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THE LONG INTERVIEW

Bringing Critical Humanistic Thinking to Contemporary Biomedicine[1]

Vincent Di Stefano, educator and practitioner of natural medicine, is interviewed by Richard House

Richard House [**RH**]: Vincent, it's with great pleasure and anticipation that I embark on this conversation with you. I recently came across an inspiring paper of yours on the great Ivan Illich (whose legacy is very much living in this interview), and then subsequently your Routledge book *Holism and Complementary Medicine: Origins and Principles* (2006, 2021). You've also introduced me to that great historical, 'revolutionary' figure of Renaissance medicine, Paracelsus (1493–1541) (Di Stefano, 1994), whose extraordinary life might also have some resonances with the kind of paradigmatic revolution in medicine that we will discuss in this interview.

As I understand it, you have qualifications in osteopathy, Western herbal medicine, naturopathy and acupuncture, and have been involved in teaching philosophical concepts of healing at university level to undergraduate and postgraduate students. These are ideal 'qualifications' for an interview exploring the limits of modern medical bioscience! Can we begin with you sharing something of your professional and personal journey that led you to making complementary medicine a central feature of your career?

Vincent Di Stefano [**VDS**]: Thanks, Richard. Where to begin? I guess the thing is to try and find some coherent thread through all of this. I am of a generation that can still remember home visits from the family doctor when anyone got sick. Our family doctor not only was the person who gave me injections for tonsillitis but was also a friendly presence in our household. I remember he once asked me, 'What do you want to be when you grow up?'. Looking back, that may have been where the first seeds of medicine as a possible life direction were planted. By the time I was 15 or 16, I had set my sights on studying medicine, along with a bunch of other sons of Italian migrants at the school I went to. I now realise that this was probably more of a social thing than a real inner calling or drive, though it is curious how these things work out.

I did well enough to get into medical school but was not a good student. I took advantage of the new freedoms and enjoyments made possible by being at a university. I missed far too many lectures and spent far too little time in the library, though I guess I have probably made up for that as a form of penance in the decades since. Conversations in the cafeteria and in the many open spaces around the university soon

helped me to realise that there were more ways of seeing the world than through the lens of dissecting rooms and physiology laboratories.

Things really began to break up for me when I discovered the existence of a vast literature grounded in human experience and in philosophical ideas, rather than in facts and figures. I spent three years at medical school, which at least gave me familiarity with the language; but I made the decision to leave soon after discovering the writings of Albert Camus, the European philosophers and the English poets.

Early in 1972, I met with my darling Gill, later to become my wife, and I took on units in psychology and philosophy at university while she was completing her graduate studies. Having found little satisfaction in the material presented in the courses I was attending, I found myself spending more time with the works of such writers as Carl Jung, Carl Rogers, R.D. Laing and Friedrich Nietzsche than with the set texts. Things weren't quite working out, so after Gill completed her studies, we decided to travel. We spent two years on the road, working all the way – which was possible in those days – and travelled through New Zealand, the South and the North Pacific, America, Europe and Asia. These were an extraordinary two years in which we seemed to be carried from one enriching experiencing to another. We attended an outdoor lecture given by Ram Dass in Hawaii, spent time with a group of people in California who lived in tipis they had constructed, and attended a conference at St Martin-in-the-Fields in London in which Satish Kumar offered his view of the world and where it was going. We learned much about community, about simplicity, about cultural steadiness, about the perennial presence of traditions about which we had known very little beforehand.

I was still at a loose end when we got back to Australia, but then things started to move in ways that I could never have anticipated. First off, I had the good fortune of coming across a copy of H.S. Dakin's *High Voltage Photography* in a Melbourne bookshop. It included a number of electrophotographic images that Dakin had recorded with such highly bioenergetic individuals as Uri Geller and Rev. John Scudder, a psychic healer. The captured images revealed extraordinary psycholuminescent effects. The circuitry and construction details for the device Dakin had used were included as an appendix. My companion in the bookshop was a friend who was renowned for his knowledge of electronics. I asked him, 'Can we build one of these things?'. He looked at the circuit diagram, smiled and said, 'Sure'.

We were soon in possession of a marvellous device capable of generating high-voltage, low-amperage fields with which we could luminously interact. This device, together with a transparent electrode that we built, provided us with a remarkable instrument with which to examine both mundane and peculiar phenomena. Soon afterwards, I was introduced to a fellow who taught at the RMIT School of Architecture. I showed him the device we had built and some of the early images we had obtained. He suggested that I consider enrolling in the Environmental Design unit at his School and thereby gain access to technical support, a darkroom, a supervisor and a supportive framework for my investigations. I followed his advice and enrolled soon afterwards.

One of my early queries was whether acupuncture treatment would cause any alteration in the corona discharge pattern. Through contacts in the department, I was able to find an acupuncturist who was also a practitioner of natural medicine. We did some interesting work together, but more importantly, he spoke enthusiastically about the work of an older fellow who was highly knowledgeable in European traditional systems of medicine who would be visiting Australia early the following year. I decided to sign up for the two-week residential programme being offered on the outskirts of Melbourne.

That fortnight completely changed my life. During the course of those two weeks, what began as a large brown paper bag filled with dried rosemary herb was progressively transformed into a number of vials of mother tincture, fluid extract, resin, fragrant essential oil, and a small dish of brilliantly refractive

crystalline mineral salts. Between the lines, the old man had also retraced the movement of the mind of medicine from its magical beginnings in ancient Egypt, through its revolutionary changes in post-Renaissance Europe, and on to its complex manifestation in the present time.

During those two weeks, I learned that there was far more to the story of medicine and the ways in which it can be practised than what I had been introduced to in the lecture theatres and laboratories a decade beforehand. I felt that this was the medicine I had been looking for all along. As soon as the course ended, I set out looking for schools of herbal medicine in Melbourne, but there were none to be found. I did, however, find a school of naturopathy that offered classes in herbal medicine as part of the general curriculum. The school also happened to offer programmes in osteopathy and in acupuncture and I duly enrolled three days later. I completed the three courses and set up my first clinic in 1980. Within two years of graduating, my wife and I had started a family. Our children were born at home in keeping with the understandings we had gleaned along the way, and we have tried to live in mindfulness of the principles behind natural medicine. Along with my clinical practice, I also started lecturing in herbal medicine at the school from which I had graduated, and teaching anatomy at an acupuncture college. I guess things just kept moving from there.

RH: What a fascinating story, Vincent! I'm especially interested in interrogating the paradigmatic divide between mainstream biomedicine, and alternatives that may already exist, or *could* exist in a plausible or conceivable world that wasn't dominated by monocultural biomedical approaches. You are ideally placed to elucidate these questions, given your intimate familiarity with both mainstream and alternative-holistic approaches to human well-being. What do you see as the main differences between mainstream biomedicine and more nature-based complementary / alternative approaches?

VDS: Looking at paradigmatic *divides* between biomedicine and other approaches, there's clearly a coherent underlying paradigm that governs much of what goes on in biomedicine that could be crudely described in terms of a materialist and reductionist ethos. This is not only in biomedicine, but is part of a broader scientific and cultural ethos. And it gets back to our understanding of what it is to be human. Are we simply a mechanism whereby genetic continuity is sustained, or is there more to the picture? Looking at it further, the paradigmatic divides are not just between biomedicine and other approaches, but *within* biomedicine itself. Individual doctors have the freedom to work in their own way once they've ascertained that the patient is not grievously ill or dying or in immediate need of dramatic intervention.

Michael Balint did some lovely work in the UK in the 1950s that he wrote about in his book *The Doctor, His Patient and the Illness* (1986). Even then, Balint had identified that much of the real work in medicine happened between the lines, through the relationship built up between the doctor and the patient. He said that between a quarter and a third of the work of GPs was essentially psychotherapy. What needed to be changed a lot of the time was not the patient's biochemistry, but their attitudes, fixations, self-defeating patterns of behaviour, things of that nature. This of course means that doctors need to know as much about their patients and their circumstances as they know about what examinations and tests can pick up. Biomedicine has become far more technologically oriented since Balint was around. One could reasonably argue that practitioners of complementary medicine have to a certain extent stepped in to fill the role that he was describing.

The more obvious divides turn on both philosophical and pragmatic issues, like whether one operates out of a reductionist mind-set or whether one is more holistically oriented. So, an acute bacterial infection can be dealt with by using antibiotics, but there are some who would also be looking at the state of the patient's immune system, and whether there is anything going on in their lives that can be changed, like stress levels, toxic overload, inactivity, for example. And in the direction in which Michael Balint was clearly pointing, things happen not only at a material level. How do you deal with

phenomena and realities that are not of a material nature from within a materialist paradigm?

That is why something like homoeopathy is so problematic. And there are echoes of this in the practice of acupuncture. According to traditional theory, acupuncture treatment serves to direct and activate the movement and flow of a luminous vital energy, or *Ch'I*, within and around the body. If all goes well, this in turn corrects somatic disturbances and alleviates symptoms. What is biomedicine to make of this? Then there are subtle techniques like cranio-sacral osteopathy where there is no obvious structural intervention performed, no high-velocity, low-amplitude thrust, no joint cracking – just a state of attentive abiding between practitioner and patient. Although these days we know a little more about the nature of psychosomatic medicine than when Michael Balint was around, it still remains a mysterious wonderland of neuro-humoral conjecture. So, elements of intentionality and receptivity start to come into this. Every experienced physician knows about this side of things, yet it is difficult if not impossible to accommodate into a materialist, reductionist frame.

Another of the key elements here is the *standardisation* implicit in the methods of scientific medicine. Once you have a formal diagnosis, things then follow a set trajectory according to 'best practice'. Yet the methods of biomedicine, powerful as they are, are not divinely pre-established but are, a lot of the time, among a *range* of methods that may be equally efficacious. The big move towards complementary and alternative medicine during the 1980s and 1990s was driven by the *stories* people told each other of how they had benefited from other approaches.

To fully describe the paradigmatic divisions between biomedicine and alternative approaches is a huge task. To start with, there is no common language to articulate the energetic and intentional dimensions that are implicit in a number of complementary-medicine approaches. Nor is there a commonly agreed perspective on human nature. Are we just chance events in a meaningless universe, or is there something else going on? Much of biomedicine continues to turn around the *bio* aspect of the bio-psycho-social realities that we embody. Even from within the purely biological side of things, there is very little consideration given in biomedicine to such notions as the *vis medicatrix naturae* – in simple terms, the healing power of nature – which is expressed and facilitated, for example, in the subtle interventions that characterise the practice of traditional herbal medicine, and in the hygienist diet-based therapies such as those developed by Max Gerson and Bernard Jensen.

Biomedicine is characterised by powerful and often dramatic interventions, while other approaches are rarely so.

RH: You earlier mentioned your participation in a personally transformative two-week course that retraced the historic movement of medicine from ancient Egypt, through Renaissance Europe, to the present time. Would you agree that one of the gross limitations of mainstream scientific biomedicine is its inherent assumption of superiority, its effective ruling as 'unscientific' and invalid all earlier historical forms that medicine and healing have taken? Has scientific medicine and its accompanying metaphysical assumptions become incapable of understanding the traditional wisdoms that informed earlier ways of medicine?

VDS: That is definitely part of what is going on, Richard. One could talk about 'babies and bathwater' in that regard. There are elements of power, predictability and professionalisation at work here. First, there is the indisputable power of the therapeutic biomedical interventions that have been developed over the past century or so, like the understanding of endocrine disorders, the development of antiseptic procedures in surgery, the development and use of antibiotics since Paul Ehrlich's early work with aniline derivatives. The movement of medical education into hospital environments has also ensured a commonality of understanding transmitted between teachers and medical students in what are *highly regulated* spaces. As the 'successes' of biomedicine multiplied, the cultural and professional authority of its practitioners steadily

grew to the point where competing approaches or systems either withered on the vine through disregard and withdrawal of support – and in some contexts, active hostility and suppression – or maintained a quiet but sustained presence on the margins.

Practitioners of scientific medicine are certainly capable of understanding what is going on in other approaches to medicine and in more traditional ways of healing. But who is going to follow through and take these on as active practices? Sure, there is now no shortage of General Practitioners who know a little about herbal medicine, perhaps practising musculoskeletal acupuncture, who work in with yoga teachers, osteopaths, naturopaths and chiropractors, who know who is who in cancer support groups. But they are certainly not among the majority. In a way, they show a willingness to suspend judgement in the matter of the efficacy of other healing modalities. What this bespeaks to me is not so much a matter of professional accommodation but, rather, something of an openness, a porosity to the idea that biomedicine does not necessarily have all the answers. They have probably listened to their patients, to their friends and come to accept that many people actually benefit from modalities other than scientific biomedicine.

RH: You mention ‘the principles behind natural medicine’, Vincent. Can you define ‘natural medicine’ for us (including, perhaps, what distinguishes it from *non*-natural medicine); and then outline the core principles of natural medicine itself. And in the process, perhaps you could say something about ‘holism’ and ‘holistic approaches’, as these terms are commonly used in these kinds of discussions, but perhaps without as rigorous and careful a definition of what the terms actually mean than is desirable.

VDS: A tall order, Richard! I accept that ‘natural medicine’ is a difficult and perhaps unsatisfactory term. What is natural and what is not? There are some followers of Teilhard de Chardin who are these days attracted to ‘transhuman’ and ‘posthuman’ developments with the view that the integration of humans into cybernetic systems is part of a divinising evolutionary trajectory towards Teilhard’s *Omega Point*. Everything human agency is capable of can be considered ‘natural’ from such a frame, like cruising the ocean floor in nuclear-armed submarines, or repairing communications satellites from orbiting space stations.

The term ‘natural medicine’, as I understand it, is more a convenient marker for perennial methods of healing that will retain their relevance and their usefulness independently of the technical or technological capacities of any given historical situation. So ‘natural’ methods of medicine would be recognisable across widely varying cultures – and even civilisations. Plants have been used for their medicinal effects for as long as we can remember. So, too, has human touch, be it in the form of the laying-on of hands, massage, bone-setting, osteopathy or minor surgery. There are further extensions of this notion in something as universal as birthing practices. So here we have the difference between traditional active birthing and the stirrup-birthing in the lithotomy position that not so long ago routinely characterised hospital birthing practices. Similarly with the promotion of infant formulas as being equivalent to breast milk, also not so long ago. So, the term ‘natural’ in natural medicine points towards methods and approaches that can be identified in traditional, naturalistic cultures. The term ‘complementary medicine’ is probably more widely used and understood.

The core principles of complementary medicine can be identified in a certain *style* that is independent of the modality practised. So these core principles will inform the work of homoeopaths, herbalists, practitioners of Ayurveda and Traditional Chinese Medicine, naturopaths, osteopaths, and even practitioners of integrative medicine. You have correctly identified the principle of holism as being central to these approaches. ‘Holism’ is a relatively recent term, having been coined by the philosopher/statesman/polymath Jan Smuts in the mid-1920s to describe the *double* of the materialist reductionism that had by then become the primary epistemological signature of the physical and biological sciences. By coining this term, Smuts in a way sought to draw attention to

what had been lost or by-passed in the quantitative, reductive methods by which scientific knowledge was gained.

With the progressive identification of biomedicine as an essentially reductive enterprise, as evidenced in such notions as specific aetiology and such disciplines as molecular biology, it's no surprise that the term 'holism' came increasingly to signify perspectives that focused on the broader range of influences that condition both health and disease. An aspect of this holism sought to locate the individual within the many nexuses that constitute our being in the world as whole beings, rather than merely as carriers of symptoms requiring remediation through whatever means technological/scientific medicine can provide.

Beyond this situated holism with its multiple influential dimensions – relational, environmental, occupational and so on – there remains, as we mentioned earlier, the issue of what it is to *be* a whole being, of what constitutes a human being. We are more than our biology and what is contained within our skins. So the holistic sensibility also seeks to engage with the meaning of such notions as soul, spirit, mind as integral to understanding the whole person in their lived context.

How this is actualised in clinical practice involves much more than the techniques and the methods employed by the practitioner. It involves an ongoing relational process that offers far more than a simple course of treatment, but rather, the possibility of transformation for the patient.

RH: Your earlier point that materialism and reductionism are not merely the preserve of biomedicine but are 'part of a broader scientific and cultural ethos' is certainly very important to remember. Critics of mainstream allopathic biomedicine (amongst which I count myself), with their searing critiques, have tended to place much emphasis on 'hostility and suppression' – including radical critics of widespread alleged Big Pharma corruption and the alleged machinations of, for example, the American Medical Association (AMA). I'm interested in your reading of the history around this, and just how important deliberate attempts to obliterate complementary, natural and indigenous medicine have been in the course of the inexorable rise of biomedicine. To what extent has *positional power* trumped genuine scientific reasoning in the onward march and ascendancy of biomedicine, in relation to other healing practices?

VDS: It was very satisfying for me to see you mention Howard Stein's work in our email exchanges. It's been well over two decades since I have heard anyone voice his name. Probably, even more than Michael Balint, Stein (1985) explored the relational dynamics that operate in any healing relationship, whether shamanic/traditional, biomedical/technological, or complementary/alternative. What I like about Howard Stein's work is that he attends carefully to the power relations in the clinical context, be it between doctor and patient – the culture of medicine interacting with the culture of patients – or between medical students and hospital doctors on medical rounds. He is vitally aware that within a non-critical medical engagement, the projection of control and authority by the doctor may serve the doctor well, but not necessarily the patient. We are obviously not talking here about life-and-death situations in the emergency ward, but about the regular business of doctoring. Armouring and professional distancing on the part of the doctor can effectively insulate the doctor from the continuous stream of subtle – and often important – clues that each of us gives to the other in any encounter.

Both Stein and Balint have understood that the practice of medicine in its essence is not a technological exercise but is, as Rachel Naomi Remen (1996) once put it, 'a special kind of love'. And love is a two-way street. Being sensitised to the affective dimension in any clinical engagement potentially changes the experience from a transactional matching of symptoms and medication to a transformational encounter where both patient and doctor are changed. This is way beyond the style that

characterises fast street-level biomedical practice.

Could mainstream medical practice have taken a different route? That's a huge question. What drives such contingencies? What is the nature of the forces that determine the direction that *anything* goes in? Obviously, there are many interests involved in the enterprise of biomedicine as it has developed over the past century and a half. But that has always been part of the picture, from the hieratic medicine of old Egypt, the austere and ritualised style of Hippocratic and pre-Hippocratic medicine in Greece, and the privileging of the European medical caste in Paracelsus's day. There is more to this than the application of knowledge, and understanding systematically gained and prudentially applied. Phenomena like professional power, occupational territoriality, the appropriation of institutional authority are all at play. And this is to say nothing of the role of money – *big* money – as E.R. Brown so eloquently unpacked in his review of the bankrolling of what eventually became biomedicine by the medical 'philanthropies' of Rockefeller and Carnegie early in the twentieth century. The development of biotechnology – again, big-money, highly sophisticated technology – is also part of this.

Might another, more psychologically oriented style of medicine have emerged in the wake of Balint's insightful work? Clearly it *could* have done so, but the cards were stacked against it. It would have required a complete re-orientation of the biomedical frame from the ground up. For a start, the selection of suitable 'candidates' for a medical education would have needed to extend beyond high-level competencies in physics, chemistry and mathematics, which have been the traditional pre-requisites. This still continues to hold sway, although there are now more medical schools that encourage humanistic studies as a precursor to medical studies. Fritjof Capra (1982) was wise to this side of things in the early 1980s in his recognition of the value of such attributes as openness, sensitivity and intuition in any who would don the mantle of medicine.

Regarding the possibility of a new, post-biomedical paradigm for medicine and healing, one that would incorporate psychodynamic and psychosomatic perspectives: there *are* minor movements in that direction, though not at truly committed levels. Over the past couple of decades, a number of Australian medical schools have introduced pre-clinical students to approaches like psychosomatic medicine and meditation techniques. These programmes were usually driven by individual teachers who had come to their own understandings and used their freedom to add a unit or two to the curriculum. But to my knowledge, such elements have not been systematically integrated into medical education as a whole as part of the formation of young doctors.

Another recent development has been the movement towards *integrative medicine*, which consciously operates out of a holistic paradigm, and returns the depth perspective to the clinical encounter. In the part of Australia where I live, those who were instrumental in developing integrative models of clinical practice cut their teeth working collaboratively with cancer support groups during the 1980s – so they were outliers to begin with. These doctors accept the centrality of diet and life-style, and also the role of psychological, social and spiritual elements in the creation of both health and sickness. Most have some understanding of the allegoric/metaphoric dimensions, and the potentially transformational function of sickness, especially deep sickness. But even today, such approaches are generally only available to those who are well cashed up, and who are already attuned to begin with. You won't find much of this on the National Health Service or Medicare.

The perceived power of biomedicine and the cultural authority it has harnessed during the course of its development are really difficult to address. The fact is that biomedical approaches are unquestionably powerful in emergency or trauma medicine, in what needs to be done if you are pulled out of a wrecked car, broken and bleeding. And the treatment of endocrine disorders. And of acute bacterial infections. And of enabling one to regain some measure of freedom and livability by replacing an utterly

ruined hip joint with a titanium prosthesis. The real problem is that many believe that such efficacy is inherent in *all* the practices, treatments and modalities of biomedicine. The doctor always knows best. This is a cultural thing, a cultivated phenomenon, an aspect of ‘professionalism’ and the possession of arcane knowledge. And this is not new. Early in the piece, the profession of medicine claimed much of the credit for improvements in population health when the really consequential work was being done behind the scenes by sanitary engineers and urban planners who cleared wastes from city streets and increased the availability of fresh food and clean water. This was understood by early epidemiologists.

It is obvious that over the course of the past century, the methods of biomedicine have given extraordinary diagnostic and treatment capabilities to the medical profession. But it has been at the cost of diminishing human nature, with its many ambiguities and uncertainties, to an essentially biological function, a complex of mechanisms that, when understood, can be influenced and manipulated in a predictable manner. And this certainly can be done. But is it the only way? The materialist/reductionist way of seeing things has rendered us into machine-like beings with specific identifiable functions that can be corrected, repaired or controlled by specific interventions, be they pharmaceutical or physical. But the *whole* being has been lost in the process.

The technology of biomedicine is also very impressive. Who can argue with what is revealed by a CT or radio-isotope scan? Who can question the numerically defined read-out of blood tests? So there is a mystification inherent in such methods, where the understanding and interpretation of diagnostic tests and pathology reports remain the sacrosanct domain of the doctor or the specialist. This contributes to a separation of the patient from the processes within and underlying their own illness, and affirms further the cultural authority of the doctor.

Most of the time, this suits both the doctor and the patient. The doctor is affirmed as being in charge, and the patient is comforted in transferring benign, all-knowing, parental authority to the doctor. The patient is in good hands. The doctor knows best. This of course is an exaggerated representation of what goes on to varying degrees in the relationship between doctor and patient. Now to alter this situation, to alter this dynamic requires *a change of consciousness* in both doctor *and* patient. But prior to this, there is the fact that we all have different needs and different temperaments. Some are by nature disposed towards dependency relationships, others towards autonomy. The skilled physician needs to be able to read such differences and to act accordingly. Many patients don’t want to take personal responsibility for their own health. This too is a cultural phenomenon. Philosophers may speak in terms of such ‘ideals’ as autonomy, self-determination and rationality, but that is not, by and large, how most people live their lives. Professional bodies, political institutions and media conglomerates know this intimately.

What you seem to be pointing towards, Richard, is the notion of cultivating or activating a state of consciousness capable of discerning the hidden and opportunistic webs of influence that encourage conformity to norms of medical and social expectation. These webs include the vast bio-industrial-pharmaceutical-technological infrastructures through which immense amounts of money move, and by which vast numbers of people are kept in a state of perpetual vigilance regarding the state of their health through attention to such things as cholesterol levels, blood pressure, and the next bowel, prostate, breast or pap screening test. How are people to awaken to the exploitative capacities of the biomedical enterprise, and how are they to become conscious of the value of taking responsibility for their own health? This goes right to the roots of the present civilisational problem, of the dominant cultural ethos that sanctions a collective somnambulism in virtually every dimension, extending from the state of the environment to our own bodies, and that offers the psychological reassurance that all is well and that we are being well looked after by ‘the powers that be’.

Anything that perturbs the status quo will find immensely powerful forces arraigned against it. This is the Thrasymachean principle at work: might is right. There is no shortage of historical evidence here in regard to the activities of the profession of medicine. E.R. Brown has detailed the North American experience with great finesse. I have personally seen a number of hostile attacks levelled against complementary medicine in Australia. During the mid-1980s, the Therapeutic Goods Administration (TGA), directed by biomedical heavyweights, sought to shut down the availability of health supplements through health-food stores and other outlets. The various complementary-medicine associations around the country that were usually at war with each other put aside their differences and managed to mobilise an extraordinary level of grassroots support throughout Australia – something that surprised the TGA. They succeeded in having the proposed legislation shelved. There have been a couple of feeble attempts to repeat the process since, but they didn't get very far.

And there is the infamous attack in the pages of the *Medical Journal of Australia* in 1989 launched against Ian Gawler, a cancer 'survivor' who started up the first and one of the most influential cancer support groups in Australia. The intensity of the attack was unbelievable. Apart from including a damning review of Gawler's book detailing his own experiences in overcoming osteosarcoma, the editors of the *MJA* enlisted the support of UK oncologist Michael Baum who provided an op-ed piece entitled 'Rationalism versus irrationalism in the care of the sick: science versus the absurd'. It was a full-frontal assault on both Gawler and his work, which Baum described as 'another symptom of the virus of irrationalism that is a serious threat to the health and welfare of all nations'. Ironically, many of the doctors who worked with Gawler and his groups were later instrumental in spear-heading the Integrative Medicine movement in Australia, and introducing psychosomatic medicine and meditation training into the curriculum of undergraduate medical students.

And then there was a further brazen episode during the early 1990s when the Australian Medical Association tried to shut down the first university-based naturopathic degree programme in this country being offered by Southern Cross University, New South Wales. The course itself was put together largely by a group of heroic nurses who had done their time walking hospital corridors, and who had subsequently decided to put their energies into making more widely available other approaches to health and healing than those of biomedicine. The Vice-Chancellor backed the women all the way, and effectively told the AMA to mind its own business. They were truly extraordinary times.

So positional power is clearly at work in all this. There is an established history of deliberate attempts to suppress approaches outside of the biomedical mainstream. It's just part of how things go. A little like what goes on between green politics and big-money politics further afield.

RH: I've recently finished reading your outstanding 1998 Masters thesis, Vincent, which leaves me wishing to ask you so many more questions! But I'll ration myself. As you rightly say, many (or even most?) patients *want to* collude with the doctor–patient power dynamic, and play out the role of quasi-'victim' in the drama triangle of 'Persecutor–Victim–Rescuer' (e.g. Karpman, 2014; Hall, 1993) – with ill-health/disease constituting the 'external' **Persecutor**; the patient being the relatively helpless **Victim** of this 'external' persecutor – and then the doctor being the **Rescuer**. Very powerful psychological-archetypal forces thus collude to hold these mutually reinforcing positionings in place. Perhaps the weakest link in this triangle, and the one most amenable to change, could well be where patients transcend the 'victim' position by taking far more personal responsibility for their own health (something you touch on at length in your thesis). I'm wondering whether you see any other hopeful possibilities for breaking into (and thence out of!) this drama triangle as it plays out in doctor–patient relationships.

On my bookshelf I have Dethlefsen and Dahlke's seminal book *The Healing Power of Illness: Understanding what Your Symptoms Are Telling You*; and a quotation from Rudolf Steiner also speaks to this when he said, 'We fall ill for our own development'.

I'm wondering what your view is on this, and whether you think that a re-founded holistic 'medical' paradigm would need to embrace such paradoxes explicitly in its cosmology and praxis. I sense that holistic practitioners tend to positively embrace and work with paradox and uncertainty, whereas biomedicine tries to eradicate them at all costs! Is this an accurate characterisation?

And would I be right in saying that given your generous recognition of the power and success of biomedicine *when applied in the appropriate contexts* (a huge proviso, of course!), in terms of paradigm change it's not necessarily a case of *the wholesale rejection* of biomedicine *in toto*, but rather, of only jettisoning those ways in which it is decidedly unhelpful and *iatrogenic* (i.e. illness-generating), and infusing medical praxis as a whole with a far more wide-ranging cosmology that integrates the material/biological with the soul–spiritual–psychological–social–mysterious dimensions of human well-being. And I don't underestimate what 'big questions' these are!

VDS: There's a lot of ground to be covered here, Richard. We have the professional power of medicine and its political implications; the relational dimensions of physicianship and a dense psychological representation of the doctor, the patient, and their illness; the meaning of sickness as a potential source of transformation; and we return to the paradigms that frame the theory and the practice of medicine. Within all this, there is an understanding that things could be done differently, that there is more to the picture than we have been led to believe, that there are aspects that are integral to the life of the body and of the mind that have somehow been missed – or even dismissed. These are all, as you say, 'big questions'.

First, the political power that medicine exercises both among its own, and more broadly, is clearly part of a much bigger picture that has traditionally been associated with medicine, law and religion, but that manifests near-universally wherever the possibility of power and its exercise emerge. Though there may nominally be a noble core in each of these callings, things seem to get messy when agreed-upon norms are challenged or defied. Galileo was able to avoid the fate suffered by Giordano Bruno by recanting his 'claim' that the earth moved around the sun – even while silently whispering 'e pur si muove'. Poor old Semmelweis had a somewhat harder time. In the mid-1800s, he famously waged a 20-year-long campaign to convince his colleagues at the Vienna General Hospital that they should wash their hands between the time they left the hospital dissecting room and entered the birthing ward so as to prevent young mothers from dying of puerperal fever. It cost him his job at the hospital – and eventually his sanity. He died in an insane asylum in 1865.

So it's not surprising to learn that, for example, a number of North American nature-cure practitioners have literally been imprisoned to prevent them doing their work as recently as the last century. Coercive and restrictive powers have always been used by those in high places who would call the tune. These nature-cure practitioners may have been outside the fold, but they weren't outside the jurisdiction of those who would decree what forms of medical practice are deemed acceptable and what are not. This brings to mind some things that have happened closer to home that show how biomedicine continues to hold political power over those who would too sharply question mainstream medical approaches.

In 2018, for example, John Piesse, a Melbourne-based doctor and practitioner of integrative medicine, was removed from the medical register because he was too vocal in his support for parents who tried to get their children exempted from legislation enacted in Victoria in 2016 that required certificated vaccination before enrolment in child-care and kindergarten facilities. John Piesse was one of the few who had the courage to challenge the principle of

mandated vaccination. He managed to draw down the condemnation and the contempt of medical and public health bodies intent on silencing all dissenting views. Even as I write, both the media and the medical establishment are attacking a Western-suburbs doctor who has written out 'too many' exemption slips for his patients after the recent mandating of Covid vaccination for a number of occupational groups – including teachers at every level – in Victoria (Australia). So, the doctor is now required to serve the expectations of State and medical bureaucracies rather than the needs of their patients. And it doesn't end there. As we all know, home-birth doctors and nurses everywhere in the 'developed' world have been similarly demonised for a long time now.

To understand what's going on here requires more than a familiarity with the dynamics of institutional structures and of professional dominance. As you suggest, there are deep psychological forces at work at every level of the medical project, sometimes consciously, sometimes not. This concerns how we perceive ourselves as beings in the world, and how we deal with one another. Are we condemned to live in a neo-Darwinian universe where dominance, competition and control are the ruling metaphors; or are there ways-of-being based more on a commitment to unity, to openness, to empathy, to co-presence?

Might a change in consciousness be needed before the currently entrenched phenomenon of fixed power relations and hierarchical control at all levels of medical engagement – from the clinical to the political – can be dissolved? Jean Gebser had some interesting things to say in that regard. He was of the view that the only way we would survive the destructive and dehumanising tendencies that seem to have progressively engulfed the twentieth century was precisely through a species-wide shift in the evolution of human consciousness (to use your term). Gebser wrote of the emergence of what he termed the *Integral* structure of consciousness, in which all of the earlier structures that have conditioned our natures throughout human history are incorporated. And the ability to accommodate paradox, to balance and reconcile opposing perspectives, is a central aspect of such a change or shift. This has long been an understanding of the wisdom traditions. 'He who speaks does not know'; 'When I am weak, then I am strong'; 'And the first shall be last'. Zen is full of it. And it is everywhere in life, if we are open to it.

So, I guess a central question becomes, what is it to which we are to be open? This is a huge issue because it concerns essential honesty. And that includes honesty towards each other. And dominance models are simply not part of that. It's not just about collusion in the clinical context between putative *victims* and *rescuers*, though such characterisations may help us to get a handle on what might be going on in certain co-dependent clinical relationships. But it is as you say, Richard: once the wound has been dressed, once it is clear that the patient is not dangerously ill, if the encounter is to be a truly transformative one, the healer's task is to become available to the other with all the vulnerability and the uncertainty that implies. And this in turn depends on the *awareness* and the *personal development* of the physician, and an essential willingness to be open to the other. Perhaps this can be taught, but there's very little room for that in the context of contemporary medical education, with its relentless pressure to memorise everything there is to know about the body, its diseases, the ever-growing biomedical pharmacopoeia, and the labyrinthine maze of diagnostic and therapeutic technologies. My feeling is that these qualities depend more on one's nature and one's capacity for self-reflection and recognition of the essential unity within which we all participate, consciously or unconsciously. Perhaps this *can* be taught, but it seems rather to be something that is *given* which begs the question – given from what source? Which brings us back to where we started: What is it to which we are to be open? The philosopher Charles Taylor speaks in terms of the *porous* and the *buffered* self, which is another way of differentiating between an open attitude and an armoured or guarded attitude towards the uncertain and elusive dimensions of life.

With regard to patients taking far more personal responsibility for their own health and well-being as a possible means of changing the power

relations that are built into clinical medicine: A cardiologist recently told me that despite informing his patients that they had a good chance of lowering both their blood pressure and their cholesterol levels if they changed the way they lived, many were simply not interested. It is a lot easier to take lipostatics and anti-hypertensives than to change one's diet, increase one's exercise, slow down, and perhaps learn to meditate. It's not just the biomedical frame that defines what's going on here. There is an entire social and cultural milieu that can be as constricting and as ultimately limiting as any dependency relationship, be it conscious or unconscious. The way we see the world and our assumptions regarding our own natures all come into this.

You talk about the meaning of sickness, quoting Rudolf Steiner when he says, 'We fall ill for our own development'. There is a similar Italian saying: 'Non tutti i mali vengano per nuocere', which roughly translates as 'Not all evils necessarily come to harm us'. The very notion of sickness having a meaning is simply not part of the biomedical understanding. Sickness is perceived as *a deviancy*, as an imposition that must be 'corrected', controlled or managed, using whatever means are available. Why has it taken so long for biomedicine to acknowledge that the way we live influences the way we are? How is it that big-name fast-food outlets can be established with the full support of the State government in two of the largest children's hospitals in Melbourne? This is the sort of thing that enraged Ivan Illich nearly half a century ago. And it has gotten worse. It's not just medicine. It's the whole game.

So much can now be controlled that we think that we can control everything. The fact of Covid has shown that we all live within uncertainty. Yet ironically, that uncertainty has driven a medico-political strategy – especially in Australia – that has deemed the only way to get through this crisis with any 'certainty' is through mandated mass vaccination programmes in which, in the idealised fantasies of some biomedical technocrats, *everybody* – young and old, healthy and sick, strong and weak – absolutely *everybody* in the world gets vaccinated. This is deemed to be the only way forward. The vaccines themselves, whether derived from m-RNA and its associated delivery systems, from adenovirus particles incubated in chimpanzee cells, or from recombinant spike-protein produced in moth cells, unquestionably modify the human immune response to SARS-CoV-2, but nobody can hazard the longer-term consequences of injecting such powerful genetically derived and engineered molecules into most of the population. And this is quite apart from the issue of the acute reactions in many who are physiologically sensitive to the vaccines, whose experiences are largely disregarded in the new 'coercive consensus' of population medicine.

And the amount of money changing hands in all this is simply staggering. Potentially simpler, individualised treatments have been systematically discredited from the start. Newly developed drugs like Merck's Molnupiravir are now fast-tracked through the traditionally mandated safety trials for new pharmaceuticals, while older drugs like Ivermectin – developed by Merck in the early 1980s but out of patent since 1996 – whose safety is well established, and which many studies suggest may have a role in mitigating the effects and the lethality of the virus, have been effectively taken off the table. A 10-day course of Molnupiravir costs $700. That translates to $70 per tablet. The Ivermectin-based kits distributed through India, Bangladesh, Mexico and some parts of South America cost a dollar or two. As I write, Merck is planning to produce 10 million courses of Molnupiravir by the end of 2021. It has signed an initial agreement to supply 1.7 million courses to the US government for the treatment of 'mild-to-moderate' Covid-19 for $1.2 billion dollars. In real terms, that is equivalent to a stack of tightly compressed $100 notes well over a kilometre high. This might give some idea of what incentives are operating behind the scenes.

The amazing thing is that so little has been said about protective and supportive treatments for 'mild-to-moderate' Covid. Those who test positive to the virus are told to go home, to isolate, and to hope they won't need to call an ambulance. There just might be some room in

this situation to consider the potential usefulness of vitamin D, zinc, plant-based immune modulators, curcumin, oral or intravenous vitamin C, and simple breathing exercises. But these don't seem to count, the way that the role of diet, environmental stresses, rest and activity levels, and mental and emotional patterns in the lives of patients, don't seem to count in a lot of *walk in, walk out*, fast street-level medical practices. It's the vaccine, or its nothing. It's the drug, or it's nothing. So, Richard, we're in a situation where things clearly could be done differently; but the boundaries have been so set that 'good medicine' is defined by what is practised according to the book, according to a calculus of 'risk factors', and according to a linear matching of specific diagnoses to specific treatments.

You speak of the need to extend the medical perspective to include such intangibles as the soul, the spiritual, the psychological, the social, and the mysterious. I can only agree with you. I fully accept that it *is* possible to integrate these within a biological framework; but it requires a willingness to accept and to work with uncertainty, however tentatively. Such elements can be eliminated from a paradigm, but they can't be eliminated from life. The quest for certainty, beginning with Descartes' *cogito*, may have given us immense understanding and control of materiality, but it has not helped us to understand who we are, why we're here, how we are to live. Nor has it helped us to understand the deeper roots of suffering, how sickness and limitation can become sources of strength and of insight, how our mortality may be more in the nature of a transition than of a terminus. The integration that you speak of is not an either/or situation as it is presented according to the reductionist/materialist paradigm that underlies biomedicine. These phenomena are part of the world, part of our experience, part of our natures, and need to be accommodated in any view of the world that purports to describe the way things are.

To be 'between paradigms' is a little like being in the *metaxu* described by William Desmond, to be between the immanent, transactional, empirical modes of being and the transcendental, essential, originary and barely graspable modes. The physical and the material can be defined, delineated, determined, worked with. The transcendent and the transpersonal are indefinable, insubstantial, indeterminate, yet available to insight and intuition. It is difficult for me to even begin to envisage what the paradigm that might replace that of biomedicine might actually look like. But much that has been excluded from the present paradigm will need to be reconsidered. Materiality needs to be complemented by spirituality, reductionism by holism, the defined by the indefinite, specific aetiology by multidimensional causality, because they're all part of the picture. From such a perspective, there is room to move from one operative frame to another, for the surgeon to work with care and precision in the operating theatre but also to discuss the deeper concerns and fears of their patients.

Beyond this, there's the whole issue of how biomedicine handles death. Illich understood this intimately. He would have considered putting pig's valves into the hearts of 85 year-old men, just because it can be done, as insanity. Here again, this is not entirely driven by biomedicine. Ernest Becker (1973) did a great work in pointing out the extent to which modern society hides, negates, denies the reality of death. We are to be shielded from it in every way. We are to be kept alive at all costs using everything that technology can throw at us. The mind of medicine has yet to awaken to the need for a sensitised and sensitive thanatology – a thanatology that draws on far more than the option of technologically mediated 'assisted suicide' using State-sanctioned poisons.

I cannot imagine a formal medical paradigm that incorporates all these elements, Richard. Perhaps they can never be circumscribed by defined practices and methods. So much of what you've raised turns on the personal qualities of the physician. Whether such considerations can be incorporated into medical education is certainly worth pondering. But it would seem that skilled and sensitive physicianship is more in the nature of a *calling* requiring life-long commitment, than it is an occupation to be chosen from among many possible occupations.

RH: Placing questions of death and mortality alongside notions of certainty, uncertainty and control, Vincent, I'm wondering whether we might be on to something essential here that connects up 'modernity', scientism and the drive for control and certainty, biomedicine and death, and whether you could expand on these connections.

I recently came across a very interesting book titled *Greater than the Parts: Holism in Biomedicine, 1920–1950* (Lawrence & Weisz, 1998). In this book, the almost forgotten nature of biomedical holism in the inter-war years is deeply explored, with, for example, what's referred to as 'constitutionalist theories of disease' shifting attention from the microbe alone, to *the relationship* between the microbe and the host. And we find Mendelsohn (1998) arguing that bacteriologists' experience of the properties of epidemics during and after the Great War made it very difficult to sustain the view that the germ was all-important in disease. With medical holism attracting considerable attention between the world wars, this suggests that there isn't something *intrinsic* to biomedicine that rules out an approach incorporating some kind of holistic ontology or organicism.

You've written a lot about the late, great Ivan Illich and his devastating critique of mainstream medicine half a century ago (Illich, 1976). In light of your studies on the great man's work, I'm wondering if you could say something brief about the extent to which Illich's critique still has purchase today – and perhaps how he might write that revolutionary book of his, were he writing an updated edition today.

I'm finding that in the 'Era of Covid' and mass vaccination, increasing numbers of people are deciding to completely abandon pharmaceutical medicine, and to live as natural and healthy a life-style as possible. This entails abandoning allopathic medicine, and instead seeking to set up something akin to a local 'Wellness Service' that would be completely outside of State and NHS control and jurisdiction, eschewing pharmaceutical medicine, and housing a wide body of practitioners sharing a broadly common worldview about medicine and health – as you elucidate so well in your 1998 thesis. As a very experienced medical practitioner and deep thinker on these questions, do you think something along these lines might be at least one aspect of the fundamental paradigm change that some of us believe to be urgently necessary?

Heart-felt thanks for the time and commitment you've offered for this interview, Vincent; the sharing of your deep wisdom with our readers is greatly appreciated. The last words are fittingly yours.

VDS: Thank you, Richard. You've raised several essentially interrelated issues in your final question. The overarching issue is 'the bigger picture' and where biomedicine fits into it. This concerns 'the drive for control and certainty' that now extends from the subjection of the natural world to the human will to the control of human biological processes – and even destiny – in the practice of biomedicine. Secondly, you refer to Lawrence and Weisz's 1998 study, raising the fascinating question of whether biomedicine might have taken a different course. You then look to the critique of biomedicine by Ivan Illich – which was part of a broader cultural critique – and ask how he might perceive what's going on in the present time. And you consider the possibility of personally foregoing pharmaceutical medicine and participating in an exploration of new forms of medical practice – a courageous and committed response to a sense that the perennial values underlying the practice of medicine are vitally in need of being rescued.

With regard to getting a handle on the bigger picture, this is at the core of a philosophical quest that's been playing out over the past few centuries. Something has changed not only in the way we live, but in the way we *think*. Regarding the pre-modern acceptance and understanding of, and even a reverence for, the existential realities of life and death, there's clearly a metaphysical underlay to this. Despite what the present ethos would tell us, it *is* conceivable that both life and death have meaning. And despite Thomas Hobbes's infamous quip, the terms *ars vivendi* and *ars moriendi* have in the past been a living part of the common lexicon. This implies an

undivided *telos* that provided continuity between life and death. Such an integral perspective finds expression both in the sustained meditations on death that have been central to traditional Buddhist practice and in the closing phrase of the *Hail Mary* prayer.

The drive for control and certainty were not uniquely ordained by Francis Bacon or Descartes; many traditional cultures had their rain-makers. The lightning storm could offer a prognostication of whether a battle would end favourably or not. The manipulation of yarrow stalks could yield a frame from which to interpret perplexing situations. The shape of a plant could offer a signature of its medical uses. What *did* change with Descartes was the loss of non-dualism as a way of both experiencing and deriving meaning from the world. In earlier ways of being, we were part of a whole. This is something that Jean Gebser has made clear in *The Ever-Present Origin*. The modern temper has, however, valorised the logical over the analogical, the causal over the synchronic. A major consequence has been the negation – even the elimination – of narratives other than the dominant one sanctioned by the scientific frame: when you're dead, you're dead; there is no soul to be found on the dissecting table, in CT scans, or in a full blood count. And if there is nothing beyond embodied life, and if there is no soul, then all things become permissible. There are complex philosophical and theological dimensions to this, to the hubris that lays claim to all possibilities enabled by new technologies without consideration of moral boundaries. For if there is nothing beyond the immediate, there is no 'objective' basis for morality, as there is no 'objective' basis for soul, or principle of continuity. This is a terrain that many have sought to understand, even if only to chart other possible ways of traversing it than those proposed by a relentless materialistic biomedicine, as you call it.

Your reference to the work of Lawrence and Weisz again confirms the contingent nature of biomedicine. It could indeed have been otherwise. Under different circumstances, biomedicine might have been informed by holistic principles as well as reductionistic ones. There is more at work here than noble ideals and altruistic intentions. We've already spoken about the role of big money, of technology, of institutional and political power structures. These have all shaped the direction Western medicine has taken, particularly over the past century. And it's not just the West any more. The bare-foot doctors have all but disappeared. Traditional systems of medicine are sidelined once nations have become sufficiently 'developed' or wealthy enough to afford the hardware and the infrastructures of biomedicine. One must ask whether there is a historical determinism at work here, or whether it is human agency all the way. Biomedicine has in some ways taken on the salvationist myth, the messianic function, the task of mediating a *paradisum in terram*. Medical knowledge has been formalised and standardised to the point where earlier coherent understandings of health and sickness embodied in identifiable cultural modes of medical theory and practice have been displaced or silenced. These practices were not entirely useless.

The ideas explored by Lawrence and Weisz, especially in regard to holism and constitutionality, were integral to both earlier forms and other cultural expressions of medicine. The humoral understanding of Graeco-Arabic medicine linked constitutional factors within the patient to particular qualities ascribed to medicines. These principles similarly inform Ayurveda and traditional Chinese medicine. The patient and the medicine – the inner and the outer – are to be matched. In addition, patients are to be treated as *individual beings* rather than being characterised according to their pathology. The practice of pulse diagnosis in oriental systems of medicine reflects this. We are not all equally prone to the same perturbing influence. Covid-19 has certainly shown this with regard to its effects on the elderly and the compromised, compared to the young and the healthy. So the notion of paying attention 'to the *relationship* between the microbe and the host', as you put it, is central to holistic practice. This is something that every naturopath knows.

In the 1950s, René Dubos tried to rein in the triumphalism of an increasingly reductionist biomedicine, writing of the need to think in terms of equilibrium and harmony and other categories that were part of Hippocratic medicine. Dubos himself was no outsider. In 1939 he had isolated tyrothricin – one of the first known antibiotics – from a soil bacterium. The application of reductionist methods was central to his discovery. Thirty years later, he went on to co-author *Only One Earth: The Care and Maintenance of a Small Planet* with Barbara Ward (Ward & Dubos, 1972). Now there is a truly holistic mind. Barbara Ward herself had been instrumental in obtaining UN funding in the post-war years for the construction of the *Casa Sollievo Della Sofferenza* hospital after meeting with Padre Pio, the Capuchin monk of San Giovanni Rotondo who carried the five wounds of Christ. So as you've suggested, Richard, there is nothing *inherent* in the practice of medicine that categorically rules out a holistic ontology. We can be as comfortable in the laboratory as in the garden. We can as fully embrace scientific epistemologies as divine and transpersonal realities.

Holism accepts the reality of non-material dimensions in the creation of both health and disease. Psycho-somatic medicine is founded on this understanding. Reductionism, however, is grounded in matter, and cannot deal with intangibles and relational gestalts. It is difficult to see how to get around this through any bounded paradigm. And an unbounded paradigm is no paradigm at all. So, is the practice of medicine to be divided into technocratic and hieratic castes, as some have suggested? This is a thorny problem that may have its roots more in the structure of the consciousness of the physician than in the mastery of theory, practice or technique. My sense is that this involves more than a binary 'right brain/left brain' disposition (*à la* Iain McGilchrist, 2012). We come back again to the notion that despite its extraordinary differentiations and its technological sophistications, the practice of medicine is ultimately *relational*. It's one person to another. So of course the personal qualities of the physician are, as you've suggested in a different context, massively more important than the technical modality in which they function and with which they label their practice. What you're pointing towards is a sense that those who practise medicine should be actualised beings who have not only mastered the knowledge base of their respective modalities but have cultivated openness, sensitivity, empathy, honesty, morality and wisdom. The same could be said of lawyers, priests, economists and politicians. Without overly romanticising this, these are top-end tasks, Richard – the consequence of individual awakening and a conscious determination to perfect one's life to the best of one's capacities. This is ascribing archetypal nobility to the profession of medicine, to the commitment to serve as an agent of healing in whatever form is given to us.

Etymologically, the work of the doctor is that of *docere*, of *teaching*, not simply that of diagnosing, prescribing drugs or arranging tests, though these are equally part of the practice of good medicine. This again points to the centrality of the relational dimensions of medical practice. The cardiologist I mentioned earlier said to me on another occasion, 'When all else fails, it's probably a good idea to listen to the patient'. This was an oblique admission on his part of just how far the control aspect has permeated clinical reality. This is what Ivan Illich picked up on in the 1970s when he described the social and cultural 'iatrogenesis' created by forces within biomedicine determined to control and to medicalise every aspect of the life process from birthing, to sickness episodes, to the life-long monitoring of health through screening programmes, to the pharmacological management of age-related degenerative change, and finally to the stretching out of the dying process as far as the technology would allow. If anything, these approaches have intensified further and become even more entrenched since the time Illich wrote his book *Limits to Medicine*.

You ask about Illich's relevance today. Illich was a man of his times. He flourished during the 1960s and the 1970s. Along with a number of other prescient and highly perceptive commentators, he understood the nature of what was going down, of how social, political,

technological-industrial and institutional structures were increasingly configuring towards centralised and homogenised norms where the individual was submerged and made subservient to the values deemed by those structures. He was an unusual character. Born into an aristocratic European family, he'd been groomed from an early age to become part of the Vatican inner circle. Instead, he chose to travel to New York and to work as a priest in impoverished Puerto Rican communities. In fact, he visited Puerto Rico many times, often travelling between villages on horseback. Though he was accustomed to satin and silk in his early life, he was later to immerse himself fully in the life of both small and large communities, paying close attention all the while to the health and the resilience that characterised the diversity and the deep cultural and historical roots that sustained these groups. In naming his later critique *The **Limits** to Medicine*, Illich was in his own characteristic way pointing towards the pathological and damaging nature of *limitless* perspectives. He was alluding to the lack of restraint in virtually all fields of endeavour that characterised the positivism of the times.

Illich's ideas were early informed by his friend and colleague Leopold Kohr, who had throughout the late 1940s and early 1950s explored the political and economic consequences of gigantism – later to morph into globalisation – and the consequences of centralisation and corporatisation of influence and control. Kohr's ideas also had a profound influence on the work of E.F. Schumacher as presented in his book *Small is Beautiful*. These men were all of their time: each of them offered their gifts, their prophetic prognostications to small receptive audiences, only to retreat when it became clear that things were not turning around, when they progressively came to realise that their calls would not be heeded. Yet each, in his own way, understood that the seeds they'd planted would be carried into the future by small groups and by individuals who chose to step outside of the mainstream and to consciously inhabit the margins of an increasingly chaotic civilisation. So, Richard, it's safe to conclude that Illich would heartily approve of your and others' current stepping away from biomedicine, and your intention to support the largely marginalised body of practitioners who share a broadly common worldview about medicine and health. This is precisely what Illich did in the end, in refusing conventional treatment for a disfiguring facial tumour, choosing rather to make use of a small pipe and a ball of opium that enabled him to weather the pain.

In response to your final question, I certainly have deep sympathy with the idea of supporting forms of medicine that are outside of the mainstream, that are not dependent on elaborate and expensive technologies, that welcome a plurality of approaches, and that serve the needs of individual patients rather than conforming to prescribed biopolitical protocols that assume the indefinite continuity of techno-industrial infrastructures and global supply chains. Who can tell what lies ahead for all of us?

Note

1 A longer version of this interview will appear in the forthcoming book *Limits to Medical Science: 'Revolutionary' Conversations* by Richard House and others (InterActions, Stroud, 2022).

References

Balint, M. (1986). *The Doctor, His Patient and the Illness,* 2nd edn. London: Churchill Livingstone.

Baum, M. (1989). Rationalism versus irrationalism in the care of the sick: science versus the absurd. *Medical Journal of Australia,* 151 (11–12): 607–8.

Becker, E. (1973). *The Denial of Death*. New York: Simon & Schuster.

Brown, E.R. (1980). *Rockefeller Medicine Men: Medicine and Capitalism in America*. Berkeley, Calif.: Regents of the University of California.

Capra, F. (1982). *The Turning Point: Science, Society and the Rising Culture*. London: Fontana.

Dakin, H.S. (1975). *High Voltage Photography* (2nd edn). San Francisco: H.S. Dakin.

Dethlefsen,T. & Dahlke, R. (2016).*The Healing Power of Illness: Understanding what Your Symptoms Are Telling You*. Boulder, Colo.: Sentient Publications (orig. German publication, 1983).

Di Stefano, V. (1998). The Meaning of Natural Medicine: An Interpretive Study. St Albans, Victoria, Australia: Unpublished Masters thesis, Department of Health Sciences, Victoria University of Technology. Available at https://tinyurl.com/mu78d653 (accessed 28 September 2021).

Di Stefano, V. (2021). *Holism and Complementary Medicine: Origins and Principles*. Abingdon, Oxon: Routledge (earlier edn, Allen & Unwin, 2006).

Dubos, R. (1959). *Mirage of Health: Utopias, Progress and Biological Change*. New York: Anchor Books

Gebser, J. (1949). *The Ever-Present Origin*. Athens, Ohio: Ohio University Press (trans. Noel Barstad).

Hall, J. (1993). *The Reluctant Adult: An Exploration of Choice.* Bridport: Prism Press.

Illich, I. (1976). *Limits to Medicine: Medical Nemesis. The Expropriation of Health*. London: Marion Boyars.

Karpman, S.B. (2014). *A Game Free Life: The Definitive Book on the Drama Triangle and Compassion Triangle by the Originator*. San Francisco: Drama Triangle Publications.

Kohr, L. (1978). *The Breakdown of Nations*. New York: E.P. Dutton (1st edn, Routledge & Kegan Paul, 1957).

Lawrence, C. & Weisz, G. (eds) (1998). *Greater than the Parts: Holism in Biomedicine, 1920–1950.* Oxford: Oxford University Press.

McGilchrist, I. (2012). *The Master and His Emissary: The Divided Brain and the Making of the Western World*. New Haven, Conn.: Yale University Press (orig. 2007).

Mendelsohn, J.A. (1996). From eradication to equilibrium: how epidemics became complex after World War I. In C. Lawrence & G. Weisz (eds), *Greater than the Parts: Holism in Biomedicine, 1920–1950* (pp. 303–31). Oxford: Oxford University Press.

Remen, R.N. (1996). *Kitchen Table Wisdom. Stories that Heal*. Sydney, NSW: Pan Macmillan.

Schumacher, E.F. (1974). *Small is Beautiful. A Study of Economics as if People Mattered*. London: Abacus

Smuts, J. (1925). *Holism and Evolution*. Calif.: Sierra Sunrise Books (reprinted 1999, ed. Sanford Holst).

Stein, H.S. (1985). *The Psychodynamics of Medical Practice: Unconscious Factors in Patient Care*. Berkeley, Calif.: University of California Press.

Taylor, C. (2007). *A Secular Age*. Cambridge, Mass: Belknap Press of Harvard University Press.

Ward, B. & Dubos, R. (1972). *Only One Earth: The Care and Maintenance of a Small Planet.* New York: Norton.

About the contributors

Vincent Di Stefano: in his professional life, Vincent has served as a practitioner of and educator in osteopathic medicine, Western herbal medicine and naturopathic medicine. Politically active in the development of natural medicine in Australia, he has served in an executive capacity in professional associations representing practitioners of natural medicine. Founding editor of the *Journal of the Australian Natural Therapists Association*, the first peer-reviewed natural-medicine journal in Australia, Vincent served as Course Co-ordinator of the first graduate programme in Western Herbal Medicine in an Australian university. His book *Holism and Complementary Medicine: Origins and Principles* was originally published in Australia by Allan and Unwin, recently re-published in Europe by Routledge.

Richard House Ph.D. is a chartered psychologist, a former senior university lecturer in psychology and education studies, and a trained Steiner Waldorf teacher who lives, writes and campaigns in Stroud, Gloucestershire. He has a particular interest in the philosophy of science, and contesting medical and healing paradigms. Richard also edits *Self & Society* and this, its online magazine.