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ALTERNATIVE MEDICINE IN FINLAND

A Background paper for the Workshop on 'The Impact of non-orthodox medicine on health care expenditure.'
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1. DEFINING ALTERNATIVE MEDICINE

Alternative medicine is the most frequently used term in everyday language and in official as well as in research practice. However, there exist several other concepts (traditional(folk)medicine, complementary medicine, "soft" medicine, extended,ogranic,natural medicine, unofficial medicine) sometimes these different terms have been used as synonyms and sometimes in specific meaning. This confusion depends on different interests and powerstruggle and also on unstructured situation.

1.1. Definition in research and publications.

Alternative medicine is most commonly used term. There are some exceptions: The Academy of Finland has used also the term "physiological therapies" it was in the name of a working group and also in the name of the publication of this working group. This term was defined to mean un-orthodox medicine i.e. therapies which are outside of the school (scientific) medicine. There is a collaborative working group under the Academy of Finland and it has taken as its title "folk (popular health care " and this concept has been applied to mean the therapies outside school medicine.

In individual researchprojects,researches, scientific publications AM is the most commonly used term and in the ethnografic studies folk medicine or traditional medicine which means medicine of primitive societies. Often the concept has not been defined. The most specific definition in Finland has been:"The AM means all the therapies which are not included in the medical curriculum and which are not subsidized by our National Sickness Insurance."

1.2. Official definition

There do not exist any official definitions. The National Board of Health, Institution of Sickness Insurance, The Medical Association they all have used in their reports the term of AM and it has been used in a vague meaning generally speaking therapies which are given by therapists who are lacking medical qualification.

The conceptualisation differs from "insiders" and "outsiders". It depends on the involvement level, those who are tightly integrated into the alternative philosophies are more conscious with the terms and concepts and define them more carefully than "the ousiders".

In publications, seminars, discussiongroups AM is frequently defined by individuals as medicine which is lacking scientific evidence and proof.

1.3. Splitting up the definition as regards the law

The Finnish Law does not recognise AM; no traditional healers, no healers. According to the law"only medically qualified doctor is allowed to practice medicine". It has been in pracatice interpreted to mean right to diagnose and to take fees from the service. There exists legal regulations for medicine and phramseutical products; the products which have been classified by the National Board of Health as medicines or which are comparable with medicine these products are allowed to be sold only in the chemistry and the natural products, natural food, health products can be sold in any shops.

1.4. Inventory of methods of medicine

The methods can be classified with traditional Finnish medicine and modern alternative methods.

Finnish traditional Medicine: 1) Manipulative methods:traditional massage, traditional bone setting,cupping, 2) Medicine: herbs, alcohol, ash, tar, etc 3) Natural medicine:Sauna,Spass, 4) Spiritua psychosocial methods: bloodletting, shamanism, 5)Life style advices

Modern AM : 1) Manipulative methods: chiropractice,naprapathy zone theraphy, lymphatheraphy etc (different forms of manipulative methods) and different physiotherapies of which some are regarded as official and some unofficial, 2) Medicines,natural products,health products, homeopathy,anthropology,phytoterapic medicine 3)Natural therapies: new forms and theniques in naturotheraphy 4)Spiritual Healing: Different oriental philosophies, cults, spiritual healers, shamans foreign origin, scientism, parapsychological schools,

5) Psychological, psychosocial methods: different pshyco therapies music therapy, art theraphy,relaxing therapies (youga,TM)
6)Life styles: diets,excercise,dancing therapies etc

2. THE LEGAL CONTEXT OF AM IN FINLAND

In Finland Acupuncture is accepted as a part of official medicine, it is in the medical curriculum.

AM is now in the process of organising. In 1988 there were establis there new organisations: Biomedicine Association, AM Association, The establisment of AM Center and then there are two old associatio: These organisations are interests organisations. There is no formal training centers, instead there are several individual training organisations,individuals, different private groups. These courses have no legal or formal status.

In Finland there are about 15-20 medically qualified doctors who practice AM. There is also a group which practice is based on Vitamins and minerals ant they prefer to call their practice Biomedicine.

There is no repayments from private or pubpis (social) sivkness insurance. The illegal issues com out when the clientrs complain malpractice.

3. THE FREQUENCY OF USE AND PATIENTS' CHARACTERISTICS

There are surveys on the use of AM since 1970's, some are based on the qualified samples with specific demografic groups or disease and some based on local areas.

The latest survey based on the active age group population in the whole country shows the following figures:

Table 1 The percentage rates of the use of scientific and AM among the Finnish Population 15-64 years of age with respect to sex 1982.

	Male % (N=783)	Female % (N=830)	All % (N=1613)	Used someti in lif
Scientific medicine				
Visits to doctor	62	74	69	
Prescribed drugs	51	65	59	
Non-precribed drugs	59	69	64	
Alternative Medicine				
Finnish Folk Medicine				
Massage	10	12	11	28
Bone setting	3	5	4	17
Cupping/blood letting	0.5	0.5	0.5	4
Other folk healers				
Modern Alternative Medicine				
(Health Products	48	59	54	
- Natural Food	27	38	33	
- special products	21	34	28	
Natural remedies	10	24	17	
Physiotherapeutic treatm.	10	14	12	
Relaxing treatments	5	6	5	
(Acupuncture)	1	2	2	
Hypnosis	0.5	0.5	0.5	

Modern alternative medicine (excluding health products) were used by 27% and traditional medicine by 14%.

These figures can be assumed to give the underestimation of the real use rates to-day. Specially it seems that spiritual healing and different other "mixture "forms of therapies with non empirical bacground have increased and also it can be assumed that these therapies are not reported as often as the others. Also it is obviou that different types of physitherapies, new age movements and vegetarian life-styles has increased.

The Pattern of Use

There were 60% out of the respondents who had used only official medicine and there were mixture users altogether 32%. Only 1% were "pure" types of AM,they had used during one year only MA.

22% had used both some scientific and some alternative treatments there 10% heavy consumers who had used all the different treatments form (scientific,modern and traditional AM)

Demographic characteristics of the users

Women used AM more often than men, there are some specific exceptions,but that was the general trend. It was typical for heavy traditional AM rural dwelling, low educational level and low income and middle or old age. Modern AM is attractive for middle and younger urban population. Natural remedies are used nowadays more often by low educated groups. However, it seems that there exist several subcultures and no definete characteristic come out. There are middle class culture and specially educated well off women population in their middle age which starts new fashion. And different treatments come as inovation and are transmitted into society. From the traditional medicine massage is the most frequently used treatment and natural remedies in modern alternative medicine. Specially homeopatic,anthroposofic and some oriental and also spiritual healing seemms to be most common among high social class group.

The profile of symtoms

In Finland the most common chronical diseases which causes incapasit in work are: cardiovascular diseases, muscularskeltor,mental disorde tumors. Symptoms are those which are either very difficult to classifie or/and diagnose or fatal dieseases. It varies accuring to the treatemnt in manipulative treatments are mentioned pain. back pains, head ,neck, . It is mentioned also skin diseases , fatal diseases(cancer), hypertension, stress,sociopsychological problems.

In the motivational backgroud there can be distinguished curiosity, desire to try everything and in prevention and health promotion a desire for eternal life! There are also patients who have tried all scientific medicine without positive effect and AM is the last hope.

4. THE NUMBER OF THERAPISTS (supply)

There exists no study on the supply in Finland. We do not have any registers either. There are some organisations of therapists and last year was established a ceiling organisation which tries to combine all different groups together, there are also individual therapists outside the organisations.

There are 8 chiropracticers in Finland and they have got their traing in USA ans England. There are some therapists who are traine in Sweden in the School of AM,but their number is not known.There are different organisations,individula people and associations who take the trainees, but no estimation on the number. The Finns have been also in USA,England,Sweden, Germany in the training courses.

In 1985 the book on the names and addresses of AM therapists was published. The book is for the public and based on the information give by the therapists themselves according to this book there were 659 therapists/healers/ , 51 spass, 277 health shops. Ther biggest group among therapists were zone therapists 30% and then bone setting,10% and spiritual healers 6%. All these figures are underestimation of the real situation.In Finland there was 956 specialists in general practice and in the other specialti 5 160.

5. PATIENT SATISFACTION

According to the different surveys about 60% - 80% express their satisfaction towards AM. however most of them express satisfaction towards official medicine as well. The data collection method has itse own effects on the results.

6 ECONOMIC IMPLICATIONS

There does not exist any reimbursement system for AM in the Finnish Sickness Insurance: no public no private.

There is no study on the amount of money spend for AM also there is no estimation for that. In the official health care system general practice (health center practice including doctor,nurses, exams home care)is free for the users and the clients pay only a small fraction from the real costs. The specialist care in private sector is covered partly also by the social insurance. The clients can have also private insurance to covers sickneess costs but it does not include AM

It is difficult to give any estimation for the fees of AM. A massage varies between 50 Fmk - 300 Fmk /hour ,health products varies according to the content but the general observation is that they are more expensive than drugs , the gap is even wider if we take into account the reimbursement of Sickness insurance. For the clients AM is more expensive than scientific medicine.

LEGAL PRACTICE OF ACUPUNCTURE IN FRANCE

Jean BOSSY

1 - Defining alternative medicine.

The term of alternative medicine covers only a part of the acupuncture. As a matter of fact, this therapy may be used as :

1) Alternative (instead of conventional therapy without advantage or disavantage for one or the other).
2) Complementary (the sommation of the both improves the results).
3) Substitutive (to remplace the lack of efficacy of the other).

The word "complementary" seems more general and may include the two others.

The "Commission Ministérielle chargée d'étudier les problèmes liés à l'exercice de l'Acupuncture" considers the acupuncture as a medical act, including diagnosis and therapeutics, and as a **complementary** method.

2 - Legal framework in which acupuncture is situated.

From 1952, acupuncture is considered as a medical act which includes diagnosis and therapeutics. Proceeding from this, only the medical doctors are authorized to practice acupuncture, and they must have to carry out all the steps of this act, including removing the needle.

In these conditions, the Social Security repays the acupuncture act in a routine way for the three first ones ; beyond a previous agreement is necessary.

From 1987, an interuniversitary diploma of acupuncture groups 6 universities (7 very probably for the next academic year). This diploma has been recognized by the "Conseil National de l'Ordre des Médecins" in october 1988.

The acupuncture methodes includes any kind of stimulation of the channel network : needles, moxa, laser, massages, vibrotherapy,

cryotherapy, sonotherapy, digipressure, etc.

3 - Frequency of use and patients characteristics.

According to the Niboyet report (1984) more than 50 % of the population uses or have used acupuncture and/or homeopathy.

The socio-demographic characteristics of the population which uses acupuncture, shows a predominance of women and especially beyond 40 years.

Three classic kinds of complaints prevails : pains, gynecology, and psychic disorders including sleep. But now, at least in my department, the fan is extending to all kinds of diseases, even pediatrics.

A second aspect of the request of patients (in progress) is the reject of iatrogenic or unpleasant effects of conventional drugs.

Sometimes, a philosophico-cultural point of view or a "media" impact is responsable for this demand.

4 - Number of therapists.

Three years ago, among 120.000 MD, about 9.000 or 10.000 use acupuncture in their daily practice, and only 1.000 as an exclusive one. In 1989, for 180.000 M.D., the number of acupuncturists has not changed.

Most of them use acupuncture and/or conventional drugs or methods according to the diseases of the patients. Many of them associate acupuncture and homeopathy or manipulative medicine.

Full time acupuncturist-MD sees not more than 15 to 20 patients per day, that is 80 to 100 by week.

In my department, about 30 % of the patients are referred by another M.D..

In addition to the M.D. formation, the acupuncturist follows a three years training, including theoretical formation and practice.

5 - Patient satisfaction.

It is very difficult to give here a sure value to the answer. As a matter of fact, in our consultation we see the patients disappointed by the conventional medicine ; and reversely, we

don't see any more the patients disappointed by acupuncture.

Thus only a statistical inquiry without any bias can bring a correct response to this question.

More, it will be important to precise correctly the field of satisfaction ; for instance a patient enduring scapulo-humeral periarthritis and tinnitus may be improved only for one, and if you ask him for the other the satisfaction will be negative.

6 - Economic implication : financial aspects and reimbursement.

Here also, it is not possible to give a correct response.

The acupuncture act is repaid by the Social Security according to a national rate. In public hospital or some private M.D. only the official rate is charged, but in many cases, the rate is higher.

The relation between the amounts spend within alternative and allopathic sectors is impossible to appreciate without a correct definition ; for instance if in a year, you add or not an hospitalization or any surgery you change completely the relation; more in France many people do not pay anything with Social Security and complementary insurance for allopathic sector, and reversely they forget the prices of "dietetic" foods, vitaminic complexes, etc.

Besides, for many people the payment of an illegal practice is normal, and does not interfer in a health budget ; and often for the same people, the payment of a TV set in a hospital room is anormal !

The real problem is the evaluation of the health cost. In a study (1985) by an inspector M.D. of the Social Security, the total cost of lowback pain decreased of 20 % for people receiving acupuncture (including "arrêt de travail"). In a another study (1976), comparing the depenses of Social Security of a patient a year before acupuncture and a year with acupuncture or the opposite, the cost decreased of 20 to 30 % during the year with acupuncture.

7 - Conclusion.

The evaluation must be done according various aspects ; some of them are suggested below :

- subjective satisfaction,
- objective cost :
  . How evaluate fault by omission involving over-expenses?
  . How estimate necessity, confort and superfluity ?
- repayment by insurance implicates organization and supervision of the training.
- officialization would most often suppress the placebo effect.

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EUROPEAN WORKSHOP ON ALTERNATIVE MEDICINE

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A general approach to the French situation

Françoise BOUCHAYER

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In France, since around the middle of the 1970's, alternative medicines have been the subject of increasing social success. The number of practitioners, doctors and non-doctors, as well as the number of users of these medicines have increased substantially. In parallel, the cultural and media-related products devoted to these questions have grown strongly, in particular aimed at the general public: books, magazines, exhibitions, radio or television programs, initiation courses, etc. The phenomenon is therefore moving well beyond the strict bounds of the care distribution system and it is rightly often qualified as a "social phenomenon".

As far as public authorities are concerned, no really new legislative order has been made in this area over the last few years. But between 1982 and 1986, the government requested the setting up of two missions. The first was entrusted to Dr. Niboyet (acupuncture doctor) and led to a document entitled "Rapport sur certaines techniques de soins ne faisant pas l'objet d'un enseignement organisé au niveau national" ("Report about certain care techniques not forming the subject of nationally organized teachings") (1). This report refers to a highly reserved standpoint concerning theoretical references and therapeutic values of most alternative medicines. However, it did open on to certain recommendations made in favor of the teaching of homeopathy, acupuncture and manual medicine in medical faculties.

The second mission, led by a thinking group consisting of doctors, researchers and representatives of user associations led to the publication of a report "Les médecines différentes, un défi?" (The different medicines, a challenge?) (2). It outlined standpoints - sometimes divergent - of the different parties confronting one another with respect to a desirable policy in the terms of the qualification and training of practitioners and the evaluation of the therapeutic efficiency of different medicines. This report also underscored the importance of social diffusion obtained by non-orthodox medicines. Because of the governmental change which took place during 1986 (and the departure of Mme. Georgina Dufoix, Minister of Social Affairs and Employment), this consultation did not lead up to any new measures being made.

As far as research into alternative medicines is concerned, two major areas should be considered: that of bio-medical and clinical research and that of the sciences of man and of society. The information given in the text relative to the research accomplished already, or underway in France, concerns only the social sciences. In this area of research, few works have so far been devoted to different medicines.

To render this outline of a few pages clearer, I will first deal with the six major themes proposed for the preparatory works for the "European workshop on alternative medicine".

I. DEFINING ALTERNATIVE MEDICINE

Several terms are used to qualify the care methods in France which do not fall within the sphere of conventional medicine: "natural", "parallel", "alternative", "different", "non-official", "heterodox", "non-proven", "gentle" therapies, etc. While the general public often talks about "médecines douces" (gentle medicines), the formulation "different medicines" is used preferable at the official level.

For the Ministry of Health and the representatives of the medical profession, one of the main points which is common to the different alternative medicines is the fact that they are not taught at a national echelon in medical faculties. Another parameter which is put forward to attempt to define these medicines is that of their heterodox character concerning doctrinal and epistemological bases of official bio-medicine. For example we might refer to the infinitesimal notion and the law of similitude in homeopathy, the concept of energy and references to Taoism for acupuncture, the principle of "primary breathing movements" for functional osteopathy, etc. However, other medicines also qualified as alternatives do not appear to be far removed from the doctrinal standpoint from official medicine; at this point, we might mention phytotherapy or structural osteopathy.

Researchers in social sciences who dealt with such questions took this institutional and epistemological data into consideration, while adding to it a historical viewpoint and principles of definition based on the examination of the current usage of such medicines: more or less extensiveness of their social diffusion, "innovations", types of practitioners implementing these care modes (doctors and/or non-doctors) etc. (3).

In the perspective of research development into alternative medicines, attempts at definition must take account of social processes without exclusively attempting to establish typologies which more often than not do not prove to be very satisfactory. Among such social processes we might mention:

– determinisms which govern the permanent "invention" of new labels, if not new therapies. Indeed, there is an almost constant multiplication of alternative care techniques (mesokinergy, osteodynamics, meso-energy, etc.). As far as most of them are concerned, these new therapies are derivatives or associations of derivatives of "mother disciplines" such as acupuncture, bio-energy, manual medicine, etc. Some are economic, professional, psychological and cultural logics which explain this phenomena of sissiparity. Who are the people who promote such therapies?

– The breakdowns between the area of different medicines and the different adjacent sectors such as regular medicine (a question which is the main transverse point of discussion for this workshop), but also the entire field of psycho-bodily therapies; that of popular medicines (traditional healing practices); the field of the sacred and of religious beliefs (healing by faith and prayer); and finally, the "para-scientific" sphere (or of esoteric beliefs and practices) such as astrology, seerism, phenomena of communication at a distance etc.

The borders between what forms the field of different medicines and what belongs to other social practice areas must be placed somewhere, but where?

II. THE LEGAL FRAMEWORK IN WHICH ALTERNATIVE MEDICINE IS SITUATUATED

When applied to the practice of alternative medicines, the legislative bases of the health system in France generate a series of ambiguities and paradoxes. They are extensively due to the fact that official recognition of different medicines is primarily part of an action of legitimation (or of non-legitimation) by such and such an authority and in reality has little to do with actually being entered into the laws applying to the different categories of players and of institutions concerned. Thus, while homeopathy and to a lesser extent acupuncture are disciplines whose validity is still being contested by the Academy of Medicine, prescriptions or medical consultations to which they give rise are codified and reimbursed by the social security and have been for several years and are thus blessed by their backing.

Similarly, no alternative therapy, including the most widespread acupuncture; homeopathy; phytotherapy, osteopathy), is the subject of teaching at a national level. Except for the DUMENAT (Diplôme Universitaire de Médecines naturelles), issued by a university in the Paris area (Bobigny), there are no officially recognized qualifications in the field. Indeed, certificates or diplomas for homeopathy or acupuncture, issued by certain medical faculties, are not considered as official national diplomas. Obviously, the same applies to formations and diplomas issued by a great many private schools. However, any doctor can declare himself to be a homeopath or an acupunctor, regardless of any additional training he may have or have not followed.

More generally, in France, there is a two-fold movement as far as the legitimation of the practice is concerned at the level of doctors for alternative therapies: first there is a loosening up or even an opening up, most of the official authorities (national order of doctors, faculties of medicine, Ministry of Health, etc.) with respect to these doctors; secondly, there is greater vigilance, in particular among the national order of doctors - regarding the conditions under which these medicines are applied: the struggle against medical charlatans (i.e. even within the medical profession), for instance, regarding the prescriptions for natural therapies in the case of serious illness, etc. This vigilance is becoming apparent through the increased number of appearances of doctors before disciplinary boards. From the legislative standpoint, the keystone is the freedom that the doctor is legally entitled to in prescribing therapy that he considers appropriate to the case to be dealt with.

However, alternative medicines in France are not only practiced by doctors. The main legal problem that arises is due to the fact that doctors have a monopoly for exercising medicine (drawing up diagnosis and decisions regarding therapeutic behavior). However, many non-doctors, in particular among kinestherapists have been trained in non-orthodoxed therapies and claim the right to practice acupuncture, osteopathy and other alternative therapeutic disciplines. The fact that there is no official regulation concerning acupunctors, osteopaths; naturopaths, etc. forms a legal loophole giving ground to their claims. These non-doctor practitioners expect a great deal of the European market dispositions which should enter into effect as of 1992. On their side of things, doctors-acupunctors and osteopaths in particular - are very actively organizing matters to deal with such claims and to ensure a monopoly for the distribution of alternative care.

In terms of research questions, we might consider carrying out comparative analysis between the different European countries regarding for instance:

– offsets between legislations in the health area and existing practices,

– the complex non-monolithic character of this legislation and the ambiguities or paradoxes resulting from it,

– the modifications and regulation adaptations retained in an attempt to integrate - or to combat - the development of certain practices and of certain practitioners.

III. NUMBER AND CHARACTERISTICS OF THERAPISTS

Because there is no regulation concerning alternative medical "specialities", the number of practitioners cannot be evaluated with any accuracy. This is particularly the case of non-doctor therapists.

Several estimations come together in evaluating at approximately 10,000 the number of acupuncture doctors while the number of homeopathic doctors is evaluated at 3 to 6,000; osteopaths are estimated to be 150 to 300. Among them, is there any reason to distinguish between doctors who make exclusive or majority use of these therapies from those who implement them more occasionally.

According to a survey in 1987 (4) among a specimen range representative of 200 general practitioners, 46% of the doctors investigated declared that they practiced 1 or several alternative methods (in France in 1987 there were 54,500 general practitioners working on an independent basis); among these 46%, 5.4% used them exclusively, 20.7% used them often, 72.8% used them occasionally (no answer: 1.1%). Approximately 1 GP out of four cares for his patients regularly by alternative therapies. Other soundings give similar results.

Doctors using unorthodox therapies are for the very greater part general practitioners. An increasing number of pediatricians (even if this is still a minority) are turning toward homeopathy and some rhumotologists are becoming interested in acupuncture or manual medicines. Sophrology appears to be having some success among dentists and mid-wives.

The number of kinestherapists using alternative therapies can be estimated at 2 to 4,000 (out of 25,700 kinestherapists working on a freelance basis).

It is estimated that the number of practitioners who have no official diploma as health professional - among whom there are many naturopaths - is even more difficult to evaluate; it must be around several thousand.

The type and length of training of these therapists, doctors or non-doctors appear to vary greatly. Some (perhaps the great majority?) have very solid training while others are far less well equipped. It should be observed that in particular, as far as osteopathy and acupuncture are concerned, some practitioners declare that they were trained on the "compagnonage" basis (i.e. by working with a qualified an experienced practitioner). This type of apprenticeship may or may not be a complement to more "scholarly" training.

The number of schools and training courses in alternative medicines has increased substantially over the last 15 years or so. Alongside the "benchmark" schools which obtain their letters of legitimacy in the field of different medicines (even if the diplomas they issue are not officially recognized), many more or less "serious" training centers have been founded.

More generally, the field of different medicines in France is strongly structured and institutionalized. One important point to be underscored is that the major therapeutic and heterodox disciplines (acupuncture, homeopathy, phytotherapy, osteopathy) do not form consistent wholes. Within each of these medicines there are doctrinal cleavages which extend the institutional cleavages that exist (among the unions of practitioners, training schools, knowledgeable societies, etc.).

In France, much research has been devoted to practitioners of different medicines on the basis of original data collections (surveys by questionnaires or by conversations). This work forms part of what we might well call the sociology of the health professions; a study of the professional and social trajectories, positioning on the care market (choice of practicing conventional or fee-free systems), doctrinal and therapeutic orientations, relations with professional groups (unions, knowledgeable companies, etc.), methods of legitimization through the acquisition of knowledge, by "donation", by reference to major cultural traditions, etc.).

One very interesting avenue of research consist in analyzing for such and such a country and such and such a time, the links, the connections between the regulations in force on the one hand and on the doctrinal orientations and privileged therapeutic orientations on the other hand for categories of practitioners (doctors or non-doctors) regarding a given therapy. On this point, the case of osteopathy might bare much information.

IV. FREQUENCY OF USE AND PATIENTS' CHARACTERISTICS

The main source of quantitative information relative to users of alternative medicines is a survey carried out in 1985 among a representative sample of 1,000 people (5). 49% of the people questioned had already used "if only just once", alternative medicine. This percentage was 46% one year previously). Unfortunately, the formulation of the question did not enable us to evaluate the recent or old character of recourse or the frequency employed.

Again, according to this survey, the alternative medicine most widely used is homeopathy (32%), followed by acupuncture (21%), phytotherapy (12%), chiropraxy (4%) and osteopathy (3%).

This recourse appears to be particularly frequent among executives and higher intellectual professions (68%), average executives and intermediate professions (60%), artisans, traders, company managers (50%) and other employees (52%). Farmers (40%) appear to be relatively less frequent users of different medicines.

44% of men and 53% of women have had recourse to these medicines. The highest percentages of recourse are to be found in the 35-49 years age group (59%), followed by the 50-64 years (50%), then the 25-34 years (45%). Other surveys reveal similar results, in particular concerning the socio-professional distribution of the users.

An extensive survey into the living conditions carried out in 1987 by INSEE (Institut National de la statistique and des Etudes Economiques) among 13,000 people, brought together a complete series of questions concerning health. One of them had to give new results regarding recourse to parallel medicines (currently the survey is being enquired into).

Beyond a few soundings very little work has been devoted in France to users of alternative medicines. The perspective of forthcoming research, two points should be underscored:

– the users of alternative medicines are not a "separate" category among all health users. It is precisely the articulations and superimpositions between regular recourses and alternative recourses that are interesting to study. The notion of a therapeutic route i.e. a succession and combination of different recourses established by the same user) can be fruitful from the standpoint.

– social, cultural and psychological determinacies which governor the orientation of users toward alternative medicines are extremely diversified. Some users are mainly in quest of efficient and non iatrogenous therapies while other are tinted and "human" practitioners (slow medicine, "listening" medicine etc) exist. Other yet again are strongly attracted and interested in the universe of philosophies and beliefs about the human being, his position in the universe, the meaning of existence etc and convey the major transissions on which some different medicines are based.

V PATIENT SATISFACTION

The aforementioned soundings (5) included a question regarding the evaluation of alternative medicine efficiency according to the experience of the integrated users themselves. 70% of them estimate that these therapies are very relatively efficient for minor aliments (such as flu, colds, general fatigue, headaches), 65% for chronic symptoms (sleeplessness, rheumatisms, digestive problems, allergies), 9% for serious aliments (cancer, cardiac problems etc). Conversely, 11% only consider that these doctors are not or are not at all efficient for minor aliments, 15% for chronic symptoms, 38% for serious

illnesses. For each of these three categories of problems, respectively 19%, 20% and 63% of alternative medicine users have nothing to declare.

49% of users have consulted doctors for minor aliments, 50% for chronic symptoms, 3% for serious illnesses and 17% preventively in order to keep healthy.

It might be possible to carry out, as part of research into human and social sciences and approach towards the notion of the efficiency and results therapeutical interventions which have now broken free of the conventional bio-medical approaches. What status should be given to the notion of patient satisfaction, to the profane evaluation of the effects of care? How can this dimension be taken into account at a methodological level?

VI ECONOMIC IMPLEMENTATIONS: FINANCIAL ASPECTS AND REIMBURSEMENT

Some writers consider that the amount of the economic flow is linked with alternative medicines is between 3.5 and 7% of the total health expenditure in France, excluding the alternative care provided within a hospital framework. On this point, we might underscore that an increase in the number of homeopathy and acupuncture consultants are made in a hospital environment for 10 years or so.

We have already underscored the fact that acupuncture sessions and homeopathic prescriptions are reimbursed by the Social Security as soon as a doctor who issues them is an agreed doctor. In addition, even if they are not the subject of specific codification, medical phythotherapy consultations, or consultations for different therapies, or alternative technical sessions by an approved kinesitherapists are reimbursed by the Social Security. More often than not, the Social Security is "unaware" of the alternative or other nature of the service provided. Conversely, costs linked with the purchase of phytotherapy products are not handles in any way.

In the current state of knowledge about the question, there is not way of evaluating the share of care cost and alternative pharmaceutical products which are respectively assumed by Social Security, by users (we would also have to take account of mutual insurance and private insurance schemes). It might also be interesting to look at the evolution and the financial significance of alternative cares for these different categories of players and institutions. Is the development of alternative medicines a factor of additional costs for Social Security? For users?

We can be sure that the share of the cost of alternative care remaining at the charge of the user is substantially more than the share of the cost regular care at his expense. Indeed, the proportion of acupuncturists, homeopath and osteopath doctors who have chosen the free fees area is substantially higher than of the general practitioners of even of conventional specialists. Since 1982, doctors working on a freelance basis have had the possibility, while remaining within the conventions established between the Medical Unions and the Social Security, to chose between "sector I" of this convention (in which case, they agree to abide by conventional prices) or "sector II"; in the latter case, the doctor freely establishes the amount of his fees; the patient, on the other hand, is paid only on the basis of the conventional price. In addition, homeopaths or acupuncturists more frequently chose that their colleagues no longer agreed at all; consultation fees are then fully at the expense of the patient.

1985	Sector 1	Free fees	Non-agreed
homeopath doctors	17.6%	73.3%	7.5%
acupuncture doctors	31.5%	63.5%	4.1%
general practitioner doctors	82.6%	14.5%	0.8%
specialist doctors	68.2%	16.3%	0.4%

Conversely, the amount of prescriptions issued in the homeopathic medical field is substantially less than the regular medicine field and is almost nil for acupuncture.

From these statistic drawn up by the Social Security among part of the doctors practicing homeopathy and acupuncture, the average overall amount of the annual fees received appears to be less than that of regular general practitioners (in 1986):

- homeopathic doctors: 382,851 francs
- acupuncture doctors: 413,934 francs
- general practitioners: 442,631 francs

Among kinesitherapists, there is no free fee area. Because of the difficulty of compatibility between the operations conducted by an alternative kinistherapists - osteopath for instance - which calls much time, and the "conventional" price rates established for the profession, an increasing number of kinesitherapists are surveying their patients on a "non-conventionalized" basis or on a totally "de-conventionalized" basis. The same applies for kinesitherapists who practice acupuncture. In these cases, care costs established freely by the practitioner, are fully at the expense of the user.

It is obviously the same thing for the fees requested by therapists who have no profession health diploma.

The great majority of mutual insurance schemes does not ensure complementary reimbursement of care fees when the practitioner is "approved", even more so within the limits of the price lists in sector I. Several private insurance schemes propose more interesting complementary reimbursement rates for medical fees in sector II (but no reimbursement for non-agreed (non conventionnés) practitioner fees).

As far as a more accurate estimation of the financial flow is linked with the supply and consumption of alternative methods is concerned, and also concerning the more fundamental research into health economy regarding the alternative care market and its articulations with the established health system, in France, almost everything is yet to be done.

TO CONCLUDE

In the perspective of the European Research Programme relating to alternative medicines, we might make a few suggestions:

- in site people toward the development of work based on the rigorous replacement of empirical data. Indeed, it would appear that many recent publications correspond more to general thinking about alternative medicines and their social usages than to real and original research works. This refers directly back to the question of the methodologies to be retained which can be quantitative, qualitative, and which allow comparative approaches etc;

– retaining a certain number of pertinent guidelines in order to get to know the level of integration of alternative medicines in the Health Systems in place in different countries and to follow their evolution. Is there not a trend toward the redevelopment of the traditional break away between alternative medicines on the one hand and conventional medicines on the other? Indeed, will not gradual recognition of part of different trend medicines go hand in hand with the radicalization and the new marginalization of an entire sector of social practices relative to these same medicines?

– in spite of its apparent homogenous, the total present day success of alternative medicines refers to very diversified determinisms. They therefore fall within social movements which are inherent to the future of medicine and health, but also to the aspirations and social-cultural evolutions of a more general nature. These different settings into perspective must be considered for all of the points dealt with in this text.

Notes:

(1) Dr. E.H. Niboyet, Rapport sur certaines techniques de soins ne faisant pas l'objet d'un enseignement organisé au niveau national. Maisonneuve 1984.

(2) Les médecines différentes, un defi? Rapport au ministre des Affaires sociales et de la solidarité nationale et au secrètaire d'Etat chargé de la Santé. La documentation française, 1988.

(3) Y. Barel, A.M. Butel, les médecines parallèles quelques lignes de force MIRE, La Documentation française, 1988.

(4) Sondage Impact Médecin-CAM, Février 1987.

(4) Sondage SOFRES-Médecines douces, Octobre 1985.

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- Médecines différentes, parcours de généralistes. Prospective et santé, no 34, été 1985, 43-50.

- Les usagers des médecines alternatives; itinéraires thérapeutiques, culturels, existentiels. Revue Française des Affaires Sociales, no hors-série, mai 1986, 105-115.

- La nébuleuse des autres médecines; essai de cartographie. Etudes, octobre 1986, 317-330.

- Direction du numéro de la revue Autrement: Autres médecines, autres moeurs; l'explosion des nouvelles pratiques de santé, no 85, décembre 1986, 236 p.
  .Rédaction de trois articles, pour ce numéro:
  - Le champ, de quelques notes sensibles.
  - L'alliance de l'orthodoxe et de l'hétérodoxe.
  - Qui n'est si nouveau thérapeute?

- L'orientation des professionnels de la santé vers les médecines différentes; une diversité de déterminismes et d'aménagements. Colloque international "Comprendre le recours aux médecines parallèles", Bruxelles, 3-5 décembre 1987. A paraître dans les actes du colloque, 1989.

- Les praticiens des "nouvelles" thérapies; stratégies de rétablissement professionnel et d'ajustement à la demande. Rapport de fin de recherche. Programme "Santé-maladie-Société", CNRS-MIRE (Mission Recherche-Expérimentation, ministère des affaires sociales et de l'emploi), 1987, 157 p + 41 p annexes.

- Le cheminement social des médecines parallèles. Postface au rapport d'Y. Barel et A.M. Butel, Les médecines parallèles, quelques lignes de force. La documentation française, 1988, 278-285.

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Using 'Alternative Therapies';marginal medicine and central concerns.

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The legitimacy of alternative medicine is an issue of vital public concern and the growing body of social science research on alternative 'healing' should surely illuminate the political problems involved. I shall begin by reviewing some of the results of this research, and then outline some findings from my own investigations. These suggest that the use of alternative medicine is associated with many other changes in health care practice on the part of individuals and families. Alternative practitioners may be marginal (in a political sense) to the orthodox medical establishment, but the issues which are raised by the use of alternative medicine are central if we are concerned with what patients demand of the health services and how they conceive of health and well-being.

Three large scale studies conducted in industrial countries suggest that the usage of alternative medicine is substantial. The Threshold Foundation study carried out in the UK projected a rate of usage amounting to 5% of the rate of consultation of GPs (Fulder 1984:43). In Holland, Langendijk Opinion Research carried out a survey for the Netherlands Working Group of Practitioners in Natural Healing and found that 21% of 1030 adult interviewees had used 'natural' methods of healing at some time, and as many as 38% of these had used such healing in the last year (Ooijendijk et al. 1981:1). The study carried out by the Dutch Institute for Preventive Health Care and the Technical and

Industrial Organisation was directed towards a comparison of opinions and experience of alternative medicine and official medicine; the survey found that 6.9.% of the sample of adults had visited one or more natural healer in the past year (Ooijendijk et al. 1981:44). In the absence of prior research the rate of increase in usage of alternative medicine in recent years can only be estimated, and there are problems of comparability between studies (partly arising from research design, partly from the differing provision of alternative health care in different western countries. But the evidence from these studies, along with the rapid growth in the number of healers practicing various forms of alternative medicine, leads one writer to predict a 'UK medical upheaval by the end of the decade' (Fulder 1984: 44)

Who uses alternative medicine? A hypothesis which seems to have informed some research, either explicitly or implicitly, is the idea that users of alternative medicine are possibly marginal *people* as well as users of marginal *medicine*. Much American research seems to address itself to combatting the notion that users of unorthodox medicine are likely to be the uneducated amd illiterate (McGuire 1988:10, Avina and Schneiderman 1978). Most studies report that users come from a wide range of backgrounds and suggest no evidence that alternative medicine is the preserve of the 'crank' or hill billy. The Threshold Foundation study suggests that in Britain users of alternative medicine tend to be bunched in the young amd middle aged cohorts and, although coming from a variety of class backgrounds, are somewhat more likely to be from the higher status groups (Fulder 1984:46). An an Australian study of new patients to alternative care finds the same; patients come from all social classes, with a somewhat

higher proportion coming from the professional managerial and clerical grades than the occupation distribution of the whole population would lead one to expect and having a slightly higher level of education than the Autralian population as a whole (Boven et al. 1977:303 ff).The Dutch Institute for Preventive Health Care study also found a slightly higher representation of high status patients among users of alternative medicine taken as an undifferentiated group (Ooijendijk et al. 1981:19).

However,as these authors and others have pointed out, different profiles might be obtained if the various types of healing are isolated;faith healing ,being free, is more common among the poor whilst more expensive forms of therapy such as acupuncture,are less likely to be favoured by the poor or unemployed.In the Midlands locality in which I conducted research there seems to have been a tradition among some working class families of using herbalism,dating from the period prior to the establishment of the NHS when the services of herbalists could be obtained at little greater cost than those of an ordinary doctor.(Many of the healers whom I am interviewing as part of a further research project on alternative healing claim to operate a sliding fee scale so that the very poor are not disadvantaged.Also some insurance companies are now prepared to cover payments made to certain categories of complementary therapist,so it is possible that alternative medicine will become financially accessible to more working class people in the future).

A number of smaller studies in Europe ,Australia and America have found either minor differences in demographic and socio-economic characteristics between samples of users of alternative medicine and

control populations(generally a slightly higher poportion of educated or high status patients and a young/middle-aged age profile),or no differences at all (Furnham and Smith 1988,Kronenfeld and Wasner,1982,Avina and Schneiderman 1978, Parker and Tupling 1976).Some studies have found slightly different distributions in religious affiliation or ethnicity,but comparisons between countries are difficult here.There is however consistent evidence that higher proportions of alternative medicine patients are female (Ooijenjijk,Mackenbach and Limberger 1981;10,Fulder 1984;46).Are there characteristics of alternative medicine which render it more acceptable or accessible to women,or is it rather that women are more likely to have the kind of health problems which conventional medicine cannot cure?

Why do people use alternative medicine?There can be no doubt that the straightforward answer to this question is simply 'because they have illnesses which conventional medicine has not been able to cure.'A study of patients at the Centre for Alternative Therapies in Southampton indicated that the three complaints for which consultations were most frequently initiated were pain (arthritis,back pain,abdominal pain,headaches),allergies(eczema,urticaria,asthma,rhinitis) and non specific symptoms such as 'feeling unwell or run down',malaise (Moore et al.1985).Very similar findings are reported for the Threshold Foundation study (Fulder 1984:47).The Australian 'Three City' study revealed that problems of the musculo-skeletal skeletal system figured most prominently among the complaints for which patients sought alternative healers (Boven et al. 1977:325).The Dutch Institute for Preventive Health Care study found that the compalaints mentioned most frequently as occasioning use of alternative healing were;stiffness in

movement,'feeling really sick',tiredness or listlessness,pain somewhere in the body,insomnia,tension or depression (Ooijendijk et al. 1981:33).

It is not easy to compare data from surveys which rely on the patient's own definition of his/her problem or complaint;respondents use a variety of diagnostic vocabularies which may or may not correspond with those used by conventional doctors or alternative healers .Many alternative systems of healing have their own distinctive nosologies which are not necessarily adopted by their users.Classification by reported symptoms may be more satisfactory but leads to vagueness.'Malaise','feeling unwell', are not very felicitous terms, considered as diagnostic categories.Also if individual forms of therapy are taken separately,there may be wider variation since some medical systemss are suited to (or are perceived as being suited to) particular kinds of complaint(osteopathy and chiropractic for problems of the musculo-skeletal system,for instance).However the general picture is not at all difficult to grasp.Patients are using unorthodox medicine to deal with conditions (mainly chronic and non-life threatening)for which orthodox medicine can offer symptomatic relief rather than cure.The insistence of the BMA that alternative medicine prove its efficacy through double blind trials of medications or other methods acceptable to orthodox medical science seems therefore oddly irrelevant to the these patients' perceptions of their needs.An asthma sufferer who has been unable to obtain more than temporary symptomatic relief from his/her condition under orthodox treatment and is desparate for a permanent cure is unlikely to demand this kind of proof for the efficacy of homoeopathy or acupuncture.He or she is already convinced of the inefficacy of orthodox medicine in respect of his/her disease and has

reached a stage of readiness to experiment with other systems.The same is not true of many alternative practitioners as represented through their professional asociations or broad groupings like the Research Council for Complementary Medicine or the Confederation of Healing Organisations, some of which are very much concerned with the question of demonstrating the efficacy of alternative medicine in terms acceptable to the scientific establishment.

Social science research can shed little direct light on the question of whether alternative medicine actually works (or at least not in the sense that the medical profession would accept);however it has a good deal to say on the question of customer satisfaction with the services provided by practitioners.Here again,comparability is a problem,because different studies have used different indicators of satisfaction or have questioned users at different stages of treatment,but the general picture is far from negative.Moore,Phipps and Marcer found that 59% of patients interviewed at a Centre for Alternative Therapies said that they felt better after eight weeks of treatment though only 19 had completed their treatment at the time (Moore et al.1985:28.The Dutch study used much more complex methods of assessing patients' perceptions of results of treatment and its findings are harder to summarize,but on most counts the majority of users of alternative medicine reported improvements in their condition after treatment (Ooijendijk et al. 1980;33).Parker and Tupling in Australia found that of a sample of chiropractic patients 45% reported 'very great' or 'almost total' relief of symptoms,with another 31% stating that they had 'some ' relief immediately after treatment.After ten weeks a follow up enquiry indicated that 37% patients reported total improvement and 32%

considerable improvement, 19% some improvement and only 11% no improvement at all (Parker and Tupling 1976:374). An interesting American study of the perceptions of osteopaths and ordinary physicians in a small town reports a 'cognitive bias in favour of MDs (conventional doctors) but a countervailing pragmatic bias in favour of DOs' (osteopaths) (Riley 1980:1170. That is, clients had internalized the ideological notion that orthodox medicine has superior efficacy, but in practice expressed satisfaction with unorthodox practitioners whose services they had used to deal with problems the orthodox physicians could not treat. Findings such as these do not, of course, prove that alternative medicine works *better* than conventional medicine (probably most users of orthodox medicine would also be prepared to state that it effects 'some' improvement in their condition if asked) nor does it say anything about whether alternative medicine works according to its own claims or theories. What it does suggest is that levels of patient satisfaction are high enough to ensure that there will be a vigourous demand for the services of alternative healers for the foreseeable future.

I stated earlier that there was a 'simple' answer to the 'straightforward' question as to why people use alternative medicine, and my review of research so far has concentrated on researchers' answer to fairly straightforward questions (who uses alternative medicine? for what disorders do they seek treatment?). Simple questions however are not always the best conceived or most interesting. We may correlate usage of alternative medicine with all kinds of demographic and medical characteristics of sample populations and compare them with control groups in all kinds of respects and

still miss some very important dimensions of the demand for services. Can we treat usage of alternative medicine as a 'variable', an isolable piece of behaviour, rather than as a feature of an individual's life situation, perhaps a stage in some wider process of change in health care practice. And are individuals most appropriately taken as the units of study, given that medical sociology has made us aware that individuals frequently take decisions about health care in consultation with households members and kin?

The study which I undertook in 1986 was not designed to compare users of alternative medicine with non-users, but to discover the routes by which patients came to use it. The term 'routes' has a double sense here. It refers both to the particular experiences (ill health, dissatisfaction with NHS) through which the individual arrived at the decision to seek treatment from an alternative practitioner, and also (more literally) the path by which they came to be treated by the particular practitioner selected (the sources of information, referral, etc). I interviewed 30 people in the Stoke-on-Trent area who had used at least one form of alternative medicine in the past twelve months. The sample was largely obtained by inviting readers of the local newspaper to volunteer their experiences of alternative medicine. We cannot draw any conclusions about the representativeness of such a self selected sample in terms of demographic or socio-economic characteristics, but this was not the purpose of the research.

The interviews were structured to the extent that they covered some standard questions and elicited a corpus of comparable data, but as far as possible I encouraged respondents to deliver this information in the context of their own 'story' of how they had come to use alternative

medicine. This left them free to include in their accounts much that I would not have elicited through standardized questions in a set order. For most of the respondents the 'story of how they had come to use alternative medicine ' was a narrative with a point, even a moral, which they wished to convey. Those who had been impressed by a particularly efficacious treatment wanted to urge the value of the cure. But many showed a desire to communicate far more than this, stressing the sense of independence and confidence in their own judgement they had felt they had acquired through the experience of searching for relief, and the way in which their perceptions of medicine , health and healing had changed. It is quite possible to obtain comparable data from a number of respondents with minimal interference with the flow of such a 'story', although extracting this data from the recorded narratives for quantification takes time. The point at which the interviewer encounters the patient cannot be supposed to be the final point in the latter's search for satisfactory health care , and longitudinal studies of individuals (or more appropriately households) will probably be more useful in future.

Using alternative medicine is therefore part of a *process* . While some interviewees could pin-point predisposing factors in their family background (e.g. usage of herbal medicine by parents, horrific experiences of orthodox medical treatment by a close relative) most took as their starting point their own experience of some chronic disorder and their and subsequent dissatisfaction with the treatment they received for this under the NHS. All had taken consulted their GP about this illness in the first place and several had seen specialists in connection with diagnosis or treatment. (Interestingly, only one patient reported that

she had been to see a private consultant). I did not encounter any who had used alternative medicine because they had been brought up to do so, because it was the norm in their ethnic/religious group or for other 'cultural' reasons, apart from one woman whose parents had been ardent adherents of naturopathy, though a larger sample might well identify cases of this kind of usage).

It is important to discuss users' sources of dissatisfaction with orthodox medicine at some length because many of them do not relate straightforwardly to conventional medicine's failure to 'cure' disease so much as to its failure to 'cure' disease on terms that are acceptable to the particular patient. Two individuals did report a conflictual relationship with their GP, but in most cases dissatisfaction was not focussed on the perceived incompetence of individual doctors or consultants. The problems with orthodox medicine as offered under the NHS which interviewees mentioned could be grouped as follows

1). *The claim that conventional medicine fails to get at the 'root cause' of chronic illness or to take a preventive approach, and can therefore only treat the symptoms.* For example, a young man suffering from chronic depression had been referred to a psychiatrist and had received anti-depressant drugs which had some temporary effect. But he felt that the basic cause of his state had not been discovered and that therefore he would continue to be liable to periods of depression, a prospect which he did not wish to accept. The experience of acupuncture described by friends who had used it suggested to him that this therapy might effect a long term change in his condition. When he tried acupuncture it so fascinated him that he decided to train as an acupuncturist himself, and whilst his depression has not entirely ceased to be a problem, the

periods of disability are shorter and less frequent. A young man who had had persistent and painful ear trouble for many years and who had received considerable relief from herbal treatment, felt positively indignant that conventional doctors had failed to point out the quite simple preventive and health-improving dietary measures which the herbalist had showed him. He felt that he could have been saved a great deal of pain and suffering if the causes of his general ill health had been addressed rather than the symptoms

This is not to say that patients always required a detailed diagnosis or a technical description of what the healer saw as the problem; patients varied very much as to the degree of interest they took in the actual rationale or theory of the forms of healing used. What was more often reported was relief that their dissatisfaction with symptomatic 'cures' had been acknowledged as legitimate and reasonable, and an appreciative sense that the healer was tackling the problem at a more fundamental level than conventional doctors had managed to do.

2). *The fear of drugs which might become habit forming, or the intolerance of side effects of particular drugs.* Sometimes this took a rather diffuse concern about drugs that are too 'strong' - an imprecise fear of the body being interfered with in some way. Sometimes there was general anxiety that prolonged or frequent use of drugs would interfere with the body's ability to react to drugs in acute situations, especially with regard to the use of anti-biotics for childhood ailments. In other cases the dissatisfaction was based on a very specific experience. For instance one interviewee 's consultant had prescribed drugs for high blood pressure which, she said, made her feel exhausted and weak, 'like an old woman'. When she discovered a herbalist who could treat her she was

relieved to be offered medicine which, she said, controlled her condition with no side effects whatsoever. The same interviewees expressed concern over the state of health of her sister who suffered from arthritis and who, she said, had been given ever stronger drugs to control the condition without any real imporvement

The editors of a recent volume on chronic illness point out that, for many patients, living with long term illness involves coping not only with the discomfort or disability caused by the illness itself but also coping with the demands made by the medical regime prescribed to deal with the illness (Anderson and Bury, 1988; 250). Such regimes are demanding - either in the sense that they are actually unpleasant for the patient or in the wider sense that they involve the diversion of personal or family resources from other activities. Another way of presenting point (2) might be to say that some patients find the cost of the regime prescribed for an illness outweighs the benefit it confers in terms of increased well being or ability to live a normal life, and therefore they seek alternative regimes in the hope that their costs will be more acceptable.

3). *Fear or dislike of forms of treatment which are seen as too radical or invasive.* A middle aged woman who suffered from back pain had been offered surgery under the NHS without, however, any guarantee that her condition would be cured. Indeed, she had been told that there was a slight risk that it might become worse. A major operation which did not have any certain outcome seemed to her too drastic a step to take and the risk of a deterioriation dismayed her as her work required her to move and lift inmates in an old people's home. She visited a chiropractor at the suggestion of a colleague of her husband and after a fairly

lengthy (and at first painful) course of treatment reported an almost complete recovery.

4). *The inability of conventional medicine to cope with the social and experiential aspects of illness.* There is now more awareness of the need for personal support in severe or terminal illness, yet even apparently trivial conditions like ezcema pose a need for personal support when they are chronic (as patients' self help groups recognize). The sufferer needs to feel that the healer (of whatever kind) appreciates and does not dismiss the forms of distress or inconvenience which the illness causes. Some interviewees emphasized a desire for practical advice in the day to day management of their illness, (useful adjustments to diet, suggestions for patterns of rest and exercise, stress management techniques etc). Not all forms of alternative medicine claim to be holistic, but we could say that holism is what many chronic patients seek in practice. It is not by any means the case that all conventional doctors are unable to offer this personal interest and support, nor is it the case that all sufferers found alternative healers willing to provide it. Many healers however allow for much longer consultation times than do GPs, especially for a first consultation which may (especially in systems like homoeopathy) involve taking a very detailed case history. While a number of patients expressed dissatisfaction with the NHS on account of the time taken to obtain hospital appointments or treatment, it is clear that a time consuming form of treatment may be acceptable to the sufferer if it is on terms that are acceptable to him/her or if the patient feels it is producing some lasting effect.

4. Dissatisfaction with the kind of relationship between doctor and patient which interviewees feel that conventional medicine requires or presupposes. In many of the interviews, patients communicated a conscious appreciation of the more active role they felt able to play in the management of their illness or the general pursuit of health. Usually this feeling of being in control was described as a by-product of their experiences rather as the goal they had been seeking in the first place. A woman who had suffered from asthma for many years described her encounters with conventional and numerous forms of alternative medicine by saying 'I am not criticizing other people....but I think that very often they go to the doctor and they just accept what the doctor says. I would advises anybody to go to the doctor first, but now I would always use alternative medicine to get a second opinion and treatment if you are not satisfied'. Many took an explicitly consumerist approach; one young man who had recently begun to consult and iridologist and to use herbal medicine described his and his wife's attitude to conventional medicine thus ;' If we need to, then we do go to our GP - we are not totally blinkered. We aim to get the best out of both systems'. Another interviewee who had used homoeopathy to deal with her child's allergies and for herself said, 'I feel more active in my treatment. With the GP you have to be passive, and there is never time to ask questions. Now I feel more in control of my health and more confident to deal with my children's health'.

Yet some interviewees recognized that this active, critical and perhaps eclectic approach to health care might be incompatible with the model of the doctor-patient relationship in which the doctor has total responsibility for the treatment and the patient has only to trust and

comply. Most interviewees had avoided telling their GPs about any alternative treatment they had received because they intended to continue to use the GP's services and did not wish to be seen to violate this model of the GP/patient relationship.

So far I have concentrated on the critical point at which the patient decides for the first time to seek alternative treatmenmt and I have stressed that this decision is compounded of desire for treatment for a specific and (usually) chronic condition and dissatisfaction with form of treatment received under the NHS, which may not simply relate to conventional medicine's failure to *cure* as much as with failure to cure *on terms acceptable to the patient.*

The search for a satisfactory cure for a chronic illness or disorder does not always lead a sufferer directly to the door of an alternative practitioner. Many respondents recounted what can best be described as a programme of self education about their disorder which they had undertaken once they had realized that a quick cure was not likely. One patient had read and assimilated a large number of popular medical books on diet obtained from local bookshops and the public library to inform herself about her dietary allergy before she sought treatmnent from a herbalist. A woman with chronic asthma had obtained a great deal of information from the popular media, mainly television programmes and women's magazines before contacting a spiritual healer, about whom she had read a magazine article. (Women's magazines are evidently an important source of information about the treatment of illness, both orthodox and unorthodox; several healers whom I have interviewed have reported a spate of patients seeking treatment after a widely circulated magazine has carried an article dealing with or mentioning their

particular form of healing). Many interviewees described this process of self education as one which changed some of their views on health in general, as well as their views on a specific health problem. A young husband who had suffered from chest problems described how the dietary recommendations of an iridologist caused him and his wife to think more in general about what they ate ; 'There has been a lot of information on television and so forth about additives. I started to notice this sort of information more. And I began to talk to Jennifer(a family friend who used the same healer) and I began to wonder whether our diet had always been at fault'. His wife continued, 'It (i.e. the changes in diet which they had made) has improved the quality of our life. We think more about the effects of aging; one day we shall be at the wrong end of thirty, then forty, then fifty.... we have been eating wholefoods for two years now, but it is all too easy to abuse your body'.

Most interviewees in the sample, however, described the initial decision to use alternative medicine as prompted by a recommendation to a specific practitioner by a specific member of their network (see Table 1). This confirms what many other researchers have found, i.e. that most users come to alternative healing via personal recommendation obtained through informal networks than via GP's referrals or formal channels of information. Table 1 however refers to the *first* experience of alternative medicine, and many patients had used more than one form of alternative medicine, either for the same disease at different times, or more usually, for different diseases. If we include sources of information used for all consultations (not just the first) we find more diverse sources of information, with cultural and political organizations playing a greater part. One patients mentioned the Soil Association, which has in

the past few years invited a number of local healers to address its members, as providing the stimulus to seek the services of a herbalist. Another patient had heard about the reflexologist whom she had consulted through the woman who taught the vegetarian cookery class which she attended. Most patients however seemed to have gained the confidence to approach a non-orthodox healer in the first place after hearing some kind of success story about that healer from a relative, friend and colleague, and only used information from more impersonal sources once a personal recommendation had yielded some kind of useful experience. The enquiries which I received in the course of this research from people intending to begin to use alternative medicine appeared to be from people whose social networks did not yield information about individual healers and were hesitant about taking the plunge to use unorthodox medicine without the assurance of a personal recommendation.

This confirms what practitioners whom I have interviewed have said, i.e. advertisement is hardly an issue. Recommendations circulate by word of mouth and most practitioners interviewed so far have stated that a satisfactory level of clientele can be built up very quickly in this way. Many healers do educational work of one kind and another, especially when they are just starting their practice and have the time to do so. Some devote quite a lot of energy to running workshops and evening classes relating to the type of healing they practice or to more general health issues, so it is likely that in future such activities will provide another channel of information and generate recommendations for would-be users of alternative medicine.

What is striking about the interviewees' stories is that initial usage of one form of alternative medicine is often followed by use of other forms, either serially or simultaneously, for the same or for different illnesses. Some patients had used as many as five types in as many years (see Table 2). In only one case was this due to continued failure to obtain any relief. A young man who had a skin condition affecting his scalp and had seen a consultant dermatologist, but without any significant improvement , announced to me his dogged intention of trying as many different forms of medicine in turn until he found one which had some effect. What seemed more common was that some degree of satisfaction (not necessarily total) with the particular form of alternative medicine first sampled led to a more eclectic and experimental attitude and eventually to trials of other kinds of healing. A woman who had suffered from both low back pain and chronic hayfever had used both Alexander Technique (not strictly speaking a form of healing, but often used by patients experiencing back pain) and chiropractic for her back problem and had visited a homoeopath in connection with her hay fever, then a second homoeopath in connection with her son's more acute episodes of hay fever. She had also consulted an osteopath about her back pain while spending a year in America. She felt that she had benefitted from all these forms of treatment in some degree but could envisage trying other forms of alternative medicine if she felt that they could offer even better or more permanent relief.

In many cases this change to a more eclectic approach to health care was one which affected the whole family. This could happen in several ways. In some cases the interviewee had recommended a form of treatment which s/he had used to other members of the family or had used it for

children. In other cases the treatment involved the family indirectly insofar as the patient had to observe some regime (usually dietary) which affected the family. A woman who used a particular kind of diet recomneded by a herbalist in treating chronic arthritis said that whilst she could not insist that her family eat the diet prescribed for herself, it was convenient to plan meals so that her work was not unnecessarily duplicated. Her family had accepted these changes in family eating patterns, indeed had come to appreciate them. In other cases the regime presented more problems. One woman who had been recommended by a herbalist to follow a more or less vegetarian diet to treat an allergic condition found it difficult to persuade her young children to accept this diet and , I suspect, would probably have been discouraged from persisting with the treatment had not her husband enthusiastically offered to share her diet, since he thought that it was one which would make for greater fitness all round. Only one patient reported downright unco-operative or dismissive attitudes on the part of household members to their usage of alternative medicine . This was a woman with chronic fatigue and depression which she attributed to post-viral fatigue syndrome. Her husband had (she said) been very dismissive of her experiences with homoeopathy. (The marriage had broken up shortly before I interviewed her). In a few cases patients reported that a spouse or children had regarded their usage of alternative medicine in the light of an eccentric aberration but had not put any obstacles in the way of the interviewee's sticking to the regime prescribed.

When looking at the effects of use of alternative medicine on family health care practices it is important to place these changes in a broader context. Some of the dietary changes and shifts in lifestyle

reported by patients as stemming from the recommendations of alternative healers are changes which are by being recommended by many other sources of medical authority or information (GPs, popular medical journals, health promotion campaigns) and are by no means peculiar to alternative medicine 'sub-cultures'. Reduced consumption of animal fats, high fibre diets, regimes of excercise and use of relaxation techniques might be examples. Such changes should be seen as part of more general shifts in thinking about personal and family health care voiced particularly effectively, but not exclusively, by holistic healers.

More significantly, there is little evidence that users of alternative medicine cease entirely to use orthodox medicine, though they may use it less, or for different purposes, or more critically. A sceptical attitude to orthodox medicine did not lead to its abandonment. Usually patients used alternative medicine for specific illnesses or problems and GP for others. Interv ewees had not abandoned the NHS even though dissatisfied with it. In Table 3 I have tried to summarize some of the main patterns of usage which I found among the individuals I interviewed. This is not a very satisfactory exercise since it is clear that many people are in the process of changing the pattern of theirn 'health seeking behaviour' either as individuals or at the household level, and many of the people I interviewed were likely to change their patterns further in future. But from this table we can see that we do not have to treat users of alternative medicine and users of the health service as two discrete sets of people. Use of alternative medicine generated in a particular situation of illness may continue but alongside orthodox medicine. In some cases initial use of alternative medicine had eventually led to comitted devotion to a

particular system of alternative medicine to the virtual exclusion of all other systems. This was the case with a farmer who had become convinced of the efficacy of homoeopathy in his twenties, after a severe and painful ear infection. He has, he claimed, never consulted an ordinary doctor since, except once to have a broken arm x-rayed and immobilized, and is an enthusisatic evangelist for homeopathic treatment.

This degree of exclusive comittment however was unusual. Most interviewees could think of occasions during the past 12 months when they had consulted their GP for themselves or for other members of their family, and could envisage other in future. Of course it is possible that users of alternative medicine continue to consult their GPs whilst failing to comply with their prescriptions or instructions for treatment. A study of users of ritual healing groups in America notes that many respondents in the study did consult their doctors about symptoms and might value some aspects of their services (in particular their diagnostic skills) but would reserve the right not to follow the doctor's sugestions for treatment. As the authors point out, the very notion of 'compliance' implies a power relationship which some users of alternative medicine have(either explicitly or implicitly) put into question. (Mc Guire 1988. p. 194)

This all reveals a very fluid scene in which individuals and families are changing their patterns of 'health seeking behaviour' and may change them more radically yet. This being so, precise estimates of demand for alternative medicine would be difficult to arrive at using the kind of survey methods which concentrate on a synchronic set of correlations valid at a particular time - a snapshot approach -rather than on personal or family *processes*. This is not to say that large

scale survey research is irrelevant, rather that as usage of alternative medicine becomes more widespread some of the assumptions on which studies have been based hitherto will have to be revised (that users of alternative medicine and conventional medicine can be treated as distinct sets of people, that users of alternative medicine might be very distinct types of people in terms of demographic or social characteristics) and different questions will need to be asked.

One very widespread idea which seems to me to be a misconception (at least so far as this country is concerned) is that users of alternative healing are naively attracted by the ideological claims of alternative medicine . Jonathan Miller suggested in a recent newspaper article that 'much alternative medicine on offer - acupuncture or homoeopathy, for example - appeals to soft primitivism', a concept which he defines as ' a belief that there was a time when men were harmonious and happy - the myth of the Golden Age - possessed with wisdoms we are foolish to ignore and idiotic to forget' (Miller 1989). Possibly this is so; certainly such ideas are frequently expressed in a variety of quarters. But this would not in itself suffice to explain the increasing use of alternative medicine, which seems related to quite pragmatic objectives such as obtaining a cure for a specific illness or leading a more active and healthy life. Only a very few of the people I interviewed gave explicitly ideological reasons for their initial attraction to alternative medicine, though some, as I have indicated, have altered their way of looking at care of the body and mind as a result of their encounter. So ideological committment might explain why some people *continue* to use alternative medicine having once used it successfully, insofar as they are convinced by what they learn about it

from practitioners ,but it would not account for the initial resort to unorthodox medicine itself.

Yet most patients using alternative medicine would seem to be (negatively) dissatisfied with the service offered by orthodox medicine,coming on the whole from its areas notable failure,rather than (positivley) attracted by any alternative world view it may claim to offer.Two themes recur very frequently in the interviews,and receive widespread mention in the literature on the subject.

1.The demand that the patient's experience and understanding of his or her disease should be acknowledged and treated with respect.Not all interviewees spoke in terms of a more 'equal' relationship with the doctor or healer,but many wanted to be better informed so that they could exercise more control in the management of their illness.Where alternative practitioners took the trouble to explain the rationale of treatment to the patient this was appreciated,and often contrasted with the failure of orthodox doctors to take time to provide information about treatment or to take account of the patients experience of his/her illness.

2.The demand for what could loosely be called a more 'holistic' approach on the part of doctors.Patients do not always use the term holism,and when they do,they do not always mean exactly the same thing.However a recurrent theme in the interviews was the desire that the personal context of illness should be taken into account.The treatment by drugs,which is all that many patients can obtain under the NHS was often seen as too narrow,even where it was 'effective' in terms of sheer relief of symptoms.

The first demand appears to correspond to a feature of the health philosophy of the present government,namely the patient should be in a position to 'choose' treatment and to take a high measure of responsibility for his or her own health.Health education is seen very largely in terms of campaigns to modify aspects of lifestyle which are held to carry risks of ill health.The 'choice' which the patient is to exercise seems at the moment only to refer to the choice between private and public medicine or between different private doctors practicing orthodox medicine,but the terms of the rhetoric are not dissimilar.The consumer movement,as expressed through journals such as 'Which' and 'Self Health' also implicitly espouses a philosophy of individual responsibility and choice in health matters.All these voices imply the possibility of a demand led health system,even if they are coming at the idea from different directions.The logic of the free market is that alternative medicine should be allowed to flourish;it will prosper or decline according to the state of demand for its services.Many doctors currently practicing orthodox forms of medicine already offer forms of alternative medicine to their patients or take an interest in the holistic health movement.How long will the generally extremely conservative atittude of the medical profession(as expressed officially through the BMA) be able to withstand the effects of a growing market in a political climate dominated by the ethic of the market ?

As regards the second demand,the need for a more holistic approach is evidently recognized by many members of the medical profession,even those who are by no means in favour of alternative medicine itself.The British Holistic Medicine Association has many general practitioners

among its members and one may find contributions from medical doctors as well as healers and lay people in journals such as Cadduceus. Jonathan Miller in the article already mentioned admits that the mechanistic model of the human person espoused by modern medicine , and its consequences for treatment ,are repulsive to many patients. Many of the patients I interviewed attributed the aspects of NHS treatment which they did not like to the mode of delivery rather than to the system of medicine itself. That is, they recognized that pressures of time and organisation made it impossible for doctors to deal with them as whole person even if they wishes to. It is curious that only one of the patients I interviewed had actually obtained orthodox treatment from a private consultant for the condition for which they subsequently sought alternative healing. Another patient who had had experience of private conventional medicine in the past admitted that the service she had received from this practitioner was comparable to the attention she received from the herbalist whom she was using at present. Adequate time to devote to the patient was, in her view, the key to the good practice she sought. Perhaps a larger sample would throw light on why some patients consider prvate medicine as an option and others do not. It has to be remembered that in an area like the one in which I researched, use of alternative medicine is not necessarily more expensive that use of a private consultant. In fact some of it is remarkably cheap. (At the time of writing £15 for an initial session of 3/4 hour to an hour is not unusual for many healers; if one feels better after one or two sessions this may be a cheaper option than visiting a consultant. So, again, it is difficult to disentangle ideological factors affecting patients' choice of treatment from other more practical considerations.

Use of alternative medicine is still a minority choice, but from what I have said here, it will be clear that it is not a marginal issue. If sociologists are to make a positive contribution to the debate about its legitimacy then they should study it both from the point of view of the patient and the practitioner. Rather little work has been conducted on the first count, but on the second, alternative medicine is best researched and discussed in the context of concepts such as help/health seeking behaviour or 'treatment strategies' . Though some patients do change their cultural expectations about what doctors or healers should do or about how illness is caused as a result of their encounters with alternative medicine, most cannot be said to belong to a separate cultural group; where they express unease over the way in which orthodox medicine delivers its services, they are generally voicing anxieties which they share with many who do not use alternative medicine. Whilst the temptation to treat the study of alternative medicine as analogous to the study of sectarian groups is understandable (especially where therapeutic communities and psychic healing groups are concerned) I think that this approach is less illuminating where current public issues of legitimacy and demand are concerned. Users of alternative medicine are making certain kinds of consumer choice, albeit choices which may have radical consequences for the entire household's lifestyle and habits. As with other patients, their choices derive from the interaction between the nature of their illnesses (chronic, difficult for orthodox medicine to treat) and the nature of their lay referral networks (access to information about specific healers, cultural and political resources).

Alternative medicine therefore is marginal medicine only in the obvious sense that it is still used by minority (albeit a substantial one), and in the political sense that it has limited recognition by the state. Its study has raised issues concerning changes in household health care practice, consumer eclecticism, and sources of disssatisfaction with orthodox medicine which should be of central concern to the medical professionals and social scientists alike.

Footnote.

1. The term alternative medicine is controversial. Some practitioners prefer the term complementary medicine, implying a less radical stance in relation to conventional medicine. Others elect to stress their difference. There are problems with either terminology and my choice of the term 'alternative' medicine is based solely on the grounds that it is more widely used by the public.

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Table 1

How respondents heard about the 'alternative' healer they used first.

SOURCE OF INFORMATION	NO. OF RESPONDENTS
'Public' sources :	
Advertisements/Yellow pages	3
G.P.'s recommendation	1
Local association/organisation	1
'Private' sources :	
Friends/acquaintances/colleagues	23
Relatives	2
TOTAL	30

Table 2

Number of types of alternative medicine used by respondents (either serially or simultaneously)

Types of alternative medicine used;	1	2	3	4	4+
No. of respondents;	9	8	4	7	2 (Total 30)

Table 3

Types of usage of alternative medicine

Conflictual relationship with GP plus occasional or regular use of alternative medicine	2
'Experimental' or eclectic use of alternative medicine	12
Stable and regular use of one form of alternative medicine	9
'Restricted' use of one form of alternative medicine(for a single illness	7
TOTAL	30

Alternatieve geneeskunde / goed-bruikbaarheid (12/899)

"ALTERNATIVE" MEDICINE IN THE U.K.

Alternatieve Symposium 1907

1. Definition

In the last ten years "fringe medicine" has been replaced by "Alternative Medicine", which in turn is now being replaced by the term "Complementary Medicine". This reflects the change of emphasis from rivalry to co-operation with orthodox medicine.

Definitions are largely unsatisfactory, being by exclusion from orthodox medicine; and scientific knowledge.

The government's Department of Health defines Alternative Medicine as;

"Practices designed to heal disease or improve health which are not 1) Subjected to scientific proof

2) Regularly included in medical curriculum."

The British Medical Association defines;

"Systems incompatible with the corpus of scientific knowledge."(14)

Some techniques may be regarded as orthodox in limited use within conventional medicine; but alternative when claims for their value are greatly extended, for example spinal manipulation. Fulder and Monro have described these therapies as "Complementary, rather than alternative or supplementary, to conventional medicine; they are hippocratic, integrative, preventive and holistic, whereas conventional medicine is galenical, analytical, curative and specific." (10)

The major techniques considered to be "Complementary Medicine" are (in approximate order of importance).

Manipulation (Osteopathy, Chiropractic)
Acupuncture
Hypnosis
Homeopathy
Herbal Medicine
Naturopathy
Healing (Spiritual, Christian)

Some techniques form a "grey area" between orthodox and complementary medicine, for example psychotherapy, relaxation, meditation, massage.

Other techniques with smaller followings include; BACH flower remedies,

aromatotherapy, Iridology and reflexology. All of these are generally practised outside the National Health Service (N.H.S.). However, on a small scale the N.H.S. does allow homeopathy, acupuncture and manipulation, varying from one area to another. The free market policies of the Thatcher government and the present N.H.S. review, which will create an internal market in the N.H.S. for health care, may well break down the monolithic structure which excludes complementary therapists. For example, if doctors control patient care funding and consider complementary therapy good value for money, they may arrange this within N.H.S. funding.

2. The Legal Framework

Britain is somewhat unique in having no governmental control on either doctors or non-medical practitioners. Under British "common law" evolved over many centuries, there are no restrictions on practice per se, except with respect to general laws on negligence, fraud and trade descriptions. Thus, any practitioner regardless of qualifications may practice unhindered. However, many therapies are well organised with responsible and respected national bodies who hold examinations and award qualifications, for example the British Register of Osteopaths. It is then up to the individual to discern the better qualified practitioner, but this remains difficult for the public without guidance.

Doctors in Britain are regulated by the autonomous General Medical Council (G.M.C.). Until the 1970's the G.M.C. code specifically forbade referral to non-medical practitioners. An important change was then made, and the paragraph now reads; "A doctor who delegates treatment or other procedures must be satisfied that the person to whom they are delegated is competent to carry them out. Doctors should retain ultimate responsibility for ..... management."

However, doctors can, and frequently do, practice techniques in which they have little or no training - perhaps just a weekend course or after a stimulating lecture. Certain professionals are controlled as "Supplemental to medicine". These include Radiographers and Physiotherapists. No major complementary therapies have recently sought this status, probably because of fear of restrictions being imposed by the establishment.

As in many aspects of British life, different professional associations of therapists value their independence. In 1986, 145 organisations could

be identified in the complementary field. Attempts have been made, most recently by the "Council for Complementary and Alternative Medicine" (C.C.A.M.) to unite the major training organisations in order to gain approval (and status) similar to the doctors, under the G.M.C. These have not yet succeeded. Thus there is no regulation of educational standards in complementary medicine in Britain.

This independence has recently been threatened in several ways. Some local authorities, notably in London, are seeking to regulate practitioners in their areas. Recently publiscised cases of fraud have led to doctors setting up the "Council Against Health Fraud". The new Education Reform Act will bring legal safeguards against unrecognised degrees and diplomas. European harmonisation in 1992 may override the above mentioned British Common Law which is in any case very vague. Legislation also threatens the free availability of homeopathic and herbal remedies without prescription. Despite all this, therapists continue to argue whether their techniques can, or should, be externally validated.

Some specific legal points; Death and Sickness Certificates may only be signed by doctors. However reports for legal cases may be accepted by qualified non-medical practitioners, e.g. osteopaths. Medical insurance increasingly reimburses costs of mainstream alternative therapies, sometimes only with medical recommendation. Recently a separate private health insurance policy exclusively for alternative medicine has been launched.

My own interest in the field is as a practising full-time General Practitioner in the primary care service of the N.H.S.

In 1984 I was asked to arrange a Seminar on Alternative Medicine. The growth of this phenomenon was at that time much discussed in the media, although poorly documented. (1-5) Interest in the subject contrasted starkly with a lack of hard data on the numbers of practitioners, patients and doctors involved, and the attitude of the medical profession generally. My search for information took time and covered such varied sources as the British Medical Journal (1-2), The Lancet (3), The Times (4-5), Which? (6), foreign government reports (7-9) and Charitable Institutes (10-12), along with some help from professional associations such as the National Institute of Medical Herbalists. My interest was stimulated by undertaking a simple questionnaire poll of 30 trainee colleagues, which indicated a generally positive approach reflecting the results of Reilly (13). This was at odds

with the cautious and sceptical approach of the medical establishment, embodied in the report commissioned by the Board of Education and Science of the British Medical Association published in 1986 (14). It seems unlikely that G.P. Principals supported the establishment view, and I decided to undertake a study to test this hypothesis in the County of Avon. With the help of Dr. Lewith and the Research Council for Complementary Medicine, this was completed in 1986 and published in the British Medical Journal (15). In essence, our hypothesis of a more open minded approach to Complementary Medicine (the change of title is in itself significant) by G.Ps. was confirmed. The need for dialogue, education of doctors and regulation of Complementary practitioners were highlighted by our findings. The confrontational view of relations between orthodox and complementary medicine, fostered by the media and the British Medical Association report, was now being seriously challenged by a number of studies (16-18). We studied G.Ps. in Avon; another study in Oxfordshire produced similar results (19).

A full account of my research will be available at the workshop.

3. Demand and Supply, Economic Implications

As outlined above, the fragmented structure of complementary therapies in Britain has made documentation difficult.(12) Surveys of patients, practitioners and consultants have been local and of questionable validity. The detailed study from University of Sheffield by Kate Thomas and others has yet to be completed. It is to be hoped that some information and trends from this study will be available to the forthcoming workshop. What do we know from other sources?

A study in 1981(11) suggested that there were 12 alternative practitioners per 100,000 population; that numbers were growing at a rate five times greater than doctors; that half of these had formal qualifications; annual consultation rates were about 20 - 25 per 100 population. A full-time therapist would see around 25 patients per week, compared to 200 for a family doctor. It is assumed that consultation times would therefore be much greater. A rough estimate of expenditure on complementary health care (in 1981) was £250 million, or less than 2% of total health care expenditure. The recent squeeze on N.H.S. funding by the government and growth of the private sector may have increased this figure. Several studies suggest that patients are predominantly female, middle-class and middle-aged.(20) There is

evidence that complementary medicine flourishes best in more prosperous areas, where health care is of a higher standard.[17] Relations with doctors in these areas may be better. Small studies suggest that many patients have chronic conditions which have not been adequately treated by orthodox medicine.[16] They are often well informed on complementary therapies. They often deny a loss of faith in their doctor or orthodox medicine, but greatly value the personal attention and time available in complementary consultations.[17] Treated complaints are more often disorders of function, often allied to problems of living; for structual complaints such as infection, peptic ulcer, most patients would consider medical advice to be essential.[20] Such functional disorders include allergies, musculoskeletal pain, abdominal symptoms, asthma and migraine.

DR R. WHARTON
8.5.89

DOCTORS AND COMPLEMENTARY MEDICINE - DR. R.L. WHARTON

OUTLINE OF PROPOSED RESEARCH

BACKGROUND

In 1984 I was asked to arrange a Seminar on Alternative Medicine. The growth of this phenomenon was at that time much discussed in the media, although poorly documented. (1-5) Interest in the subject contrasted starkly with a lack of hard data on the numbers of practitioners, patients and doctors involved, and the attitude of the medical profession generally. My search for information took time and covered such varied sources as the British Medical Journal (1-2), The Lancet (3), The Times (4-5), Which? (6), foreign government reports (7-9) and Charitable Institutes (10-12), along with some help from professional associations such as the National Institute of Medical Herbalists. My interest was stimulated by undertaking a simple questionnaire poll of 30 trainee colleagues, which indicated a generally positive approach reflecting the results of Reilly (13). This was at odds with the cautious and sceptical approach of the medical establishment, embodied in the report commissioned by the Board of Education and Science of the British Medical Association published in 1986 (14). It seems unlikely that G.P. Principals supported the establishment view, and I decided to undertake a study to test this hypothesis in the County ofAvon. With the help of Dr. Lewith and the Research Council for Complementary Medicine, this was completed in 1986 and published in the British Medical Journal (15). In essence, our hypothesis of a more open minded approach to Complementary Medicine (the change of title is in itself significant) by G.Ps. was confirmed. The need for dialogue, education of doctors and regulation of Complementary practitioners were highlighted by our findings. The confrontational view of relations between orthodox and complementary medicine, fostered by the media and the British Medical Association report, was now being seriously challenged by a number of studies (16-18). We studied G.Ps. in Avon; another study in Oxfordshire produced similar results (19).

AIMS

As so often occurs, new questions were raised by our previous research, and this project will aim to answer some of them, including:

1. Can the results of the two regional G.P. studies (15,19) be reproduced in the rest of Britain?

2. Are there geographical or social trends in attitudes?

3. What is the level of knowledge of Complementary Medicine among G.Ps.?

4. What influences doctors in the way they interact with patients when discussing, practising and referring for Complementary Therapies?

5. Do G.Ps.' views on Complementary Medicine reflect his overall approach to his practice?

The wider question of comparing G.Ps. with other groups such as hospital doctors, nurses and the public is too large a question to be considered here, but could form the basis of a future study.

METHOD

The first part of the research will be to carry out a postal questionnaire survey of 1,000 G.Ps. selected randomly from a sampling frame of all G.P. Principals in England and Wales, which is available from D.H.S.S. Replies will be confidentially coded and this will facilitate reminders at 4 and 8 weeks with further questionnaires. Where possible, non-responders will be telephoned at 10 weeks. This formula achieved 75% response rate in a local study (15), but it is recognised that nationally a lower figure may result; our target is 60%. However, 40% response will enable meaningful analysis of data, and demographic details of non-responders will be available for comparison to exclude bias. The questionnaire will be introduced by a personally signed letter from R.L. Wharton on headed paper. It will fall into several distinct sections.

1. Demographic, personal and practice data including:

   Partnership and list size.
   University and year of qualification.
   Age, sex, years as G.P.
   Location and type of practice.
   Assessment of socioeconomic status of their area.

2. Definitions of techniques to be studied. These are:

   Manipulation (includes Chiropractic, Osteopathy).
   Acupuncture.
   Homeopathy.
   Hypnotherapy.
   Relaxation (includes meditation and Yoga).
   Spiritual Healing.
   "others" - space available for respondents to comment on their own areas of interest.

3. Factual questions asking G.Ps. to assess their:

   a) knowledge
   b) training
   c) sources of information.
   d) practice.
   e) referral patterns.

   for each technique above

4. Questions designed to assess G.Ps' attitudes to Complementary Medicine and influences on their opinions. Responses of a five point scale.

5. Finally, all sections to be coded numerically for input to computer in a right sided margin.

ANALYSIS

Firstly responders and non-responders will be compared for age, sex and other demographic details, using the X^2 test. Each factual question (see 3 under "method") will be presented as a percentage table and/or histogram for each therapy. Each of these tables will be analysed by X^2 (or Mann-Whitney U test for non-parametric data) with respect to age, sex, etc. of responders. Conventional significance levels of $p<0.05$ will be adopted.

FOLLOW-UP STUDY

The second part of the research involves the more complex question of G.Ps.' approach, motivation and influences in forming their views. It is doubtful whether this could be adequately covered by a postal questionnaire. Face to face interviews with G.Ps. selected from the nationwide study for their varied views will be undertaken. Correlations with other aspects of the G.Ps. practice such as prescribing habits, referral patterns and views on social issues may be possible. The sample size for this study will necessarily be much smaller, but (since numerical data will not be sought) this should not prevent useful conclusions being made.

CONCLUSION

I would aim to publish the findings of this study in a major journal. I am not at present aware of any other group working on such a study, and I believe the results would be of general interest and would hopefully influence the views of organisations such as the British Medical Association and the relatively new C.C.A.M. (Council for Complementary and Alternative Medicine). This work is more complex than our previous study. Considerable financial support will be required, as mail, telephone and administrative costs will be higher, and a research assistant will be needed on at least a part-time regular basis. Overall, I feel this research could be the first real attempt to answer some important questions in a field of interest both within and without the profession. If our previous findings are confirmed, the study could be a significant step towards Complementary, rather than Alternative, Health Care.

Dr. R.L. Wharton
22.9.88.

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Alternative medicine in the Netherlands.

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Introduction

Like in other European countries, alternative medicine in the Netherlands flourishes. Firstly, its popularity among patients, as measured in the number of visits paid to alternative practitioners, is still increasing. Secondly, although discussion about the theoretical concepts and possible effects continues to exercise many minds, a certain benevolence towards alternative medicine seems to prevail among regular professionals, too. A third indication of the relative strong position of alternative medicine is the interest shown by the Government and other relevant institutions. Fourthly, as compared to other countries, research into the field is quite well developed.
The facts and figures to be presented in this paper are mostly based on the results of these research efforts. Together they give an impression of both the importance of alternative medicine in the Dutch health care system and the research undertaken to measure this importance.
The Dutch health care system consists of four echelons, separated by (low) thresholds: the basic (or public health) echelon; the first (or primary care) echelon (general practitioners, social workers, physical therapists, district nurses, home help); the specialist and hospital echelon; the chronic care echelon (1). In this system the general practitioners play an important part. In general, the specialist or hospital echelon may only be consulted on referral by a general practitioner. The same goes for physical therapists, even for those who work in a primary care setting.

1. Definitions

Alternative medicine is often defined in terms of what it is not, namely as that part of medicine in which one cannot have a training nor acquire a title that is officially recognized by the Government. Alternative practitioners themselves use other definitions. According to Aakster, alternative medicine is directed towards the patient as a whole; is promoting health instead of only fighting sickness; uses natural, non harmful forms of therapy; is directed towards restoring balances and strengthening constructive forces; sees the patient as an active participant in regaining health.(2). Since the publication of the final report of the Commission for Alternative Systems of Medicine (3) six "mainstream systems" are discerned: acupuncture, anthroposophical medicine, homoeopathy, manipulative medicine, naturopathy and paranormal healing. According to the Report, these six share two characteristics. The first is that they differ in their basic assumptions from the regular medicine. The second characteristic is a more pragmatic one in the sense that these six systems are used by a relatively large number of patients.
Out of the different systems that are grouped together as "manipulative medicine" only chiropraxis and osteopathy are "alternative" in a strict sense. However, these are only rarely practised in the Netherlands. Manipulative therapy is increasingly recognised by the medical profession. The fact that it is still regarded as an alternative system is evident from the difficulties attaching to the reimbursement of the cost of treatment.

2. Legal framework

At the end of the last century, some types of medical practitioners existed. First, there were medical doctors who were trained at one of the Universities. A second group formed those who were trained at what were called Clinical Schools. Especially on the countryside, however, most help was given by a third group: those who did not have any medical schooling at all.
In 1865 a bill was passed that put an end to this situation. From that time on, the practice of medicine was restricted to medical doctors with a University background. This monopoly still exists. A modification was only made for the paramedical professions, such as physical therapy. In 1964 these professions were simply defined as being "non-medical" and were given a legal framework on their own (4).

The monopoly of University trained and qualified practitioners has been a contentious issue over the years. In the late sixties the Government was advised to provide the option for those without formal qualifications to practice medicine, although they were not to carry out specified medical operations. Furthermore, these healers were responsible for possible damage to their patients' health and were not allowed to call themselves "doctors". It is this advice that underlies the bill which is to be introduced in parliament in the near future.

Until then, non-medically qualified practitioners are, therefore, formally still traspassing law. However, criminal prosecution is only to be undertaken when the patient's health has been demonstrably damaged and a complaint has been lodged with the health inspector. In practice, this is only seldom done.
On the other hand, medical doctors are allowed to apply medical techniques, whether these are considered to be alternative or not. The only restriction is the doctors' own disciplinary law, which should prevent them from behaving in contradiction with the standards of the profession.

Within the group of alternative practitioners a distinction can be made between those who are qualified (by virtue of the legal regulations) and those who are capable (by virtue of their training) to practice alternative medicine. All medical doctors belong to the former category, but only part of them to the latter (e.g. only those who had any specific training in this field). Contrary, none of the not University trained practitioners is qualified, whereas those who graduated from one of the schools for naturopathy can rightly claim capability.

3. Frequency of use and patients' characteristics

In the last few years some surveys have been held on the frequency of use of alternative medicine (5,6). In this overview we restrict ourselves to the data that were most recently collected in the continuous Health Interview Survey of the Dutch Central Office of Statistics.

In 1987 5.2% of the Dutch population visited an alternative practitioner (not being one's own general practitioner), most often a homoeopath (1.6%), a paranormal healer (1.4%) or an acupuncturist (0.9%). Together these patients paid approximately 6.5 million visits to these practitioners. To these should be added 7.3% of the population who paid a visit to an (own) general practitioner practising alternative medicine (mostly homoeopathy) (6.1 million contacts). Due to overlap between these figures, the total percentage of patients who visited an alternative practitioner in 1987 (whether or not one's own GP) is 11.8. Together these 1.7 million patients stand for 12.6 million "alternative" visits. To compare: the number of contacts with (all) general practitioners, medical specialist and physical therapists is estimated (1986) at 51.1 million, 23.5 million and 29.2 million, respectively (7).
The number of patients who visit an alternative practitioner is still rising (1985: 9.1%, own GP's included). Especially the percentage of people who visit an own "alternative" GP is rising sharply.

More women than men pay a visit to an alternative practitioner (as is the case with regard to other medical services as well). Those aged between 30 and 59 are also a little more inclined to visit these practitioner (after the age of 60 the percentage of visitors suddenly drops) and the same goes for people with a higher education and those who are privately insured. Most important, however, is the health status: those who visit alternative practitioners feel themselves less healthy than those who don't and are ill for a relatively long period of time (8).

Pain in the muscoskeletal system (back pain, stiff neck and such) is the most common complaint to be presented to alternative practitioners. Nervous complaints (such as serious headache) are a second well known reason for visiting them.

These characteristics and complaints, however, do not fully explain why people take refuge with alternative medicine. A well-known distinction is between those who are frustrated in the regular care, those who "go alternative" for pragmatic reasons (because "it might work") and those who choose for alternative medicine out of conviction (9). Whenever these concepts are used in empirical research, the latter group turns out to be very small (5,10). Most people try an alternative treatment because they were told that it might help them (by friends or relatives) or because they read about it in a newspaper or magazine. It follows that most patients do not seek alternative help as a substitution to regular help, but as a supplement to it. While being treated by an alternative practitioner, most of them keep visiting their GP or medical specialist.

This does not mean that all these patients keep their general practitioner informed about their visits. In a recent survey about one half of those who visited an alternative practitioner said that their GP knew about these visits (10). For those who visit a manipulative practitioner the willingness to inform their GP seems to be greater than for those who visit a paranormal healer. It might be inferred that patients are well aware of the GP's preferences. While acupuncture, homoeopathy and especially

manipulative medicine are increasingly accepted by general practitioners, only very few of them have a positive attitude towards naturopathy and paranormal treatment.

4. Supply: the number of therapists.

The exact number of alternative practitioners in the Netherlands is not known, due to the fact that many practitioners are not organized in any professional organization. A survey in 1985 among the organizations of practitioners counted more than 4000 practising alternative professionals: 735 naturopaths, 300 paranormal healers, 220 homoeopaths, 475 anthroposophical professionals (either medical doctors or other professionals, such as anthroposophical nurses), 945 acupuncturists and 1450 manual therapists (11). About 60% of these organized professionals had a regular education, either as a medical doctor, a physical therapist or a nurse. To compare: the number of general practitioners in the Netherlands is (1987) 6200, the number of physiotherapists (in a primary care setting) 9000, the number of medical specialists 11.000. (7)
The number of non-organized alternative practitioners is not known.

A recent survey among a representative sample of 360 general practitioners showed that almost one half of them applied one or more alternative methods, mostly homeopathy (40%) (10) . Only 9%, 4% and 4% of the respondents applied manipulative medicine , acupuncture and naturopathy, respectively. The 'alternative' practices were not very large: the number of patients treated with homeopathic medicines varied from only 4 to 2000 in every practice (median: 60). Less than 60% of the GPs concerned had any specific training in alternative medicine.

Medical doctors who want a training in one of the alternative systems can take a (part-time) course in anthroposophical medicine, acupuncture, homeopathy or manipulative therapy, lasting from one to four years (12). Because the title is not legally protected, anybody can call oneself a homoeopath or an acupuncturist without having done this specific training. Like medical doctors, physical therapists can also take a (post-graduate) course; most of them qualify for acupuncture or manipulative therapy.
Without a medical or paramedical training an alternative practitioner-to-be can matriculate in one of the three Academies for Naturopathy that have 3-4 years full-time courses. As can be inferred from the definition of alternative medicine given before, no official status can be derived from the certificate.

5. Patient satisfaction

Where patient satisfaction is concerned, only few data have yet been collected. In a 1981 survey among visitors of alternative medicine 56% of the respondents said that they improved quite a lot, 22% showed some improvement, 22% did not improve at all (5).

Of course these are subjective opinions, and the patients' expectations before treatment had not been measured. It is interesting to note, though, that these figures do not differ much from those collected in the same survey among visitors of medical specialists. A survey among alternative practitioners' patients in the city of Nijmegen (13) showed much satisfaction. However, relatively many patients were not satisfied with the costs or the results of the treatment and the information given by the practitioner.

6. Economic implication: financial aspects and reimbursement

The Dutch sick funds (to which some 60% of the population is inscribed) have the legal obligation to reimburse all help given by the patient's general practitioner, including homoeopathy and other alternative treatments. Medicines prescribed by the GPs are also reimbursed, but only in so far as they have been registered. As homoeopathic medicines and anthroposophical medicines are excused from registration, their reimbursement is easy. In the future, household remedies that are (also) available at the chemist's will no longer be reimbursed when prescribed by a GP. However, this will not apply to homoeopathic and anthroposophical medicines either.

Next to the legally defined "standard package" that is the same for all 45 sick funds in the country, each single one of them offers a supplementary package to which its clients can voluntarily subscribe. The substance of this package is to be defined by the sick fund itself. In 1988 26 of the sick funds reimbursed some forms of alternative treatment (mostly homoeopathy, acupuncture and anthroposophical medicine), next to the reimbursement given for the GPs' help.
All larger private insurance companies have at least homoeopathy, acupuncture and manipulative therapy either in their standard package or in a supplementary package. In many cases reimbursement is only given as far as the practitioner concerned is a medical doctor or a physical therapist and is a member of the professional organization (7). Recently a new insurance was developed which pays for a broad range of alternative and additional therapies, even when practiced by non medical professionals.

It is unknown how much money is spent on alternative medicine each year. Some years ago this amount was valued at 175 to 200 million guilder (5). (1 guilder equals approximatele half US Dollar). For 1987 an amount of 400 to 600 million guilders was mentioned (11). To compare: the costs of the health care system are valued at approximately 33 thousand million (extramural health care: 13 thousand million) (1987). To estimate the costs of alternative medicine for the health system, the (unknown) possible effects of substitution should be taken into account.

7. Conclusion

When characterising the Dutch health system in terms of its approach towards alternative medicine (14), it might be called tolerant: although the right to practice medicine is formally reserved to medical doctors, non medically trained practitioners

have almost nothing to fear. And although scientific medicine forms the core of the system, alternative methods are certainly not totally excluded, as might be the case in more monopolistic systems. In recent years a trend towards integration and interaction between regular and alternative medicine shows up, notwithstanding the fact that the effects of alternative methods have hardly been scientifically proved. As indicated in the introduction to this paper this trend can be seen on the level of Government (that installed a State Commission for Alternative Systems of Medicine in 1977) and financial agencies (such as the sick funds) as well as on the level of both medical doctors and patients. The former incorporate (some) alternative practitioners, the latter often combine alternative and regular treatments, given by different practitioners. In the research into alternative medicine, much of which is financed by the Ministery of Health, two topics stand out. Research into the efficacy of alternative methods (such as manipulative therapy, homoeopathy) is beyond the scope of this paper and shall not be discussed here. Secondly, some research is either done or planned into the process of interaction and intergration and its possible outcome in terms of costs. In the near future two experiments will be set up (one in a region, one in a health center) in which general practitioners will cooperate on the basis of a formal agreement. In the evaluation of these experiments the possible effects of this cooperation (in terms of better, co-ordinated care) will be made visible. Furthermore, on the ground of a common advise to the State Secretary of Health given by the National Council of Public Health and the Sickness Fund Council, a research program will be developed into the possible substitution of regular by alternative care. This program will consist of studies about, for instance, the consumption pattern of patients and the production (in terms of referring patients and prescribing medicines) of general practitioners who do apply alternative methods versus those who do not (15).

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