SL Hartman

Committee 5-
Healing Through the Pathways of Wisdom

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BEYOND THE MEDICAL MODEL'S CAPACITY TO PROMOTE WHOLENESS

BY

Sherry Hartman, Dr.P.H., R.N.
Associate Professor
College of Nursing
University of Southern Mississippi
Hattiesburg, Mississippi

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INTRODUCTION

Post modern thought has helped move scientists to a recognition of both the embededness of research data in biases, contradictions and values and the transitory nature of theory. The biomedical model that has informed our practice of "healing" humans has not escaped this critique. Some scientists in medicine and related health care disciplines are engaged in dialogue that recognizes and seeks to address the issues and problems raised by the entrenched paradigm of biomedicine. Many have come to agree that the major health professions need not another technological advancement, but rather a new model or theory to guide research and inquiry.

Concerns with today's cost containment and quality of care issues in the health industry (really an illness industry) are not unrelated to the model we have chosen for care. Costs can be traced to support of high-powered medical interventions and research. Our technological interventions have a common derivation in a mechanistic model. They aggressively attack disease, are expensive and are geared to tertiary prevention or treatment. Iatrogenic diseases are often produced and many interventions are not effective for the patient's complaint. There are unresolved ethical problems as well as the questionable value emphasis on discovery of new knowledge versus promotion of health and a meaningful life for those receiving care.

In this paper I will review some of the critiqism leveled at the biomedical model as a belief system and also some of the negative consequences that are linked to a reliance on the model. I will draw the larger portion of this review from the critique by Allan and Hall[1] of what they

refer to as the "technocratic model." In spite of the strong influence of the biomedical model, the weaknesses identified in the critiques of its assumptions, methods and outcomes have led many associated with the healing professions to seek new ways of approaching and conceptualizing their practice. Foremost among these new approaches is an emphasis on holism which is contrasted with the reductionism of the biomedical model. An example from nursing theory, in which the declaration of nursing as holistic is well accepted, will be presented. In keeping with the topic of the Committee a comparison will be drawn between aspects of the Buddhist wisdom tradition and one theory of nursing as well as an example of it's application in practice to holistic healing.

THE BIOMEDICAL MODEL

In spite of its acceptance as scientific "fact", the medical model is simply a way of looking at phenomena that has proven to be useful for some purposes. As such it is no different from the folk beliefs of nonwestern societies who address biological interests from different but equally plausible views.[2] As Dacher [3] has claimed, it forms a framework that organizes and defines the questions asked, the information sought, the diagnostic and therapeutic options considered, and ultimately the outcome of interventions. Because of custom and conditioning to think and act within a specific framework, the fundamental conceptual principles underlying practice are rarely considered, even though these principles can assume a powerful, although often unseen, authority over professional lives.

Based on germ theory, medical science has provided a rationale for continual adherence

to the Cartesian belief in the opposition of mind and body. Hughes and Kennedy[4] have pointed out that the medical model represents an "ontological view" of disease, treating it as a "thing". Each disease is considered a monocausal entity that attacks the individual. Symptoms for each of thousands of conditions then, must be evaluated, diagnosed, the single cause discovered and a specific cure or treatment initiated. The germ theory has led to a biochemical orientation stressing causation and treatment within a mechanistic view of the body.

Theoretical Issues of Content and Method

Although Allen and Hall are more thorough, a summary of four of the most obvious theoretical limits of the biomedical model discussed by them will be presented here. ***First,*** is the issue of the necessity of limiting the subjective experience of those with altered physiological, social and psychological states to abstract categories of biological malfunctions. Such diagnostic labeling and separation of the person from the disease robs people of control over their lives and what they feel about their bodies and leads to the ***second*** problem of the medicalization of life processes (pregnancy, grief, menopause, the aged with chronic illness who view themselves as healthy). In addition to life processes, social (and some ethical) problems are transformed into biological format, for example, violence, abuse, childhood behavioral problems, reproductive decisions, use of organs for transplant. The result is that physicians/healers have gained power over a wide range of human life. Dehumanization is the ***third*** issue. The technology that is used to treat disease is often very dehumanizing. Cancer is "battled" in ways that ignore the cost to the human person in order to kill the disease. Life is often prolonged in ways that deprive the

individual of human dignity. The ***fourth*** issue arises from the focus on cure and a treatment orientation. The medical encounter is initiated with a "complaint" which elicits a treatment response . Attention is directed away from health promotion and illness prevention.

Perhaps the above can be summarized as a problem of conceptualizing health/illness concerns apart from the environment and larger contextual factors within which they are embedded. For Dascher this is connected to the basis of the biomedical model,

> "in three underlying, yet untested, assumptions and principles: (1) *objectivism,* the idea that accurate knowledge can be exclusively achieved through an impersonal assessment of sensory based information; (2) *determinism,* the idea that causation is exclusively characterized by an upward and linear mechanistic linkage; and (3) *positivism,* the idea that knowledge exclusively accumulates through the accretion of data from the positive results of sensory based experimentation."[5]

According to Dascher , due to the progressive urbanization of life accompanied by the industrial and technologic revolutions humankind is seeing evidence of new and very different challenges. These have resulted in the emergence of uniquely new categories of ailments confronting people today, particularly stress related diseases, acute and chronic. that are directly linked to complex person-environment relationships. As a result, the limitations of a medical model that cannot effectively incorporate multifactorial and interacting psychological, psychosocial, or spiritual components - components that are at the source of these ailments - become increasingly evident.

Medical Model and Contributions to Health

Even though the medical model is often credited with improvement in health status and decreased morbidity, Allan and Hall concluded that with the exception of infectious disease the model does not work well as a clinical framework. Citing numerous authors and studies, the following were among their findings. Over time, medical advances have generally coincided with, rather than caused, improvements in the populations' health. Only 10% of mortality improvement could be attributed to medicine and this was related to antibiotics used with infectious disease. Other improvements are judged to be a result of general public health efforts, improved nutrition, and better quality of life. Many have cited improved nutrition, sanitation, pasteurization of milk, and changes in reproductive patterns as accounting for improved mortality. Even with the majority of the nation's research and clinical resources directed to medical interventions, they often have the least effect on health. Cancer research is cited as an example where, in spite of tremendous research, almost all the rise in longevity can be attributed to methods of early detection and not to treatment.

The power, strength, proficiency, and capability of medical technology is held questionable by Allan and Hall. Citing the statistics on tremendous increases in coronary artery by-pass surgery, they also cited studies that showed no advantages of the surgery over drug therapy except for a small percentage of cases. The development of high tech CCU's was also widespread in spite of no research showing CCU's positively affected outcomes, and some research that showed noneffectiveness. Mention was made of the patient who survived for close to two years on the artificial heart (Jarvik pump). Allan and Hall note the absence of attention by

the medical community or press to the quality of his life and indications from his wife of his regret at the choice. Very recently a study was published that lends support to Allan and Hall in their doubts about the efficacy of some or much high tech medicine. This study indicated that geography predicted the use of some technological interventions more than more likely variables. This was linked to the number of specialists using that technology and the prevailing practice patterns and not differences in patient population needs. For Allan and Hall, the use and development of high technology for intervention evolves from the epistemological tradition of medical science that concerns itself only with what can be understood through the scientific process and ignores metaphysical issues.

Economics of the medical model

Two economic issues are relevant and arise from the beliefs underpinning the biomedical model and the philosophy resulting from those beliefs. Both of these issues are tied to social policies. First is our policy in the US of funding only disease and disability treatment. The skyrocketing expenditures in the last two decades have not produced any significant improvements in health. The US still lags far behind other countries in such important health indicators as infant mortality. We have yet to recognize the economic and value incentives for prevention and health promotion.

The second "social policy" has been an exclusion of practitioners who fall outside of the accepted biomedical model. Medicine has attained power and authority that has let it use economic and political power to restrict licensure of other fields. Challenges to alternative

practitioners such as homeopaths, religious and spiritual healers, druggists, and herbal doctors have been on the grounds of eliminating "quacks". The few alternative providers who have managed to be legitimized have opted to be influenced by the medical point of view. In spite of research that supports the cost-effectiveness, high quality and high consumer acceptance of nurse practitioners, biomedicine has actively limited their practice. The nursing approach, based on health, the environment, and prevention has been restricted. Allan and Hall claim that the economics of health care have been effective in working against the consumer, non-medical model physicians, nurses and other alternative health care providers.

A SHIFT TO HOLISM

Dissatisfaction with the traditional biomedical model brought about through concerns raised by critique such as that reviewed above has had an effect. Although the interest in new alternatives had already begun among health care providers, including physicians, research by Eisenberg et al[6] was strong evidence of the prevalence and acceptance of alternative healing modalities among the public. They showed, both in terms of numbers of visits and amount of money spent, that there was something to which consumers were strongly attracted. Unfortunately, the only conclusion drawn by the researchers was that medical doctors assess their patients use of alternative therapies. The bigger implication was emerging public interest in health promotion, self-care, alternative healing practices, and mind/body medicine as a response to the limitations of the biomedical model. Theorists, scientists and health practitioners also have gained at least an interest in these practices. Auer [7]reported on medical schools offering or

developing courses in alternative medicine and listed 32. One was planning a post-graduate fellowship in integrative medicine. There are at least four nursing programs nationwide offering masters degrees in holistic nursing practice. Such action on the part of those in the health care field provides a challenge to the theoreticians and researchers to develop a more comprehensive understanding and approach to the care of individuals. Ideally, such an approach would maintain the scientific rigor and discipline that has so successfully served the biomedical model while at the same time expand the vision and reach of modern health care.

In the remaining portion of this paper, I will first describe one (among many) framework which has been proposed to account for both those practices derived from biomedical nursing actions and those actions derived from the holistic focus of nursing. Although there are models proposed that are by and for medical practitioners (such as Dacher's), nursing was chosen because it has been well accepted among nurse scholars that one differentiating feature of nursing was holism, which is contrasted with biomedical reductionism. According to the author,

> "a consistent holistic framework incorporates science but does not hold that paradigm a sufficient for explaining the human experience or for brining about health or healing. The model proposed recognizes the holistic nature of nursing and expands the domain from disease treatment to the broader concept of health by incorporating several paradigms and their adjunctive ideological perspectives on humans, health and therapeutic actions." [8]

Engebretson describes her model as a multiparadigm approach with two axis which both

represent philosophical dualism between the material and nonmaterial. Four paradigms of healing are included and are represented on the horizontal axis from the most material to the most nonmaterial. This represents logical positivism to metaphysics. The mechanical paradigm is on the extreme left with progressively more nonmaterial paradigms moving to the right and ending in the most metaphysical, supranormal. The vertical axis represents the Cartesian body-mind dualism activities of healing. As they move down, activities become progressively less material moving from physical to psychological or spiritual. Figure 1 displays the model.

Materia l	*Modalities*	*Mechanical*	*Purification*	*Balance*	*Supranormal*
	Physical manipulation	Biomedical surgery	Colonics Cupping	Magnetic healing Polarity	Drumming Dancing
	Applied and ingested substances	Pharmacolog y	Chelation	Humoral medicine	Flower remedies
	Energy	Laser Radiation	Bioenergetics	Tai Chi Chi gong Acupuncture Accupressure	Healing touch Laying on of hands
	Psychological	Mind-body	Self-help (confessional type)	Mindfulness	Imagery
Nonmateria l	Spiritual	Attendance at organized religious functions	Forgiveness Penance	Meditation Chakra Balancing	Primal religious Experience Prayer

Positivist -- Metaphysical

The model is presented as an example of an integating holistic model of healing. The full description of this model can be found in the author's recently published article. One important point that might be missed by just noting the contents of the cells is the reflection of the activity of the healer. The positioning of the philosophical continuums reflects the degree of passivity and activity of the healer. Starting in the upper left with the most materialistic modalities the recipient is passive and the healer most active. As movement is made diagonally down and across the roles reversed and the healer becomes a facilitator with the real healing done by the "healee". This is consistent with healing , holistic philosophy.

AN APPLICATION OF "WISDOM" TO HEALING

Some author's have claimed that Eastern philosophy has contributed directly and indirectly to the development of nursing frameworks. Martha Rogers' science of unitary human beings has been compared with Buddhist philosophy with the conclusion that her worldview holds areas of similarity to that of some Buddhist concepts.[9] In the early 70's Rogers introduced into nursing the concept that the fundamental unit of the living system was an energy field, coextensive with the environmental energy field. Then it was not, but today this idea is of interest to Western medicine as attempts are made to understand and integrate Eastern ideas and treatments. These concepts include viewing the human being as a nonmaterial, multidimensional field integral with the environment/universal field; that consciousness is nonlocal, unbounded by physical structure and function; and that separateness of the individual from all other individuals

is an illusion. This is both an ancient wisdom and emerging view of the nature of persons and of environment.

I will focus here on the comparison of Rogers' concept of integrality with the Buddhist concept of "dependent arising." For Rogers the human energy field and the environmental fields were infinite and integral with continuously changing patterning. They are different only in the pattern, such that there are two integral fields of dynamic unity. The Buddha expressed the present as "that which is arisen dependent upon" [10] "In very brief form, dependent arising ...indicates the interrelatedness of things in the universe. Things arise dependent on causes and conditions, they gain their identities in relation to other things. Nothing stands alone, autonomous and isolated, but instead exists only in a web of interconnectedness."[11] According to dependent arising, phenomenon and their functions are recognizable by ordinary persons. For Rogers manifestations of field patterning require recognition of the behaviors of the individual. Integrality the continuous mutual human and environment field process demands recognition of the interconnected web of reality.

Quinn[12] asked the question of the implications of such a view of human nature and environment for nursing practice. "How do our conceptions of harmony in the human environment relationship shift when we are talking fundamentally about an energy resonance, a vibrational phenomenon, patterning? ....How can nurses use these views to maximize healing?"(p.28). Her answer was through a study exploring the potential for resonance of two

individual human fields (nurse and patient with nurse conceptualized as the environment of the patient) during a healing interaction. Her premise was that the intentional use of expanded consciousness can allow a unique, healing human environment process, regardless of the specific means or modality the nurse uses to knowingly participate in this process. Therapeutic touch as a technique was used as an exemplar of the premise that the nurse can be the healing environment for the client during treatment. She reports her findings of both a time resonance and a decrease in anxiety for those patients receiving a centering and intentional Therapeutic touch versus those who did not respond to a mimic healing touch.

Her broad conclusions based on her premise were as follows:

"...a challenge and a call to the nurse who aspires to practice out of a holistic, unitary framework. If we accept the basic premise of holism, of an interconnected universe, and of the fundamental inseparability of individuals one from another, then we are called to look anew at how we knowingly participate in that universe. We no longer can view the environment solely as being out there, amenable to our knowing participation in repatterning it yet somehow fundamentally other than self. We are the environment, for our patients, our colleagues, our communities, and our world". (p. 35).

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