the fact that the patient takes three pills after dinner is an essential part of the therapy, we must - if the case in question is to be a good test of a particular therapy - be acquainted with the relevant conditions and in a position to manipulate them, so that we can be sure that the patient does not take six pills before dinner. Also, if someone has been given a biological-dynamic diet by a natural therapist, we shall have to know or find out whether the food sold as such really is biological-dynamic. In other words, when testing, we aim at closing systems by trying to specify and control the relevant conditions.

As is clear from the above examples, more is required than just theoretical knowledge, viz. social knowledge and power to be able to effect the closing of systems in practice. It must be possible for the physician to call in the help of social workers to ensure that the patient in the example takes the right number of pills at the right time. And the natural therapist who recommends breast feeding to increase a baby's resistance is acutely aware of his lack of social power when mother's milk is shown to be so badly polluted by PCBs that the wholesome effect becomes doubtful (19).

In testability and testing we are concerned therefore with the possibilities for closing systems in such a way that it becomes possible for us to make predictions or pronounce expectations with regard to the expected course of illness and treatment. Essential to this way of thinking is that testability and testing of therapies will always have both cognitive and social aspects. The social aspects are of quite a different nature from the social aspects that play a role in scientific testing in laboratories or clinics. As a result, testing therapies is not just a matter of applying scientific theoretical knowledge. The aspect of social knowledge and control is not an additional problem, but an essential part of testing alternative and regular therapies.

Let us give an example to illustrate our point. Beatrix suffers from chronic frontal sinusitis. Three (or more) possible hypotheses and suitable ways of testing can be imagined.

(a) The nasal septum is in an oblique position, which hinders an adequate abduction of waste matter. Test: Operate and put the septum straight.

(b) As a result of Beatrix's habit of smoking too much and eating bad quality food she has a low resistance and cannot therefore cope with the inflammation herself. Test: Psychotherapy to help her get rid of her nicotine addiction, instruct and motivate her to adopt different food habits, based, for instance, on a natural therapy, plus a financial allowance to cover the higher cost of this kind of food.

(c) Beatrix works in a hospital and the affliction is caused by the profusion of bacteria present in that environment. Test: She leaves the hospital and takes a different job.

How do these possibilities for testing work out in practice?

For (a): This therapy is undoubtedly testable in present-day society (the costs will be paid for by the national health insurance scheme); in the meantime the test has been carried out, with a negative result.

For (b): This therapy has not yet been considered, as it is not part of regular medicine. Therefore: not testable for practical reasons.

For (c): It has been suggested that Beatrix give up her job

in the hospital. However, in practice this is impossible, since there is no other work to be found and the money is badly needed. Therefore, for social and personal reasons (c) is not testable in practice.

Conclusion

It will be clear that the ideas on testability and testing are as yet sweeping and sketchy. However, we feel that our exposition does show that the problems concerning the testing and testability of therapies are much more complex than the KNMG would have us believe in its comment on the CAG report. At the same time the contours of an alternative approach to the problem start emerging.

As we have seen, testing a therapy not only involves scientific knowledge and technical-scientific control, but also, at the same time, social knowledge and social control of the conditions that are necessary for effective medical measures. Closing open systems in a social force-field is an essential aspect of testing alternative (and regular) therapies. It is this aspect that has not received nearly enough attention in the CAG report.

What we have said so far in this article will make it possible to gauge more accurately the social significance of the alternative therapies. Now we can wonder if we wish to submit ourselves to the social control necessary for an effective application of alternative therapies, and if so, whose control we are willing to submit ourselves to. We feel that the scientific strategy pursued by the CAG leads far too easily to increased social control by the medical professions, the state bureaucracy, the pharmaceutical industry, etc., in other words: to an increasing medicalisation of man and society. Our condition for an official approval of alternative therapies is, therefore, a more open and more democratic form of 'social control', leading to alternative therapies that will not disregard the social causes of disease. For this purpose, it will be necessary to formulate differentiated and specific counter strategies and to form social counter forces. But in fact we shall have to go even further. In general it is by no means always desirable to close open systems and put up with the necessary social control to render testing the therapy possible. Patients/clients may decide, on grounds of personal and social analyses and priorities, not to cooperate in effecting therapies. In this case again the availability of counter strategies and counter forces will be a prerequisite.

In the second part of this article we shall show that - and how - it is possible to analyse and evaluate this same set of problems from a social point of view by using the notion of (regular and alternative) medicalisation.

PART II: SOCIAL ASPECTS

What contribution can the alternative therapies make in bringing the process of continuing medicalisation of society to a halt or even to reverse it? This crucial point is mentioned only indirectly by the CAG. On the one hand, the CAG is of the opinion that 'some alternative therapies can be said to offer in any case a certain counter force to medicalisation as a result of the attention paid to matters such as life-styles, the individual's relationship with his environment, food and food habits, etc.' ((5), p. 44). On the other hand the CAG says that it realises that a particular use of alternative therapies also harbours the danger of medicalisation. In this part of our article we shall try to reach a more tangible view of medicalisation and demedicalisation tendencies within alternative medicine. We shall start by analysing the concept of medicalisation into three elements: the concept or label of disease, the sick role and, connected with it, the mechanism of social control.

1 Medicalisation

Until quite recently, troublesome children who cannot be made to sit still, have problems with concentrating and are prone to sudden changes of mood were simply troublesome children. Since 1966 a medical label is available for these children: 'hyperkinesis' or 'minimum brain dysfunction'. To the immense satisfaction of parents, teachers as well as the pharmaceutical industry, troublesome children are now a medical problem. Other well-known new labels are to do with female sexuality and procreation - such as the 'post-natal depression' and the 'pre-menstrual syndrome' - and with certain food habits, such as 'obesitas' and 'anorexia'. These are a few examples of 'regular' medicalisation, which we want to distinguish from 'alternative medicalisation'.

The concept of medicalisation originated within the framework of the sociology of deviant behaviour ((20), p. 1). According to the interactionist deviance sociologists, deviance arises not on the basis of individual factors such as motivation and physique, but is caused by social reactions to a particular way of behaving. Behaviour is deviant only because it is labelled as such. In this way the emphasis is shifted from the person who has been labelled deviant to the institution attributing the 'deviant' labels. The theoreticians of the labelling approach in no way mean to deny that the above examples may cover situations that can be measured objectively and described in scientific terms. However, whether this situation should be regarded as healthy or sick is not a cognitive-theoretical question, but a moral-practical one, even though it is not always recognised as such in our science-oriented society ((21, p. 343).

Once people accept the judgment of their environment, the label will bring about a reorganisation of their behaviour, and they will adopt the corresponding sick role. The dominant sick role is the regular one. In it, sick people are made not to feel morally responsible for their deviant behaviour: they 'cannot help it' and must, therefore, be helped. The legitimacy of the sick role, however, is limited: sick people are relieved of the fulfilment of their normal duties only on the condition that they regard their sickness as undesirable and accept the obligation to get 'well'. To this end they need to call in the competent help of a physician and to obey strictly the latter's orders. As a result the sick person is in fact powerless against the doctor's decisions. The regular sick role also offers patients few possibilities for resisting prescribed therapies and their possible side effects, hospital treatment, application of advanced medical technology, etc.

At the same time, the sick role functions as a mechanism of social control. By means of the system of privileges and obligations outlined above, the regular sick role manages to channel deviant behaviour in such a way that the existing social order and stability is not endangered. The mechanism of social control 'isolates' the sick person from the healthy one, and in doing so the former's legitimacy of being ill is restricted, while strengthening the latter's motivation not to become ill. At the same time the sick person is forced to enter professional institutions where he or she is made dependent on those who are not ill ((22), pp. 428-480).

In sum, we see that three elements are distinguishable in the medicalisation process. It is a process in which the labels 'healthy' and 'ill' are being made to bear on an ever increasing part of human life. The process is accompanied by an extension of the sick role to new areas. From a social perspective, this means an increase in the possibilities for social control. The three elements also play a part in testing therapies. As we made clear in Part I, testing presupposes the possibility of closing systems in such a way that we are able to make predictions and pronounce expectations on the course of the disease and the treatment. In order to effect the closing of systems in practice, not only theoretical knowledge - and especially a concept of disease - is required, but also social control over the conditions necessary for successful treatment. The sick role is, therefore - in

terms used by Foucault - the point of intersection of the technologies of the body, the representations of knowledge and the mechanisms of power.

2 Drawbacks of the regular model

What the theoreticians of the labelling approach have done, in fact, is to describe the regular medicalisation process. According to them a shift has taken place in the course of time, from the religious and legal definition of deviance as a sin and crime, to a medical definition of it as a disease. At the same time, penance and punishment have increasingly been replaced by treatment and care. The hospital has succeeded the church and the law court as the most important institution of social control: 'The gowns remained but changed in colour, from red and black to white' ((23), p. 15). The labelling theoreticians generally tend to emphasise the negative aspects of the shift from the role of sinner or criminal to the role of patient - a shift which in slightly older literature is regarded as a 'more humane' attitude towards social intercourse with deviant behaviour.

They point out the iatrogenous (side)effects of medicalisation. In doing so, they distinguish clinical from social iatrogenesis. Clinical iatrogenesis refers to any harm done by a medical technology. Social iatrogenesis refers to the far-reaching dependence of the layman in comparison with the medical expert, which decreases the health stimulating and curing aspects of the social and natural environment and in this way diminishes the physical and mental fighting spirit of ordinary people ((24), pp. 40-41).

The medicalisation of society also leads to an obscuration of the social etiology of many diseases. As soon as something is labelled a 'disease', it has by definition become an individual problem; generally speaking, the level of intervention will then also be individual. The label 'disease', therefore, has a depoliticising effect and a strong conflict-suppressive power. The result is that medical expert knowledge is called upon more and more frequently to mask explosive social oppositions, when taking controversial measures concerning labour relations (for instance, matters like the legislation concerning disability allowances, etc.), when assigning scarce commodities (such as flats and houses), selecting personnel (medical examinations, etc. for admittance into the army or a variety of jobs), estimating collective risks (toxicity of food), etc. In this way the medical profession is collecting a steadily increasing number of managerial positions. This entails, on the one hand, an increase in individual physicians' chances of a decent income and considerable social status. But it is also threatening to undermine to a considerable extent the position of authority occupied by the regular medical profession as a whole. It is the alternative therapists who are gaining by the loss of authority by a rapid rise in status ((28), pp. 208-224).

We should like to point out that the model of the sick role as outlined above is valid only in acute cases. People suffering from chronic ailments and handicaps have an unconditional legitimacy in the sense that they are excused permanently from certain obligations. This also means, however, that their privileges are curbed very clearly. Their needs are always the last thing to be considered, especially in times of economic crisis: they must not be too demanding and should be satisfied with what is considered 'sufficient' by others <2>. The rise of alternative therapies undoubtedly is also connected with the attempts made by large groups of patients who are considered incurable, and have been given up by the regular physician, to (re)gain the status of acute patient ((21), pp. 224-244).

3 'Alternative medicalisation'

The alternative therapies do not constitute a unity. They differ widely in underlying philosophy and consequent forms of diagnosing and therapy. The CAG report shows, however, that they also have substantial features in common; it is possible, therefore, to speak here of an alternative medicalisation type, the contours of which we should like to sketch briefly.

Within the alternative therapies a new concept of disease was developed. Illness should no longer be regarded as a completely negative phenomenon, as a deviation from some established norm. Pain, disease and death are essential experiences with which each of us shall have to learn to live. The alternative therapists agree with Illich's hypothesis that traditional cultures derived their health-stimulating function precisely from the ability to teach human beings that pain can be bearable, illness understood and the encounter with death meaningful ((24), pp. 40-41). Modern medical civilisation has eroded this ability by regarding pain, illness and death as nothing more than accidents which require medical treatment. Not until human beings have learned to go through illness, pain and suffering again, will a regeneration of people's self-healing power occur. Health, according to alternative therapists, also needs to be formulated in positive terms - that is, in terms of an optimal sense of well-being or comfort - rather than in exclusively negative terms, as the absence of complaints and ailments. As a result, the emphasis shifts from the curative to the preventive level: rather than combatting disease it is the stimulation of health that should come first. It is also within the alternative therapies that a new sick role was conceived. In it, the patient's personal responsibility for the state of his or her health is stressed. He or she is encouraged to adopt an active role instead of being passive and dependent. Healing, according to the alternative therapists, always is self-healing. The point is that the 'inner doctor' who is present in every human being should be activated. It is easier to achieve this when the healing process is based on the patient's personal experiences rather than on concepts formulated by the medical profession. Changing the concept of disease and the sick role involves changing the form of social control which now will no longer be imposed from above: the patient gets a say in the way in which it should be exercised. In short, the alternative medicalisation type is characterised by a positive concept of disease, a moralised sick role and a democratised form of social control.

In this type of medicalisation, the iatrogenous (side)-effects are diminished or even abolished altogether. In order to prevent clinical iatrogenesis, alternative therapists prefer limiting medical intervention by means of medicines or surgery to a minimum. When necessary, they make use of simple and 'natural' techniques, partly derived from Eastern and traditional therapies, and partly from modern forms of psycho-therapy that stress 'body-work'. Most important of all, however, are the so-called 'life-style' recommendations, concerning eating and sleeping habits, work, pain, grief, etc. As the above techniques and recommendations can, in general, be understood and applied by anyone, they tend to have a de-professionalising effect. This leads us to the issue of social iatrogenesis. To prevent this happening, a larger degree of equality between physician and patient is aimed for, which is expressed by such things as the use of the same sort of language, wearing the same clothes, openness with regard to the diagnosis, therapy and prognosis. There are no medical secrets to make patients dependent and insecure, and it is not assumed that they know nothing about their own health or illness or the functioning of their own body. The obscuring of the social etiologyis also avoided to a large extent by alternative therapies. This results from the holistic principle on which these therapies are based. Alternative therapists assume that illness and health should be placed within the context of people's total functioning. They resolutely reject the body-mind dualism that for a long time was a central philosophical theme in Western thought, and also pay attention (to some extent, at least) to the spiritual dimension of human life. Health and illness should, according to the alternative therapists, be seen in terms of harmony and disharmony between the somatic, mental and

spiritual aspects, all of which form a fundamental and integral whole. However, humans should be in harmony not only with themselves, but also with their natural and social environment. That is why alternative therapists will take ecological and social factors into account when making their analysis of the origins and development of illness.

4 Dangers of alternative medicalisation

'Too good to be true' the patient reader will say at this point. And quite rightly, seeing that daily practice is often in shrill contrast with the rose-coloured self-image fostered by alternative therapists, as is clear from the CAG report. Three dangers in particular are connected with the alternative medicalisation model, which we shall examine in more detail: the positive approach to health and illness may lead to an unprecedented expansion of accompanying labels; the moralised sick role may lead to quite new forms of 'victim blaming'; and finally, attempts at preventing iatrogenesis may lead to 'secondary iatrogenesis'.

Healthism

Crawford accuses the proponents of the new health movements (to which alternative therapists and their patients and supporters should also be considered to belong) of a one-sided preoccupation with personal health as the highest aim in life and as the main source of well-being. This obsession, labelled 'healthism' by Crawford, may clear the way for total medicalisation, in which the labels 'ill' and 'healthy' will gradually be applied to practically all phenomena and activities of daily life. The labelling process will no longer limit itself to manifest sickness behaviour, but will extend to all risk-bearing behaviour, i.e. to all ways of behaviour and all habits that are regarded as being bad for one's health. The result will be that we shall all of us become deviants in our daily lives - 'when we light up a cigarette, when we consume eggs at breakfast, and when we are unable to express fully our emotions' ((26), p. 380). We should all of us be aware of our duty - as potential patients - to diminish health risks by correcting 'bad' habits.

Crawford's criticism of the new health movements did not fail to excite a response. Putting the individual's health first must not, according to Katz and Levin, be regarded as a 'solipsistic trap' which a generation of disillusioned activists walks into with its eyes open (as Crawford would have us believe). The growing consciousness of the dangers that threaten our health, it is said, should be seen as a condition rather than an impediment for social action. Participation in the new health movements has, therefore, nothing to do with narcissism or social escapism; on the contrary, it is 'a specific antidote to passivity, apathy, and dependency in the health care area, and has potential extension to other areas of living as well, including the political sphere' ((27), p. 333). The increased health consciousness that is indicated by the term 'healthism' by Crawford cannot therefore be simply explained in terms of increasing medicalisation.

To prevent 'healthism' from deteriorating into medicalisation, the power to define what counts as 'ill' and 'healthy', which is now held unilaterally by the medical profession, will have to be spread. After all, the question what should be called 'ill' and 'healthy' is a moral-practical one, not just a cognitive-theoretical one, to answer which the medical profession does not possess any special competence.

In order to achieve this, a certain amount of openness is required in the relationship between physician and patient, and between the medical profession and the public. Among alternative therapists in the Netherlands this relationship leaves much to be desired. Instead of openness, a certain amount of obscurantism can be seen. This is partly due to the monopoly position of academically trained physicians, as it was laid down in 1865 in the 'Act on the Execution of Medical Practice'. The science-based approach to illness and health was elevated by the Act to the only 'regular' approach. The alternative therapies, which were practised largely by unqualified practitioners, were reduced to the status of quack remedies and clandestine status. This aura of taboo will not disappear until the 1865 Act is replaced. In a proposed new Act, the exclusive monopoly of medical practitioners is changed into a partial monopoly, while the professional protection is replaced by protection of the title to create room for the application of therapies by non-qualified practitioners.

Another important cause of lack of openness is to be found in the fact that alternative therapists in the Netherlands tend towards a certain amount of sectarism. This can be explained from the fact that a number of alternative therapies arose in the context of a particular life philosophy - usually one with religious overtones.

Victim Blaming

Another danger mentioned by Crawford concerns the moralised sick role. He points out that the holism of alternative therapists is of a very limited character: although it is true that the ecological and social context is not ignored or denied, it is, as a rule, reduced to the immediate environment and area of personal relationships. As a result, the problem of illness and health is still, just as in orthodox medical science, largely formulated and dealt with at the individual level. Combined with the strong emphasis on personal responsibility typical of the alternative sick role, this reduction will inevitably lead to all kinds of 'victim blaming'. The diseased will then be made responsible for matters and circumstances that from the nature of things are out of their control and which they cannot possibly manipulate on their own. Disease is (once again) turned into punishment for moral decline and lack of will-power. We want to add to Crawford's critique that this state of affairs may lead the patient to a situation that is comparable in all respects to the situation in regular medicine. A patient who is guilty of his own illness is not in a position to question the views and actions of his or her physician or therapist. In this way one kind of intimidation may lead to another, so that the dependency relationship is continued rather than abolished.

The dangers that are pointed out by Crawford can no doubt also be detected in the development of alternative therapies in the Netherlands. Although it is true that fairly recently the importance of good - 'stable and warm' - interhuman relationships was discovered and a certain amount of ecological awareness can be said to exist, as is apparent from the mounting aversion to technology and 'chemicals', nevertheless there is nothing substantial to be found in the CAG report on the pollution of the environment, inner city decay, the militarisation of society, the nuclear threat, alienated labour, racism or paternalistic attitudes as (co-)originators of disease. Moreover, it is far too often the sick individual who is blamed for his or her disease (seen as a result of disharmony in the person-environment relationship). It is not the environment that needs changing, but the patient's life style.

Patients who are not sufficiently motivated or capable of discarding certain habits and making quite drastic changes in their life styles are, therefore, not accepted. Some alternative therapists want to extend the patient's personal responsibility to the financial sphere by asking for a private contribution and a retribution system: 'if the patient is not aware of the costs he himself is causing, and does not, in the first instance, have to pay for them himself, he will not be fully conscious of his personal responsibility' ((5), appendix F, p. 30).

Secondary iatrogenesis

The final danger that we should like to discuss is pointed out by Illich. He argues that health service reforms, although aimed at fighting clinical and social iatrogenesis, will generally only lead to secondary iatrogenesis. 'Acupuncturists, homeopaths, and witches can be assigned departments in a world-wide hospital for life-long patients. In a ther-

apy-oriented society, all kinds of Aesculapians can share the monopoly of assigning the sick role, but the more different professional cliques can exempt the sick from their normal obligations, the less people on their own define how they wish to be known and treated' ((24), p. 79). According to this view, alternative therapists would do better to shut up shop, if they want to do us a favour.

Illich undoubtedly is right in saying that within alternative medicine there is a tendency towards professionalisation. Over the past decade especially all kinds of professional organisations of alternative therapists have been founded, which concern themselves with drawing up rules for admission, fee charging and disciplinary measures. The CAG report focuses on the demarcation problems with respect to regular medicine resulting from this process of professionalisation. However, it is not a matter of course at all that this rise of an alternative profession side by side with the regular medical profession will lead to increased dependence on the part of the average patient, as Illich would have it <3>. This danger would arise only in a situation of complete 'regularisation', i.e. in case of a frictionless incorporation of alternative medicine within the framework of the existing health service, without any changes in the framework itself. It is by no means impossible that those therapies that regard themselves as 'additive' rather than 'alternative' will be allotted a place in the social system of health care, their main function being to assist in streamlining existing medical treatment. In that case there will, indeed, be secondary iatrogenesis: for the problems caused by regular medicalisation a new medical channel will have been created. The problems will simply repeat themselves at a higher level, by creating new, more subtle forms of making people dependent. In this way alternative therapies may well become the end of the line for all hopeless, chronic and/or terminal cases that have gone the full round of the (regular) medical profession.

According to the CAG report, natural therapists and - although to a lesser extent - ESP therapists are the only ones who recognise the dangers connected with complete regularisation, such as limitations on the consultation duration, large-scale practices, profit making and conformity demands ((5), pp. 93 and 112; (5), appendix D, p. 35).

Since the recent foundation of the 'Organisation of Alternative Therapists in the Netherlands' (NOVAG), all warnings with respect to these dangers seem to have died down. The organisation, 'the alternative KNMG', is an offshoot of an organisation in which patients as well as therapists were represented. While the patients have found a place in a 'National Consultative Organisation for Patients of Alternative Therapies', the therapists have joined forces in NOVAG. NOVAG is trying to win complete official approval by cutting off all offshoots. Since 1 January 1984, a stop has been issued in all subsidiary organisations for members who do not come up to the standards - stricter now than before - with regard to training, the organisation of their practices and experience. They are hoping for money for 'real' effect research and have given matters such as cooperation with regular medicine high priority.

The question is whether the patients will be prepared and able to offer some kind of resistance and call the alternative therapists back. When we see what motivates the average patient to go and see an alternative therapist, there does not seem to be much chance of this happening. As is clear from the CAG report, users of alternative therapies may be divided into three categories: frustrated patients (frustrated by regular medicine, that is), pragmatic patients (using now regular, now alternative therapy) and high principled patients (choosing an alternative therapy as part of their life philosophy or religion) ((5), p. 59). A section of the high principled patients, who number no more than twenty percent of the total number of patients, received its preference for alternative therapies as part of its upbringing, one might say ((5), appendix F, p. 57), e.g. many patients of homeopathic therapists traditionally belong to the Dutch Calvinist Church. It seems reasonable to assume that another section of ideologically motivated patients stems from the countermovement. Two indications for this assumption may be found in the CAG report. First, a number of patients' organisations have seen a marked increase in the number of young patients who have 'a new way of looking at things' ((5), appendix F, p. 48). Secondly, we find that alternative therapists not only have a large following among adherents of small right-wing parties but also among those of small left-wing parties. The fact that the alternative therapists - with the political victory in sight - have been able to move so easily in the direction of total regularisation may well be connected with the fact that the counter-movement has been able to develop so little strength up to now among patients of alternative therapists.

Translated by Thea Summerfield

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1 From approximately 1960 a 'historical wave' can be detected in the theory of science with which the names of Kuhn, Feyerabend and Lakatos especially are connected. See (7), (8) and (9). At a later stage, from approximately 1975, an important 'sociological wave' came into being; see (10) and (11).

2 People with a disease that is stigmatised by society, such as many venereal diseases, AIDS, epilepsy, leprosy, dementia and psychic disorders, have an even harder time. These diseases are frequently regarded as completely illegitimate: the patient is, admittedly, discharged from a number of responsibilties, but he/she is forced to contract new responsibilities and enjoys few, if any, privileges.

3 Even if Illich were proved right on this point, only half of his statement will have been proved, and he will still have to make credible that the sparing use made of soft and natural techniques by alternative therapists will lead to secondary clinical iatrogenesis, which it is very hard indeed to imagine.