Varieties of Healing. 1: Medical Pluralism in the United States

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Medicine has become interested in unconventional healing practices, ostensibly because of recent demographic research that reveals a thriving medical market of multiple options. This essay presents a historical overview of medical pluralism in the United States. Consistent evidence is examined suggesting that unconventional medicine has been a persistent presence in U.S. health care. Despite parallels with the past, the recent widespread interest in alternative medicine also represents a dramatic reconfiguration of medical pluralism—from historical antagonism to what might arguably be described as a topical acknowledgment of postmodern medical diversity. This recent shift may have less to do with acknowledging "new" survey data than with representing shifts in medicine's institutional authority in a consumer-driven health care environment. This essay is an introduction to a discussion of a taxonomy of contemporary U.S. medical pluralism, which also appears in this issue.

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Much recent demographic research has highlighted the extensive use of unconventional medical practices both in the United States and throughout the industrial world (1–4). The phenomenon seems to be increasing: A replication of a 1990 national survey conducted in 1997 showed a substantial increase in the use of, and expenditures for, alternative medicine (5). Specifically, the number of respondents who used at least 1 of 15 representative alternative therapies during a 12-month period increased from 34% to 42%. Such data challenge the biomedical profession's previous assumption that a single biomedical system defines our society's health care. The medical profession no longer uniformly categorizes alternative medicine as deviant, marginal, fringe, fraudulent, and of little consequence (6–10). Rather, the profession has begun to realize that it is a cohabitant in what seems to be a postmodern medical network in which consumer preferences dictate the service profile (11). Also, this survey research confirms what anthropologists have labeled "medical pluralism": People frequently adopt multiple healing practices even when biomedicine is generally available (12–16).

This essay examines the specific development of medical pluralism in the United States. A second essay in this issue (pp 196-204) presents a taxonomy of contemporary unconventional healing practices. First, however, we must caution the reader about potential semantic chaos. This subject is a linguistic minefield because there has been no agreement on terminology. Terms change through historical periods; new names arise continuously, and meanings shift. Labels often embody rhetorical stances, power relationships, and value judgments. In this essay, we have tried to use terms that are consistent with the historical time frame and specific context of the discussion. For example, depending on the situation, orthodox medicine may be called regular, mainstream, or biomedicine, while unorthodox medicine may be designated as irregular, drugless, or complementary. We have tried to avoid judgmental labels (for example, scientific, allopathic, sectarian, quackery, allopathy, unproven, natural, or integrative) unless they actually clarify the discussion. We have chosen the label unconventional or alternative medicine as a generic title for this field of inquiry.

U.S. Pluralism: Its Origins and Development

Medicine in the United States began in a rich pluralistic environment. Before the early 19th century, U.S. medicine was a shifting collection of coexisting options not rigidly or permanently defined: "A broad spectrum of practitioners—diverse in social background and intellectual attainment—shared the self-perception of being legitimate . . . practitioners" (17). The public had little conception of the medical profession as a corporate entity (18). By 1800, there were only about 200 graduates of elite U.S. medical schools in the United States, supplemented by another 300 or so immigrants with European diplomas. By 1830, there were still only 6800 MDs, serving primarily the upper classes (19). Professional care was mostly provided by botanical healers and midwives, supplemented by surgeons, barber–surgeons, apothecaries, and "uncounted cancer doctors, bonesetters, inoculaters, abortionists, and sellers of nostrums"

(20). Ethnic practitioners, such as Native American healers, slave doctors, and New Amsterdam's Zieckentroosters ("comforters of the sick") ministered to their own and to neighbors (21). Some practitioners claimed only specific skills, while others saw their competence as equivalent to that of physicians.

The fluid situation gradually hardened into sharp antagonism. The medical profession sought to extend its authority both for economic self-interest and as part of the Enlightenment's agenda for universalizing the benefits of science. Non-MD practitioners saw themselves "not merely [as] improvised substitute[s] for professional medicine [but rather they] became active rival[s] with a coherent structure of [their] own. Lay healers . . . saw the medical profession as a bulwark of privilege, and they adopted a position hostile to both its therapeutic tenets and its social aspirations" (20). By the first decade of the 19th century, "Elite educated physicians were actively conscious of their precarious cultural authority" (22).

Regular (that is, elite) medicine's plan for expansion and exclusive authority was easily thwarted. With the democratic fervor of the post-Revolution United States and the egalitarianism of the Jacksonian era, nonelite medicine had a heightened appeal and underscored the tension between professional ideals and democratic culture (22). Also, elite medicine's "heroic therapy" of bleeding and mercury provided further incentives to avoid the regular physicians. Paradoxically, after the 1820s, it was "sectarian" resistance to elite medicine's expansionist plans that allowed "a self-conscious group awareness of being orthodox to emerge among regular physicians" (17). Antagonism and competition replaced a situation of unstable coexistence. Medical systems began to collide.

In the 19th century, U.S. medical pluralism was a war zone. Beginning in the earlier 1800s, the first wave of organized opposition to orthodoxy was led by the Thomsonians (botanical healing), Grahamites (health food), homeopaths (microdilution medicine), hydropaths (water-cure therapies), and mesmerists (the "energy" healing of the time). Beginning at the end of the 19th century, a second advance was spearheaded by the osteopaths, chiropractors, drugless practitioners, and Christian Scientists.

Historically, the ammunition of the medical conflict included rhetoric, legislative maneuvers, and nonfraternizing clauses. Samuel Hahnemann (1755–1842), the founder of homeopathy, claimed that the regulars (for whom he coined the term *allopaths*) practiced a "nonhealing art . . . which shortened the lives of ten times as many human beings as the most destructive wars and rendered many millions of patients more diseased and wretched than they were originally" (23). Oliver Wendell Holmes (1809–1894), of Harvard Medical School, responded that homeopathy was "a mingled mass of perverse ingenuity, of tinsel erudition, of imbecile credulity, and of artful misrepresentation" (24). In 1847, the American Medical Association (AMA) was founded to erect a barricade between orthodoxy and the irregulars (25). The AMA's antisectarian consultation clause and later its Committee on Quackery internally policed against any collaborationist tendencies (26–29). (Even so, many MDs cooperated with the irregulars, which caused numerous conflicts within orthodox medicine [25]). Even until quite recently, the rhetoric continued. One could still read in the *Journal of the American Medical Association* (*JAMA*) announcements of meetings on "medical deviance" jointly sponsored by the AMA and the U.S. Food and Drug Administration where, in 1962, "50 government officials and representatives of private agencies concerned with quackery [met] to review advances made against the modern-day 'medicine man' " (30).

The irregulars also witch-hunted any of their own who might adopt "enemy" therapeutics or beliefs. Diatribes and discrimination against "mongrel homeopaths" (31) and "ChiropracTOIDS" (32) punished those who might borrow any "regular" methods and betray their alternative fraternities.

Cultural symbols were often more important than medical outcomes in this tug of war (33, 34). Just as regular medicine often upheld dominant cultural assumptions, unorthodox healing often became a badge for social activism and religious dissent: "Medical heretics typically doubled as heretics in politics and faith" (35). Resistance to the "system" was often a broad-based alliance: "The genius of [medical irregulars] was to express a protest against the dominant order in its therapeutics as well as its political [or religious] ideas" (20).

At the beginning of the 19th century, the alliance was more religious. At the same time that Mother Ann, the Shaker prophetess, and her successors proclaimed that Jesus would take a female form at the Second Com-

ing, the Shakers also built a sophisticated herbal delivery system to help people avoid the "pollution" of regular physicians (36, 37). By the middle of the 19th century, social reform movements that opposed the consequences of an emerging industrialization and market economy became more important than religious partnership (38). For example, when the American Vegetarian Society met in 1855, they welcomed, besides a wide assortment of healers, such enthusiastic attendees as Susan B. Anthony, the leading advocate of women's rights; Amelia Bloomer, of clothing reform fame; and Horace Greeley, a leading antislavery and spiritualist proponent, as well as pioneers for sexual emancipation and working class rights (38).

The Magnitude of Alternative Medicine in U.S. History

To what extent does the recent dramatic shift in awareness about alternative medicine describe a new phenomenon or "boom" in alternative medicine use? To what extent is contemporary alternative medicine a continuation of older oscillations and tendencies? Unfortunately, the historical magnitude of alternative medicine has rarely been studied with anything resembling modern survey methods or with the intensity of recent efforts. Nonetheless, the existing evidence shows that alternative medicine has had a pronounced presence in health care throughout U.S. history. For example, in 1924, a leading physician in Philadelphia published the results of a 4-year survey conducted as part of his intake history of all patients. Of the patients seen in his private office, 34% had, within 3 months of their first visit, "been under the care of agents of one or more of the numerous cults" (39). During the same period, 26% of patients treated at a free dispensary connected with one of the larger hospitals in Philadelphia had received treatment through "pseudo medical agencies." At approximately the same time, an Illinois Medical Society survey of 6000 people in Chicago found that 87% of those questioned had "dabbled" in cult medicine (40).

The findings of such local surveys of the late 1920s were confirmed by one of the first massive nationally representative surveys jointly undertaken by health policy planners from the U.S. federal government and professional statisticians. Between 1928 and 1931, 8758 representative families (a total of 39 183 persons) were periodically visited at intervals of 2 to 4 months for 12 consecutive months to document illness incidence and rates of health care use. Whenever possible, health care providers were contacted to confirm or adjust self-reported illnesses and visit rates. (In contrast, the two contemporary U.S. telephone surveys mentioned earlier involved 1539 adults in 1990 and 2055 in 1997 [5]). Of approximately 7800 families who received some form of medical care during a given year between 1928 and 1931, "10% resorted on one occasion or another to sectarian [alternative] practitioners" (40). The surveyed families received from nonmedical practitioners "139 home and 569 office visits per 1000 persons, or one-eleventh as many services as they received from the doctors of medicine" (41). (Approximately 85% of this particular statistic included visits to chiropractors, osteopaths [who were still considered unorthodox], Christian Scientists, faith healers, and naturopaths. The other 15% happened to include practitioners who could be considered allied health professionals [for example, midwives and chiropodists] [42]). Most of the illnesses treated by strictly defined unconventional practitioners could be classified as backache, pain (for example, neuralgia, chronic rheumatism, and arthritis), "nervousness," and "neurasthenia" (42). Visits for wellness, prevention, and health maintenance were explicitly not tabulated (42); neither was massage (which contemporary surveys usually include). Expenditures for the alternative practitioners counted represented approximately 12% of the total annual expenditure for MDs (40). (Mainstream medical costs were much lower than they are today.) Strikingly, if wellness and prevention visits, which in modern surveys comprise the bulk of visits (1), could be added, these prevalence rates would probably be similar to, or debatably even larger than, those seen in contemporary data.

Scrutinized more closely, these numbers from 1928 to 1931 are especially conservative compared with modern surveys. As the survey researchers noted, they did not include the costs of unsupervised self-care alternative medicine and " 'cure-all' frauds offered for sale at medicine shows or advertised through the mails or newspapers" (43). (In contemporary surveys, self-care can include one third to one half of the tabulated expenditures for alternative medicine.) Despite the absence of precise cost estimates for these unsupervised self-care remedies and treatments, it is likely that Americans at this time,

like the contemporary public, were enthralled with this aspect of unconventional medicine. Many of the "rich and famous" were involved; Greta Garbo, Mae West, Gloria Swanson, Paulette Goddard, John D. Rockefeller, and Bernarr Macfadden were all committed to alternative health lifestyles, and their habits were frequently covered in the media (44–46). Royal S. Copeland, the eminent New York senator and homeopathic physician, wrote a popular weekly health column for the Hearst papers devoted to the value of drugless healing (47). Also, mainstream journals of that period, such as the *New England Journal of Medicine*, continually warned physicians to protect their patients from nostrums that involved "fraudulent exploitation" (48). Editors of major medical journals felt it necessary to write popular books about the subject, such as *The Medical Follies: An Analysis of the Foibles of Some Healing Cults*, by Morris Fishbein of *JAMA*. From such anecdotal evidence, and the additional important fact that the patent medicine business was one of the largest industries in the United States (45, 47), it seems reasonable to assume that self-care aspects of alternative medicine were thriving during the 1920s and 1930s.

Looking farther back, accurate numbers tend to exist only for practitioners. In 1900, government sources found that homeopaths and eclectic physicians (the licensed botanical practitioner at this time) accounted for 12.5% of health care providers (25, 49). Undoubtedly, the numbers would further increase if the unlicensed army of magnetic healers, drugless practitioners, osteopaths, chiropractors, midwives, and faith healers was included. For 1850, the figures for registered unorthodox practitioners are essentially identical to those of 1900 (25), and again, mid-19th century observers noted that such data did not include "Indian doctors, clairvoyants, natural bone-setters, mesmerists [and practitioners of] galvanic, astrologic, magnetic, uriscope, 7th sons, etc. etc. etc [healing]" (50). In terms of total costs, estimates or guesses are the only quantification available. For example, in 1858, a leading New York State physician declared that "I believe there is not a town or city in this State, in which there is not more money paid to irregular practitioners of various names, and for nostrums and patent medicines, than is received by regularly educated physicians" (51). Numerous other early sources made similar appraisals (52–57).

While most of the historical data are not as rigorous as the survey performed from 1928 to 1931, all of the historical quantitative information taken together allows one to argue that alternative medicine has always had a persistent and powerful presence. Whether these survey data are a sign of constant high usage or happen to represent times when there were peaks in the public's interest remains unclear. Fluctuations undoubtedly occurred. Perhaps alternative medicine surveys are mainly performed during periods of high utilization, or perhaps such surveys encourage the very phenomena they study. Specific historical events (for example, the discovery of antibiotics or a linkage between acupuncture and endorphins) and general secular trends (for example, confidence in scientific progress) undoubtedly affected utilization patterns and trends. It may be that the high prevalences in the 1920s and 1930s and in the 1990s and 2000s represent two peaks within oscillations. For example, without citing its methods, one government report estimated that in 1970 "Quackery . . . cost $1-2 billion a year [and today, 1984,] it probably totals at least $10 billion" (58). Unfortunately, the data for the years between 1940 and 1990 seem to be imprecise and scanty and preclude firm conclusions. In any case, it is clear that alternative medicine has been an enduring phenomenon (with or without fluctuations) in U.S. health care.

Recent Shifts in U.S. Medical Pluralism

Until recently, the medical community has mainly sought to ignore or suppress unconventional healing. Recently, it seems, a new dialogue is emerging (59). The recent publication of data concerning the public's use of alternative medicine, however, is in itself insufficient to explain the new attitude toward alternative medicine. Any attempt to adopt such a simple argument is undercut by the fact that similar information in earlier eras was consistently used as an incentive to eradicate the threat of quackery (30, 40). Nor can recently performed randomized, controlled trials (which are definitely not uniformly positive and are often equivocal or contradictory) be considered the impetus for the realignment (60). Rather, the new biomedical discussion is probably substantially due to changes in the internal orientation of the biomedical community.

Undoubtedly, the recent discussion of alternative medicine must be related to an awareness in biomedi-

cine that its institutions (for example, the AMA, medical schools, the pharmaceutical industry, and the National Institutes of Health) have a limited ability to set the health care agenda in the face of a developing consumer-oriented health care system (11). Also contributing to the recent reconsideration of alternative medicine is a societal acknowledgment of cultural, religious, and ethnic diversity. This dissolving of a single modernist medical narrative has formed an increased awareness of medical pluralism. The old cultural war of a dominant culture versus heretical rebellion in politics and religion as well as medicine has begun to transform into a recognition of postmodern multiple narratives. Also, alternative medicine may provide a vehicle for establishment medicine to become more consumer-savvy and to "placate" public dissatisfaction with such perceived mainstream health care problems as the impersonality of medical technology or the absence of robust patient–physician relationships. In addition, emerging economic and legal forces undoubtedly play a huge role in the recent rapprochement. Perhaps because it is beleaguered from battles on other fronts, orthodox medicine has simply abandoned its crusade against alternative medicine.

Regardless of the reasons, substantial portions of the medical system have begun to seek reconciliation with alternative medicine. Managed care, insurance carriers, hospital providers, major academic medical centers, and individual MDs are increasingly receptive to developing new "integrative" models of health care that would have been unthinkable just a short time ago (61, 62). Complementary medicine has become a serious subject in medical schools (63). In 1998, the AMA initiated a coordinated theme on alternative medicine for a specific issue of each of its nine journals. In a dramatic softening of rhetoric, the lead editorial spoke of a situation in which "There is no alternative medicine. There is only scientifically proven, evidence-based medicine . . . or unproven medicine" (64). Major pharmaceutical companies now "complement" their pharmaceutical lines with herbal products (65). The National Center for Complementary and Alternative Medicine at the National Institutes of Health has exponentially increased its research fund for alternative medicine (66). The Food and Drug Administration has been more willing to facilitate research in herbal products. While some in the biomedical community yearn for a continuation of the old-fashioned dominance, or at least the appearance of it (67–69), it would be an understatement to say that, minimally, there is a widespread acknowledgment of the need for new dialogue and a new relationship between what were once regarded as opposing forces (59).

Alternative medicine has also shifted. Besides having new therapies drawn from afar (for example, acupuncture or Tibetan medicine), the current third wave of alternative medicine has left behind its old rhetoric. Instead of provoking antagonism, complementary and integrative medicine have become the new politically correct buzzwords. Many alternative providers see themselves in a partnership with biomedicine. A cease-fire, if not a complete armistice, has been declared.

The past 200 years of U.S. pluralism represent a history of conflict. The current period is one of rapid, almost breathless transition. Most participants want a peaceful and mutually advantageous reconfiguration. It is to be hoped that patients will be served. Yet many unknowns and hurdles remain, and the future is unpredictable. It is unclear how issues of power, prestige, autonomy, authority, and resource allocation will play out. Will the medical profession seek to absorb only scientifically proven therapies, or will it include therapies that provide marketing advantages? Who gets to decide? What is the role of science and evidence? Will those with less expendable income be excluded? To what extent will alternative medicine remain a distinct option or become assimilated, "co-opted," or truly integrated into a new single "system"? Does "integration" mean elimination of pluralism? Do alternative professional self-identity, patient commitment and satisfaction, and perhaps even effectiveness depend, to some extent, on the ability to represent distinct alternatives (70)? All that can be said for certain is that medical pluralism remains alive and well in the United States.

Conclusion

At all points in the history of the United States, several medical options have been available to its citizens. The recent increased awareness of alternative medicine represents both a historic continuation of U.S. medical pluralism and a dramatic reconfiguration away from antagonism and toward a postmodern acknowledgment of diversity. Many issues remain unresolved.

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