RECLAIMING THE FULL STORY OF HUMAN HEALTH

THE ETHICAL SIGNIFICANCE OF COMPLEMENTARY AND ALTERNATIVE MEDICINES

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A thesis submitted for the degree of
Doctor of Philosophy
in
Bioethics
at the University of Otago, Dunedin,
New Zealand

September 2004

Für meine Eltern

Abstract

This thesis investigates the moral content of illness ontologies in different healing systems, in particular biomedicine and homeopathy. It was motivated by the wish to gain a greater understanding of the possible meaning and ethical significance underlying the increasing popularity of complementary and alternative medicine (CAM) in Western countries. CAM is an umbrella term for a diverse group of therapeutic approaches, indicating their marginalized status in relation to conventional, scientific medicine. However, despite their diversity most CAM share a common bond by subscribing to a holistic perspective on life, health and illness. It is for this reason that this thesis concentrates on the conceptual level. The subject is approached by making use of interview material from five homeopathic doctors from Austria. Their perspective on different aspects of non-conventional, as well as biomedical, practice and underlying theory provides the springboard for theoretical investigations.

The demand for scientific evidence of CAM is critically examined. The issue of increasing pluralism in health care is explored, along with its challenge of finding appropriate epistemological approaches for therapeutic systems that are based on different illness ontologies. The favored approach in this thesis is based on the recognition by medical historians that there are four basic illness axioms: “illness as loss of balance”, “illness as disruption of interpersonal communication”, “illness as a physical defect” and “illness as pathic creation”. These axioms are matched respectively with four different epistemic pathways: the dialectical, the hermeneutical, the analytical and the phenomenological.

The interviewees considered the more humane quality of the doctor/patient relationship in their homeopathic practices to be due to the holistic premises of homeopathy, which place the subjective dimension of patients at their center. The difficulty of achieving informed consent in the commonly used sense in homeopathic practice was solved by engaging in a shared decision-making process. Life was explained by the interviewees in vitalistic terms. Although rejected by science, the notion of vitalism appears to hold significance for the public. Illness was always perceived as a multidimensional process and not as a purely physico-chemical dysfunction. It became evident that the holistic perspective takes account of the many dimensions of human illness, of which neither the conventional reductionist conception nor

the dualistic mind/body approach are capable. However, the unmanageable complexity of holism poses a problem for therapeutic practice. A conceptual approach providing some structure for the holistic multidimensionality is found in the four illness axioms and in analogous observations by Aristotle.

It is concluded that there could be a connection between the increased popularity of CAM and their underlying holistic perspective, since this theoretical foundation allows the practitioner to address the patient in a whole-person way. At the same time the holistic perspective provides a much broader scope than biomedicine for patients to influence their health. The recognition that human multidimensionality needs to be appreciated at the level of illness ontology may also provide an impetus for bioethics to approach contemporary ethical challenges from a perspective of an ethics of the good life, instead of concerning itself predominantly with setting limits in the arena of technological medicine.

Acknowledgements

Writing this thesis would not have been possible without the valuable input and support from numerous colleagues, friends and family members who have all contributed to this project in their unique and important way.

I first would like to express my special gratitude to my bioethics supervisor Dr. Jing-Bao Nie for his thoughtful guidance and unwavering encouragement throughout. I also want to thank my sociology supervisor Dr. Kevin Dew very much for his support and for the many astute comments and questions, which have been invaluable for the coherent construction of this thesis.

I am also very grateful to Dr. Mike King, for his good ideas, humor, and untiring goodwill, which were all highly appreciated. I am indebted to Prof. Grant Gillett for interesting conversations that have helped me clarify my thoughts, and also for much of my knowledge of medical ethics. Similarly I want to thank Dr. Neil Pickering for the useful discussions we had during the formative stages of my thesis. I am very grateful to the other staff of the Bioethics Centre, Prof. Donald Evans, Lynley Anderson, Dana Wensley, Claire Gallop and Sandy Elkin for creating not only a stimulating academic environment but also an enjoyable collegial atmosphere. Very special thanks go to Vicki Lang for her consistent helpfulness, friendliness and administrative support.

I also want to acknowledge the research participants, who have generously given their time and shared their insights. Without their valued input this thesis could not be what it is.

I also would like to thank my parents Karl Grill and Marianne Grill and my son Stephan Clark for their optimism, enthusiasm and general trust in my abilities, which helped greatly to keep my spirits up. I also feel gratitude to all my friends whose encouragement and support was invaluable. In particular I want to thank Christine Johnston for her friendship and for proof-reading the thesis and ironing out all those Germanic grammatical idiosyncrasies.

Finally, I want to express my immense gratitude to my partner Peter Taylor for his unfailing love, his readiness to listen, his belief in me, and, of course, for always making sure that the home fires kept burning.

The financial support by a Fanny Evans Scholarship is gratefully acknowledged.

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Chapter One

Introduction

Complementary and alternative medicines and the focus of this thesis

The growing popularity of complementary and alternative medicines (CAM)[1] in recent decades has elicited many and often polarized reactions, particularly since it has become obvious that the use of these therapies is steadily increasing and that despite their marginal or marginalized position they are already an integral part of the public's regular health care (Silenzio, 2002).[2] Positions on this issue range from urging that these healing modalities should be properly integrated as a means of improving health care (Snyderman & Weil, 2002), to an outright dismissiveness of them, which has come particularly from "a large and prestigious group of clinicians and biomedical researchers" (Callahan, 2002, p.vii).

A number of issues have been raised so far in connection with the high use of CAM. Most frequently debated has been their lack of scientific validity. It is argued, for example, that for reasons of consumer protection it is mandatory that their effectiveness and safety need to be established through scientific research. Another focus, also with an eye on consumer protection, is the regulatory status of practitioners from different therapeutic modalities. Another issue is that of access to CAM. Some see it as a lack of social justice that these healing practices are reserved to those people who can afford them, as they have to be paid for out-of-pocket in the majority of cases.

However, despite the many discussions, Callahan (2002) points out that not enough thought has gone into the fundamental question of why these treatments have become so attractive to people. It seems particularly surprising that non-proven and low-tech therapeutic modalities

[1] Throughout this thesis the terms complementary and alternative medicine, CAM, non-conventional healing approaches, un-orthodox treatments, holistic medicine, are used interchangeably.

[2] A survey conducted in the US in 1997 showed that 42.1% of the American population was visiting alternative medicine practitioners, which was a 47.3% increase in visits compared to 1990 (Eisenberg et al., 1998). Similar high use was found in other Western countries: for example 48% in Australia, 70% in Canada, 38% in Belgium and 75% in France (WHO, 2002).

have become so popular at a time when modern scientific medicine[3] is more proficient than ever before in history and has broken all previously known limits. In addition people are much better protected than in the past due to patient rights laws. Thus the very same sentiment that Callahan expresses has motivated this thesis.

> What is the meaning of the public interest? If not just out of ignorance of good methodology, the most convenient explanation, why do so many people turn to CAM? What is lacking in conventional medicine that they seek (Callahan, 2002, p. viii)

Before going any further, however, the term "complementary and alternative medicines" needs to be examined. It has been pointed out that this term, and its synonyms, say nothing about what these therapeutic approaches are but indicate instead where they are positioned in relation to mainstream medicine (WHO, 2002), implying that they do not hold the "control over scientific, political and economic discourses" as biomedicine has done in Western countries for over a century now (Silenzio, 2002). In addition, by calling a healing system "traditional medicine", as it is used in connection with traditional Chinese medicine or Indian ayurveda, the impression is given that only they are linked to the history, culture and belief of a particular people. This will then be read as though, in contrast, biomedicine exists outside these constraints and is occupying some absolute and neutral realm.

To delineate what is meant by CAM the following working definition is often used. It was coined by the United States' Office for Alternative Medicine at the National Institute of Health.

> Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp and fixed (O'Connor et al. 1997, cited in Ministerial Advisory Committee on Complementary and Alternative Health, 2004, p.1).

Although it is correct that a great number of therapeutic approaches are brought together under the umbrella-term CAM, it is still important to acknowledge that they do have, at least

[3] The terms used as synonyms for modern scientific medicine throughout this thesis are biomedicine, orthodox medicine, conventional medicine, Western medicine, allopathic medicine.

in the great majority, something fundamental in common, which distinguishes them from the approach biomedicine takes to illness. As Fulder (1996) summarized:

> Despite their diversity, a common bond unites the therapies. They all attempt in varying degrees, to recruit the self-healing capacities of the body. They amplify natural recuperative processes and augment the energy upon which the patient's health depends, helping him to adapt harmoniously to his surroundings (Fulder, 1996, p.4).

In fact, when examining that common bond closer, it becomes clear that it is made up by the holistic perspective on human existence, which underlies most of the different CAM approaches. Holism originally is the term for a concept that was developed by J.C. Smuts (1927). In health care, holism indicates the belief in the inseparable multidimensionality of physical, emotional, mental and spiritual aspects within the human organism and the interrelatedness of the human organism with the physical and social environment. The reason for the great diversity of CAM approaches despite their basic unifying framework has been explained by Lyng (1990). He uses the term "human Gestalt" to illustrate what is meant with the "whole" of the human organism.

> Different holistic health modalities focus on different aspects of the human system (because it would be impossible for any one modality to deal with every aspect of the human Gestalt), but all of the modalities share a common belief in the multifactorial nature of bodily disfunction [sic] (Lyng, 1990, p.82).

> While the separate modalities are rooted in a common set of presuppositions, they each focus on different dimensions of the human Gestalt: iridology is concerned exclusively with the eyes; T'ai Chi with body movement; acupuncture with the vital energy field. In addition, different modalities dealing with the same realm of the Gestalt often use different conceptual categories for organizing that realm (Lyng, 1990, p.94).

The different therapeutic modalities, Lyng (1990) claims, can only be considered as representing different access points. From this understanding it also follows that there cannot be one all-encompassing medicine suited to address all illness phenomena and causes.

> What distinguishes the holistic health model, then, is its eclectic approach to medical thinking and practice. A basic tenet of holistic health thinking is that no one body of medical knowledge can take into account all aspects of health reality, and, therefore, all medical perspectives are inherently partial. Consequently, the only way to deal with all the different facets of health reality is to adopt a multitherapeutic approach, which, in turn, demands a multiperspectival system (Lyng, 1990, p.94).

The ontology of illness lies at the center of every healing approach. How illness is understood will determine what follows in practice. It will shape the scope of the diagnostic gaze and will

define what therapeutic responses are suitable. It will also influence which epistemic methods can be used in the search for more knowledge, which will be undertaken along that particular trail of perception.

These are both important issues to consider in relation to CAM and therefore will find some discussion in this thesis. However, the main concern of this thesis is the moral content of the ontologies of illness in different medical systems and the ethical consequences that come to pass as their result. The ontology of human illness cannot be morally neutral as it defines by its very nature in a fundamental way how this existentially threatening experience that human beings have to contend with is perceived and responded to. Illness, as experienced, never only affects physical aspects but is naturally as multidimensional as human beings are. An illness ontology that does not take account of this human multidimensionality, like that of scientific medicine, which interprets illness as merely a physical defect or dysfunction, will therefore be missing the crucial conceptual tool that is necessary for meeting sick persons in their human entirety. Tauber (2002) claims that there has been a "quest for holism" in medicine for many decades now, even going back to the nineteenth century, as a challenge to the positivist, reductionist orthodoxy, in order to seek "a synthesis of increasingly fragmented knowledge to understand the character of integrated wholes" (Tauber, 2002, p. 185). But in addition, Tauber also sees the moral dimension as an integral part of this quest for holism.

> This was both an epistemological project and a moral one: The ethical imperative to maintain human relations always marked holism in opposition to the underlying positivist orientation that sought to minimize the human element (Tauber, 2002, p.185).

Through reflection on the moral content of different illness ontologies it is hoped that insights will be gained about their consequences for practice, which in turn might provide some understanding of why people increasingly tend to consult practitioners who practice non-conventional therapies. In this thesis the underlying premises of healing approaches based on a holistic perspective are compared with those of scientific medicine. Empirical data from interviews with five homeopathic doctors from Austria provide the spring board for a theoretical enquiry, which covers the analysis of the moral content inherent in illness ontology and also addresses issues that are most commonly debated in relation to the use of non-conventional therapies.

Because of the great number and variety of non-conventional healing approaches homeopathy was chosen to be representative of CAM as homeopathy suits well the purpose of this thesis. Its underlying ontology presents a very different understanding of illness compared to the ontology of scientific medicine. In addition homeopathic theory was developed on Western soil and was therefore influenced by the same cultural features as conventional medicine. This helps to focus on the underlying conceptualization because culture-specific differences in understanding do not have to be considered. If acupuncture was chosen, for example, the Eastern belief in yin and yang forces would have added another dimension.

As a starting point and especially for a better appreciation of the interview data it is necessary to give the reader some background knowledge of homeopathy. The next section thus provides a brief overview including a description of its founder, the conceptual premises of homeopathy, its 200 year history and the research findings of homeopathic treatment studies.

The field of homeopathy

The founder of homeopathic medicine, Samuel Hahnemann [1755-1843] was a German physician who published the principles of his therapeutic system in "*The Organon*" in 1810. Hahnemann started off as an ordinary doctor but soon became disenchanted with the medicine of his time because it did not produce the therapeutic effects it claimed and its methods of, for example, blood letting, purging and the use of calomel caused a tremendous degree of harm to patients.

> Hahnemann was so disillusioned with the state of medical practice and knowledge that, soon after his marriage in 1782, he totally refrained from practicing medicine… so deep was his belief that the tools he had been given would do more harm than good (Danziger, 1987, p.5 cited in Morrell, 2004, p.3).

Hahnemann objected to the way regular medicine approached human illness. In his view it was putting all efforts into giving spurious theoretical explanations about underlying causes rather than responding to the patient's needs by addressing the illness phenomena that were encountered.

> Surely by now we have had enough of these pretentious fantasies called *theoretical medicine*, for which university chairs have even been established, and it is time for those calling themselves physicians to stop deceiving the poor human beings by their talk and to *start acting instead* – that is, really helping and healing (Hahnemann,[1810] 1983, p.9).

Morrell observes that the system Hahnemann developed was in direct opposition to the principles of allopathic medicine, which were "using mixed remedies, using high doses and using contraries". Hahnemann instead used "single drugs, small doses and similars". He saw his new method as capable of doing what he believed an ideal therapeutic approach should do.

> The highest ideal of therapy is to restore health rapidly, gently, permanently; to remove and destroy the disease in the shortest, surest, least harmful way, according to clearly comprehensible principles (Hahnemann, [1810]1983, p.10).

Hahnemann had arrived at the homeopathic method after years of careful and systematic observation and through experimentation, which he initially performed on himself. His crucial first experiment in 1790 involved taking high doses of Peruvian bark cinchona [quinine], which was used for the treatment of malaria in his time. He experienced symptoms and sensations that closely resembled those of malarial fever (Campbell, 1984). This led him to the most significant principle of homeopathic theory: "like is cured by like" – *similar similibus curantur.* It refers to the observation that the symptoms of a sick person can be cured by using a substance that would induce similar symptoms in a healthy person.

Hahnemann was not the first to recognize that phenomenon, however. In fact it had been part of the Western medical tradition and is mentioned in many places in the Hippocratic Corpus.

> In Greece and Rome this trend was represented by the Empirical School. After the Dark Ages it re-emerged in the writings of the Swiss physician, Theophrastus Paracelsus [1490-1541] and was taken up subsequently by such less known figures as the Fleming, Jan Baptisia Van Helmont [1578-1644], the Englishman, Thomas Sydenham [1642-1689], the German, Georg Ernst Stahl [1660-1734], and the Frenchman, Theophile Bordeu [1722-1776] (Coulter, 1984, p.61).

In biomedicine this effect of similars is also used in some situations, where it is seen as a paradoxical drug reaction: examples include Ritalin, an amphetamine-based, drug being used for the treatment of attention deficit hyperactivity disorder (ADHD); or the desensitization therapies in allergic conditions with low doses of the allergen (Eskinazi, 1999).

The next important principles developed by Hahnemann is the "totality of symptoms", which means that every treatment has to be individualized. The particular homeopathic remedy that the physician selects for a patient has to be based on the consideration of the unique combination of all physical, emotional and mental symptoms that patient exhibits. The underlying understanding of this approach is that

> There are no "diseases"… only sick persons. That is, a person does not become ill in part but rather that person's whole becomes ill in body, mind, and spirit. Thus a person is not sick because he/she has a local disease. Instead a local disease is there because a person is sick (Raymond, 1993, p.37).

Homeopathy uses a vitalistic model of understanding life. A vital force, *dynamis,* infuses the organism.

> The organism is the material instrument of life; but it is no more conceivable without the life-giving, regulating, instinctively feeling *dynamis* than this *dynamis* is conceivable without the organism. The two are one, even if thought separates them to facilitate comprehension (Hahnemann, [1810] 1983, p.20).

Illness is considered an un-tunement of the vital force, and symptoms are the product of the organism's attempt to restore homeostasis.

The third main principle is the principle of the minimal dose, which was developed to stimulate the organism's inherent self-healing mechanisms but without doing it any harm. It is this principle that has caused the greatest controversy as it has led homeopaths to use such highly diluted remedies that they physically cannot contain any molecule of the original mother substance. For this reason critics consider these remedies as incapable of exerting a therapeutic effect beyond that of placebo.

Hahnemann had discovered that even high dilutions were still effective when they underwent the systematic preparation of dilution followed by succussion, a vigorous shaking of the remedy. This process is called "potentizing" as the diluted remedy seemed to have an even greater therapeutic effect than one that was less diluted. Homeopaths explain this phenomenon by maintaining that illness as disturbance of the vital force is an energetic process and therefore has to be responded to on an energetic level. The potentization process is meant to release the energetic quality of a substance.[4]

At present there are more than 2000 remedies in the homeopathic pharmacopoeia, which is continually added to (Jacobs & Moskowitz, 1996). Remedies derive from all spheres: plants,

[4] For further information on research in this area see: Popp, 1998; *Hypothesis of modes of action of homeopathy: theoretical background and the experimental situation.* Harisch & Dittmann, 1998; *Biochemical studies of the development of the effect of selected homeopathic agents – in vivo and in vitro models*. Anagnostatos et al., 1998; *Theory and experiments on high dilutions*.

animal products, minerals, human derived materials like breast milk or illness products, but also ephemeral things like moon light.

The range of characteristics a homeopathic remedy exhibits is established through so-called provings, now termed "pathogenetic trials", of homeopathic substances on healthy individuals. The effects that these provers notice after taking a homeopathic remedy are recorded and gathered in the homeopathic materia medica.[5] To arrive at the correct homeopathic therapy the symptoms of the patient are compared with those recorded in the homeopathic materia medica, and a therapeutic effect can be expected when the totality of the symptom patterns are matched as closely as possible. Hahnemann's rule of "single remedy" is connected to this understanding.

> The purpose of the prescription is not to eliminate one symptom or another. It is to match the idiosyncratic essence of the remedy with the idiosyncratic essence of the patient (Coulter, 1984, p.65).

In recent decades homeopathic treatments have been increasingly put to the test in randomized double-blind controlled clinical trials to establish if homeopathy is more effective than a placebo. Although the first meta-analyses of 89 trials suggested that homeopathy showed a significant positive effect (Linde et al., 1997), the developments since are much less convincing, leaving it still unresolved if homeopathic remedies are better than placebos or not (Walach & Jonas, 2002). However these authors argue that trying to establish whether homeopathy is better than placebo might be the wrong approach in the first place, if we want to find out whether homeopathy has therapeutic merit or not.

> For it is the prejudice of the pharmacological era which implants the idea that only pharmacologically specific effects may be called efficacy (Walach & Jonas, 2002, p.240).

In accordance with its underlying theory, homeopathy might be capable of stimulating the organism's self-healing mechanisms, and therefore Walach and Jonas argue, homeopathy should rather be judged from that perspective.

> So the bottom line would be that homeopathy is a clever way of triggering self-healing, certainly a cheaper and less dangerous one than other approaches, maybe even a more effective one or one that is at least as effective as other approaches (Walach & Jonas, 2002, p.240).

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[5] See also: Dantas & Fisher, 1998; *A systematic review of homeopathic pathogenetic trials ('provings') published in the United Kingdom from 1945 to 1995.*

It is now nearly 200 years ago since Hahnemann introduced his healing approach. The method has spread worldwide and, after its initial spectacular rise it declined in the early twentieth century in most Western countries but has been steadily on the rise again since the 1960s (Coulter, 1984). The reasons that were responsible for its success contained at the same time the seeds for its decline, which was caused by a number of factors and greatly promoted by a hostile orthodox medical profession. Kaufmann (1988) compares homeopathy with another medical heresy in America, Thomsonism, which was also seen as an alternative to the standard heroic medical treatments of that time and based on good self-care and botanical medicines.

> For several reasons, homeopathy was a far greater threat to orthodox medicine than was Thomsonism. First, most homeopathic physicians were once orthodox practitioners, unlike the poorly educated farmers and backwoodsmen who were philosophically attracted to botanical treatment. In addition, homeopathy was based on a scientific approach, an experimental pharmacology; in many ways it had a better claim to scientific accuracy than did the practice of bloodletting and the use of calomel. Moreover, with its belief in the body's vital force, it was especially attractive to America's Transcendentalists and clergymen, a group which included some of the country's most influential citizens. Finally, homeopathy provided the opportunity to treat oneself, which had been a major factor in the appeal of botanical medicine (Kaufman, 1988, p.101).

Another reason for the decline was a division of homeopathy into two fractions (Campbell, 1984), splitting the profession into those homeopaths who were skeptical of high potencies and who remained conceptually within the allopathic framework of diseases, and those who closely followed Hahnemann's vitalist doctrine, and in the case of the American transcendentalists, even "expanding beyond the limits of early Hahnemannian homeopathy" (Morrell, 2003, p.26). Some authors blame much of the difficult dynamics within the homeopathic profession and also its antagonistic relationship with allopathic medicine on the dogmatic character of Hahnemann, whose pugnacious tone in the Organon, which was often emulated by his followers, set the scene for conflict (Morrell, 2004). However, other powerful influences played an even more significant role during that time, as will be discussed in some of the coming chapters.

In recent decades homeopathy has experienced a resurgence and has produced prominent contemporary homeopathic figures like Sankaran, Scholten, Vithoulkas, Eizayaga, and Candegabe, who introduced some new angles to the method (Morrell, 2003).

> The most striking characteristic of modern homoeopathy is its extraordinary vitality. After passing through a lull from 1910 to the mid 1960s, it has once again become infused with energy and is today increasing its numbers and influence wherever it is practiced (Coulter, 1984, p.72).

Since Coulter's remark twenty years have passed and the practice of homeopathy has continued to expand.

CAM, medical ethics and this thesis

Although much has been written about CAM in the medical literature in the last few decades, it has not been a subject that many authors from the field of bioethics have taken up so far. There might be a number of reasons for this. One is that CAM is mostly practiced in the primary health care field and not the "high-price, high-tech, high-drama biomedical settings", as Kleinman (1995, p.51) expresses it, on which the bioethics discourse predominantly focuses.

CAM practices, as a rule, do not pose the same degree of potential risk for people as modern technological medicine does, neither in the individual context nor for society at large. This might be another reason that they have not attracted the same interest with regard to medical ethics. However it is noticeable that most of the bioethical contributions that have addressed CAM up to this point have been modeled on the standard agenda of bioethics, which according to McKenny (1997) is comprised of three mainstays.

> For every new issue that arises in biomedical research and care its task is to safe-guard individual autonomy, calculate potential risks and harms, and determine whether or not a just distribution will follow (McKenny, 1997, p.8).

Therefore most ethical investigations into CAM are predominantly concerned with aspects of effectiveness and safety (Komesaroff, 1998; Ernst et al., 2004), or have considered those issues that are regularly addressed in the bioethics discourse, for example informed consent (Boozang, 1998; Gruner, 2000) and the ethical behavior of practitioners towards patients (Drane, 1995; Stone, 2002) or justice in relation to fair accessibility. Although as McKenny (1997) writes "It would be foolish to deny the importance of this agenda" (McKenny, 1997, p.8) it does appear, as Callahan (2002) suggests, that this approach is not sufficient in relation to CAM because, despite overlaps, the issue of CAM raises a different set of questions than those encountered in relation to the practice and research of modern technological medicine.

The most basic question that has been asked in recent years: why this popularity? (Callahan, 2002) could also be seen as a particularly pertinent question for bioethics to have answered, as the rise in the use of CAM cannot be considered as unconnected to the agenda of bioethics. Historically, at about the same time as bioethics emerged as a discipline in the 1960s, public support for CAM was also gathering momentum (Berliner & Salmon, 1980). Many of the efforts of bioethics went into humanizing modern medicine. Despite the inner reforms that have taken place in biomedicine, however, the number of people who are choosing to have their health problems treated outside conventional medicine has continually increased. This leads one to think that the reasons for the public support of unorthodox healing approaches might be found on an even more fundamental level, which was not touched by the changes that have occurred within orthodox medicine in the last few decades. When following this trail of thinking, one comes to realize that it is the ontological premises and assumptions of scientific medicine that have been left intact throughout this time. CAM's fundamental difference lies in their underlying holistic perspective and this might be the key to understanding their appeal. If it was indeed correct, that what was missing in modern medicine was due to its metaphysical outlook, the phenomenon of CAM would not only hold a significant message with regards to medical ethics but to our understanding of ethics in general because modern Western medicine is a manifestation of Western life, its aspirations and its problems. As Pellegrino (1993) writes:

> …medical ethics holds more hope of a better grounding of principles, rules, virtues, and moral psychology than any other field of ethics. That hope rests on the universality of the phenomena of illness and healing and on the proximate and long-term aims of medicine (Pellegrino, 1993, p. 1162).

This thesis constitutes my attempt to further the discussion on CAM by addressing the fundamental conceptual differences between holistic, non-conventional therapies, in particular homeopathy, and scientific Western medicine.

Chapter Two outlines the methodology of this thesis. The chosen format is adhered to throughout the four major chapters. All chapters start with the qualitative research data from interviews with five homeopathic doctors from Austria. These are taken to demonstrate some of the issues that arise in relation to the practice and use of CAM. They also provide the launching pad for the theoretical analysis of those issues. In addition an attempt is made in this thesis to develop a theoretical approach that leaves intact a holistic understanding but

introduces a conceptual structure to make the multidimensional phenomena of illness more manageable for practice.

Chapter Three begins with an exploration of the reasons the five research participants gave for making the change from being mainstream, conventional physicians to becoming homeopathic doctors. Although the actual trigger was different in each individual case, the underlying motivation was similar. All were looking for a more humane but at the same time effective therapeutic approach. Positive personal experience with homeopathic treatment was given as the reason for choosing homeopathy by some of the participants. This highlighted the issue of anecdotal versus scientific evidence, and raises the question of whether doctors should be required to base their practice on scientifically derived knowledge, as some authors demand. The theoretical discussion takes up the subject of scientific evidence in relation to CAM, and also investigates whether scientific research trials should be regarded as best arbiters of medical knowledge. Some ethical problems that arise from the demand for scientific validation of CAM are identified in this chapter, for example the unjust distribution of research opportunities and funds.

Chapter Four addresses the subject of a pluralistic approach to healthcare. The interviews revealed that, although the research participants regarded themselves as classical homeopaths, in their practices they were employing a variety of therapeutic approaches, including conventional medical treatments. A research of the literature confirms this trend to pluralism in health care and shows that people increasingly access a variety of CAM as well as orthodox medicine for their health problems. The theoretical part in this chapter picks up on the challenging problem of epistemology and method in view of the great variety of CAM and their underlying holistic perspective. The suggestions of different authors on how to approach this issue are examined for their theoretical consistency as well as for their practical applicability. The approach favored sees human illness reflected in four basic conceptual ontologies, or axioms. These can be accessed through our four epistemic pathways, the analytical, the dialectical, the phenomenological and the hermeneutical. It is argued that research methods need to be tailored to the specific illness ontology and make use of the most suitable epistemic pathway.

Chapter Five focuses on the quality of the doctor/patient relationship in homeopathic practice compared with conventional medical practice. The interviewees concurred in their opinion that practicing from the theoretical basis of homeopathy made it easier for them to develop a positive relationship with their patients. In homeopathy great emphasis lies on the comprehension of the subjective experiences of patients, which requires the homeopathic physician to relate in a whole-person way. The practical issue of longer consultation time and the positive effect on the doctor/patient relationship was also raised by the participants and compared with the constraints in conventional medical practice. The theoretical investigation in this chapter explores the related medical ethical issues, for example, respect for patients, informed consent and the challenging issue of treating malignant and life-threatening illnesses with non-conventional therapeutic approaches.

Chapter Six focuses directly on the main concern of this thesis, the underlying conceptualization of illness in different medical approaches and their moral content and ethical implications. It begins with an exploration of the interviewee's conceptual foundations about life, health and illness. Although varying in detail, all were based on a holistic perspective. In all cases, they did not confine the ontology of individual illness to homeopathic theory but could also accommodate scientific explanations as well as emotional or spiritual causes. The concept of healing and the meaning of suffering were specifically addressed. The theoretical part of this chapter juxtaposes the Cartesian materialistic reductionism of the human body, the dualistic mind/body perspective and the holistic whole-person approach and compares their merits and their problems. The views of authors who promote a humane practice of biomedicine are compared with the holistic stance of the research participants, followed by two different ways in which a holistic perspective has been approached. The challenge of the holistic perspective lies in its great complexity, which makes accessibility difficult in practice. By utilizing the four illness axioms, which closely resemble Aristotle's "four parts of the human soul", the holistic perspective on human health and illness can be conceptually grounded without losing the whole-person in the process.

Chapter Seven provides a summary over the main points this thesis addresses. It concludes by drawing attention to the close conceptual bond between standard bioethics and biomedicine, which hinders bioethics in achieving an unbiased ethical appraisal of biomedical

interventions. It is argued that it would be necessary for bioethics to acquire a position where human values are included already at the level of ontology.

Chapter Two

Methodology

The Aim of the Research, Hypothesis and Research Question

The motivation for this research was the wish to explore the meaning and ethical significance of the increasing popularity of CAM. Literature on CAM suggests that people might be searching for a more humane health care as the growing trend for the use of CAM has been attributed, among other reasons, to the desire of people to be treated in a whole-person way that addresses all human dimensions; the physical, emotional, mental and spiritual. CAM approaches and scientific medicine differ in their underlying conceptualization of health and illness. In CAM the perspective is mostly holistic, whereas contemporary Western medicine is based on the scientific framework. The central research question that derived from this recognition is: Does the illness ontology, which underlies a healing approach, determine its ethical practice? Although this is not the only area that is explored in the thesis, it is however the primary concern.

Why empirical research over a theoretical analysis?

This thesis is based on the qualitative research data from interviews with five Austrian homeopathic doctors. The decision to use qualitative research material was made after some deliberation. When I embarked on this project I asked myself how best to design this research and initially thought that a theoretical route would be superior, because, I reasoned in line with my research question, that whatever happened in practice would be fundamentally dependent on the underlying theoretical understanding. As a result, I initially planned to perform a theoretical investigation in which I was going to compare the ontology of scientific medicine with the ontology of homeopathy, as the chosen representative of a holistic approach. An ethical analysis of the underlying theories, I believed, would lead me to the moral consequences that one could anticipate to flow on from each method. It seemed to me that such a theoretical investigation would be ideal, as it would draw directly on the conceptual foundations of the therapeutic system in question. The result of this study would then also help clarify what aspects of non-conventional healing practices might be appealing

to patients because of their concept-inherent manifestations in practice. Another reason that I originally wanted to base this thesis purely on theory was that within the discourse of bioethics a philosophical exploration of concepts appears to be the more favored approach compared to research based on qualitative findings

In the end, however, I altered this plan in preference of starting with a knowledgebase that was derived from practice. The reason for this turn-around was that it seemed inappropriate to look only at theory when medicine, whatever the kind, is in fact preeminently practice. From my own clinical work I had also gained the impression that in the relationship with illness, ontology does not remain a hard and fast theoretical entity. Modern medicine, despite all the efforts to remind its practitioners of its scientific base is very obviously neither uniform nor consistent, but rather exists in a constant flux of formation. Similarly, this applies to homeopathy, even though homeopathy has comparatively few and quite clearly defined principles. The confirmation for the validity of this view came from a number of authors, but especially from Annemarie Mol (2002). She studied biomedical clinicians with the explicit aim of investigating this subject and discovered how even different clinical environments brought about different medical ontologies. Her conclusion is that

> ..*ontology* is not a given in the order of things, but that, instead, *ontologies* are brought into being, sustained, or allowed to wither away in common, day-to-day, sociomaterial practices. Medical practices among them (Mol, 2002, p.6).

Therefore, by taking into account the shifting grounds of ontologies, I ended up with the conviction that qualitative research data would give valuable insights that could not be found through theoretical analysis alone. Although on the surface philosophically less tidy, the stories and reflections from practitioners “at the coal face” promised to provide a more genuine springboard for the kind of inquiry that is anticipated here. Therefore even an ethical analysis which aims to distinguish moral consequences that are connected to the underlying premises of a healing system might paradoxically be more reliably informed by first drawing from the insights of a few contemporary individual practitioners than from seemingly clear cut concepts. Theory, however, was still not to be neglected. A thorough and critical conceptual analysis was built on the pertinent issues that could be identified from the empirical research.

However, there is a second reason, which has motivated the approach for this study. It is a personal reason and therefore possibly quite powerful. I myself was once a doctor in Austria

and chose to train in homeopathy. I worked for many years as a general medical practitioner in a provincial town in New Zealand, using conventional medicine but also homeopathy until I became involved in bioethics a few years ago. I have personally lived the tension that comes with practicing from two different conceptual bases and from bridging two, mostly hostile camps. I am also very familiar with the advantages and disadvantages of each therapeutic modality and know about the dilemmas that arise from working in a health care context that legitimizes one but not the other approach. My involvement with bioethics has highlighted for me what I had found so valuable about homeopathy. Through having become more aware about ethics in general, I have now come to believe that my career movement towards homeopathy was in fact influenced by ethical intuitions, even though I was not conscious of this at the time. For me, doing research into this particular issue therefore gives me not only the opportunity to enter the world and thoughts of others and learn from them, but at the same time retrace my own path and the motivating forces that were decisive in my professional career.

The Participants

The research data came from interviews with five Austrian homeopathic doctors. The sample size was originally planned to be around eight. Because the interviews were going to provide rich, in-depth material, the findings from a sample size of eight promised to be sufficient on one hand and not too great to analyze on the other. The number of doctors who were actually interviewed was nine: the five homeopathic doctors already mentioned, one Chinese doctor, who was practicing acupuncture, one gynecologist, who regularly referred patients to homeopathic doctors, one Anthroposophist doctor and one general practitioner, who had studied homeopathy but did not practice it. In the early stages of the research project it was thought that participants, who were not strictly classical homeopaths, but who had a wider interest in CAM approaches would be suitable. However, the further the research project developed and became focused on homeopathy, it became clear that, in order to be coherent, the interviewees would need to be limited to homeopathic doctors only. For this reason, and also because the interviews with the five classical homeopaths turned out to be very extensive, the relatively small sample size was deemed to be a sufficient source for the study.

The reason for choosing homeopathic practitioners from Austria was that Austrian law, contrary to for example New Zealand or German law, permits only fully qualified and

registered medical doctors to practice homeopathy. Therefore all participants in this study had to first be trained in orthodox medicine and then work for three years as house surgeons before they could register with the Ärztekammer (Medical Council) as medical practitioners. Although homeopathy is not part of mainstream medicine in Austria, the Ärztekammer endorses a postgraduate diploma in homeopathy and training courses exist in different centers that are specifically geared towards medical practitioners. Compared to New Zealand there are many more homeopathic physicians, which made the recruitment relatively easy as, once I had been in Austria for a family visit, recruitment required little extra traveling.

The decision to approach people from this group for my interviews, rather than lay homeopaths in New Zealand, was a very conscious one. A few points that had led to this choice:

- In contrast to lay homeopaths, who had not studied medicine, these doctors were expected to have an understanding that would bridge the foundations of scientific medicine as well as homeopathy and other approaches.
- On top of the theoretical knowledge they would also have an insider appreciation of the reality of conventional medical practice. Having worked for a minimum of three years in hospitals, they would have been able to observe and been part of the often problematic and ethically challenging dynamics that have been described by some authors (Fox, 1999; Kushner & Thomasma, 2001).
- They would have first-hand appreciation of the role of the doctor in the conventional doctor/patient relationship as they themselves would have experienced it in their clinical years with all the possibilities and pitfalls that come with this position.
- They would have implemented orthodox medical treatments themselves and were able to follow and assess the effectiveness and the harms of these therapies.
- Last, and this is a particularly important point, they would have also come into contact with patients who suffered the most severe and life-threatening conditions and were able to personally witness where conventional medicine and medical technology were at their strongest, an opportunity that lay homeopaths mostly did not have through their work. From these experiences they would be aware of the whole spectrum of illness, acute and chronic, from minor to fatal.

With this background I thought that they would be ideally suited to speak from a place of knowledge and competence about the issues I was hoping to address. However, it is also precisely for the reason that they are doctors, that the findings about the doctor-patient relationship from this research cannot be taken to be representative of other, non-medical CAM practitioners. The participants had not only been acculturated into the medical profession but were still legally part of it, even though they had chosen to go into the field of homeopathy. They were also perceived by their patients as physicians, with all the mental and emotional associations that are attached to the role and position of the doctor. The information that one can get from these interviews, however, is how the homeopathic doctor-patient relationship compares with one that is conducted under the premises and working conditions of conventional medicine.

There was another significant reason for choosing these particular people as research participants, keeping in mind that the aim was to understand the ethical consequences that were related to the ontology of a different therapeutic modality. I thought medical practitioners who took such a drastic step in their career needed to be motivated by quite a compelling force, as the usual reasons for a major and deliberate move, an increase in professional or financial status, do not apply here. The possibility that it was ethical aspects that had the power to make them change from practicing in a conventional to a homeopathic way made this group of doctors particularly interesting.

The recruitment was done following suggestions from friends and acquaintances in Austria who had had personal experiences with these doctors. One of the participants I had met previously many years ago. At that time he used to lead a weekly homeopathic teaching session in which I took part. Three of the participants, Dr A, Dr C and Dr D were practicing in an Austrian city. The two others, Dr B and Dr E were working in a rural setting. Dr E was the only female interviewee. I contacted all five doctors by telephone and explained what kind of research I was doing, which university I was associated with, and my own background. All participants agreed to the interview without hesitation. The interview with Dr E was held at my house, as she happened to visit the city where I was staying. The other four interviews were all held in the practices of the interviewees. I guaranteed to preserve their anonymity even though there did not seem to be any concern about this. Instead of their names I used letters in the sequence in which the interviews had taken place.

The Interviews

All interviews were held in a semi-structured way using open-ended questions. They lasted between fifty-five and seventy-five minutes. There were only a few questions that concerned particular areas of interest, which I put to all of the interviewees, even though not necessarily in the same order in each interview or with the same wording. Most parts of the conversation I chose to conduct in a less directive way but instead responded to what the interviewees considered as important to focus on. The questions that I wanted all participants to address in the interviews were: What were the reasons that had initially motivated them to explore homeopathy? How were they practicing now? What theory on life, health and illness had they adopted? How did they see the difference in the doctor/patient relationship in the practice of homeopathy compared with conventional medicine?

The language used was German. German is my first language and also the language of the participants. Although very fluent in English, I still feel a greater level of comfort when conversing in German. From my perspective, this aspect therefore will have helped with creating a greater depth and avoiding misunderstandings due to the subtleties of language.

The interviews were recorded on audiotape and then translated and transcribed, but without indicating intonations or pauses. Naturally, the translation posed quite a few difficulties. Some German words don't have an equivalent in the English vocabulary. In these cases I tried to paraphrase them in ways that came as close as possible to the meaning. If this still did not seem to fully capture the sense of the German term, I have added the German word in brackets. Some phrases, if I had directly translated them into English would have come across as very strange indeed. In this case I tried my best to preserve the content but also the spirit in which it was said by using words that would make it sound appropriate to the English speaking reader. The hardest to translate were the parts where the participants used word plays. By this they were able to transmit a meaning in a very succinct way, but because they were relying on what could be called "poetic sound connections" the German was not transferable into English. I have put these word plays into brackets next to the closest paraphrase that I could find.

Although the translation is as good as can be, there is a certain amount of alienation that has accompanied the process for me, particularly when the German version seemed to hold

several layers that could not be reproduced in the same way in English. This is of course unavoidable but it still needs to be acknowledged.

In the final write-up of the interview findings I consciously chose to make much use of the first-person, rather than resorting to the less personal third-person, which is the more common style in academic literature. In the qualitative research process two or more individuals interact in a communicative inter-subjective dynamic, which I intended to acknowledge through this form of writing as it would have been inaccurate to convey an impression of myself as a detached, un-embodied researcher.

Researcher and Research Participants

The fact that I, the researcher, had been a homeopathic doctor myself would no doubt have had an effect on the interviewees. The fact, that I had come from so far away, from an English speaking country and was going to translate the interviews and write in English, could also have had an effect. My impression was that this was conducive to the openness of the interviewees and the flow of the interviews. I had a sense that the opportunity to speak and explain was appreciated by all of the participants, as was the potential for reaching a broader audience through the English language. Knowing that I was familiar with the subject matter might at times have led to the assumption that I would naturally understand what concepts and thoughts were underlying homeopathy. I tried to be conscious of that risk and whenever I became aware of a tendency to slip into insider talk I would put some clarifying questions into the conversation. Interestingly, and in line with my impression of the interactions with the participants, a qualitative research study of GPs conducted by a fellow GP was found to be "broader in scope" and provide "richer and more personal accounts of attitudes and behavior in clinical practice" when the researcher was identified as being a colleague than when this was not the case (Chew-Graham et al., 2002, p.285).

That the material would be used in a very distant place and not within their immediate social and professional environment might have also contributed to the willingness to speak freely, even though none of the participants gave me the impression of being fearful or guarded at any time. On the contrary, I earned a slightly mocking laughter when I presented one of the interviewees with the consent form, which had to be signed as a requirement for ethical

approval of my research. In this it is stated, among other explanatory and precautionary details, that the research participant can withdraw at any time without any disadvantage.

My present professional location in bioethics, which I also explained to the interviewees, did not appear to have any effect other than expressions of mild interest in the field. In Austria bioethics is not as well known a discipline as in Anglophonic countries and mental associations of potentially being judged as unethical seemed not to be an issue to the interviewees as it might be here in New Zealand. It also did not elicit any negative responses from the participants as one could have expected from some people in Germany and Austria who criticize the way euthanasia is dealt with in the bioethics discourse.

Analysis of interviews and interpretation of emerging themes

The interview material was analyzed and different parts were placed into four chosen categories. These categories were selected with the intent to traverse all the relevant areas in which ethical issues could be expected to present to a homeopathic physician. Within each of these categories another layer of themes was identified. These themes were then explored further and interpreted for their ethical content. The method used for interpretation of the research material is therefore best described as hermeneutical. Hermeneutics is textual interpretation, finding meaning in the text, in the case of this research, finding meaning in the interview transcripts (Byrne, 2001). The meaning that needed to be found in this study is what could be interpreted as ethically significant. Ethical content was derived either from explicit statements the interviewees made or had to be uncovered from something that was eluded to in an implicit way by the participants.

The initial areas of inquiry were:

1. First awareness and reasons for pursuit of homeopathy by the participants
2. Characteristics of the individual practicing styles and healing approaches
3. Qualities of the doctor/patient relationship in the homeopathic encounter
4. Conceptualizations of life, illness, healing and the meaning of suffering

The interviews were conducted in a style which mostly followed the flow of the interviewees' interests and imposed only a minimal external structure. Giving the participants room for unrestricted expression seemed to promise the greatest degree of authenticity and would therefore yield valuable material.

The data were interpreted into themes and each of them discussed. Then they were used to provide the starting point for an exploration of issues that have been raised in the debate about CAM, as, for example, that of scientific evidence or of the merit, or otherwise, of pluralistic healing practices. This was followed by a theoretical investigation, which went into two directions. One was to compare different conceptual frameworks and their consequences for practice. These were foremost analyses of the framework of scientific medicine and the framework of a holistic healing approach and their effects on practice, but included the underlying premise of a distinctly humane, science-based medicine and its limitation. The other theoretical investigation went into identifying and exploring the philosophical and epistemological difficulties a holistic perspective poses for practice because of its inaccessible complexity. A variety of theoretical approaches towards a more humane and holistic medicine were introduced and examined for both their conceptual consistency, and their merit for practice and for research. These included the humanistic approaches of Cassell (1991) and Kleinman (1988) and the notion of the "lived body" by Leder (1992). All appeared insufficient to take account of two requirements that were deemed fundamentally necessary: one, that it is a framework, which could take account of the multidimensionality of illness, and two, that it would also provide an accessible conceptual approach for the practice and research of holistic medicine. An alternative theoretical concept was offered as suggestion to solve this difficulty.

Limits

Apart from the limits that have been mentioned so far throughout this chapter, this thesis has one major drawback, which is related to the breadth of the subject matter. In order to gain the understanding that can only come from that perspective it was necessary to take a bird's-eye view. However, even though the terrain was explored from two different angles, one based on empirical research, the other through a theoretical investigation, many of the issues that were raised could not be examined in the depth that they deserve.

Chapter Three

The Ethics of Evidence

To move outside the circle of accepted medicine would be a big step for any physician. Although the Austrian Ärztekammer tolerates and to some extent legitimizes the practice of homeopathy through the provision of a diploma, becoming a homeopathic doctor still means becoming a "heretic" (Gillett, 1994; Dew, 2003) or "sectarian" (Flexner, 1912). The repercussions that follow this move are manifold. They span professional and personal life and affect security and status. To get an understanding of their motivation the first question to all participants "How did you come to homeopathy?" was followed by a deeper inquiry into their background. The intention was to explore what positions or leanings the interviewees were holding before they actively orientated themselves towards homeopathic medicine. How early on in their personal history had they come into contact with alternative healing approaches? Austria, like many other Continental European countries, has a long tradition of folk medicine and people often still use herbs for teas, gargles and poultices in the treatment of minor illnesses at home. Spas and other water treatments are also very popular. So it was very possible that the interviewees were already "primed" through their personal history and family habits to be open to non-conventional healing approaches. On the other hand, exploring what had motivated them in the first place to choose a medical career could also uncover particular leanings or sensitivities from which a mismatch with the practice of conventional medicine might have been predictable.

I was also interested to find out if there had been a specific incident, which had prompted the participants to take the step of seriously contemplating homeopathy. The sort of event it had been and its interpretation by the interviewee would provide insight into the interviewees' values and reactions. The underlying, but unspoken question for me during those interviews was: "Could it have been an ethical concern with the practice of biomedicine, which had been so significant that it could tip the balance towards a different kind of medicine altogether?" It showed that the initial impetus that had brought the participants to homeopathy was unique in each case but that there were also quite a number of parallels and common themes.

From all the issues that were raised in this part of the interviews one seemed particularly pertinent and will be the focus of this chapter. It is the issue of scientific evidence. Some of the interviewees made the decision to become homeopathic doctors after they personally experienced positive results from homeopathic treatments but without confirming this impression by reference to accepted scientific research findings. From an ethical perspective, the predominant question here is if doctors should only offer non-conventional treatments, which have been sufficiently validated through randomized controlled trials, as it is commonly demanded, or if it is acceptable for doctors to respond to anecdotal evidence. The different sections will explore the issue of scientific evidence from a number of angles, beginning with an analysis of how doctors are expected to grade the different sources of medical knowledge and what this means for the clinical encounter. The subsequent section investigate what findings hold sway as being proof of evidence in contemporary Western medicine. The relative nature of evidence will be uncovered in this part. The section that follows will deal with the impact of power holders on the creation of evidence, because the overall social and political influences are significant factors on medicine and on medical research. A further section then shows that the level of science-based treatments in conventional medicine is much lower than is usually upheld, which raises the question whether the strong demand for scientific evidence of non-conventional therapies is consistent with the reality of medicine in general. In another section the impossibility of attaining scientific certainty in medicine will be contemplated and the need to accept uncertainty in order to be open to other appropriate responses to illness will be highlighted. Finally there is the matter of who should be the ultimate arbiter in evaluating a treatment's success. Although there is a strong emphasis in bioethics on autonomy of patients and regard for subjective values, in the appraisal of therapeutic responses it is still the objective measurement that is given a much higher rating.

Becoming a heretic

Doctor E: Therapeutic success

Being asked how she had come to homeopathy, Dr E laughed and told me that it had been through the therapeutic success story of a friend:

> I have a friend who had leukemia as a very small child and who had been given up by the hospital in Graz and he was given one dose of a high potency from a homeopath in Salzburg and he is now totally healthy. I initially learned from that homeopath. I went

> to her during one summer for my medical internship and it was so fascinating that I started with the full training.

For Dr E, however, homeopathy was not a completely new concept. She was, as it turned out, the only interviewee, who had been already very familiar with non-biomedical therapeutic methods before she even entered medical school. Having grown up in a household where it was commonplace to treat minor illnesses at home, Dr E had been given a first hand appreciation of other treatment possibilities:

> My mother was a nurse and at home we were never given drugs but gargles and wraps (Wickeln), always household medicine and naturopathy (Naturheilkunde) and I have simply experienced that even with forty-one degrees fever and purulent tonsillitis you don't get diseased heart valves even when you are not taking an antibiotic. So for me my whole medical training was already a bit of a double-track event. I did study the one thing but I have also always known that it was possible to do it in a different way and have in fact done both in parallel.

For Dr E taking up homeopathy came as a natural consequence of her personal experience, transmitted through a family culture that valued non-conventional treatments. There were no doubts in her mind that those treatments were effective. In fact she considered the common medical perspective as not correct. With such a strong predisposition towards alternative healing methods it comes as no surprise that Dr E did not find it difficult to credit homeopathy with the survival of her friend and become eager to learn more about it. Most other people would probably have had problems accepting that one dose of a homeopathic remedy could have restored a terminally ill child back to health.

Doctor D: Do no harm

Contrary to Dr E, Dr D did not have any previous exposure or particular interest in alternative approaches. But he had already become curious during his medical training when he saw another medical student reading books on homeopathy:

> I always looked and wondered: "What kind of books is she reading there?" and then was somewhat amused about it because it all sounded pretty weird.

But it was only when his family members became ill that Dr D decided to turn to homeopathy. Dr D was already married as a medical student and was the father of young children. When his children suffered from infections he found himself reluctant to treat them with antibiotics. In this situation, where he was personally affected, he came to realize how important it was to

him to keep away from any treatment that could cause harm and he found himself motivated to look for therapies that had little, or better, no side effects:

> One naturally doesn't want to inflict anything bad on one's own children. And antibiotics have side effects. One wants to, if possible, avoid them for one's own child. So we took them to a pediatrician who uses alternative methods. He treated them with homeopathic remedies and it went surprisingly well. And then I thought, maybe one should look at that a bit more closely, what's going on there, maybe there is something in it.

After this positive experience with homeopathic treatment he decided to take part in a homeopathic training seminar for doctors. He described how he had another confirming experience, which not only affected his thinking about medicine, but also gave him a demonstration of a better quality in the doctor/patient relationship:

> I decided to take part in a seminar, a training seminar, in Vienna with Professor Dorzci. That was the next key experience for me. I was so impressed by the way Professor Dorzci, who has sadly died recently, described his views of medicine and particularly seeing how he dealt with his patients. That was really fascinating. He had a great ability to communicate. And then I decided that I wanted to continue with that. And that is how it all came about.

Still, Dr D might not have been prepared to make such a radical career change if his judgment about conventional medicine had been generally more positive. But his disappointment and disenchantment were tangible when he spoke about what he had noticed early on in medical practice and he contrasted this to the expectations he had held as a young medical student:

> In our medical training we were given the impression that so much is known in medicine and that everything is doable and also that medicine is something noble and there are no real problems, that diseases are quite clear-cut. That is the impression that one was given. But then you saw in clinical practice that it isn't really like that at all, completely to the contrary.
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> During my house surgeon time I worked on an oncology ward and I had to witness how most of the people were dying there in excruciating pain. And that the treatments had lots of side effects and ultimately many, many people were dying there anyway every day. I saw them dying on my shifts, under pain and agony. And there I saw that it isn't like that at all, that in fact there are a lot of limits in medicine and that a lot is not possible. And so I slowly understood (laugh) that particularly in the area of chronic diseases the orthodox system is of little effectiveness. And then I also comprehended that it isn't really healing that is happening there but that it is suppression, it is just to keep the symptoms under control.

An even further development in his thinking was brought about by an encounter with another teacher, Rajan Sankaran, a homeopath from India. Dr D described the new understanding he gained through him as a "quantum leap". He followed up this encounter up by taking part in training courses in India and expressed his gratitude for his personal progress and the therapeutic successes he had with his patients since he approached their problems with the new insights he had reached.

For Dr D several factors came together that set him on to the path to homeopathy. The initial driving force in Dr D's case was, that he did not want to do harm to his own family, which is of course a very natural notion. It is also a common human feature that one often only becomes conscious of the reality of a situation when it affects one's personal life (Frank, 1995). Although weighing up potential harm of treatments against their potential benefit is one of the basic tasks a physician has to do for and with their patients, possible harm becomes certainly more highlighted and less abstract when it concerns oneself or a loved one. It is still significant though that most medical professionals don't question the benefits of conventional medical treatments and treat their patients according to what is promoted within the biomedical literature. Even if they were unsure, most medical doctors would still consider only the treatment options for their patients, which had credibility within the scientific medical literature. Evidence-based medicine is a strong argument in favor of this stance (Cochrane, 1972). However, when the personal element is added, Dr D is not acting unusually to turn to a treatment outside the conventionally accepted field. Studies on general practitioners in Australia have shown that 67.8% would refer to alternative practitioners and that it is often personal experience that had led these doctors to consider non-conventional therapies (Hall & Giles-Corti, 2000). A major motivation for this choice is the avoidance of adverse effects (Astin et al., 1998), which is also cited as a very common reason for patients to seek out alternative therapies (Astin, 1998).

For a doctor the process of deciding between conventional medicine and a non-scientific approach in the analysis of harm versus benefit is marred with conflict. What should be trusted? A socially legitimized and scientifically validated medicine or one that is on the fringe and perhaps feeds into our wishful thinking of being effective but harmless? If non-conventional treatments were indeed less harmful but still as effective, the ethical mandate for doctors would have to be to choose them. But most conventional medical publications only

present the perspective of biomedicine and any harm/benefit assessments are only undertaken within that framework. So there is hardly an objective way outside of the dominant discourse in which doctors can make comparisons.

There is also the question of why a doctor would come to doubt the conventional medical guidelines for treatments and their associated benefits. In Dr D's case this does not strike one as a surprise given his already very critical attitude. For both Dr D and Dr E, the personal experience with effective non-conventional treatment was powerful and obviously more convincing than scientific evidence.

Doctor B: Negative effects of medicalization of life

For Dr B it was the disenchantment with conventional medicine that made him search for another approach. But he was not so much frustrated with the limits of conventional medicine as with the negative effects that an increasing medicalization of life's normal problems and challenges had on people:

> One thing I became more and more aware of was the abuse of psycho-pharmaceuticals in daily clinical practice. Lots of people just get psycho-pharmaceuticals prescribed when they have sleeping problems or fears or if they are disgruntled, when they need counsel, when they are at a loss, in situations when there is a death. All the natural matters of life are treated by medicine simply with psycho-pharmaceuticals, particularly with tranquilizers. And in my seven year long general medical practice, government health insurance funded practice, just like every other doctor here in Austria, I only saw the changes in people. That they became increasingly less reflective about their existence, the purpose of life, the values of life and all the natural things in bringing up children, in pregnancy, in the suffering of human beings. All that gets nowadays more or less sedated in medicine. I just didn't want to continue like that any more.

Ironically the suggestion to explore homeopathy came from a visiting representative of a pharmaceutical company. He suggested that Dr B should contact a homeopathic doctor he knew of. Dr B arranged to sit in with this practitioner for a day and was quickly convinced that this was going to be the right path for him. What he found particularly persuasive about homeopathy was the notion of restoring health rather than a focus on treating symptoms. He told me how the homeopathic physician had explained this to him:

> We don't treat migraine, we don't treat thyroid dysfunction, we make people healthier and through this their migraine will improve and their thyroid dysfunction will get better. But we do not "make" anything; we are not makers (Macher – in the sense of constructing, interfering, manipulating). We just get people to become healthier; we lead them towards better health.

This approach also addressed Dr B's major concern with modern medicine. His perception was that medicine was depriving people of experiencing life in a full way and was therefore taking away the opportunity to learn how to deal with its normal challenges. In contrast, he said:

> Homeopathy is a healing method, which works without limiting consciousness, without limiting the ability to suffer, the things we have to suffer. Of course we have to help, but in a way that the patient can cope with the difficulties life brings.

After this, he did not look back:

> I found I really liked homeopathy. So I studied it and gave up my practice after seven and half years. And I started off very small with only a few patients per day, from previously eighty to one hundred per day down to less than twelve, now they are about twenty. I started on a path, which was very intense. But I was convinced that it was the right way and that's how I do medicine now.

Dr B's discomfort resonates with the powerful and unsettling critique Ivan Illich (1975) had leveled at modern medicine. Like Dr B, Illich also points to the dependency and learned helplessness amongst a number of other negative effects he attributes to medicine. Rather than equipping people to cope with the difficulties human life brings, Illich argues that modern medicine disenfranchises them from their own resources. This is a strong challenge to the aims of conventional medicine and an assault on the generally held belief in the overall beneficence of medicine. Dr B's judgment sounds similar. He had come to the conclusion that by giving his patients conventional medical treatments he was in effect doing more harm to them than good. Following from this it seems only a natural consequence for a conscientious doctor that he would find it extremely difficult to continue to practice in that way.

In later parts of the interview Dr B expressed also awareness that it wasn't just medicine but a number of societal forces, which in his opinion produced unhealthy and detrimental dynamics. Similarly to the observations, which had already been voiced by Rene Dubos (1959) in his influential book "Mirage of Health" he noted the negative affects on people, which paradoxically arise from material affluence and security. Dubos' view, which can also be found in the statements of Dr B, is that it is not the freedom from wants or any suffering that makes for a happy and fulfilled life. In fact, a good number of challenges are considered to be necessary. This of course stands in direct contradiction to the collective aspirations of Western civilized countries. Nevertheless, Dubos noted that this stance has been supported by research.

For example, statistics on suicide and homicide rates show that "the lowest rates occurred in countries where nature, economic circumstances, and inadequate social legislation seem to make life harder and more uncertain" (Dubos, 1959, p.175). Dr B's attitude appeared to be that suffering was a normal and in some ways a "healthy" part of human life. A similar position could be found in statements of the other participants as well. Its implications for ethical practice will be discussed more thoroughly in Chapters Five and Six.

Another notion, which is part of Dr B's conception, also shared by all other participants, was the respect and even an admiration for the organism as a whole. Rather than picking out a presenting symptom and attempting to eliminate that, the therapeutic focus was on "making people healthier". The way in which Dr B spoke about this issue and pointed out that homeopaths weren't interferers (Macher), quite clearly showed his disapproval with the manner of conventional doctors, who he saw as unsophisticatedly controlling and manipulating the body rather than being responsive to its integrity. This concept, in which it is believed that the physical, emotional, mental and spiritual aspects are interrelated and inseparable in the human organism is best described as "holism" (Smuts, 1927). A holistic view in that sense represents the greatest distinguishing feature between the premises of scientific medicine and those of homeopathy and many other CAM practices (Lyng, 1990).

Doctor C: Search for a better doctor/patient relationship

Dr C explained how his interest in homeopathy was paradoxically first stimulated by a critic of homeopathy. He told me how he, still a medical student, was attending a lecture in Internal medicine. The lecturer, Professor F, used as his example a patient, who was terminally ill with heart failure. Dr C, still indignant even now, described how Professor F treated the patient:

> ..of course in the usual style as it is done in the hospital, which means that the patients is wheeled in and lab results and x-ray pictures are dispersed above his head. And there was no conversation with him at all. There he was lying, gasping for air, blue like a plum. There was no dialogue and as an introduction to all this, to the medical students, came the sentence: "See, this is the work of a homeopath!"
>
> And then I thought to myself "strange, if the big F."– and at that time I had already had clinical semesters and practical training at the medical ward and I had seen there that people die without Homeopathy. So "if the big F. thinks that he needs to find a guilty party for this medical situation" – there is illness and there is decompensated illness and there is dying – so "if he has to bring the devil, so to speak, into this then I find this very interesting; because then he must have a lot of power to have an effect in a good and a bad way".

After this situation he became interested in Homeopathy. He joined the practice of Professor Dorczi, who was teaching homeopathy to doctors at that time.

> I was allowed to be there during his work, and have seen what an encounter between doctor and patient can also be like. Very different! And that has completely convinced me and that was for me already then, two years before qualifying as a doctor, so motivational that I knew that that would be the future for me.

Dr C's statement that homeopathy "must have a lot of power to have an effect in a good and in a bad way" seems somewhat surprising as it appears not necessarily a logical conclusion. A therapy does not need to be powerful to do harm; the harm could, for example, be done through the omission of effective treatment. However, one could understand his position from two angles. Seen within the context of the situation that Dr C witnessed at that time, it would be legitimate to think that he might have been looking for any interpretation that provided a strong contrast to the inhumane style he was exposed to. A young medical student, dismayed by how he experienced the authority figure, he may have rebelled against "the big F", who was acting in a most unethical way, not only in the treatment of the patient but also in the mis-portrayal of medical facts. It would be understandable that in that frame of mind, the remarks by the lecturer that were meant to deter from homeopathy, could have had the opposite effect on Dr C and might even have promoted an idealizing reaction.

Another interpretation of Dr C's belief that something, which has a lot of power must have it in good and bad way, would be to think that he might have been influenced by ideas from the Eastern philosophy of Taoism. The notion of polarities and their interdependency is expressed in the Tao Te Ching (Wing, 1986). "When all the world knows beauty as beauty, there is ugliness. When they know good as good, there there is evil" (2. passage). It is, of course not known if Dr C had in fact been partial to this approach, but a number of his later statements could make this quite a probability.

All the other interviewees concurred with Dr C about a better doctor/patient relationship in homeopathic practice when compared to the conventional medical setting. This issue will be explored further in Chapter Five.

Doctor A: Discontent with reductionism

For Dr A the main reason to look at alternative healing approaches was his dissatisfaction with the reductive approach of conventional medicine. He found the predominant mode of conventional medicine to think and operate in objectively measurable parameters too limited for him. At the time when he was wondering what he should study, he was wavering between medicine and psychology. He was attracted to both these fields because of what he called "his deep interest in the human being with all its facets". He chose medicine, and explained his reason:

> I made the decision for medicine, because the physical aspects were also rather important to me but I saw during my training that it was too one-sided for me, to express it mildly, and that I did not learn much else about the human being other than physical and chemical connections. Otherwise there appeared to be nothing. And then I got to know homeopathy, already very early during my training, and there I saw – that was the first time where I had that feeling: here the human being is looked at, also in his other dimensions. And that was when I have felt at home and I continued to go on double-tracked, which wasn't always easy.

Dr A's impression that scientific medicine is too one-dimensional is a commonly voiced critique even from within conventional medicine (Engel, 1977) and there are sincere attempts to remedy this state of affairs (Stewart et al., 1995). It does not fit into the ethos of an ethical medical practice to conceive the patient purely as a biological entity, and a "patient-centered" approach is now promoted as an example within conventional medicine to acknowledge other aspects that are crucial in the patient's life. For Dr A, homeopathy was the therapeutic system that provided these elements naturally.

Summary of themes

The review of the motives, which had brought the participants to base their medical practice on homeopathy, showed that all were relevant with regards to medical ethics. Four main themes were identified from the information the participants had given about their reasons for switching from conventional to homeopathic practice. These were:

1. Discovering the benefits of homeopathy.
    a. Through experiencing the effectiveness of a specific homeopathic treatment:
        i. on self
        ii. on family members

iii. on a friend with life threatening illness, where conventional treatment had failed

b. As a more desirable treatment approach:
    i. Homeopathy aims at supporting the healing process rather than at controlling symptoms
    ii. Homeopathy heals without limiting consciousness

2. Dissatisfaction with aspects of conventional medicine:
    a. Concerns about conventional treatments
        i. Too many side-effects
        ii. Lack of effectiveness in chronic illness
    b. Concerns about general harm to people through medicalization of normal reactions to life events
    c. Concerns about misrepresentation of the effectiveness of conventional medical treatments
3. Finding greater affinity with the conceptual framework of homeopathy than with that of scientific medicine.
    a. Homeopathy considers all dimensions of human life.
    b. Homeopathy offers a superior perception of medicine compared to that given by scientific medicine
4. Improved doctor/patient relationship through practicing within the homeopathic framework.

The last two themes were explored further through specific interview questions. The resulting data and their ethical analysis can be found in Chapters Five and Six. The first two themes provide the focus for the discussion in this chapter, which will look at question if scientific evidence is needed for an ethical practice of medicine.

The "right" and the "wrong" medical knowledge

The scenarios, as described by the participants, on how they had come to appreciate the effectiveness of homeopathy are not unusual. It is natural for both patient and practitioner to believe that a therapeutic intervention had been effective when it is followed by obvious improvements of health. Prima facie one would not see a problem with making that causal relationship, especially in cases where the illness was experienced as progressing or static and

the change came chronologically clearly after the implementation of a particular treatment. It certainly would be accepted as being a completely reasonable conclusion if the positive response had come after a conventional medical intervention. But how should that claim be taken after the use of non-conventional therapies? For a medical doctor this question can be quite difficult. Doctors are not encouraged to take therapeutic success stories at face value when they come from outside the approved medical arsenal. Scientific skepticism demands that they distrust anecdotes. Even if a health improvement was experienced personally or closely observed in a patient, and although this can be very convincing, doctors are required to stay suspicious until this experience can be backed up by scientific research findings. This applies particularly when the therapy that was given is built on different principles to those credible within the scientific discourse, which most of the alternative healing approaches are. Only through scientific evidence, it is stated, can one be sure that it was the treatment that was effective. Therefore, if a patient reports a positive outcome after a therapeutic intervention, which is not part of the established medical repertoire, the patient could find that his claim is dismissed by medical doctors, either through open disbelief or, more often, through being explained away as the result of pure coincidence or of a placebo effect. In cases of successful treatment in terminal illness, particularly when there can be no question that improvement had taken place, the original diagnosis might be put in doubt (Baldwin, 2003).

Although it does appear somewhat problematic if a doctor denies that a patient's account of a successful treatment is significant, in effect this is what the medical profession requires from its members (Cole & St George, 1993). For a doctor of scientific medicine it is not right to trust anecdotes.

> The major difference between scientific medicine and alternative treatments lies in the importance doctors place on establishing the burden of proof. As a profession, we do not value experiment until reliability of outcome is proven, and tend to dismiss evidence based on anecdote unless it is supported by proven fact (Wiles, 1999, p. 2).

There are a great number of authors, who vigorously take this position, in some instances pushing the argument to the point where the status of being a medicine is put into question for any scientifically un-validated treatment modality.

> Medicine, as we generally understand it, has to do with restoring health and alleviating suffering by preventing and treating disease. Therefore, any activity – if it calls itself medicine - whether it uses the term alternative, complementary, or integrated medicine, should be expected to adhere to these goals and to standards of evidence for efficacy.

> Today, we expect claims of therapeutic efficacy to be based not on unsubstantiated theories, but on a scientific method that includes randomized assignment of intervention and control subjects, informed consent, clear definitions of interventions and outcome measures, unbiased double-blind data collection, appropriate use of statistical analysis, and confirmation of observation by independent researchers (Schneidermann, 2003, p.191).

Or even stronger:

> There is no alternative medicine. There is only scientifically proven, evidence-based medicine supported by solid data or unproven medicine, for which evidence is lacking (Fontanarosa & Lundberg, 1998, p.1618).

Similarly Angell and Kassirer (1998)

> There cannot be two kinds of medicine – conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work (Angell & Kassirer, 1998, p.841).

As a consequence therapeutic practices that are not based on scientific principles and research evidence have been called unethical and fraudulent. Fraudulent, because practitioners, who are promoting and charging for treatments that had no scientifically proven benefit would be misleading patients. Unethical, because without such scientifically proven effectiveness patients who consult alternative medical practitioners would be denied true autonomy for which the process of an informed choice is necessary (Gruner, 2000). Even worse, alternative health practitioners would in effect be taking advantage of the suggestibility of desperate people, who would cling to any straw of hope in the light of serious illness (Wiles, 1999). This concern has led another author to ask the questions:

> Does the community have an obligation to protect vulnerable citizens from exploitation by practitioners holding uncertain qualifications, who apply practices with dubious benefits and unknown risks?
>
> Should special measures be introduced to protect children, especially from practices that may lead to their being denied conventional therapies of proven efficacy (Komesaroff, 1998, p. 181)?

The same author however closes his series of questions by wondering: “Why have risk and lack of evidence not deterred potential patients and practitioners?”

And indeed this is a crucial question, which deserves further exploration, not only for any judgment about what is an ethical medical practice in relation to non-conventional and

unproven approaches but also in order to grasp the broader meaning of this issue. In it may lie a fundamental critique of the way that mainstream scientific medicine is conceptualized and conducted.

Many practicing physicians, particularly in the area of primary health care, are now offering some form of complementary medicine to their patients. Surveys in England, for example, found that it was half of their general practices (Dobson, 2003). Most practitioners have come to the decision to use non-conventional treatments through some personal experience.

> The motive of established and alternative practitioners to learn and carry out alternative treatments is often their own frustration over the ineffectiveness of established treatments. These frustrations are often experienced in connection with the practitioners' own health problems or those of family members (Launsø, 2000, p.103).

At some stage these general practitioners, similar to the interviewees, must have all been presented with the very same dilemma: should they adhere to conventional treatments or should their personal experience of effective and less invasive therapeutic interventions override the mandate for scientific validation? In the case of the research participants the verdict went against this directive and instead they chose to include homeopathic treatments for patient care. But were they right to trust anecdotal evidence or were they in fact acting unethically by transgressing the boundaries of what was accepted medical truth?

The non-evident aspects of evidence

To come closer towards an informed position with regard to this question it is crucial to first appreciate what is counted as the legitimate evidence, which is requested from alternative medical practices. Authors, who criticize alternative medicine for not showing scientific evidence, mostly refer to the lack of data from randomized, controlled, double blind, empirical trials (RCTs). RCTs have been given the status of gold standard in medical research and are designed to provide an objective evaluation on the effectiveness of a therapeutic intervention in comparison to what can be gained through stimulating the placebo effect. This is a shift from previous times, where non-scientific methods were predominantly disapproved of on the basis of their belief systems, because they contradicted what was considered to be true in conventional medicine. Although there is still a strong claim that alternative medicines are built on irrational and implausible theories, the emphasis is now on empirical proof.

Medicine itself has only recently come under the strong influence of empiricism, enforced by the need to evaluate the effectiveness of interventions for their economic sense. "Evidence based medicine" (EBM) as an explicit endeavor has only been established in 1992 (Evidence-based Medicine Working Group, 1992). It was meant to provide a rating method for the assessment of "quality of evidence" (Hadorn et al., 1996), and to bring relevant scientific results to clinicians so that medical practice can make use of these findings (Sackett et al., 2000). The effects of treatments are captured in a quantitative way and are therefore made easily comparable. Contrary to previous understanding, nowadays when someone says that there is "scientific evidence" for a medical treatment, this statement means *that* the treatment has been shown to work, rather than *why* it has worked.

This kind of evidence could of course be very advantageous for establishing credibility of alternative medicines, as underlying theories are apparently of less importance than the proof of a therapeutic effect. And indeed, some authors encourage the community of alternative practitioners to put all their efforts into quality empirical research and to observe the methodological standards that are set by EBM, claiming that EBM places alternative medicine on an equal footing with conventional medicine (Ernst, 2002; Vickers, 2001).

But although EBM gives the appearance of being an unbiased path towards medical truth, this should not be taken at face value, as can be shown. Even though empirical trials will arbitrate if a treatment is effective or not, one has to also consider which focus a research effort favors. As any research focus that is under the umbrella of scientific medicine will be informed by the particular stance that is typical of the biomedical discourse, certain aspects of an illness situation will be highlighted, others ignored as seemingly immaterial.

> For instance, if we place a subject in a scientific medical discourse, the level of sodium would be more important than the subject's felt isolation from her family and cultural context, but to a less conditioned perspective, either could help explain the person's current distress and confusion. This difference reflects the fact that medical scientific discourse validates discussions of serum sodium levels but not the less measurable aspects of cultural and familial estrangement, or concepts of balance and attunement in the body, which we doctors find deeply mysterious (Gillett, 2004 b, p.729).

Therefore, whichever aspect of a pathological condition has become "signified" will be the determinant of the route of inquiry that will be pursued further. This becomes clear when one looks at the essence of the orthodox medical discourse. It is structured around human biology,

which is perceived as matter that interacts on a physico-chemical level. Accordingly, evidence will be located here. The question what counts as evidence becomes particularly pertinent when one then looks outside the Western cultural bounds, for example towards Chinese and Indian traditional medicines. In these traditions medicine occupied a very different place in society than contemporary Western medicine does today. Also the understanding of health and illness were based on premises that were very unlike to those of biomedicine. What counted as therapeutic evidence there would have taken a vastly different form to any biomedical evidence, as it had to be congruent with the prevailing belief systems.

> Both civilizations understood bodily health and sickness within a formulation about the way the whole cosmos and society functioned. A natural philosophy encompassed the workings of the macrocosm, or society, and the microcosm, or body. This philosophy was complemented by and blended with a philosophical and theological perspective about personal behavior, social responsibility, and morality (Fabrega Jr., 2002, p.396).

Fabrega comes to the conclusion that because of the great differences in ontologies and epistemologies between these traditional systems, including also Western traditions from past generations, their biomedical validity would be "virtually impossible to determine".

This point is also strongly made by Bauer (2000), a medical historian and Pieringer (2000), who both build on the Heidelberg tradition of medical anthropology, which gives an overview of the different illness theories. These authors use the argument that medicine is not made up of one single theory but has historically passed through four implicit but distinct axioms, which are all still relevant. With the term "axiom" they are describing a characteristic thinking style that is based on premises, which can themselves not be verified empirically any further. Each axiom has its own inherent epistemology and approach of validation. Because each style selects such different sets of fundamentals for the formulation of its theory and also for its verification process, findings within one axiom can hardly be validated with the methods of another.[6] The meaning of the term axiom resembles closely what Kuhn (1962) described as "paradigms", which again expresses the notion of incommensurable thinking styles. In the chapter "Trying New and Unusual Things" in their book "Medical Ethics" Campbell, Gillett and Jones (2001, p. 233) also tried to capture the idea that one system of thought "may be incapable of detecting patterns evident to other ways of thinking" by devising the word "cross-grained" for that purpose.

The dominant axiom for present day medicine is the one that conceptualizes the processes of human nature as causally linked, mechanistic and deterministic. However, the other three axioms that have also been documented, although not in the foreground of medicine at present, are still existing and relevant for contemporary life. In this respect medicine reacts differently to what Kuhn had described with regards to other sciences, where a new paradigm supersedes the old. Although the four axioms are incommensurable, none can be a substitute for any of the others. Patients who gravitate to one of the various alternative healing systems, or to psychotherapy for that matter, are in effect seeking a therapeutic response that operates on a distinctive level. The recent popularity of alternative medicine could therefore be seen as a sign that people are looking for these different axioms to be included to enjoy a more rounded kind of health care than what is possible within the frame of scientific medicine. Engel's (1977) criticism of medicine in his seminal article "The Need for a New Medical Model: A Challenge to Biomedicine" is also directed against the exclusive biological conception of illness. He coined the term "bio-psycho-social", which does remind us of the dimensions that are neglected in scientific medicine.

Concluding from this, what counts as evidence in medicine depends very much on the illness conception, which determines what elements from any complex set of details is given significance. To insist that all evidence has to match one particular perception becomes a proposition of dubious value.

Still, the question remains how a particular signification had become dominant within a culture or a discourse in the first place. Here both Foucault (1973) and Kuhn (1962) point to the profound influence of power which silences the aspects of knowledge that do not fit into its particular sphere of interest and fosters the discourse that supports it. Kay (1993) has reached a similar conclusion. In her book "The Molecular Vision of Life: Caltech, The Rockefeller Foundation and the Rise of the New Biology" she re-traces the spectacular expansion of molecular biology and found that the success of this distinctive direction towards viewing life was due to a "synergy between intellectual capital and economic resources" and "a potent convergence of scientific goals and social agendas". In "Rockefeller Medicine Men" Brown (1979) makes a similar analysis. As summarized by Gillett:

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[6] These four axioms, their meaning and their significance will be explored further in Chapters Four and Six.

> The underlying thought is that validated knowledge in an area of human inquiry is a joint product of intellectual exploration and the power structures that legitimate certain conceptualizations and modes of investigation. For instance, power is exercised in medical scholarship by authoritative bodies enforcing positivist conception of argument and investigation which go under the name of evidence-based medicine (Gillett, 2004 b, p. 730).

It can be concluded that the influence of powerful interests, which is supporting the dominant medical discourse will also be profoundly supportive of its preferences in focus and methodology to establish evidence. As a flip side, not unlike other examples in the medical field where power differentials have led to the sidelining of unwanted perspectives, alternative medical discourses that represent a different view on health and illness are in danger of being suppressed.

The influences of power on evidence

Traditionally one of bioethics' most important themes has been the detrimental effect of power in the medical context. Through this focus reflection was stimulated and changes achieved. Ethics committees now act as a standard safeguard to protect research subjects from exploitation by researchers, as had often been the case in the past. Also the power gradient between doctor and patient in the clinical encounter and its potential for harm came under ethical and legal scrutiny and doctors are bound by law now to respect patients' values and choices. Similarly the powerlessness that comes from lack of adequate economic resources whilst being in need of certain health care measures has been taken on as an issue of justice within the bioethics discourse. These and other examples could be named where a difference in power has been recognized as an issue, which can lead to moral problems in the field of medicine.

Therefore, it is ethically significant to consider whether power is wielded in the demand for scientific evidence of alternative medicines, especially as the influence of power on what is regarded credible within the biomedical discourse could be shown already.

A demand that a particular requirement is met, can only be rightfully made if the conditions exist that make it possible for the demand to be fulfilled. "Ought implies can" (Kant). It is of no use to request something if it is clear from the outset that the party to which that request is directed is not in the position to respond. If it is obvious that this is indeed the case and a party

will not be able to satisfy the demand, insisting on it becomes in itself problematic even if the demand as such appears justified. It is even more questionable if the requirement is considered essential, but no note is taken of the conditions that are prohibitive and no effective action is taken to change them. In this case the party, who cannot live up to the standard that is required will be presented to be at fault, rather than the circumstances that have made it impossible to comply in the first place.

Demanding scientific evidence on alternative medicine could be seen as an example of such a scenario. Despite a wide spread consensus that research should be done to evaluate the effectiveness of the different healing modalities (Margolin et al., 1998; Ezzo et al., 1998; Nahin & Strauss, 2001; Cornbleet & Ross, 2001), there are a number of obstacles that seriously hinder the achievement of that aim and need addressing. Ezkinazi (1998) has summarized some of the factors that stand in the way of research into non-conventional healing approaches or otherwise influence the legitimization of those practices. The excluding and discriminatory attitude of academia towards alternative medicine he sees as a major reason as to why no research was conducted in academic institutions in the past.

> For decades Western academia has excluded alternative medicine research and practice; this has contributed much to the paucity of data in this area. Established academic researchers have been discredited and have had difficulties when attempting to conduct alternative medicine research. At times, explicit threats were made by mainstream medicine to individuals and institutions that would associate with alternative medicine practitioners. Consequently, most alternative medicine research has been conducted outside of academia by individuals with limited research training and resources, and their investigations are often methodologically inadequate (Ezkinazi, 1998, p.1622).

Similar observations come from another author, who notes how ideological constraints have the power to inhibit scientists and prevent them from freely addressing phenomena that would require further exploration.

> Unconventional interests – let alone actual research – have such a strong anti-tenure effect that most of us know at least several research scientists who have strong interests in CAM but *never* mention those interests within their medical school (Hufford, 2003, p.205).

According to Hufford, current theories within science exercise a disproportionate influence, which limits the ability of scientists to respond to observations that do not fit into the expected pattern.

> It was one thing for Western scientists to be reluctant to accept theories of traditional Chinese medicine rooted in *Qi* and *yin* and *yang,* concepts foreign to modern Western science. It was another for this reluctance to result in almost a century of unwillingness to look seriously at the observational claims of millions of physicians, acupuncturists, and patients in Asia and many other parts of the world (Hufford, 2003, p.206).

He has some sympathy for scientists who, in view of restricted resources, tend to go down the road, which was "reasonable for current theory", but Hufford takes the "intransigence in the face of widespread anomalous observations, often from reputable sources" again as a sign of the disproportionate influence of current theory. "In this case it prevents even the possibility of science-based rejection, producing instead mere dogmatism" (Hufford, 2003, p.206).

It is not surprising that mainstream scientists give the appearance of being prejudiced. In the US, for example, not even the fact that alternative medical practices were clearly becoming more popular (Eisenberg et al., 1998) held enough sway to bring about research from within medical academia. In the end it took public intervention through a Congressional mandate to create an Office of Unconventional Medical Practices (now the National Center of Complementary and Alternative Medicine) as part of the NIH to begin the process of rectifying this situation. "Many voters thought that the unconventional treatments they believed to be warranted by their experience were not getting a fair hearing in the scientific arena" (Hufford, 2003, p.206). Nonetheless, although only 0.02% of the NIH's annual budget was earmarked for research into alternative medicine, there was still reluctance. "The congressional mandate was met with a less than enthusiastic response from the NIH, but simultaneously with high public expectations" (Ezkinazi, 1998, p.1622).

In the United Kingdom, the House of Lords Select Committee on Science and Technology recommended the implementation of similar government funded research centers of excellence in their report in 2000. The greater openness towards complementary and alternative medicines that had developed by that time was acknowledged but also the practical difficulties that researchers were facing.

> From the evidence we have received it is clear that there has been a change of attitude of a few higher education institutions towards CAM as a legitimate subject for both quantitative and qualitative research. However, the small base and fragmentation from which this research will have to be conducted would seem to be a major barrier to progress (House of Lords – Science and Technology – Sixth Report, 7.57).

In a number of Western countries there are now some efforts made, either by government or by charitable trusts, to fund research into alternative medicines. However, compared with the amount of research that is conducted by pharmaceutical corporations, these enterprises are truly miniscule and will also only be able to support small research trials. This situation is not likely to change, as there is little incentive for the profit driven pharmaceutical companies to take on research into alternative medicines:

> For example, research into homeopathy or medicinal plants usually does not lead to economic advantages for sponsors, because these products are not proprietary. (Eskinazi, 1998, p.1622)

Another author gathered some evidence to demonstrate the detrimental consequences of commercial bias in general. Large-scale drug trials are predominantly, if not exclusively, sponsored by pharmaceutical corporations who are therefore also in the position to determine what basic research will be considered as being worthy for such follow up. The determining factors hinge very much on what treatment is projected to be financially worthwhile. Because of this situation, even inexpensive conventional drugs, despite having shown promising effects in small trials or through clinical experience, can find themselves in a similarly disadvantaged position as alternative treatments. One example cited describes how the drug Clonidine was found clinically to be very effective in heart failure. However, no interest could be stimulated to fund large controlled studies, as it was not regarded to be a commercially attractive proposition. In another instance a pharmaceutical company launched a drug for the treatment of sepsis. Each dose cost $ 7000. At the same time no research funding could be found to further explore the very promising effects that low dose steroids had shown in some studies. So, even if government funded basic research does show the effectiveness of a treatment, because the trials are small, they will never be given the same scientific credibility as if they would have been followed by a large-scale trial (Morreim, 2003). This will of course remain a significant problem for most if not all alternative medicines, as it is unlikely that any of the alternative modalities will ever be able to promise enough commercial benefit to attract industry funding.

The combination of these economic and attitudinal factors have so far prevented a thorough scientific evaluation of non-conventional therapies and even though some research is being undertaken the obstacles are still too substantial to come even close to an ideal research situation. The demand for scientific data is, although theoretically valid, practically unrealistic

at this point in time. For the individual medical practitioner however, who has come into contact with an alternative treatment and experienced a positive effect, as was the case for some of the participants, the requirement to abstain from it unless it has been backed up by scientific evidence can be ethically very trying. This applies particularly to the situation where the practitioner is faced with a long-suffering patient, who has resisted previous conventional treatment attempts and who might be helped by this approach. In view of the existing disproportion of research data and the obvious resistance of power holders to allow a level playing field for adequate research into alternative therapies to develop, the claim that medical doctors who initiate non-conventional treatments are acting unethically cannot be supported solely on the grounds that their treatments are lacking scientific evidence.

Looking at consistency

Apart from the question, if there is a realistic chance that comprehensive research will be conducted into alternative medicine, another question also needs answering. Because the fiercest demands for scientific evidence of alternative therapies come from the orthodox medical profession, examining if biomedical practice has been able to meet its own set of standards will establish if they are indeed achievable. If that were not the case, it would hardly be reasonable to expect this from practitioners who use non-conventional methods. As it appears, there are many indications that conventional medical practice is by far not as scientific as it alleges to be.

E. Haavi Morreim (2003) has questioned whether the scientific standard to which CAM is expected to conform has been achieved by conventional clinical medicine. Her conclusion is that it has not. “The actual clinical practice of medicine cannot realistically, faithfully claim to be the scientific enterprise that is presupposed when CAM modalities are criticized as being ‘unscientific’”(Morreim, 2003, p.226).

The reasons for this failure are multi factorial and it is not possible to cover them comprehensively within the frame of this thesis. However, the issue does have relevance for this study and therefore warrants at least some further attention. The factors that prevent conventional medical practice from being as scientifically informed as ideally envisaged can be placed roughly under two main rubrics. The first rubric could perhaps be called “failure due to insufficiently following own standards”. These contain quite a substantial number of

blunders that are in the way of scientifically evidenced medical practice, but could theoretically be remedied. The great majority of causes that were identified, however, were related to what might be classified under a second heading: “Lack due to the inescapable uncertainties inherent in the field of medicine”. This category is the particularly relevant with regards to this research. Examples, which fall under this rubric, mostly taken from general practice, give evidence for the complexities of human illness and stand in contrast to the tools of scientific research practices, which focus on comparably simplistic causal chains (Naylor, 1995; Knottnerus & Dinant, 1997; Culpepper & Gilbert, 1999; Rosser, 1999; van Weel & Knottnerus, 1999).

There can be grave repercussions for the patient when invasive biomedical interventions have not been empirically evaluated, as the greater the risks the more is at stake. For this reason it is crucial that treatments that intrinsically do harm, as all invasive biomedical treatments do, are backed up by scientific verification of effectiveness. When a therapeutic intervention has shown to be of greater benefit compared to the harm it initially inflicts, it naturally will be a justifiable option. However the opposite is true when an invasive treatment cannot be shown to be beneficial, as only the harmful part remains.

Examples of the first category, where the standards of empirical evidence had been neglected were found where interventions were done because they seemed compellingly plausible in theory, but without empirical validation. The cooling down of babies after birth to prevent brain damage was such an intervention. When finally tested this approach was shown to actually be responsible for many deaths in the newborns (Chalmers, 1995). Pulmonary artery catheterization was another un-evaluated medical technique. After it was used for three decades this procedure was demonstrated to be rather more harmful than beneficial (Morreim, 2003). In this case it was particularly the length of time in which this intervention was part of normal clinical practice and the accumulated potential for damage that makes its lack of scientific validation problematic. Another example cited by Morreim in the same article, is a surgical, and therefore also invasive, treatment, the arthroscopic debridement for osteoarthritis of the knee, which was performed on more than 650,000 people per year, even though the rationale for this operation was based on very inadequate research. Finally, when randomized, double-blind, placebo-controlled trials were carried out, this intervention proved to be no better than sham-surgery. The consequences were not only the unjustifiable risk of an

operation and unnecessary pain, but also great financial waste, with each operation costing $7000.

Another problem, which would fit into this rubric, is the issue of publication bias. Not all research findings end up being released for publication. Negative findings are often omitted. As a result the published studies, which are mostly positive, turn into a biased sample of all the trials that were undertaken. "This bias potentially leads to an over-estimation of the efficacy of a particular intervention" (McCray, 2000). So even if doctors want to incorporate only scientifically proven interventions into their practice and consult credible, peer reviewed journals, they still cannot be certain about the trustworthiness of this evidence.

Outcome studies have been cited as potentially very problematic because of their inherent vulnerability. Often it is poor methodology that makes these studies unreliable. In the debate about this research approach it has also been argued:

> ..that many important outcomes of treatment cannot be measured. This arises from the fact that evidence based medicine claims to provide a simple, logical process for reasoning and decision making – look at the evidence and decide accordingly. But to make balanced decisions, all the relevant consequences of an action must be considered. Unfortunately, current measures of some outcomes of medical treatment (such as pain) are inadequate; some (such as justice) may not be measurable; and other complex outcomes (such as quality of life) may not even be adequately definable (Kerridge et al., 1998, p.1151).

Another great worry associated with outcome studies is their susceptibility to manipulation. What is deemed to be a meaningful change in health status is a matter of definition. Mostly, instead of this being defined by patients, agenda and power of different stakeholders in health care provision will determine what is going to be set as the desired health outcome (Ray, 1999; Morreim, 2003). Sandra J. Tanenbaum (1999), who analyzed the effects of outcome research on medical practice, comes to the conclusions that "the ascendancy of outcomes research is highly political and more likely to shape health care reform than to reshape the practice of medicine" (Tanenbaum, 1999, p.61) and is leading to "the medical legitimation of payer-promulgated practice guidelines" (Tanenbaum, 1999, p.69).

Another reason for a lack of scientific evidence in medical practice can be found in the physicians themselves. The tendency of doctors to prescribe more on the basis of drug company promotion than on medical literature would be an example; or the fact that a triple

increase in the prescription of an expensive new drug followed after doctors were hosted at luxury resorts where they learned about the new treatment (Morreim, 2003). The way doctors are trained is another hindrance to scientific medical practice. Kenny (1997) points to the style of medical education, which is considered as too fact-orientated and didactic and not preparing doctors for assessing and judging new knowledge or managing uncertainty, as is necessary for using scientific evidence and incorporating it into practice.

Consistency and truthfulness are two necessary features for the credibility of an ethical argument. When orthodox clinicians insist that alternative medicine should emulate conventional medicine, to also "take on the burden of proof" and base treatments on scientific evidence in order to become more ethical, one would expect conventional medicine to be no less than an impeccable example of exactly that demand. In view of the great gap however between the actual level of science-based practice in conventional medicine, and what is falsely held up to being achieved, the argument loses its validity.

The unavoidability of uncertainty

As mentioned, the above-described impediments to scientifically based clinical practice are in theory amenable to improvement. The remaining reason, however, which has been stipulated as being "the inescapable uncertainty in the field of medicine", would be unlikely, even theoretically, to give in to full scientific understanding and control. From all accounts, it is concluded here that indeed such a phenomenon exists in medicine, even though Greaves (1996) noted that within the common conception of medicine no admission is made of the possibility that there could be an ultimate element of not-knowing. In fact the general agreement about illness is that anything, which appears as unexplainable and mysterious at the moment, if only given time, will find its explanation and solution. This belief of course fuels the tireless pursuit of medical research and the confidence that the answers to human frailty and suffering will be found.

Before one can assert, however, that this unavoidable aspect of uncertainty exists in medicine, one needs to stand back, take in the whole picture and listen to what clinicians have to say, particularly clinicians in primary health care, where the presentations of illness are wide and varied. Many objections have been raised from the coalface of general practice to the belief that empirical studies can simply be translated into the clinical encounter and that they can

capture the workings of the individual human organism and provide the answers to its dysfunctions. Evidence-based medicine not only fails to provide the certainty it claims, but is in fact an unrealistic and unachievable aim, leading to a false sense of certainty and completeness.

Even just looking at the extent and the diversity of all the potential forms of illness, one cannot avoid becoming severely doubtful about the quest for a fully scientifically evidenced clinical practice. It is just not humanly possible to investigate all existing variations. "On the most obvious level, there is simply too much to do. The resources of science will probably never be sufficient to permit every phenomenon of human mental and physical function and well-being to be thoroughly studied" (Morreim, 2003, p.223). There will always be those patients, who present with symptoms that cannot be placed into any known disease category. There will always be new illness patterns and epidemics, and even known diseases often unfold in unexpected ways. Rosser (1999), for example, points out that in general practice approximately 40% of newly presenting disorders "do not evolve into conditions that meet accepted criteria for a diagnosis" (Rosser, 1999, p.661). The sheer variety of symptoms, therefore, leaves big gaps to our ability to know and these gaps we will never be able to close completely.

In addition, the huge volume of research that is being done and the rapid and constant changes that this brings into the medical knowledge base has become a problem. Doctors do not have an unlimited capacity to absorb new information and the onslaught and fast change of medical data has become too overwhelming for many practitioners. When one looks back it is not so very long ago that medical knowledge changed relatively slowly. It was as recently as 1948 that the first truly randomized, controlled clinical trial, on the effectiveness of Streptomycin in the treatment of tuberculosis ushered in this new era of intense research activity. Now over $55 billion are spent by the biomedical and applied research enterprise worldwide every year (Haynes & Haines, 1998).

> During the latter half of the 20th century large numbers of trials have been conducted, and current estimates suggest that many thousands are in progress at any given time. In the United States alone, approximately 13000 new investigational drug applications are filed with the Food and Drug Administration (FDA), most involving multiple clinical trials around the country (McCray, 2000, p.609).

Even though many of the research findings are appraised and summarized in journals or in practice guidelines, the failure of doctors to integrate this knowledge into their clinics is well known and no satisfactory solution has as yet been found to successfully overcome this barrier (Cranny et al., 2001). "Academics can keep producing guidelines and EBM. The difficult tasks are ensuring that information reaches practitioners and is readily available on an ongoing basis, acceptable to physicians, reviewed and updated regularly, and incorporated into practice" (Bauchner, 1999, p.1030).

So even though there are many interventions, which have shown in scientific studies that they are beneficial in treating particular health problems, they will not be used because of the paralyzing effect information overload has on practitioners (Naylor, 1995). Rather than adapt their practices in accordance with new findings, there is a tendency for physicians to hold on to the methods that they are used to. It has been calculated that it takes in fact an average of about 17 years for new knowledge that has been generated by randomized clinical trials to finally be implemented in medical practice, and even then it will be done in an inconsistent manner (Morreim, 2003).

But apart from the magnitude of both the field of medicine and the research findings that have been generated so far, there are also doubts whether the data that have been produced are actually relevant in clinical practice. Criticism comes especially from primary health care, which is of course also the sector where alternative medicines are practiced (Naylor, 1995; Knottnerus & Dinant, 1997; Culpepper & Gilbert, 1999; Rosser, 1999; van Weel & Knottnerus, 1999). From the great number of reservations that have been articulated here are only a few examples: The patients that general practitioners see are quite different to the "ideal" research subjects, who have been selected because they exhibit only the one condition for which the effectiveness of a treatment is being tested. In contrast the patient population that is encountered in general practice is usually suffering from several medical conditions simultaneously. It can be expected that having additional physical problems will influence the responses of the body to treatment. Co-morbidity also requires the implementation of multiple treatments, which leads to the problem of "Malthusian growth of uncertainty", as the combination of therapies might have very different effects than each treatment might have on its own. The lack of research that takes place in the general practice setting and the concentration of research on disease-orientated or organ-specific outcome measures rather

than a look at the overall effect on well-being have also been criticized. And then there are of course the patients, who consult their general practitioners with disorders that do not meet the criteria for a medical diagnosis in the first place or when they are presenting in the early stages of disease. Nothing much is known about this phase. "Our understanding of the early course of illness is rudimentary at best, and in most countries little or no funded research is done to address this void in our evidence" (Culpepper & Gilbert, 1999, p. 829).

Finally one other consideration about the nature of scientific research and the practice of medicine: Although scientific studies are done to provide clinicians with information about the potential effectiveness and the adverse effects of treatments, the thrust of science goes in the opposite direction to that of clinical practice. Where science looks at what can be generalized, medical practice deals with single individuals and therefore with particulars. Empirical science can offer some certainty of what is probable in general terms but there are no guarantees when it comes to applying it on the individual patient.

> Whatever the basis for judgments about the likely effects of treatments in the individual patients, there is no escape from the reality that every such judgment initiates a clinical trial in which there can be no certainty that an individual patient will benefit (Chalmers, 2004, p.475).

On reflection about the overall picture, taking into account the above-mentioned factors, the implied assertion, that the scientific research efforts of the last decades have considerably reduced the uncertainties for clinical medical practice, cannot be confirmed. The fact that there are these great areas of uncertainty does not diminish the absolute value of medical research. However, what is significant is that the extent of uncertainty in conventional medicine is not openly and sufficiently acknowledged, especially not in the context of the debate about alternative therapies. Here the impression dominates that there is a very great contrast: on one hand un-evidenced, dubious, irrational alternative therapies; on the other the scientifically proven and trustworthy approaches of conventional medicine.

Modern medicine has discovered a great number of causes for illness and has developed a wide range of effective treatments. Although it goes against the grain of scientific optimism, it might be crucial to contemplate whether it is actually reasonable to pursue the goal of certainty in medicine or if the more humble stance, which overtly accepts limits as an unavoidable reality is a more honest approach in dealing with the ambiguities of illness. If uncertainty were actively recognized as being an inevitable dimension of medicine it would

have profound consequences for the practice of medicine and the weight it gives to scientific evidence. Other ways of interpreting symptoms would be welcome, particularly for those conditions when no plausible biomedical explanations can be found. But even if there was a quantifiable biochemical disturbance, modes of thinking that touch on the potential meaning of this patient's condition could be embraced without conflict, because the scientific understanding would be recognized as a partial truth only.

Patient-based evidence

The question whether medical practice needs to be based on scientific evidence to be ethical or if a doctor can also make recommendations on experience and anecdotes, has been examined predominantly from theoretical and social/political angles so far. In the end, however, it is the patient who is the main stakeholder and therefore some reflection is needed to establish what role patients play or should play in resolving this dilemma. The increasing popularity of unevaluated alternative therapies certainly shows that people are not deterred by the lack of scientific data but make their choices on other grounds.

It might be useful to examine an interaction between a patient, who claims that a non-conventional therapy was helpful and a physician (in this case her husband), who is inclined to trust only scientific evidence, and ponder on the ethical implication of the doctor's attitude. Ian Chalmers, clinician and health services researcher, describes his reservations in the face of successful treatment with a non-conventional therapy. Quite a number of doctors would probably take a similar stance.

> People are bound to vary in what they regard as reliable evidence. A leap of faith will always be required to make causal inferences about the effect of health care. For example, after about five treatments from a chiropractor to whom she had been referred by her general practitioner, my wife began to believe that chiropractic could help relieve her chronic shoulder and neck pain. Although I was delighted that her longstanding symptoms had subsided, I did not begin to share her belief that chiropractic might have been responsible until a couple of years later when I read the report of a systematic review of the relevant controlled trials. For me "reliable evidence" about the effects of health care will usually mean evidence derived from systematic reviews of carefully controlled evaluative research (Chalmers, 1995, p.1315).

This little story provides some good material on which to base a few thoughts about the problematic dynamics that can arise in such a situation. From what the author says, namely that his wife had longstanding shoulder problems, one can assume that she already had

attempted to relieve these for an equally extended length of time. One could also quite reasonably imagine that she had put her hopes for improvement into all prior treatment approaches. Coming from a medical household and consulting a GP, it is also more likely than not that the previous therapeutic attempts had been chosen from the conventional medical repertoire and that these had probably been evaluated in scientific trials. However, they seemed not to have improved her condition and the GP referred her to a chiropractor. After five treatments the, up-to-then persistent, shoulder problem of Chalmers' wife lessened and she "believed" that it was the chiropractic treatment. He, however, "did not begin to share her belief" until two years later when he came across a scientific study verifying that chiropractic was effective. [7]

The kind of response that Chalmers displayed towards the unexpected improvement of his wife's shoulder condition is commonly found amongst scientists or contemporary "skeptics". It is based on a strict and unwavering rationality in the face of an unexplained phenomenon, which is presumably meant to serve as shield against self-delusion or any wishful thinking that might lead to a distortion of the truth. Even the positive emotions about his wife's improvement could not corrupt Chalmers' stance, nor does it seem that he could be swayed by any notion of common sense, which might have wanted to convince him that it could indeed have been the chiropractic treatment that was responsible for the turn around. He firmly maintained his disbelief until he got evidence from a scientific study. Only then did he change his opinion and took his wife's experience and her conclusion, that it was the chiropractic treatment that had helped her, as an acceptable explanation.

A physician who holds on to the principle of reason could be seen as very admirable. There is much in the world that manipulates us into all kinds of beliefs by working through our emotions, and our senses can be equally untrustworthy, as many empirical studies have shown. Schneidermann (2003) is an example of an author who strongly takes this skeptical line. His interpretation of the recent upsurge in the use of alternative medicines is that it is a misguided fad. He makes a comparison between this "collective romantic fantasy", as he calls

[7] Kleinmann (1988, p.121) tells a story about a patient with asthma, which conveys a comparable message. The patient's explanations regarding the causes of his asthma and the reasons for full recovery, which seemed highly plausible in the context of this person's life events, were not accepted by his physicians as neither fitted the biomedical understanding.

it, with the widespread belief in “a wondrous New Economy”, but warns that what is at stake here is much greater as it is the health and lives of people.

When thinking of the actual clinical encounter there is something quite unsettling about a detached and rational doctor who only accepts scientific evidence. There is no question that the attitude of a physician towards his patient has to be distinctively different to that of a scientist towards the inanimate environment or towards non-speaking beings, which he might be studying. The detached distance of the pure observer, that may be the right approach in the latter case, is not appropriate in the former. For one the patient is a fellow human being who deserves to be recognized as such and not be reduced to an object. But apart from this moral aspect the medical argument should be equally as compelling. To rely on scientific theory or evidence without taking adequate note of the patient’s account would be comparable with insisting that the chart of a terrain is more accurate than the terrain itself. It is the patient who possesses first hand knowledge about the state of his or her body through the simple fact that s/he is the one who lives through that body. That expertise can never be substituted by external data. What’s more, by the fact of being human s/he is not only able to communicate this knowledge but s/he will also put have put his or her own individual slant on the meaning and importance of the particular phenomena s/he is experiencing. The same symptom is not the same for each patient but located in the context of a whole life and determined by a complex mixture of cultural and personal significations (Widder, 2004). This information is invaluable for both doctor and patient. Dismissing this knowledge as inferior and as untrustworthy is denying the patient the benefits that would come from that insight. It means in effect thwarting, what Launsø (2000) called, the patient’s “diagnostic autonomy” and through that loss of information, autonomy in general will be decreased. Feminist writers have long criticized this stance that has also subjugated a woman’s wisdom about her own body in favor of the medical scientific perspective and has led to inappropriate interventions.

The main argument against taking the patient’s word of being helped by a particular therapy as evidence for the effectiveness of that treatment is the placebo effect. Since Beecher’s influential article in 1955 “The Powerful Placebo”, the phenomenon of achieving a therapeutic effect with an inert intervention, purely through the intention to heal, has become an accepted fact in medicine and now underlies the most valued method for biomedical research, the randomized double blind controlled trial. Beecher claimed that the symptoms of

35% of the 1082 patients taking part in 15 studies were relieved not because of active medication but through the placebo effect. Other authors have meanwhile estimated that the effect of placebos is even higher (Turner et al., 1994). Although, on the other hand, the very existence of the placebo effect has also been doubted (Kienle & Kiene, 1997) most authors agree that there is a true connection between the idea of receiving a therapeutic intervention and a physical response of the organism, between mind and body (Ernst, 1998; Reilly, 1998; Kaptschuk, 2001). How this happens is not explainable as yet and might never be, as long as the premises of medicine remain set on the "body as machine" model. But the placebo effect is a reality, albeit much more than just an unexplained but quantifiable fact, rather an unwieldy and changeable phenomenon. It is for example culturally dependent. Germans, who suffer from ulcers, react twice as well to a placebo than people from other countries, but hardly at all when it is for hypertension. It is also subject to the doctor's attitude; doctors, who are convinced that a treatment will be effective, are more likely to produce treatment success. There is unpredictability as to who will respond to placebo and who won't. Even the same person could be a responder in one instance and not in the other. These and many other surprises can be found when examining the placebo effect in depth (Moerman, 2002). From the shiftiness of the placebo phenomenon also follows of course that any research data on effectiveness of treatments can be less reliably generalized.

For modern medicine the placebo effect is like unwanted noise that needs to be excluded to arrive at the truly effective treatment. It is almost seen as the body's trickery, which researchers have to outwit. This is different though for authors who look beyond the biomedical frame. Here the placebo effect assumes a very special significance. From the view of evolutionary biology, for example the placebo effect is considered to be an advantageous feature for human survival in relation to sickness and healing. It has been speculated that its emergence is due to the natural selection process, where those people whose self healing capacity could be stimulated through ideas, images or rituals were in a better position than those who were unresponsive.

> Mind/body mechanisms come into play in contexts involving environmental challenges, including disease, when cultural expectations are created that are compelling and that activate the subcortical, limbic centers of the brain, those that bring about strong emotions and physiological responses (Fabrega Jr., 2002, p. 406).

Reilly (1998) also regards the placebo effect as an extremely valuable phenomenon, which he renamed "intention modified self healing responses". He questions whether the success of an alternative healing approach (he uses homeopathy as the example) is solely a placebo response or not, as secondary. Instead he wants us to look at the overall consequences for health care in either case. Patients who have been treated with homeopathy have reported good clinical outcomes one year after treatment. Scottish GPs who have started using homeopathy also reported good results and benefits for the quality of care and consultations. Should homeopathy in the end prove to be no more than a trigger of the placebo response but still obtain good clinical results through this and at the same time doing so without posing any risks of side effects and at reduced costs, Reilly wonders if conventional medicine was actually "ready to take the daunting implications of this on board".

We started by exploring what one should make of a doctor's disbelieving response towards his patient's account about the beneficial effect of a non-conventional and non-tested treatment. Having looked at the situation from several angles, it has become apparent that this stance cannot be supported, as it is neither respectful towards the patient, nor could one rightfully claim that it was based on strong enough scientific reasons. There remain too many open questions.

But a medical doctor should in any case not think of himself or herself as the arbiter of truth. Medicine is a practice and its purpose is to solve a patient's health problem. Seen from the patient's perspective the method is secondary. The only thing that matters at the end is that the patient has been helped in a way that s/he regards as being satisfactory. Nordin (2000) also argues this point succinctly and backs it up by asserting that medical practice operates on what he calls a "technical paradigm" rather than a scientific one, and has as its goal the solving of practical problems.

> The nature of practical problem solving is such that there is often more than one feasible method. The competition between various technological paradigms therefore differs from the competition between scientific paradigms A scientific theory is either true or false. If several theories compete with regard to giving an explanation of a natural phenomenon, at most one (perhaps none of them) is true. However, two technological paradigms competing with regard to solving one and the same practical problem may both work (Nordin, 2000, p.299).

The respective members of the different technological paradigms tend to be biased in favor of their own familiar approach and will generate their particular standard of success.

> This implies that if we do not have an independent and objective external standard it is likely that the different paradigms will reach different conclusions concerning their usefulness and rationality (Nordin, 2000, p.300).

The ultimate judge about the usefulness of a technique can therefore only be the user, as he is the one who is in the position to determine if the technique had been useful to him.

When we come back to the previous scenario, where Chalmer's wife felt that chiropractic had helped her longstanding shoulder problem, a prudent physician would be aware of the limitations of his own technological paradigm and, rather than refuse to acknowledge that therapeutic success was achieved through another method, join his patient in the appreciation of being relieved from the problem.

Conclusion

This chapter started by asking why the five participants left the straight road of conventional medicine to become homeopathic doctors, as it seems that the position of heretic is rather difficult. The answers showed that their change was motivated by the desire to practice a more humane but also effective medicine. A number of specific issues had triggered the decision in the individual participants' cases, most of which were only touched on here, as they will be discussed in greater depth in the next chapters. For this chapter the issue of scientific evidence became the focus of discussion. This seemed important, as some of the participants gave as the main reason for becoming homeopathic physicians their positive personal experience with homeopathy. None of them seemed concerned that homeopathy does not have an accepted body of scientific evidence. However, lack of scientific evidence is the most commonly mentioned critique in relation to non-conventional treatments.

The demand that non-conventional therapies should be scientifically proven is frequently voiced and appears a reasonable request, particularly since it also applies to conventional medical interventions. However, as this chapter sought to show, the formation of scientific evidence is much more layered than one may appreciate at first glance, even to the point that it seems to be too flawed to provide a reliable judgment about the usefulness of non-conventional therapies. From an ethical perspective, this opens two main problem areas. One pertains to the scientific validation of non-conventional therapies as a precondition for legitimate practice. Insisting on scientific evidence for non-conventional therapies means that

the lack of it, which we have seen does not necessarily prove ineffectiveness, could potentially be used as an instrument to prevent their legitimization. The other ethical problem arises when scientific evidence is used as a reason to dismiss the positive treatment experience of patients. In this case, one might suspect, scientific evidence became the tool to assert: “Doctor knows best”.

Chapter Four

Pluralistic Practicing

An issue I wanted to explore in this research was how the interviewees had changed their practicing style once they had become homeopathic doctors. Did they now only use homeopathy, did they incorporate homeopathy with conventional medicine or did they integrate other healing modalities as well? Had crossing over into a healing approach, which was so different from conventional medicine, opened a new window for these practitioners to also explore additional therapeutic methods that lay outside the scientific model? If that were the case, on what considerations would the participants base their decisions to suggest one kind of treatment in favor of another to their patients? And related to the main question of the research: What thinking lay behind this way of practicing? How should we understand their motivations? What does mixing up of healing methods mean when judged from an ethical perspective?

By using techniques and approaches that are based on fundamentally different conceptualizations on the nature of human health and illness, the participants were practicing in a way that might be called pluralistic. The term pluralism was originally used in a predominantly critical sense to describe a particular school of thought "the (mainly American) political science tradition of 'empirical democratic theory' of the 1950s to the early 1970s" (McLennan, 1995, p.1). In that period of time pluralism was viewed as an intellectual orientation that was superficial, merely descriptive and without commitment to an underlying paradigm. These days, McLennan observes, the attitude towards pluralism has changed and holding a pluralistic stance is now seen as an appropriate expression of our postmodernist thinking:

> In such contemporary usages, pluralism indicates amongst other things: a suitably humble and relativistic acceptance that there is a range of cultural values; opposition to all forms of cultural imperialism; release from the dead hands of Enlightenment scientism and rationalism; fruitful methodological diversity; endorsement of different ways of knowing and of being; creativity and openness in theory (McLennan, 1995, pp.2-3).

Although noting that pluralism has become an accepted position, McLennan also alludes to the great difficulties in defining what exactly this new pluralism encompasses, and the many philosophical and methodological questions it raises.

In contrast to many other disciplines the medical sector is still far away from embracing this notion of pluralism. Dew (2003) demonstrates this by describing not only the struggles by non-orthodox practitioners for a legitimized position in the New Zealand health system but also the difficulties members of the orthodox medical profession can face when attempting to stray into any non-orthodox healing approaches. Similarly Stevenson et al. (2003), who in their recent study note the barrier that is still erected against the official inclusion of therapeutic approaches that are not from the established medical repertoire. The authors concluded from their research findings "that the plural use of services continues to be a clandestine activity" (Stevenson et al., 2003, p. 525). Despite the increasing popularity of non-conventional treatment approaches, it is obviously not easy to openly hold a pluralistic stance within medicine.

This chapter will look at the meaning of medical pluralism from three angles. In the first section the focus will be on the data of this qualitative study. In the second section other research will be used to establish an understanding of why patients use non-conventional therapies, what characteristics these people share and what ethical issues emerge from these findings. The third section will again address the question of validity. In contradistinction to Chapter Three however, where the problem of scientific evidence was discussed, this chapter will consider how the different therapeutic systems can find their grounding in epistemology and method. For this purpose the most representative arguments made in relation to medical pluralism will be presented and then analyzed for their theoretical and ethical merit.

Diversity in the patient's best interest

While all research participants used a variety of alternative therapeutic methods, except for Dr D, they identified themselves in public foremost as being homeopathic doctors practicing classical homeopathy. It turned out that they had very different emphases on what each of them regarded as being the main therapeutic tools. Also notable was the difference between the interviewees in their attitude towards conventional medicine and their threshold of resorting to it. Another interesting difference was their varied level of acceptance of methods

that are not only non-biomedical but also non-western. Acupuncture, which was integrated by Dr A as one of his other healing approaches has now quite a long tradition in Western countries and is no longer considered exotic. In contrast, Shamanism, which Dr E was practicing, is clearly still on the outer fringe of Western medicine.

In the interview Dr E gave a chronological appraisal of a few of the therapeutic approaches she was incorporating. For the last twenty years, she said, she practiced classical homeopathy, but she also used herbal medicines and the method derived by Kneipp for the same length of time. Four years ago she began to integrate shamanic healing into her practice. In describing her approach she emphasized that she found it important always to also respond to the emotional state of a patient, and even if she was consulted about a physical complaint. However, although she claimed that homeopathic remedies did act on all human levels, body, emotions, mind and spirit, she tended not to just rely on one healing method but felt that by combining different approaches she would have a greater chance of achieving good results for her patient. She spoke about how helpful it could be when two methods were enhancing each other's effect and used an example of a patient who had the tendency to easily feel emotionally hurt and offended. There is a recommended homeopathic remedy for such a predisposition, but Dr E thought that to automatically resort to this remedy alone without addressing the underlying issues of the patient would not be sufficient.

> To always just use Natrium muriaticum[8] because the patient feels aggrieved easily, and not to think what else could be done won't actually help either. I was for a long time in Munich, there is a good clinic for natural healing methods and there they had good weekend seminars – and there was this one on Psychology and homeopathy together, and we could see that the best results were achieved with high potencies and psychological care together. The high potency succeeds when psychotherapy is at its limits and then one can use what has been brought out with the high potency to catch it and work it through with psychotherapy. It is a really good combination. I work a lot together with a psychotherapist.

When still in training Dr E had studied conventional medicine and homeopathy at the same time. I assumed that she must have had already some idea then how she would be practicing in the end. When I asked her what kind of practice she had envisaged she said:

> I always thought I would run a double-tracked practice but it has never eventuated that I did orthodox medicine. [She laughed] Well only on very rare occasions I have to say.

[8] A homeopathic remedy often used to help in prolonged grief

> I do give myself a limit when I say: by then the globuli[9] have to have worked otherwise we have to do something different. I might need to do that perhaps two to three times a year.

However, when it came to embracing unorthodox methods Dr E was, in comparison with the other participants, certainly "straying" furthest away from the biomedical approach with her inclusion of shamanic medicine. She also made use of the greatest variety of non-conventional healing systems. When she spoke about her eclectic way of working she projected a total ease and matter-of-factness, as though there were nothing controversial or unusual about it. I was intrigued by that and wanted to understand how she had learned about shamanic medicine and also how this fitted in for her with being a doctor.

> It is like any complementary medicine training, over a few weeks, with cases, five cases you have to document on video and have to send it to the States in English. It is quite an effort. I didn't do it because I want to call myself a shamanic counselor, I might go in that direction if somebody asks me for it but I won't hold shamanic rituals in my practice.
> I have patients who don't believe in anything like that, but who have already tried out everything else, who see it as their last chance. I don't care, as long as it helps.

I found it striking that she was prepared to diverge that far from the scientific model. Even though homeopathy is a method that is inexplicable in current terms, there is still some resemblance with the scientific method. By incorporating shamanism, she had taken a decisive step into the mystical realm. However, to make her beliefs and her way of practicing more credible, she stated the approval the WHO had given for shamanism:

> When I did my first two foundation courses the course leader told us that it was accepted by the WHO as a healing method in the area of psychosomatics. It is a healing method were you can also do something for schizophrenia and the very extreme conditions that are called the loss of soul in shamanism, or alien possessions (Fremdbesetzungen), for these it gives you the most likely chances to shift something.

She also took some confirmation from the kind of people she had met during the training courses to validate her interest:

> Normally everything that has to do with natural healing or the esoteric, it is mostly women. But here there were sixty percent men and all of them scientists. I have never seen so many engineers and physicists as I have in shamanism. They have come to this through metaphysics. In physics there are things that you cannot explain in any other

[9] Small round homeopathic pills

> way. These were people who had studied something but then they say that there is something missing, there is something that goes further.

All of the participants agreed that they would use orthodox medicine but said that they would only turn to it as a last resort. Dr E described some situations in which she thought that the use of conventional treatment was appropriate:

> Well orthodox medicine I use when there is no time for such elaborate things and still something has to happen quickly. I use it for example in a child with otitis media, when the child already had a remedy and nothing happened and the child is in pain. Then I use it. But that happens, thank God, very rarely. Or for emergencies, like car accidents and such like. There conventional medicine certainly has its legitimate place. Everything that is emergency surgery, absolutely.

In other emergencies, like for example heart attacks, she would like to be able to treat with homeopathy first, as she said was possible in India.

Dr B relied mostly on homeopathy, but also used Kneipp methods as he found that they acted in a very complementary way to homeopathy. His other emphasis was on the conversation with the patient (ärztliches Gespräch), where he saw the therapeutic effect just through explaining clearly, in simple layman's terms what the patient could expect and by giving his assurance of accompanying him through the illness. He said that he would also resort to conventional treatments, but only when the situation had become critical or hospital treatment was needed.

Dr C, when asked if he used homeopathy as the main therapy in his practice, said:

> When it comes to medication, exclusively homeopathy, but I am also a family therapist and a systems therapist and have trained in psychotherapy. I use homeopathy in conjunction with systemic and with spiritual therapeutic approaches.

He did not offer any conventional treatments himself, but when I asked him if he would ever suggest any he said:

> Absolutely. If somebody is suffocating from Asthma, I am glad that there is Cortisone. I have no difficulties at all with that. If somebody has septicemia or a severest pneumonia, naturally you would give an antibiotic. I have no problem with this, to relieve him from the most extreme pressure of suffering, gain time, breathe in and out; but then not abandon him there but continue working with it. It is then when the real therapeutic work is going to start. Of course, the acute therapy is also therapy. It's fantastic. I have greatest respect for everybody who does that.

Dr D was mostly leaning on homeopathy for patient care, but was comfortable with implementing orthodox medical treatments and acting also as a regular family physician if that was wanted. He said that his patients consulted him because they were trying to find something different:

> They don't want to continue to be treated just with orthodox medicine any longer, they are looking for an alternative and want to take another approach and that's what we are trying to do together.

When I talked to Dr A about his practicing style he told me how he had developed his particular combination of methods:

> After I completed my medical studies I started practicing acupuncture and homeopathy, at first in parallel. Then I occupied myself with psychotherapeutic methods and then looked at different spiritual directions and I have tried to bring it all together in one world-view.

Although primarily a homeopathic physician now, he said he would use conventional treatments when necessary but would also resort to acupuncture as another alternative method. When I inquired how he would decide which approach to recommend, he was quite definite that the two alternative methods were his preferred choice, and that he would only consider conventional treatment when there was no improvement. He would involve his patients in weighing the options when, for example, they had been advised to have surgery. If he was of the opinion that homeopathy might be helpful for the patient's condition, his suggestion would be to set a specific time frame to give the homeopathic treatment a realistic chance to have an effect. Similarly to Dr D he found that the reasons why patients wanted to try alternative medicine had:

> ..nothing to do with ideology but it is often brought about through an experience in which they, for example, have recurring infectious diseases that have always been treated correctly in a medical sense, but the susceptibility for catching them had never changed. And then these sorts of patients come to the homeopath and – with God's will – they will be helped so that they don't need so many antibiotics any more.

He explained that he would let his patients know in detail what he was considering when he was looking at the different choices that he could offer them. Although his patients wanted alternative treatments the main motivation underlying any advice he gave was:

> ..to find the way which is least harmful for the patient in his concrete situation or where I think that it would be most helpful to him, so that he would get the most out of it when looking at the whole picture.

And that could then also include conventional medicine. However, there had also been moments, he conceded, when he was not prepared to meet the expectations placed on him by the patient. There had been cases where he believed that it would be too dangerous for the patient's life to solely rely on homeopathy or other non-conventional treatment approaches. In these situations Dr A admitted that he would refuse the patient's wish to only use alternative therapies. Still, he qualified:

> It is not the case, however, that I have rejected the patient, only his expectation. When he comes to me and says "heal me for this or that" and you can tell that this is avoidance behavior, to avoid the conventional medical path where he might have to face for example chemotherapy. Then I try to explain to him that for his survival, for his well-being orthodox medicine would be, from my knowledge, more certain.

All participants were unanimous in supporting the need for a clinical diagnosis, even though their homeopathic treatment was based on the specific information that came out of the homeopathic case taking process. As medical doctors, however the participants felt that they had the responsibility for diagnosing an illness also in conventional terms and to recognize potentially life-threatening conditions.

When asked why that was so paramount for him, Dr A said:

> My main motivation is to avoid harm for the patient. Therefore it is important to me to recognize diseases which would need quick intervention, where one would have to avert greater damage even with the help of an intervention that comes from the outside. And because of that it is no problem at all to me to clarify the diagnosis. And if I find out that it is a problem, which allows a greater time span for treatment, then I am free to pursue the alternative healing methods.

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Dr E also saw the need for an orthodox diagnosis as a matter of course. "Yes certainly, I always want a diagnosis. Completely orthodox." She said that she had no problem accessing colleagues of the different conventional specialties for this purpose. "I send my patient for a diagnosis to them and then they come back to me. Then when there is a therapeutic plan we go over that together". With this she meant that she would weigh the pros and cons of the orthodox approach together with the patient and then compare them with the treatment suggestions she had to offer.

Dr D was very firm in his stance that a diagnosis was needed before he would proceed:

> Certainly. There has to be a biomedical diagnosis as well, there is no question about that. To move in a vague mushy space, no I don't like that. That's for sure, there has to be a diagnosis. It has to be known, what this is about. But usually the patients come to me with a completed diagnosis anyway. They have all been investigated from top to bottom and already come with their results. Or I send them for X-Ray or MRI myself when something is unclear and when it is necessary to diagnose something. I am not a hard-liner, or anything like that, that I would say I don't need a medical diagnosis any more. That would be somewhat arrogant.

Although Dr C does not work as a family physician, unlike all the other participants, he told me that he still has patients who would first consult him before seeing an orthodox physician. However he also considers it necessary to make a diagnosis and will, if necessary refer his patients to conventional medical practitioners:

> When I come to my limits and when I need further investigations, then I refer. I don't do that myself, I have decided. I have moved so far away from scientific medicine meanwhile after twenty-five or thirty years that I don't presume I am competent any more. For that there are the colleagues, who I can consult and ask about the clinical aspects. So I won't put myself under that sort of stress. And on the other hand, I am pleased when a clinical colleague refers a patient to me and says this is all diagnosed, but maybe you could get somewhere here. So I wouldn't go into competition or into presumptuousness.

There can be friction however when a homeopathic doctor involves the orthodox health care system, as in the case of Dr B, who told of two instances of very hostile reactions from hospital colleagues when he referred patients for hospital treatment. He was accused of negligence by the hospital consultants and taken to court, but was cleared of any wrongdoing in each case.

On review of the interviews, even though Dr B could be seen as being to some extent an "outlier", there was a common thread in the way the participants practiced: a willingness to draw on any therapeutic approach, or several approaches simultaneously, which seemed to promise to give the best result to the patient. The choice was made from a number of alternative therapies but could just as well be a treatment from the repertoire of conventional medicine. What is striking in the responses is the seeming lack of emotional or professional investment into a particular treatment modality. Although all participants expressed a common view of understanding, which rated a holistic frame as superior, all the different therapeutic methods, including scientific medicine, appeared to have the status of tools for

them, being more or less useful to solve the task at hand. Only Dr B, as will be shown later, maintained his perspective about the detrimental aspects of orthodox medicine more firmly than the other interviewees, which, as a consequence, made resorting to conventional medical treatments a less likely option for him.

The views that were expressed by the participants might be summed up like this:

- It is paramount to achieve an improvement of the patient's health with the least harmful treatment; the method used for this is of secondary concern.
- There is no therapy that is a panacea; therefore different methods have to be employed to help in the different situations.
- To get the best therapeutic outcome it is necessary to treat all health problems in combination with approaches that address the emotional/mental/spiritual aspects; for example with psychotherapy or, as in the case of one participant, with shamanic rituals.
- Modern medicine can be very effective, particularly in acute or life-threatening illness episodes. Therefore, a conventional medical diagnosis is vital. However, for lasting results, the root causes of any illness have to be attended to, either at the same time or after the acute crisis has settled.
- A conventional medical diagnosis, even though it gives some orientation, still does not confine the patient's illness to the biomedical conceptualization of a purely physical mal-function.
- The patient has to be involved in the process of finding the best therapeutic approaches but the attending homeopathic physician will only support the patient's wishes when s/he regards the approach as safe and not endangering the patient's life.

The greatest distinguishing feature between the practicing styles of the participants, compared with a purely conventional doctor, was the overtly pluralistic approach with a willingness to involve a variety of different methods. The choice of the kind of treatments the practitioner would employ for the individual patient was dependent on the range of therapeutic skills from which the practitioner could choose and the patient's preference. Neither a particular theory nor any epistemology was viewed as absolute and binding to the interviewees, although as will be shown more clearly in later chapters, the holistic outlook inherent in the different alternative therapies was considered as being a kind of "higher order" approach by all

interviewees and therefore ultimately preferable. The pluralistic practicing style was clearly inspired by the desire to provide treatments that were most beneficial and least harmful, with the patients' best interest as the principal motivation.

In the previous chapter the concept of the "technological paradigm" was introduced with its implications for the different therapeutic approaches and was contrasted with the "scientific paradigm". Also, with regard to the difficult question of evidence in medicine, the patient as user was placed in the center as ultimately being the only competent source to determine the usefulness of a technique (Nordin, 2000). The next section of this chapter will explore further how people, who have opted to also use non-conventional healing approaches, view their treatments and why they decided to embark on this pluralistic road to health care in the first place. One can expect to gain some insight about the limits of orthodox medical treatments but more importantly, learn about the qualities that people regard as valuable in the non-conventional therapeutic approaches.

Pluralistic medicine – from the patient's perspective

Since the increasing patient drift towards non-conventional therapies became evident in the early 1990s (see Introduction), there has been an enhanced research effort to find out what factors were responsible. Surveys and in-depth qualitative studies were undertaken to establish if there were any common features among the people who were using alternative medicines and what reasons patients of alternative practitioners gave for having made this choice. Even though the research had been conducted in a variety of countries, encompassing the US, European countries and also Australia and New Zealand, when comparing the results of the different studies it is striking to find that not only the popularity of these approaches has increased at a similar rate across the board but also that people's motives were quite analogous. Although all of these countries are considered Western they are nevertheless rather diverse. Some countries for example have very effective public health care systems where medical treatment is accessible and affordable for all citizens, while others in contrast are less organized and many people miss out on appropriate health care. The argument therefore that the growing demand for alternative practices should be blamed on the deficiencies in the organization and distribution of health care (Marcus, 2002; Ernst, 2002) does not seem valid in view of the research findings. It is similarly unjustified to hold the characteristics of the "typical" conventional doctor responsible for being the underlying reason for this movement,

as one can again find a marked disparity between the different countries. What is considered an acceptable professional style for the doctor-patient encounter in one country would be regarded objectionable in another. Even in the so-called Western world the medical approach still varies from being rather paternalistic in some countries, to hands-off and contractual in others, depending on cultural expectations and to a degree also on the medico-legal situation (Vincent, 1998; Dickenson, 1999).[10] Although it is true everywhere that patients find the "bedside manner" of alternative practitioners better than that of their general practitioners (Ernst et al., 1997), if that were the crucial reason for the trend, one would expect it to be less obvious in countries were the doctor-patient relationship has been transformed from the "doctor knows best" stance towards an attitude of greater respect for the patient's individuality and values.

And last, looking at the mix, accessibility and status of the various traditional and non-conventional healing approaches, one also finds a great diversity in the various Western countries, which is due to the historical influences unique to each of the countries, their cultural blend and, in some cases, the presence of indigenous populations. Non-conventional therapies have always been more popular in Germany for example, compared to some of the other countries and the above mentioned historical factors will be an explanation for this, and similarly for the greater popularity of some alternative therapeutic methods over others that can be found in the different countries. But it does not explain, however why there should be this general parallel trend or why it is that the motives of patients are so congruent no matter if they were interviewed in Denmark, in the US, in New Zealand or any other country that is considered Western.

Therefore the conclusion one is left with is that this phenomenon must be an expression of something more fundamental in relation to health care, something that surpasses the specific conditions of each country but goes to the very core of medicine. This impression is strengthened when examining the research more closely. A clearer picture emerges; one, which shows the dimensions of illness that are not sufficiently attended to by conventional medicine. Interestingly, they resemble many of those aspects that have been highlighted in the bioethics discourse as being necessary attributes of a humane medicine. But where, in most

[10] This claim is also based on personal observation and experience as a medical practitioner and patient in Austrian, German and New Zealand hospitals.

instances, bioethicists are supportive of the underlying premises of scientific medicine, patients of alternative practitioners, consciously or unconsciously have moved on to view health and illness from another perspective. Their conception of the factors that make up health and illness has changed and the scientific knowledgebase is not seen as the only possible explanation any more. Instead these people have chosen to look for other, non-orthodox forms of therapeutic knowledge in order to have those facets included, that are missing in the orthodox medical approach.

It is interesting to find out that people who access alternative practitioners share some distinct features compared with people who rely on solely on orthodox medicine (McGregor & Peay, 1996; Blais et al., 1997; Kelner & Wellman, 1997). These are commonalities in their social background, their health status and their value system and even though they are not part of a cohesive group in terms of a structured organization, collectively they could be seen as forming a social movement (Lyng, 1990; Goldner, 2004). From several studies (McGregor & Peay, 1996; Blais et al., 1997; Kelner & Wellman, 1997; Astin, 1998; Launsø, 2000; Marstedt & Moebus, 2002) a characteristic demographic picture of the "alternative patients" emerged: They are proportionally more female. They tend to have a higher education and higher incomes. Greater personal and financial resources are in fact necessary to locate and access non-conventional practitioners and to pay for treatments because public health funds are only provided in the minority of cases.[11] The "typical" alternative patients were also found to be more prone to suffer from chronic illnesses, which were not necessarily serious, in the sense of being life threatening, but usually had a negative affect on day-to-day functioning and enjoyment of life. One study found that they appear to experience greater "body sensitivity", which was established by looking at differences in sleeping habits, physical rest periods or how observant people were of physical signs and symptoms (Marstedt et al. 1993, cited in Marstedt & Moebus, 2002). Paradoxically, despite the propensity to chronic conditions, this group of people was on the whole in better health than the comparable population. One reason for their altogether better health status could lie in the fact that they were also found to be

[11] Some examples of public funding are: Switzerland, which has a five year trial period since 1.7.1999 for Herbal Medicine, Homeopathy, Neural therapy, Anthroposophical Medicine and Traditional Chinese Medicine. Germany: Pilot studies by Public Health Insurances in the different regions for limited lengths of time and limited therapies and indications. New Zealand: ACC incorporation of Chiropractic, Osteopathy, Acupuncture. Britain: Some public funding of Homeopathy

more health conscious than more conventionally oriented people. They were described as being more careful with their diets, doing more exercise and were in general aiming for a healthier life style.

When looking at the belief structures of people who used non-conventional therapies, they usually tended to lean towards a holistic value system. In this philosophy the physical, mental and spiritual dimensions are interrelated and not separable and for well-being all aspects have to be taken into account. There is also an awareness of the influences that culture, social and economic forces and the physical environment have on the health of the individual and an understanding that health is an ongoing process rather than the absence of disease. It could be shown that these patients have a strong sense of being ultimately responsible for their own health and that they prefer to be more reliant on themselves than on their health care practitioner, believing that they themselves can better influence an illness process than any practitioner. Many reported having "had some form type of transformational experience that has changed their worldview in some significant way, and they tend to be classified in a value subculture as cultural creatives" (Astin, 1998, p.1552). McGregor and Pleay (1996) concurred with this assessment by finding that they were more "unconventional" than people who would rely on orthodox medicine. Surprisingly, however, no study found that alternative patients abandoned conventional medicine in favor of non-conventional approaches but that

> they have health needs that go beyond what conventional medicine does or can provide, they wish to multiply their preventive and therapeutic options, they have reasons to believe these therapies may be useful, and/or they have philosophical and experiential reasons to find them attractive and reasonable choices (O'Connor, 2002, p.55).

When there were ominous physical symptoms like chest pains or lumps, most people who were otherwise in favor of alternative therapies opted for consulting conventional medical practitioners (McGregor & Peay, 1996)

> These consumers do not make dichotomous choices between medicine and alternative care. Rather, they are choosing specific kinds of practitioners for particular problems. It is misleading to assume that people will only choose one kind of health care (Kelner & Wellman, 1997, p.211).

As Siahpush (1999) found there was no evidence that this group of people is anti-scientific in their attitudes despite their generally more holistic and nature trusting belief system.

Although underlying values play a big role for being drawn to non-conventional medicines, in the first instance most people make their decision to consult an alternative practitioner on predominantly pragmatic grounds: They are suffering from a health problem and the conventional medical treatment has not been satisfactory. This is either because the treatments did not give sufficient relief or, second on the list, the side-effects of an orthodox therapy are perceived as being too risky or people, after trying, found them too unpleasant. For the majority of patients the experience with alternative medicine appears to be positive. Astin (1998), for example, established from his survey of 1035 randomly selected participants that the main reason for their use of alternative medicine was "its perceived efficacy".

> The two most frequently endorsed benefits were, "I get relief for my symptoms, the pain or discomfort is less or goes away, I feel better," and "The treatment works better for my particular health problem than standard medicine's (Astin, 1998, p.1552)."

Other studies have confirmed this finding (Sharma, 1996; Kelner & Wellman, 1997; Furnham, 1998; Paterson & Britten, 1999; Launsø, 2000; Leibrich et al., 1987). Most patients, for example in one German study it was 90% (Kahr et al., 2000 cited in Marstedt & Moebus, 2002), would recommend the kinds of alternative treatments they had received to their friends. This result makes it is not surprising that, in another study, 36% of people who consulted alternative practitioners said that they had done so through personal advice from others who had been helped (Kelner & Wellman, 1997). Apart from these positive patient appraisals there are also some interesting data, collected in two pilot studies that were initiated by German health insurance companies (IKK and BKK), conducted in two different German regions and evaluated by university institutions. To gauge the value of alternative therapies people's absenteeism due to sickness was monitored in these studies. It was found that after receiving treatment with non-conventional treatments the average number of sick days decreased from 32 to 24 days per year and the effect was still ongoing after four years (Marstedt & Moebus, 2002; Tuffs, 2002).

Looking at these research data, in contrast to the rather sparse scientific evidence that exists on the efficacy of non-conventional treatments, there seems to be an overwhelmingly positive perception about their beneficial effects from patients who have used these approaches. However, the measure of what constitutes a therapeutic benefit, can not merely be seen in terms of clinical efficacy but needs to be understood in wider terms as patients have a range of criteria with which they evaluate the advantage of one treatment over another (Sharma, 1996).

One other, already mentioned, criterion that comes very much into the equation when people make the choice for non-conventional treatments, is their wish to avoid any drastic interventions or the risks of adverse effects of orthodox medical drugs. In a survey of the general population in Germany it was found that, if there were a free choice between a herbal remedy and a conventional, chemical drug, three quarters of the people asked would opt for the herbal remedy (Marstedt & Moebus, 2002). Herbal remedies are seen as being more natural than conventional drugs and for that reason are also perceived as being less harmful.

Strictly conventional doctors might see this preference as a sign of ignorance and irrationality in their patients, as it is well known that many orthodox drugs were originally derived from plants or come from other sources in our natural environment. Indeed, for greater control and safer usage the active substances were isolated and the dose standardized, making the now refined medication superior to the original material, at least in the terms of orthodox medical thought. What is more, there are stringent research protocols to test the efficacy and safety of every conventional medicine and once it is on the market there are feedback systems in place so that adverse reactions can be reported. All these arguments in support of conventional medical drugs are valid and they would certainly appeal, at least prima facie, to any rational thinking person. Seen in this light the desire of people for natural remedies could thus easily be discounted in the way Happle (1998) put it, as being "a deeply rooted propensity to romanticism, as a movement against the technical conditions of modern life" (Happle, 1998, p.1458).

However, the picture changes dramatically when looking at the statistics. Even though there are some hazards involved in taking herbal medicines, as with other alternative treatments (Berman et al., 2000), the risks people take when using conventional medicine are a great deal higher. When we hear that adverse drug reactions are the fourth to sixth leading cause of death in American hospitals (Lazarou et al., 1998) and that similar data have emerged from a number of other studies (Ebbesen et al., 2001; Davis et al., 2002), it seems out of place and in fact irresponsible to dismiss people's concerns about the dangers of orthodox medication or deride their search for safer treatments as being a "propensity to romanticism". Wanting the least harmful treatment is not only reasonable, it is also very much in line with the Hippocratic mandate for non-maleficence even in the less dramatic, day-to-day scenarios that occur in the

primary care context. The stories from Sharma's (1996) qualitative research study make it very understandable why people would want to choose non-conventional avenues over orthodox treatments in some instances. She depicts, for example, the mother of a seven-year-old boy with eczema, who was greatly relieved when her child could be helped with homeopathy and did not have to use steroids as she knew that homeopathic remedies were less toxic; or the woman with migraines, who found the side-effects of ergotamines too great and opted instead for acupuncture and herbal treatments; or similarly the woman with kidney troubles and high blood pressure, who chose non-conventional therapies because her orthodox medication caused such breathlessness that she found it impossible to walk upstairs.

But there is another element related to this search for gentler, more natural and particularly low-tech approaches: The desire of patients to claim back more control over their own health and have a greater influence on getting and keeping well. When researchers compared the attitudes of patients of family GPs with patients of alternative practitioners (McGregor & Peay, 1996; Blais et al., 1997; Kelner & Wellman, 1997) they all confirmed that the latter group tended to take a much more pro-active role and show greater self-responsibility for their health.

> When asked who they thought could help them most with their health problems, the alternative patients made it clear that they relied mainly on themselves for help. Over a third of them (38%) said they believed that they alone would be most helpful and another fifth (21%) declared that they in partnership with their practitioner could help most with their health problems. In contrast, the patients of family physicians were most likely to subscribe to the belief that for most illnesses, it is the physician who can help most (Kelner & Wellman, 1997, p.210)

In order to be able to help oneself and become the main actor in the management of one's own health problem, the source of the disturbance has to be located within a conceptual space that brings the therapeutic measures into an accessible range for the layperson. This necessarily has to take the understanding of illness outside the purely biomedical framework, for within it there is not a lot of scope for the patient to actively influence the health problem, in fact s/he can hardly do much else but to submit to the available medical treatments. As Stephen Lyng (1990) notes:

> Insofar as laypersons do not possess medical knowledge and skill and cannot gain access to or use the technology required for medical diagnosis and treatment, they are *separated* from the means of health production. The inputs required for health production are controlled by parties other than the individuals who seek to produce their own health (Lyng, 1990, p.123).

However, when illness is perceived as a phenomenon that includes emotional, mental and spiritual dimensions, and when people make a connection between social and environmental stressors and the effect these have on their well-being, the scope for having an influence on a health problem immediately widens. As Launsø put it in the analysis of her research findings: "These studies demonstrate that the broader the construction of the scope of diagnosis, the broader the patient's scope of action is defined" (Launsø, 2000, p.104). Launsø's research involved a study of patients with chronic recurring headaches who were followed during and after the time of having reflexology treatments. Most of the patients had been taking conventional medication for years, which either just took the edge off their headaches or did not help at all any more. Up to the moment when they made the decision to try something else "the scope of action formulated by patients in connection with their headaches was to try and forget the headache by taking drugs" (Launsø, 2000, p.104). When Launsø then compared the group of patients who considered themselves "cured" with the ones who described themselves as "not cured" she found that the difference lay in the degree to which patients had involved themselves actively in their treatment. Through developing perceptiveness about their body experiences the "cured" patients became aware of the factors that were the triggers for their headaches, and implemented changes to those personal habits that they found were associated with them. The attitude of these patients had shifted from wanting to control their headache with medication to "engaging in 'dialogue' with their headache" by understanding it as an "integral part of the body-mind" and searching for new tools to respond. For successful treatment therefore it was not enough to just passively receive reflexology.

> Characteristic of this treatment is that the patient's subjectivity is incorporated into the body-oriented treatment along with her daily life in general. The practitioner becomes a catalyst who initiates learning processes and personal development in the patient. This process appears to be an important element in the healing process, meaning that the perception that treatment techniques alone determine treatment results is challenged. If reflexological treatment is to be considered effective by the patient, it must be connected to the person's concrete daily life context (Launsø, 2000, p.104).

For Launsø this therapeutic process has far-reaching ramifications, which go much further than one might appreciate at first glance and in fact cut to the very essence of what we consider to be human freedom. Being able to reflect, to reframe, to envisage new options and then respond by taking the appropriate action is a deeply human capacity. For this process to occur Launsø sees the employment of language as an essential prerequisite. To verbally describe life situations and associated symbols will be clarifying and helpful in the uncovering

of unhealthy patterns of which the patient previously had not been conscious. From this newly discovered understanding other orientations and strategies can be visualized and from here the patient can develop responses that s/he deems to be having health-producing effects. "Therefore a serious problem arises if treatment of illness is deverbalized, as in the case of drug treatments, for example" (Launsø, 2000, p.105).

Working with a practitioner who provides a platform for reflection and reframing, and who facilitates the most suitable therapeutic strategy with the patient can be very empowering. It is through this dynamic that the practitioner helps the patient to appreciate that his or her health problem represents a much wider phenomenon than only being a defect of the "body-machine".

But verbalization is not the only ingredient for patients to feel confident in their own ability to positively affect their health status. An underlying holistic health perspective, which provides the conceptual basis, is crucial. Through understanding oneself as a multidimensional being in which all aspects are interrelated and not separable and where the physical body is perceived as only one facet of the whole, it becomes plausible to the patient why it would be useful to listen to subjective sensations and perceptions and respond to them. For conventional patients, on the other hand, who do not share the holistic view but who locate health problems in the physical reality, where the disease process is not accessible other than through medical intervention, it is harder to be self-reliant and safer to defer to the physician's expertise.

Another interesting finding has come to light through some of the in-depth qualitative research. Although it was well known that users of alternative medicine were more inclined to have a holistic value system, inquiries of alternative patients made it apparent that this had not necessarily been the case from the beginning but that it was, in some instances, the personal encounter with a holistic explanatory framework, which had produced this viewpoint. O'Connor (2002) has illustrated poignantly how this fundamental transformation of perspective can take place by telling the story of a woman she interviewed: Dr Davis, the research participant, had been suffering from a number of seemingly unrelated symptoms, but the greatest bother was a longstanding recurrent posterior tibial tendonitis and chronic foot and ankle pain. After going through many unsuccessful conventional treatment attempts she finally consulted a practitioner of traditional Chinese medicine (TCM). The TCM practitioner

told her that all her health problems were lying on the kidney meridian and that they were due to the deficiency of "kidney-qi".

> Dr. Davis is stunned to hear the practitioner identify a common diagnostic category in TCM which has no counterpart in conventional biomedicine, and which describes and provides an explanatory framework (though entirely novel to Dr. Davis) that encompasses not only her immediate problem but also other bothersome symptoms that she heretofore considered to be concurrent but unrelated (O'Connor, 2002, p.61).

Dr. Davis described it as a "galvanizing moment" when she suddenly could see a connectedness between all her symptoms. Although TCM is built on a "radically divergent conceptual framework" it gave her an explanatory structure that was much more congruent with her subjective experience than viewing her different symptoms through the conventional medical lens, which portrayed them purely as a collection of several separate pathological entities. She also found it remarkable to realize that a body of medical knowledge already existed in which all her different problems could be interpreted as forming a unified diagnosis that also had a corresponding treatment approach.

This experience opened a new way of thinking for Dr Davis about what could be happening in her body, revealing the conventional medical interpretation of her symptoms as merely one of two or more possible view points, each with their own validity. The range of options for dealing with health problems in the future had also broadened for Dr Davis through adding another set of therapeutic tools that she now knew she could confidently access.

The story also lets one think about another aspect in the context of illness, the importance of a diagnosis. That it is crucial for patients to be offered a diagnosis for their symptoms is commonly acknowledged. Knowledge of the illness not only promises some predictive power about its natural course but is also the usual starting point for a therapeutic strategy. For the patient a diagnosis therefore means finding out where s/he stands, what can be expected to happen and, above all, offering hope for relief. On top of this a diagnosis also has symbolic significance as it signals to the sick person that s/he is not alone with this problem but that this illness is something "with which we are familiar" (Stewart et al, 1995). Through the diagnosis the personally experienced symptoms have been put into a bigger context and been given credibility within the system of medical knowledge. This, of course, not only has weight for the patient from a psychological point of view, but the legitimization of illness through an accepted diagnosis is in many instances a precondition for any social and financial support.

With the many implications that surround being given a diagnosis it is therefore easy to imagine how devastating it must be for patients when their doctor cannot provide a medical explanation for their health problem. Not only is there little help but also the patient's symptoms are more often than not dismissed as being "unreal". Well-known examples of this are patients who have presented with chronic fatigue syndrome or fibromyalgia. For a long time these conditions were not considered to be "real" diseases because no measurable biological disturbance or morbid anatomy can be identified, which are the usual pre-requisites for physical symptoms to be categorized into a distinctive disease entity. Many conventional medical practitioners still find this lack of objective findings unsettling and tend to look with a degree of suspicion at people who suffer from these ailments. As a consequence, patients have found themselves being called hysterical, hypochondriacal, or malingering (Hocquard, 2002; Malterud, 2002; Murdoch, 2002). For people who suffer from these so-called "ill defined symptoms" (Zollman & Vickers 1999) having them recognized as a known illness pattern within a system of medical knowledge would most likely come as a great relief, possibly even more so than in the case of Dr. Davis, who at least had been given a set of biomedical diagnoses that described the separate elements of her health problems.

The phrase "clinical legitimacy" has been coined to describe the acceptance of treatments by the public (Willis, 1989; Willis & White 2004) as opposed to "scientific legitimacy". Clinical legitimacy is based on popularity and common use of a treatment approach, whereas scientific legitimacy is dependent on the approval by experts in the field, who have set certain scientific standards with which the treatment approach has to comply. The above research findings about patient use of non-conventional treatments, their reasons and their appraisals show that non-conventional therapies enjoy a high degree of clinical legitimacy despite the low degree of scientific legitimacy.

Even if patients favor a pluralistic health care, which includes non-conventional healing modalities, there remains a crucial and so-far unanswered question, which requires some further reflection: How and where will a pluralistic medicine find its grounding in a metaphysic of health and illness that can incorporate all the different approaches? The challenge is to find a conceptual place that lies beyond the poles of scientific objectivism on the one side and relativistic eclecticism on the other. It needs to be a position that can

accommodate other relevant illness ontologies besides the biomedical, in concert with their specific epistemologies and research methods. It is only when space is given for other ontologies and epistemologies to exist that a systematic investigation into the different illness phenomena can start, as at present many of these cannot be captured within the concepts that underlie orthodox medicine. Without such a place from which to explore the different facets of illness in a methodical way, the tension about what kind of evidence is credible will not subside. It will also continue to hinder the development of any integrated health care, which ideally would be capable of responding to all the human dimensions in health and illness.

The epistemological grounding of pluralistic practices

With the strong evidence of clinical legitimacy, it is becoming ethically and politically problematic, if not untenable, to uphold orthodox medical science as the sole arbiter in the decisions whether non-conventional health care practices are to be legitimized or which of these practices are to be kept on the fringes of medicine.

In the political arena recent developments have proven that clinical legitimacy appears to have the greater convincing power compared with scientific legitimacy. This is a claim Willis and White (2004) have made after analyzing the legitimating process of two cases in Australia. One instance concerned the legal position of Traditional Chinese Medicine. Although a thorough review could not establish that there was enough scientific evidence to say that Traditional Chinese Medicine is an effective therapeutic approach, the statutory registration for Chinese medicine practitioners in Victoria/Australia went ahead. A similar response could be seen by the way the Australian government came to support naturopathic organizations. Here a project was funded, which assists professional associations of natural therapies to devise a registration system. The scarcity of scientific evidence did not even enter the considerations in this instance. There are many other indications that a popularity of non-conventional approaches is being followed up politically. The Traditional Medicine Strategy 2002-2005 document, devised by the WHO to assist the integration of non-conventional therapies into national health care systems could be regarded as being another example of this trend, and the recent legislative change in New Zealand, which resulted in the Health Practitioners Competency Assurance Act.

In the ethical debate, however, there is still a greater tendency to hold back and insist on "scientific legitimacy" before non-conventional approaches will be considered acceptable (Kopelman, 2002). Without the back up of scientific findings they are not seen as credible enough to stand up to the four ethical principles (autonomy, beneficence, non-maleficence, justice) nor, some authors argue can they meet the requirements of informed consent (Ernst, 1996; Komesaroff, 1998; Gruner, 2000; Ernst & Cohen, 2001; Kaler & Ravella, 2002; Ernst et al. 2004).

This caution might be viewed as surprising. For bioethics to be out of line with the mounting evidence of people's positive experience and their desire to access non-conventional treatments seems to contradict the original mission of the bioethics endeavor to humanize medicine, empower patients and work against medical paternalism. Critics might interpret this stance as bias in favor of biomedical premises and on an even more critical note bioethics could be seen as having entered a dubious allegiance with the power holders of modern medicine. However valid or not these claims are, it does not seem to be an unreasonable request that healing approaches should provide indication of a coherent knowledgebase, epistemology and some proof of evidence, particularly in view of the growing popularity of non-conventional treatments and their increasing political legitimization.

That this is not as simple a task as it is made out to be by some authors has been brought to light in the previous chapter, in which the demand for scientific validation of non-conventional therapies in the sense of evidence-based medicine (EBM) could be shown to be rather flawed. In this section, I will attempt to analyze the approaches that have been taken to resolve this challenging situation by looking at some of the main arguments and suggestions that have so far been brought into the discussion about this subject. The goal is to identify which of these approaches might take us closest to the required position where illness phenomena are explained by a coherent ontology from which a matching epistemic pathway can follow.

In the debate that surrounds the use of non-conventional pluralistic approaches in medicine one can first identify two distinct opposing stances. One position highlights the theoretical incommensurability between the metaphysics of scientific medicine and those of other healing approaches and denies any usefulness in taking it any further. In the other stance, the

unpredictability of individual responses to therapeutic interventions is seen as a predominant concern. Using what works best is proposed as the correct response to human suffering, even if that means being inclusive of therapies that are not based on the same premises as biomedicine.

Starting with the argument of incommensurability, within the medical arena the debate is predominantly conducted in such a way that it 1) highlights the vastly contradictory paradigms underlying scientific medicine in comparison to non-conventional approaches like, for example, homeopathy, 2) supports the assumption that, in a Kuhnian (Kuhn, 1962) sense, both cannot be correct at the same time and 3) takes the paradigm of medical science as the one that reflects reality correctly. Because of this insistence on incommensurability on the one hand, and the belief that contemporary biomedicine represents medical truth on the other, even positive results of impeccably conducted trials of non-conventional treatment approaches, as for example that of a meta-analysis of placebo-controlled trials of homeopathic therapies (Linde et al., 1997), are not accepted as being convincing. With the so-called "theoretical plausibility criterion" (Hufford, 2003; Vandenbroucke & de Craen, 2001; Vandenbroucke, 2002) the potential implications of unexpected positive empirical findings are overridden because this criterion demands that every therapeutic intervention has to be explainable in terms of biological mechanisms to fit the underlying premises of biomedicine and its view of illness as a biological deviation. A good example, which illustrates the power of this requirement, is how the gradual approval of acupuncture within the orthodox medical community took place, as it

> …followed not from the simple accumulation of good clinical evidence, but from a scientifically supported hypothesis that the effects of acupuncture come "not by manipulating Qi but rather by neuroelectric stimulation for the gene expression of neuropeptides" (Ulett et al.,1998 cited in Tonelli & Callahan 2001, p.1213).

This stance, of course allows no scope for any healing approach that does not subscribe to the same materialistic understanding as biomedicine to gain scientific legitimacy within the eyes of the medical orthodoxy, as empirical evidence alone will not be persuasive. Some authors see it as ironic to use Kuhn's concept of incommensurability between paradigms within the medical context. Kuhn himself had excluded medicine from his list of paradigms "because there were too many human factors involved" (Willis & White, 2004, p.50).

Clinicians and authors who place the improvement of individual patients in the center of their concern, approach the validation problems of pluralistic medicine predominantly from the angle of "usefulness for the patient" (Nordin, 2000; Brendel, 2003). The underlying conceptualization does not appear to be as much at issue, because the focus of interest lies on the outcome for the patient. Nordin justifies this approach by arguing that there is no external, objective standard, but that "different paradigms will reach different conclusions concerning their usefulness and rationality". What is useful is relative to the person who makes that decision on his or her own criteria.

> There are a wide variety of factors that have to be considered in the evaluation of the usefulness of a technique, like efficiency, cost, comfort, ethics, aesthetics, legality, and the personal plans and circumstances of the users. But the important thing here is that the individual user makes his own evaluation of all these factors and judges whether the technique in questions is *useful to him* (Nordin, 2000, p.300).

Similarly Brendel, a psychiatrist, makes an appeal to adopt an explicitly pragmatic approach in order to meet the challenges the clinician encounters in his or her daily practice when treating individual patients with their broad variations of therapeutic needs. In his discussion he claims that contemporary psychiatry is practiced in two contrasting ways. In one the psychiatrist relies on a single coherent explanatory model to address the patient's mental disorder. In the other, the clinician incorporates eclectic therapeutic tools, which give a greater range of options but "lacks a clear, consistent and rigorous theoretical basis". Brendel defends this last practicing style whilst at the same time acknowledging how tempting it could be for the clinician to restrict the therapeutic response to one specific theory:

> Specialized scientific models and theories, which may be conceptually elegant and clinically useful, are frequently a welcome result. But the exclusion of alternative explanatory concepts may be detrimental, especially when it comes to explaining multifaceted behavior and to treating people when their behavior becomes maladaptive and aberrant. Human action and experience usually are far too complex to be captured adequately in explanations which appeal only to the concepts and tools of a singly scientific discipline (Brendel, 2003, p.565).

The philosophical leaning underlying these two opposite approaches Brendel identifies as being a belief in either an "ultimate unity of knowledge", in which there can be a "common groundwork of explanation spanning all scientific disciplines", or as a belief in the fundamental disorder of things due to our "limited cognitive and technical abilities". Although Brendel points out that, "forces in contemporary science (and in society in general)" favor reductive scientific explanations, he makes an ethical case to promote a pragmatic solution:

> Pragmatism, as I am using the term in the current context, refers to the theory that psychiatric explanations are "true" only insofar as they promote beneficial real-world results for individuals with mental illness. As a practical discipline, psychiatry is concerned more with its methodology than its ontology: by adopting a pragmatic position on explanatory models, psychiatrists do not necessarily commit themselves to a particular view on the underlying structure of the universe (Brendel, 2003, p.569).

It seems to be no accident that this plea for a pluralistic practicing style within medical orthodoxy comes from a psychiatric perspective, reminiscent of Engel (1977), who also saw the need to extend the conception and treatment of mental illness beyond the materialist reductive understanding of conventional medicine, or any other reductive model. However, in contradistinction to Engel, whose methodological focus for the bio-psycho-social approach was systems theory (Lyng, 1990), Brendel criticizes the lack of scientific rigor he associates with the bio-psycho-social approach or other eclectic methods, and is concerned that they could be "overly inclusive and vague" and lead to a relativistic approach to psychiatry. It is at this juncture that Brendel, like many other authors and clinicians, looks for an epistemic path that will give certainty and credibility and comes to the conclusion that empirical science in the sense of evidence based medicine (EBM) will provide it. Although Brendel strongly endorses pluralism in clinical practice, even if that means that the different approaches to diagnosis and treatment are built on a range of different, also non-scientific, ontological foundations, he insists that their effectiveness will still have to be empirically proven. Brendel promotes this kind of tempered pragmatic approach, because he believes that it

> …can synthesize the strengths and minimize the shortcomings of reductive science and eclectic open-mindedness. It heeds the empirical evidence but avoids the reductive tendencies of traditional science (Brendel, 2003, p.573).

As already argued in the last chapter, this line of thinking would only hold ground if the statistical results from controlled trials were indeed able to act as primary arbiter of all medical knowledge and could also be independent of any underlying illness theory. These assumptions however have been poignantly challenged by Tonelli and Callahan (2001) who maintain that it is not so much a "scientific necessity" than a "philosophical preference" to uphold one form of medical knowledge over another. They point out that for the clinician it is often not at all the statistical evidence that is useful in the individual case. Instead a clinician can make causal inferences from observing a patient's distinctive reactions to environmental stressors or conversely to a particular therapeutic approach. These might in fact contradict

what was established as being correct in clinical trials. Therefore, they argue, despite the well-known limitations, meaningful knowledge can indeed be found from a single case study.[12]

> Demonstrating causality in a single individual is most convincing when long-standing signs or symptoms abate shortly after the institution of a therapy and recur in the absence of that therapy, only to disappear once again when therapy is re-instituted (Tonelli & Callahan, 2001, p.1215).

EBM is believed to give us a general proof of treatment effectiveness. However these authors deny that this is logically possible as EBM "lacks the ability to determine that any particular intervention is ineffective", meaning it "lacks the ability to 'falsify' claims of benefit made by individual patients and practitioners". Clinical medicine, they argue, is conducted on an individual basis, a "personal undertaking", where an individual patient meets an individual clinician. The clinical setting has requirements for medical knowledge other than, what, for example, might be necessary for decision-making in health care economics, where statistical evidence is an essential tool.

> The individual patient's perception of improvement may constitute direct evidence of benefit based on primary experience. To prefer indirect evidence such as that obtained from clinical trials, over primary experience represents an epistemic choice, not a scientific necessity (Tonelli & Callahan, 2001, p.1216).

The other line of reasoning Tonelli and Callahan use in questioning the ability of EBM to arbitrate all medical knowledge is particularly relevant for the evaluation of non-conventional therapies. They assert that empirical evidence needs to be coherent with the underlying theoretical model and to back this claim up they raise three important points: 1) Experience shows that empirical evidence alone is not taken as sufficient proof if it contradicts theory, as already illustrated in the example of homeopathic trials, where positive results were not accepted because the mechanisms of homeopathic treatments are not plausible within orthodox medical thinking, while acupuncture, which has become accepted because it now seems to be explainable within biomedical parameters 2) The main emphasis in non-conventional therapeutic approaches is on "non-measurable or non-quantifiable factors in disease and healing", therefore any empirical findings coming from research into quantifiable aspects of illness, like those in EBM, will not be useful. 3) It consequently follows that non-conventional approaches will have to find their own epistemic methods that are coherent with

[12] Kiene (2001) has expanded this argument more fully.

their underlying theory, as non-conventional practitioners will need to be able to defend their practices in a rational fashion.

Tonelli and Callahan have used two separate arguments, which are equally important in relation to the issue of how to validate non-conventional therapies. The first argument has shown that it is mistaken to believe that statistical data can always give the most reliable medical information. This view has also been supported by other authors, who have demonstrated that dependable and often more appropriate medical knowledge can come from a single case study (Kiene, 2001). The second claim goes even further by stressing the need of specifically devised epistemic methods because standard research trials are only useful for establishing statistical evidence about quantifiable illness phenomena and are not the appropriate methodological path for any approaches that address other aspects of health and illness.

Coulter (2004) also acknowledges this challenge to find suitable research methods for healing interventions, which are based on various premises, and advocates the "systems theory approach" as providing the correct conceptual foundation for such research. He describes the various features a systems model of health care had to contain, which are similar to those of Engel's (1977) bio-psycho-social model. Like Engel, Coulter stresses the multidimensionality of human existence and the embeddedness of human life within a social and environmental context. Here, contrary to the understanding of linear causality found in reductionist biomedical premises, the relationship between the different levels gives rise to an understanding of "interactivity and non-linear causality". There is also the recognition that living systems are self-organizing and have a tendency towards balance or homeostasis. From here Coulter's conception goes further than Engel's model as he also includes the concept of "emergent properties".

> Not only is the whole greater than the sum of its parts but the larger systems have properties that are simply not found in the parts of their summation (Coulter, 2004, p.116)

Logically, as Lyng (1990) points out, if the systems theory approach was consistently adhered to, it would lead to a holistic perspective of human existence in which one part could not be considered in isolation from its context or treated as a separate entity any more. But he also notes that system thinking has not been followed through to this final conclusion.

> While the systems approach does free itself of the limitations associated with the assumption of unidirectional causation, systems theorists have, by and large, ignored the further implication of this modified concept of causation. The idea of "interrelation" (reciprocal causation) implies that the character of the thing or entity changes when its relations change. This idea clearly undermines the positivist assumption that objective reality consists of discrete, well-defined entities (Lyng, 1990, p.11).

Lyng argues that even in the systems theory approach it is still assumed that there are "distinct entities given in an objective reality and observable through common sense perception". He builds on Schutz (1962) and Hegel (1966) when he explains why it might be that humans have this need to divide what they experience around them into clearly delimited entities and points to the predicament that human beings face: Human survival depends on being able to take rational action in a vastly complex environment that goes beyond human capacity to fully comprehend. To make this otherwise unmanageable environment manageable it has to be "cognitively stabilized".

> One mechanism that fulfills this function is the process of "typification". The human species possesses a unique ability to cognitively organize reality into "typical" categories, categories of phenomena that share basic qualities. An especially important aspect of this ability is the tendency to treat typifications as clearly delimited things. In doing so it becomes possible to deal with these things in a rational manner: ends and means can be clearly defined and relations between them established (Lyng, 1990, p.29).

The problem with this typification is that it represents arbitrary abstractions, which are fitting for the limitations of human consciousness but are not "inherent features of organic reality".

> The indeterminate and fluid character of organic reality is not captured by the categories of human consciousness (Lyng, 1990, p.18).

All systems theories reinforce this underlying "indeterminate and fluid" reality, and allude to the complexity that we invariably miss when we try to typify it with something that delimits it into individual entities. Nevertheless, categorization of the environment has been a vital technique in order for humans to make sense of an otherwise confusing and paralyzing complexity. It is therefore not surprising that we need to continue our search for some tangible categories despite the fact that we might believe in an unlimited complexity in our abstract conceptualization of reality.

With this realization in mind, it does not come as a surprise that Bell et al (2002) state that, so far, a systemic worldview has not been successfully introduced into the research environment

of medicine, even though Engel's analysis showed up the deficiency of the biomedical framework already nearly three decades ago.

> Medicine as a field has not yet incorporated these ideas on a wide scale. Although clinical researchers have dissected downstream effects of change on a higher-order level on lower-order levels of a system (e.g., the effects of prayer on distant healing or of psychosocial stressors on neuroimmune markers) they generally have not designed studies to examine the patient as a complex, interactive, dynamic system within the larger system as a whole (Bell et al., 2002, p.139).

On first sight this could look like a deficiency of the research, something that could be remedied if we were to put our minds to it. However, the more one ponders on the task required "to examine the patient as a complex, interactive, dynamic system within the larger system as a whole", the more the contradiction becomes obvious. We know that categorization cannot capture "the indeterminate and fluid character of organic reality" but also that all research and the resulting human knowledge comes in form of categories. Systems theory, particularly when inclusive of the implications it throws up, might perhaps be the nearest appropriation to the mystery of life and its phenomena, but it is questionable if it lends itself to a controllable epistemology.

Bell et al. (2002), however think that it is possible to bypass this obstacle by using outcome research, which they believe suits the framework of systems theory even though they simultaneously acknowledge the many fundamental difficulties. They can see, for example, that problems already start at the basic question of how health should be defined, if in narrow terms as absence of disease, or in wider terms as wellness. Other problems they mention are, who chooses what the desirable outcome would be, how this outcome should be measured and what variables should be included as being relevant to the evaluation of the system under study. Although these and many other complex issues are recognized by the authors as the great challenges of this research approach, they seem nevertheless confident that it is realistic to employ multidimensional outcomes measures, increasing qualitative research to better understand "what matters to patients" and employing "state-of–the-art, user-friendly advanced methods of data analysis".

Despite these sophisticated techniques, it is not possible to share the optimism of these authors that the complexity of dynamic systems can in fact be captured without distortion of the underlying idea through reference to already given categories. As already recognized,

human capacity is limited. Even though we might have come to appreciate that the biomedical framework is conceptually too narrow and that different aspects of health and illness would be better explained from a holistic or systemic worldview, it does not mean that we have now acquired the mental tools to grasp and represent reality in its wholeness and can therefore disregard defined categories. Outcome research will invariably have to make use of categories, even if the outcome is as broad as "general well-being", because it will have to explain the different units that "well-being" is made up of, in order to be understandable to others wanting to utilize the research. The danger of seeing outcome research as the answer to the complexities of human health and illness is that the unavoidable categorizations will not reflect coherent and rational epistemic foundations, as at least they do in biomedicine. Neither have the cognitive limitations, which we human beings cannot escape, been taken into the equation by this approach.

The dilemma could seem insurmountable, as so far it appears that no methodology or epistemic approach shows the capacity to capture the variety of human illness phenomena or their treatments. Contemporary medicine faces a choice between seeing medical truth either within the too narrow confines of the scientific framework on the one hand, or the boundless and inchoate realm of a holistic or systemic perspective on the other. The first view defies representation of the experienced human reality by excluding all phenomena that cannot be quantified; the second defies comprehension and mastery due to our restricted mental ability and our need to categorize and focus on specific parts. But "any attempt to reduce the whole to abstracted units or parts will produce distorted and partial knowledge" (Lyng, 1990, p.15).

Lyng (1990) uses first "the philosophy of internal relations" and then the visual analogy of a hologram to devise a possible way out of this conceptual impasse. Within the Hegelian view, which Lyng represents, the whole is conceived in three ways: 1) the whole is more than the sum of its parts, 2) the whole determines the nature of its parts and 3) the parts cannot be understood if considered in isolation from the whole. From this follows the impossibility of breaking the whole into its component parts without losing the interrelations among the parts and losing the essential nature of the whole. In the same way:

> When a part is individuated from the whole through the process of analytical abstraction (or through the simple act of perception) the thing produced constitutes only a partial representation of the unabstracted part; the part abstracted cannot be equated to the part unabstracted (Lyng, 1990, p.18).

By using the image of a hologram with its different facets, Lyng tries to take into account the limited nature of human cognition, which forces us to break down "formless multiplicity" into distinct but partial categories, but simultaneously stay with the awareness that the whole is ultimately indivisible:

> The idea of facet differs from the notion of part in one important way: a facet can never be logically independent of the whole or the other units of the whole. Each facet is but one unique aspect or side of the whole; when one peers into a particular facet, the whole can be seen in its entirety, albeit a view of the whole that differs from the view seen from any other facet. Hence, the idea of removing a single facet from the whole is manifestly absurd because it is impossible to know where one facet ends and another begins (Lyng, 1990, p.16).

When reflecting further on this kind of conceptualization we are brought to two fundamental realizations. Firstly, that human beings can appreciate something of the whole by looking into a particular facet, and secondly, that they have only a limited number of facets at their disposal.

Both of these conclusions contain something of the recognition in the apriorism of human knowledge. Kant is arguably the most prominent promoter of this understanding, which stands in contrast to the belief that human beings are able to gain a priori knowledge of objects (or aspects of "the whole" as some empiricists would claim). As Kant has worded it:

> …either I must assume that the *concepts*, by means of which I obtain this determination, conform to the object, or else I assume that the objects, or what is the same thing, that the *experience* in which alone, as given objects, they can be known, conform to the concepts. In the former case, I am again in the same perplexity as to how I can know anything *a priori* in regard to the objects. In the latter case the outlook is more hopeful (Kant, B xvii).

Kant's claim is that because of our need to find order and structure we have formed concepts, which in turn then shape the particular facets through which we see the world. Although we are able to get glimpses from different angles we have to be alert to the fact that there will be features, which will not be accessible to our ways of understanding. That there are only a restricted number of facets has to be accepted as a natural part of the human condition, even though they might have changed and grown throughout human history. However, the interesting challenge, not only for this context of health and illness, will be to identify and describe what our different facets look like and what they tell us about their specific epistemic

pathways. Only by being conscious and reflective about the limits on one side but also of our capabilities on the other, will we be able to use all avenues to their fullest in the quest to gain an understanding of human illness. This is the task that a number of medical historians, anthropologists, philosophers, researchers and clinicians have begun to work on.

In the quest for a system that gives access to a comprehensive understanding of illness and effectiveness of therapeutic interventions, Jonas (2002) has developed "The Evidence House", which takes into account that the different "audiences"[13] want different kinds of information. With the evidence house Jonas advocates for a balance of methods in which randomized controlled trials do not provide the ultimate arbitration about valid medical knowledge but are merely considered particular instruments within a "Balanced Evidence Hierarchy". The advantage in bringing together a variety of research approaches, including qualitative studies, observational studies, laboratory and basic science and health services research, lies in acquiring information of different types, which provide a fuller and more relevant picture than possible at present. All angles have their own validity as each focuses on a different aspect. One focus can be on "mechanisms and basic biological effects on and in living beings", but equally important to consider is "meaning and the examination of the subjective". With "attribution" Jonas describes the attention to direct causal links, as in RCTs, but "associations", which are looked for "when the identification of cause and effect links is impractical, unethical, unreasonable, or impossible" are also not neglected. Finally there is "confidence" through the use of systematic reviews and meta-analysis of scientific literature, but also "generalizability", the judgment of which requires involving the wider public (Jonas, 2002, pp.135-138).

With the evidence house, Jonas acknowledges the complexity of the subject and the tensions between the different audiences. At the same time he also outlines the different research avenues, which, in combination, will give more appropriate answers than evidence-based medicine is capable of. Jonas' system is sophisticated and the methods are all applicable in practice. However his focus is mostly on what kind of research should be conducted with methods that are available at present. He only touches briefly on the specific nature of the different ontologies that underlie the various healing approaches, like for example that of the correspondences concept in traditional Chinese medicine. How we can acquire more

knowledge, however, depends on our comprehension of the underlying ontology. To express it in the terms used previously: ontologies represent the different "facets" into which we look in order to grasp something of the whole of health and illness. Only after the ontology has become clear can an appropriate epistemology follow.

To get an understanding about illness ontologies, the most promising place to look for advice seemed to be medical history, as it provides an overview of the different approaches to illness throughout time. Medical history is, of course, not immune to interpretations that reflect the agenda of the particular historian. Axel W. Bauer (2000) critiques the manner in which some prominent medical historians, an example being Erwin H. Ackerknecht (1982), have represented medical history as though it were a linear progression. They consecutively added what they considered to be the "main streams of medical progress" with the result that approaches, which did not fit into this scenario, were classified as error paths or medical detours. This kind of depiction gives the impression that scientific medicine, as we know it today, is the logical consequence of a historical development. Bauer, in contrast, alerts us to a very different approach to the reading of medical history. By using the focus on the underlying concepts of various historical and contemporary healing approaches, Bauer builds on Karl Eduard Rothschuh (1978), also a medical historian, whose interest was to understand how the meaning of illness had changed during the ages. Rothschuh had come to identify twelve major premises that have encompassed all medical thought.[14] Bauer then further crystallized those twelve to arrive at four basic conceptual structures. He believes these axioms, as he calls them, are the foundations of all knowledge of illness, not just that of times gone by, but equally relevant today. These "axioms for systematic epistemic paths in medicine"[15] are such fundamental premises that the epistemic method of one axiom cannot be used to verify or falsify any claims within the other. Although in our present time the concept of mechanistic-deterministic processes predominates as explanation for illness, it has by no means superseded the other three, which exist as parallel belief systems to draw on. The four axioms, as Bauer sees them are:

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[13] With audiences Jonas means patients, practitioners, clinical researchers, basic scientists and policy makers.

[14] Rothschuh identified these twelve concepts: Iatro-demonology, Iatro-theology, Iatro-astrology, Iatro-magic, empirical medicine, humoral pathology, Iatro-physics, Iatro-chemistry, Iatro-dynamism, Iatro-morphology, philosophy of nature in medicine, Iatro-technology

[15] "Axiome des systematischen Erkenntnisgewinns in der Medizin"

1. The axiom of the existence of supernatural beings or forces
2. The axiom of the semiotic correspondence of phenomena
3. The axiom of mechanistic-deterministic processes in nature
4. The axiom of inter-subjective understanding through verbal and non-verbal signals

For all four axioms examples can be found in past and present medical thinking as Bauer and Pieringer (2000) have shown. Bauer's system of axioms has been somewhat modified by Hahn (2000) and by Pieringer (2000), who have also linked them to the four epistemic pathways, which have been identified as underlying the four major thinking styles in the cultural and medical history of Europe. These thinking styles are:

1. The phenomenological method
2. The dialectical method
3. The empirical-analytical method
4. The hermeneutical method

Hahn (2000) argues that all four methods should be implemented for the epistemology of medicine in the form of a "methodological circle" because each refers to a different aspect of illness and a methodological circle would have the effect of connecting the knowledge that can be gained from every particular perspective. Pieringer (2000) develops this suggestion further by elaborating on how each epistemic method could be related to a specific illness axiom. By connecting up a particular thinking mode with its matching theory of illness, the otherwise confusing complexity of illness suddenly shows an inner logic and seems to have become more coherent and manageable. From this conceptual basis the formulation of an inclusive epistemology for medicine is much more likely to be successful. The significance of this approach for non-conventional therapies but also for medical ethics can not be estimated highly enough as it opens a conceptual way to comprehend the humanitarian and subjective aspects of illness as an integral part of medical knowledge rather than just being added attributes. For this reason it is worth exploring the theoretical system Pieringer has suggested.

The approach Pieringer has taken is first to define the particular epistemic method, then to identify what object of knowledge this method is investigating, and the illness theory underlying the direction of investigation. About the phenomenological method he writes:

> The phenomenological method, as described by E. Husserl, K. Jaspers and M. Heidegger makes the emergent, timeless, existential dimension of human reality and life accessible.
> The phenomenological epistemology is a synaesthetic and holistic "seeing" (Pieringer, 2000, p.78).

Underlying the phenomenological method is the theory that "illness is pathic creation of life, or pathic emanation of life". The purpose is to grasp what theme is hidden within an illness phenomenon. To comprehend this is both the diagnostic and the therapeutic task. Through this stance illness finds a deeper meaning within the wider context of existence; illness is manifestation of, as yet unlived, existential dimensions. Health is not the opposite to illness from the perspective of a phenomenologically motivated healing approach. In the centre is the search for a fundamental understanding. Health, illness and death are all instrumental in this. Pieringer recalls the sentence, which was inscribed above the gates of antique healing places to stimulate the innate healing responses in the sick that were seeking relief there: "gnothi se auton" – "know yourself so you can recognize God". The metaphors of illness as "path" or as "opportunity" that one can find in some contemporary reflections on illness are comparable with this ancient belief of healing through self-exploration. The phenomenological method is also used when illness is seen as located within a religious or spiritual context, like what Bauer had called the "axiom of supernatural beings and forces". Again the overall "Gestalt", the meaning to which the illness connects, needs to be discovered.

The second epistemic path is the dialectical method. In classical times this method was introduced by Heraklit of Ephesos and the physician Empedokles and was more recently developed by Kant and Hegel. It recognizes the dynamic unity of subject and object with its opposing poles in an ongoing struggle for balance. Illness represents the loss of balance, a crisis point. The dialectical method relates to the tension between contrasting forces working on and in the individual, as they are between the individual and its environment, between his conscious desires and unconscious drives, between the outer and the inner world. Health, from the dialectical perspective is the ability to maintain balance in the face of ever changing conditions. Therapy built on dialectical thinking will aim to support harmony by stimulating the organism's reactive abilities. The notion of Yin and Yang found in Traditional Chinese Medicine and the "similia similibus curentur" of homeopathy are typical examples of the dialectical concept.

Of the four epistemic pathways, it is the third, the empirical-analytical method, which is treasured the most in our present times and because of our great familiarity with it, will need the least explanation here. The underlying theory is that "illness is defect or deficit". The empirical-analytical method is based on the belief in a linear causality. Illness has been caused by something that can be objectively identified and then needs to be corrected through external interventions. Health and illness are seen in direct contrast to each other. Health is freedom from disturbance and defect. Illness represents a deviation from normality, which is equated with an objectively well-functioning physical system. Subjective aspects have to be excluded to arrive at a reliable knowledge base. Therefore the randomised controlled trial is the most trusted research method within the empirical-analytical epistemic approach.

The last of these epistemic pathways is the hermeneutical method. Pieringer points to the paradoxical meaning of the word hermeneutics, which connotes "hidden and veiled" as well as "to interpret and lay open". Illness is a symbolic message, a veiled communication to be interpreted and then understood by the other. The correct therapeutic response lies in the empathic attempt to receive the message and to answer with "loving attention". This view of illness can explain the success of the placebo effect and other well-known phenomena, like that of recovery from illness through the presence of a loved one.

Conclusion

The first two sections of this chapter have shown that a pluralistic approach to health care is becoming increasingly popular. Patients rely more and more on non-conventional therapies, however not necessarily instead of but mostly in addition to orthodox medicine. All participants of this research, apart from Dr D, are practicing at least three different therapeutic approaches and are also open to others if they consider them useful for their patients. The reasons for this stance are various, but essentially it seems to indicate that illness can be more effectively treated when it is conceived in a broader way than what orthodox medicine prescribes.

Human illness, as we all know, contains at least the four dimensions that have been identified by medical historians, and perhaps even some others that are not accessible to our culturally conditioned Western perception. With the conceptual perspective of scientific medicine we only get to see illness within the particular facet that gives us an understanding about the

physical aspects. Over the last century most of our research efforts have been concentrated on that perspective which opened a great deal of knowledge about the biological functioning of the human body. Many people, particularly those suffering from acute physical illnesses, have been helped by effective biomedical treatments over the last decades. However, this success has also had its costs, one of which is that the other illness dimensions have been mostly ignored and sidelined. Health problems that would have been better addressed by attention to subjective and non-measurable aspects have been neglected. The popular movement towards non-conventional therapies can therefore be understood as a reclaiming of these elements.

Without grounding in a systematic knowledgebase however, these aspects will probably remain in the background. The scientific approach to medicine gets its great strength and convincing power through referring to what can be seen from the outside and is therefore tangible to everybody. The subjective dimensions on the other hand are hidden or consist of many layers. This leads us to view them as being imponderable, chaotic and inaccessible. The proposal to include all our known epistemic pathways and devise matching methodologies could be a new way to bring some conceptual order into a field that would otherwise be too complex. With the methodological circle that was suggested by Hahn (2000), we would be able to attend to the humane and subjective aspects of illness as well as to the biological and objective. This would not only mean that non-conventional therapies could be rationally validated but it would also provide a broader epistemological foundation for human health and illness.

The emphasis of bioethics has always been to stress subjective experience and to support patients in their humanity within the context of medical care. Most contributions to the bioethics discourse, however, leave the dominance of biomedicine unchallenged. The growing demand for a pluralistic medicine has been shown to be motivated by the public's desire for a more complete and therefore also a more ethical approach to healthcare.

Chapter Five

The Patient's Trusted Companion

The relationship between doctor and patient in conventional medicine is an often-debated subject. Much has been written about the problematic dynamics that can arise in the biomedical encounter and different ethical guidelines have been suggested to bring about improvements and safety for the patient (Gillett, 1989; Beauchamp & Childress, 1994; Katz, 1995). Some authors have made use of conceptual models to demonstrate the various ways in which this relationship can be conducted. These models illustrate how dependent the doctor-patient relationship is on the doctor's conception of his or her role, as it can vary from playing the "priestly father" to behaving like the "pal" of the patient, and any other variation that lies between and beyond those two poles (Veatch, 1991; May, 1983; Nie, 1996; Gillett, 2004 a).

It would, however, be inadequate to view the doctor-patient relationship merely as a meeting between two individuals without acknowledging that every clinical encounter is situated within a broader context and cannot be fully understood in isolation from it. The organization of a country's health system, the regulatory framework that determines the way doctors can work, free market forces, to name just a few, all have their impact on the doctor-patient relationship. The conceptualization of scientific medicine is also relevant because of the requirement that the doctor maintains a certain scientific detachment, which can hamper an empathetic interaction. The individual doctors, therefore, can only influence the development of the relationship with their patients in a limited way as a great deal remains beyond their control. Each of those wider issues that affect the doctor-patient relationship deserves thorough investigation. However, a detailed analysis would go beyond the scope of this thesis, although some of the main points will be discussed here. The reason for doing so is to highlight the link between biomedicine's underlying premises and the powerful internal and external forces that affect the quality of the doctor-patient relationship in conventional medicine, which ideally need to be taken into account when conducting a comprehensive ethical analysis.

Homeopathy is very different from conventional medicine in its underlying theory and in its treatment methods. It is also mostly practiced outside state or insurance-funded health care. These circumstances have an impact on the interaction between the homeopathic doctor and his or her patients and allow for a different dynamic to develop between them. Wherein this difference lies and what this could mean with regard to medical ethics is the focus of this chapter.

Because all participants had worked as conventional doctors prior to becoming homeopaths insights into what was special about the homeopathic doctor-patient relationship could be gained by making comparisons. For this reason, our conversations moved between the two medical fields. The participants often used stories to convey to me what they felt was particularly significant. In addition, I specifically phrased some of my questions with issues that are considered fundamental within the bioethics discourse in mind, for example the issue of informed consent.

In the first section of this chapter the discussion focuses on what the participants saw as being the most important aspects in their relationship with patients. Trust, respect, honesty and humility were highlighted, but also the need for an active participation by the patient. The metaphor of the "trusted companion" is used to encapsulate the essence of this kind of encounter. The second section, to provide a counterpoint, looks predominantly at the challenges that are faced by conventional doctors. It was particularly remarkable how quickly the participants referred to the longer consultation time when they were asked what was different in homeopathic practice. Although the issue of time might seem trivial, this clear agreement in all the interviews draws attention to its significance for the doctor-patient relationship. The third section, therefore, explores why a sufficient time frame is considered as being so crucial. It also examines what reasons lie behind the lack of time in conventional medicine. The final two sections cover the issue of informed consent and assessment of treatment effectiveness without the back up of scientific research. Through a shared decision-making process homeopathic doctors can assure that the autonomy of patients is preserved even when there are not enough scientific data to allow for an informed consent in the conventional sense.

Shared humanity

Although the interviewees spoke in general very positively about their work as homeopathic doctors, when I asked them to talk about their interactions with patients now, compared to when practicing as conventional doctors within the public health care system, their responses were even more enthusiastic.

Dr E, told me that she found the relationship with her patients very rewarding. She believed that it was much easier to achieve a deeper and more personal relationship as a homeopathic doctor than when she was practicing as a conventional general practitioner. She experienced the difference very early on, while she was still a medical student, as she had chosen to do her internship in the clinic of a homeopathic doctor.[16] There she had the opportunity to observe the relationship between this doctor and her patients:

> Initially I thought that couldn't be true, there are only friends of hers who come to her surgery until I realized that all her patients *are* her friends. I found that so great then, everybody who came went "oh hello" – really hearty. She never saw more than four or five people a day and with those she really talked. Complete families – they all came, grandparents and …

Now, in her own practice Dr E also enjoyed this sense of being involved in the lives of whole families:

> I am a family doctor in a sense, as we are in the countryside, and I am there during the nights and always there for people. I am something like a normal family doctor and I see whole families from infants to the grandparents and that over years. That's something really nice.

I was curious about what kind of people Dr E's patients were, as they all had to pay her out of their own pockets rather than getting government-funded health care:

> It is an interesting mix of people. I have lots of organic farmers of course, then I have a lot of young people, like teachers for example; there is a big school where we are. But also just very ordinary people, where there might have been an illness in the family, where the whole family had changed their lifestyle years ago to a different diet and so on and who then have discovered alternative medicine more and more. And then the children and grandchildren also have started to come to me. Often they are very ordinary people from some little houses in the suburbs, who in fact can't really afford to pay for alternative medicine, who actually had to make an active choice not to have a car so they can have all three children treated with homeopathy. I have to say I have

[16] In Austria it is possible for medical students to do such an internship because homeopathy is legally practiced under the umbrella of conventional medicine.

> a real colorful mix of patients. The only thing I really haven't got is unpleasant patients.

When I asked her why she thought her patients had chosen her and what it was about her patients that she particularly valued, she said:

> Some come and say: "My neighbor said she brought her children to you and it was very good and I want to learn about it too." I actually get that quite a bit; that we start from scratch with people who didn't know anything about it beforehand. But they are already coming with the desire to learn about it.
>
> I only have people coming to me who are keen to participate, people who have an interest to do it properly, who are co-operative; that I find very noticeable, particularly when I fill in for a colleague [practicing conventional medicine]. There are of course also nice people, but there are quite a few where you know that they only come for a medical certificate to get sick leave, and they don't seem to be interested at all if they could do something for themselves.

It was quite obvious that Dr E preferred patients who viewed their health in a similar holistic way as she did, and who would also try to help themselves by addressing the problems that came from an unhealthy lifestyle:[17]

> Hahnemann[18] at the end did not prescribe any globuli[19] to anybody if they did not also alter their lifestyle, because he would not "cast pearls before swine" [Perlen vor die Säue]. Well lifestyle is part of it. When somebody eats too much all day and drinks too much all day then I can give him Nux vomica[20] globuli as much as I want and it won't help for long.

When I asked Dr D whether he thought that the doctor-patient relationship was different in his homeopathic practice than when he was working as a conventional physician he laughed: "I think you have to ask my patients that." And then he continued:

> From the feedback from patients or from my own experience I think it is a huge difference, just considering everything around it.

With "everything around it" Dr D referred to the very different setting, like the longer consultation times or the private nature of the service, where patients had to make an active choice in order to access this approach. I asked Dr D what he saw as the most important

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[17] This could be viewed as being an exclusive stance, which some might consider ethically questionable.

[18] The founder of homeopathy.

[19] Little homeopathic pills

[20] Homeopathic remedy, often used to treat the effects of over-indulgence in food or alcohol

feature in his interaction with his patients. His immediate answer was that it was trust. When I questioned him how he made sure that he established trust, he said that he found the best way was to be completely open and honest with patients, even if that meant to also show his uncertainties and to admit when he did not know the answers:

> There are a lot of patients who really have a lot of trust in me and I think that is something that is very important. And dealing with a patient in that way, they appreciate it more than if you would always give the impression that you have everything under control and you can handle every situation. You also find that when you say, "here we can't do anything" or "let's get it looked at" [by a conventional specialist]. That is appreciated, that is conducive to building trust.

However there was also a downside. Healthy trust could, in some cases, turn into a less healthy dependency:

> I have quite a few patients, and that is actually too much of a good thing, they would never do anything without checking with me first. That is almost too much dependency. But they say, "I have so much trust, I don't want to do anything else". That is nearly too much, but principally I think it is very important that there is a basis of trust.

The issue of patients being too dependent or having unrealistic expectations also came up with the other participants. Dr C was very open about the feelings he had in situations when he was not sure how he could help a patient. He became quite passionate when he told me about some encounters with patients who expected too much of him:

> When I am at a loss or when I feel my limits, to admit that to the patient doesn't come easy to us doctors. It doesn't come easy to me either. It particularly doesn't come easy when there is a huge expectation that the patient brings to me. "Doctor, you are my last hope". Then I should start with, and sometimes I do just that, that I begin with that. Because by this he already expresses the whole dependency and the whole blindness. What does he expect of me?

When I asked him what he would say in such a situation, he took me somewhat by surprise with his stern reaction. If he was faced with that sort of expectation, he said that he would get up from his chair and move over to the side and tell the patient:

> "Continue talking to this God over here!"
> I don't want to respond on this level. Or at least respond in a way, that he becomes aware about the kind of expectations he has and that he probably has already consumed an x number of therapists and x number of doctors, always with that same introduction.

It was very noticeable how reflective and open the participants were about the effects that their own personalities had on the relationship with their patients. When I talked to Dr C how

he had come to that self-understanding and what it meant for him as a doctor in relation to his patients, he said:

> I have to watch myself. That is what I mean with an ongoing process of reflection, so that I notice, where my weak points are. I should of course not expect of myself that I will ever be perfect, and that everything will be sorted. I am as much hidden from myself as the patient is hidden from himself. I can only know what is illuminated on my island of consciousness.

Another important aspect that came out of the accounts of the participants was that the concept of respect for the patient also seemed to have a much broader meaning. This came through, for example when Dr C told me how he saw himself in relation to his patients:

> A colleague in Salzburg has introduced the term "companiero" in relation to the homeopathic remedy. So homeopathic remedies are nothing more than companions. And when I am here, as the knowledgeable and understanding homeopath, in the service of my "companieros" then I am nothing more than a companion too and I look together with the patient to what it is pointing. What sort of longing is there in the depth of that human being? What are the true aims? What wants to be brought into consciousness through this illness crisis?

He went on to explain why he saw it as so important to relate in this particular way:

> It is a "being on his side", but not a "knowing better"; because from the moment I "know better" I put my construction of the world and of reality above his and that can have a disastrous effect. How he looks at the world is his alone and that is fundamentally okay. For his conditions it is always optimal. I might be able to point out to him how certain conditions can have a destructive effect and that he might end up constructing his reality in a way that is destructive and where he does harm to himself in the process. In this way I can accompany him in a therapeutic sense.

Dr C continued to describe to me how he strongly believed that the solution was already within every patient and how his duty as a doctor was to stimulate that potential and also to help the patient to gain trust again in that ability:

> I go along with him, so that he learns to look more lovingly at himself, so to speak, more appreciatively, to start believing again in his own potential, to trust himself again, to accept the wisdom of the body and so on; and when I have guided him to this place then I can also walk together with him a little on his path to freedom, which he desperately needs, so that he can find access again to his joy for life and his acceptance of life.

The aim to enable the patient and the belief in the patient's inherent strength was based by the participants on the image of the life force that they could help support. The patient was understood as having first hand knowledge about the state of his or her own organism. From

this understanding it followed that the doctor had to respond to each patient in a way that was tailored to him or her as a unique individual; in fact an individual therapeutic approach was deemed as being essential. As Dr B expressed it:

> You can define it like that: For everybody it is what suits him. I have to let everybody be what he is. In healing that is expressed by: primum nihil nocere [first do no harm].

Not taking into account the specific needs of each patient, but imposing a generalized formulaic treatment was the same as doing harm in Dr B's view, as it would unavoidably be detrimental to those aspects of the patient that such an approach would miss or override.

For Dr E it meant that she trusted the patient's intuition and tended to follow the patient's lead:

> Well the one thing I always do is to respond to what people want. Some come and say they use Bach flowers at home and they would like to take those. Some people are very clear about what they want. And we usually find something. Not everybody is the same.

I wondered if she ever had any concerns that the patient might in fact be wrong:

> I would not do something that I would see as nonsense from a medical point of view. But that is very rare. Most people instinctively select the right approach.

Dr D spoke in a similar way about his patients' inner knowledge. He also thought that it was people's intuition that had warned them about the potential harms in conventional treatments in the first place and it was for that reason that they came to consult him:

> There is, how shall I say that, a kind of healthy instinct that people have. That they instinctively feel, it cannot be good if I have twenty pill packets at home and I am in fact getting worse from day to day. In families it is often the children who are the concern. In my case it was a step to new thinking. One has not such a good feeling; one thinks there is something about this substance [pharmaceutical] that is not entirely positive.

Dr D also, like the other participants, expressed his belief in the inner strength of the patient's organism, which he was trying to support through homeopathic therapy:

> I think one underestimates the ability of the organism to regenerate. There is certainly more possible. I think it is really only a question how much one succeeds in understanding the patient and coming to the core and finding the right remedy.

Hearing the stories of the interviewees it seemed that through practicing non-conventional therapies the participants had greater freedom to develop their own ways in finding rapport

with their patients. Although they were still registered physicians, working outside the mainstream and outside the conceptual framework of medicine, meant that they did not have to adopt that deeply engrained style of correct professional demeanor. The participants were also not hampered by time constraints, and there was no need for them to speak in "the voice of medicine", to use Mishler's (1984) term[21]. Mishler juxtaposed "the voice of medicine" with "the voice of the life world" and argued that they are not only incompatible but also that in the conventional doctor-patient interaction the use of "the voice of medicine" has the effect of asserting control and alienating patients from the meanings of their illness. Although this research is based solely on interviews, and therefore cannot give an account of the actual language used between the participants and their patients, unlike the study by Barry and colleagues (2001), it does appear that "the voice of the life world" predominates in these homeopathic consultations and is not in danger of being suppressed. The results from the research by Barry et al. (2001) will be picked up later in the discussion that contrasts the dynamics in homeopathic practice with those prevalent in conventional medicine

The idea of using a metaphor or model to describe the homeopathic doctor-patient relationship seemed fitting in view of the various models that had been suggested to describe the dynamics between doctor and patient in conventional medicine. Some of those models were intended to illustrate what manner of relating should be discouraged; others again are there to provide a positive prototype for the clinical encounter, which doctors can strive to emulate. Veatch (1991), for instance, describes and criticizes the old fashioned "priestly" doctor, who acts in a paternalistic style under the sole banner of "benefit and do no harm" but without concern for the patient's autonomy. This kind of physician chooses the treatments *for* rather than *together with* the patient, and might even resort to deceiving the patient, if this deception seems beneficial. As a contrast Veatch paints the so-called "collegial" model, in which the doctor is behaving like the "pal" of the patient. Here doctor and patient are "pursuing the common goal of eliminating illness and preserving the health of the patient".

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[21] As cited in Barry et al (2001), Mishler built on Habermas' Theory of Communicative Action and applied it to medicine. "Habermas' theory of Communicative Action posits a dialectical struggle between two types of rationality, which in turn produces two different types of world (Habermas, 1984). On the one hand, is communicative or value rationality, which inhabits the lifeworld, and on the other is purposive rationality, which inhabits the system. Habermas' project is a moral one and he sees the dangers of the growth of the system as threatening to engulf the lifeworld. (Barry et al, 2001, p.488)."

However positive that might sound, Veatch discounts this approach as inappropriate because it ignores the reality of the inequality between doctor and patient. The third of Veatch's model is that of the "doctor as the patient's covenant". For a physician to view him-or-herself in this way is considered to be the most commendable attitude in the eyes of Veatch, and of other authors (May, 1983), as it reflects the underlying "sense of vocation and the desire to help those in need" (Campbell et al., 2002, p.23) and at the same time considers the patient's perspective. Another image that has been used is that of doctor as "captain" of a ship, which Gillett (2004 a) suspects might have its origin already in Hippocratic writings. Here the patient is seen as being the "owner" of the ship. The captain, although expert and in command of the ship, is nevertheless accountable to the owner, who has the final say. Nie (1996) introduces us to an image of the doctor from the Chinese tradition in which the physician is pictured as the "general". In contrast to Western thinking, where the term "general" invokes thoughts of battlefields, in traditional Chinese medicine this military metaphor refers to quite a different scenario. According to General Sun Zi of 2000 years ago, who promoted to "subdue the enemy without fighting", a good physician is like a good general who is at his best when he has prevented war. "A good doctor treats disease by preventing its occurrence" (Nie, 1996, p.1099).

Despite the variety of models, each of them builds on the implicit assumption that the doctor has the ability to solve or help prevent the patient's health problem, as it is he or she who is in possession of the necessary medical expertise. If the doctor then offers this knowledge in a way that also takes account of the patient's overall life plan and circumstances then the interaction is seen as ethically acceptable. What all these models of the doctor-patient relationship lack however, is any explicit reference to giving respect to the patient's expertise that comes from the patient's internal, first-hand knowledge. Even though there is the notion of partnership in some of the models, it is used more in the sense that the patient joins the doctor in viewing the illness through the objective medical lens and then patient and doctor together negotiate the treatment plan. The wisdom that comes from the patient's subjective experience does not feature as an important diagnostic nor therapeutic element in biomedicine and it is not mentioned as deserving respect in any of the proposed Western doctor-patient models.

Another observation about these models is that, although quite different in character, all assign a distinctive functional role to the doctor. Neither signals that doctor and patient are at the same time also meeting as fellow human beings who share in the experience of the human condition. Reminding doctors about their own humanity, with all its limits, pains, and uncertainties, might be of great benefit to the relationship, particularly with respect to young doctors who have, in most cases, not gone through a severe illness themselves. Without this awareness, the professional role can serve as a safe place for the doctor to hide in. Kleinmann (1988) brings this aspect to the fore in his book "The Illness Narratives" when he recounts, for example, an experience he had as a young doctor with a group of quadriplegic and paraplegic adolescents. In this situation he was severely challenged by one group member for his detached professional response to their misery. In retrospect he realized that he had been unable, for a number of reasons, to react as an empathic fellow human being, who would probably feel just as bad and furious as those young people, had he been in their position. The opposite is true as well, which Kleinmann highlighted in an example of a physician who was well-known for his most humane and empathic approach to his chronically ill patients. His resolve to become a doctor had been motivated through his own personal experiences, which were his father's death from diabetes when he was still a child, and his own chronic problem with asthma.

To describe the distinct way in which practitioners of complementary and alternative medicines interact with their patients, some authors (Launsø, 2000; Lyng, 1990) have used the term "facilitator". However, from what emerged out of this research, that image does not adequately capture the characteristic of the relationship these participants had with their patients. The metaphor of "trusted companion" comes closer because it transmits something of the emotional warmth that seemed to permeate the attitude of the participants towards their patients. The term also intends to allude to an understanding of shared humanity, which was a powerful underlying theme, but not to exclude expertise on the side of the homeopathic doctor nor to ignore that there can be a differential of strength between the two parties. Notions of humility, trust, friendship, compassion, curiosity, respect, even of awe, and the consciousness of one's own fallibility together made up the model of the "trusted companion". There was in addition an expectation that patients would take an active part and not leave all responsibility on the shoulders of the doctor. On these terms, the therapeutic encounter did not only seem to

benefit the patients but also gave the doctors a great sense of job satisfaction, as they did not have to alienate themselves from their own humanity.

Among the conventional doctor-patient models it is the "covenantal doctor" that resembles most closely the "trusted companion" because of the underlying sincerity that characterizes them both (May, 1983). Dr C's description of himself as a "companiero" walking alongside his patient conveyed something similar in spirit as the "physician as covenant". "The covenant relationship is open-ended, a promise to show active concern for the welfare of others" (Campbell et al., 2002, p.22). It captures a commitment to be fully there, to not abandon and, particularly, to respect. One can also discern that this cannot be a hierarchical relationship but rather one between equals, in which one party has the ability to support the other.

The "physician as general" in the sense of the Chinese tradition resonates with the intention of the participants to help their patients maintain their wellness. Prevention as the preferred therapeutic strategy builds on the awareness that every battle has its price and therefore non-maleficence will be best understood by not letting a state of illness arise in the first place. Throughout the interviews, the participants had stressed the importance of a kind of health care that focuses on the preservation of health.

The meaning of respect for patients also had a distinctive flavor. One element is the deep regard for the patient's expert knowledge. In the homeopathic approach the main strategy is to find out how patients subjectively experience their bodies' symptoms and then to select a remedy that is most closely matched to that particular complex of symptoms. Nobody apart from the patient can have that insider knowledge and therefore the homeopathic doctor is keen to elicit as much detail as possible from the patient, and of course always views what the patient has said as being undoubtedly authentic. For orthodox practitioners this is quite a different situation. One barrier is the conventional doctor's gate keeping role, for example to social benefits, which immediately infuses a degree of vigilance and distrust in doctors when listening to the patient's story. The main difference, however, is due to biomedicine's specific approach, where the patient's symptoms have to be translated into disease, which is "defined strictly in terms of morbid anatomy" (Lyng, 1990, p.103). If the two do not match, if the patient complains of symptoms that the doctor cannot objectively validate, then it is more often than not the case that patients find that they are not believed. A qualitative study on

patients with rheumatic disease very clearly brought out this problem (Haugli, 2004). In this research quite a number of patients felt aggrieved because doctors did not acknowledge their expert knowledge and they experienced a loss of dignity as a result. In the voice of one patient:

> "It is my pain, I have started putting it like this; you are the expert in your field, but please listen to me I am the expert on my body. You cannot sit there and say how much pain I have got, or how my pain is. Trust me that is what I mean" (Haugli et al., 2004, p.171).

Another angle on the notion of respect has its origin in the holistic view about health and illness where the organism's unique way of maintaining homeostasis is in itself considered worthy of reverence. When Dr C spoke about how he wanted to help patients discover the specific significance of their illness, he was also careful not to put his own "construction of the world and reality" above his patient's. This is quite different to what Beauchamp and Childress (1994) described respect to be: a safe-guarding of the patients' autonomy, their values and life plan. Approaching patients with the attitude that what they are exhibiting is the best possible response to their external or internal conditions not only speaks of practitioner's humility but also shows another conception of health and illness. Quite in contrast to the commonly held belief, in which illness merely represents a biological defect, the underlying understanding here is that health and illness are indicators of the individual's ability to adjust and to maintain equilibrium. How successfully under varying stressful conditions health can be maintained, or how severe a sickness will become, can be seen as the organism's expression of, what Nietzsche called, it's "plastic powers" (1988, cited in Danzer et al., 2002). "Seen in this way, sickness is at the same time a deficiency and an accomplishment of the individual or the organism" (Danzer et al., 2002, p.18).

The kind of respect that the participants were displaying to their patients was therefore not only respect for the "patient as person", but included also being respectful to the "patient as organism". In medical ethics the personhood of the patient is considered as deserving respect. To be regarded a person an individual has to be "self-conscious, rational, and in possession of a minimal moral sense" (Engelhardt, 1986 cited in Campbell et al., 2002). Consciousness is the feature that we value highest and when through dementia or other brain disorders this consciousness has been lost, we find ourselves facing quite a dilemma. Can we still regard this individual worthy of care and respect now that what once was human is lost? Moral

intuition will lead most of us to answer this question with "yes" and as Campbell et al. (2002) reasoned, this intuition is grounded in the notion of human dignity and in the social embeddedness of the patient. Perceiving the organism as a holistic entity, however, brings another dimension to the conception of respect, as it fosters a feeling of reverence for the body's functioning and its inner wisdom and, although consciousness is considered a deeply human characteristic, it is still only an aspect of the whole.

As a homeopathic doctor it also seems to come easier, at least judging from the accounts of the participants, to be honest with patients. One might speculate as to why that should be so. Perhaps those doctors did not feel the need to have all the answers and to be authoritative in all situations. Therefore, truthfulness could go deeper than what we usually expect, more akin to what May (1983) described as an essential ingredient in a covenantal relationship. "The virtue of covenantal fidelity expands the question of truth-telling in the moral life. Truth becomes a question not only of truth but of being-true" (May, 1983, p.142).

Usually "truth telling" in the medical context stands for the process of conveying a diagnosis, the prognosis of an illness and the different treatment options to the patient. Medical truth is often portrayed as something that can be told with assurance because it is backed up by scientific data. For some cases that might of course be correct, the reality however is that in many cases it is not. In those situations "being true" would require that doctors would also feel able to communicate to the patient that there are uncertainties and at times even that their own limitations prevent them from dealing with the patient's health problem. Although it seems an obvious thing to do, reading Gillett's statement reminds us that this kind of honesty is definitely not the norm in medicine, but still rather the exception:

> We can communicate these uncertainties in such a way that the patient realizes that the problem is taxing and difficult and that a good outcome cannot be guaranteed. Most patients can appreciate such difficulties, but often they are offered no more than a glimpse into a complex and kaleidoscopic situation glossed by false medical assurances that we have it all under control. It is no wonder, therefore, that they become disillusioned and even cynical when our confident assertions prove empty and worthless. Statues with feet of clay should not accept the status of gods (Gillett, 2004a, p.81).

Contrary to what many doctors might fear, namely that their patients would think less of them and would no longer believe in their competence if they knew the full truth, the patients of Dr D responded to his honesty by being more trusting of him. The group of patients with

rheumatic disease Haugli and colleagues (2004) had interviewed for their study on the doctor-patient relationship reacted in exactly the same way. The researchers have summed up their findings by stating that:

> The concept of trust also included that the doctor could admit when he did not know the answer. Honesty was important to be able to establish reciprocal trust, and admitting lack of knowledge when that was the case was necessary in building a trusting relationship (Haugli et al., 2004, p.171).

Highlighting differences

To understand more about the influence the homeopathic approach was having on the doctor-patient relationship, it seemed useful to consciously contrast it with conventional medical practice. The participants, because of their prior experience as orthodox physicians, were in the best possible position to make that comparison. First of all, I wondered if they believed that it would be possible to practice conventional medicine in a humane way, similar to their description of homeopathic practice.

Dr A:

> For humane physicians, yes it is possible, for human beings, who are conscious of their inner qualities and who move towards a resonance with the inner qualities of the patient. I have met very humane orthodox medical practitioners. Principally I believe, yes. Regrettably though, the inner world gets cut out from the orthodox medical training and also from the human development of medical practitioners, also one's own inner world. They have to become hard and have to close down for the system and have to lose these qualities or suppress them, or put them aside.
> But I think we are living in a time now, in which it is highly necessary to integrate these split off parts again and to unify them with a scientific or objective knowledge

Dr A also spoke about the loneliness of his conventional medical colleagues. I was interested in what he meant by this as it seemed to me that it might be lonelier for non-conventional doctors, practicing on the fringe and in a minority position:

> He does have the legitimization through the others, who do that too [work as orthodox physicians], but as a human being he is alone. He has no supervision; he cannot express how he is doing when he sees somebody die or when his treatments don't help. Alone in this sense. When he is left alone by himself with his emotions.

When asked about what would be needed for medical doctors to change that and find a way to acknowledge and integrate their feelings better, he said:

> Self-knowledge in the sense of psycho-therapeutic openness towards oneself. Openness, awareness and acceptance of one's own feelings, emotions and intuitions, that people embrace the inner life. But again, not as a contrast to rational thinking, I don't mean to go back to pre-rational conditions, but I believe that that is definitely not a contradiction.

> I think though that nobody can be forced. Convinced perhaps yes. I believe it is necessary to work on convincing and I also believe it would be a great relief for orthodox physicians, if they would open up to their inner world, a great release, because they wouldn't have to stand so alone any more with many things. They do have problems. There is a high suicide rate amongst doctors and symptoms of strain. But I don't think you can force them into it [zu ihrem Glück zwingen kann].

Dr C's view however was much less positive or optimistic. He did not think that there was room in conventional medicine to develop the kind of doctor-patient relationship he so much valued in the style of his work. When asked if he could imagine this, his answer was:

> I have never experienced it. Neither in the hospitals nor during the three years I worked as a house surgeon. I was reprimanded by consultants when I sat down on the bed of the patient so that I could look him in the eye, not from above but from the same level. And they argued that I was lacking awareness about hygiene. And I never quite understood what this was all about. Such experiences mount up of course.

After some more reflection, however, he qualified his statement and pointed out that the difficulties for doctors to maintain a humane connection derived from the restricting structure that the biomedical perspective imposed on the communication:

> I can of course not say all doctors, there are certainly some who are, in spite of the scientific method, which doesn't need the dialogue – it needs data from the medical history. But these data are shrunk down to the minimum, but otherwise, how the patient feels, is a nuisance. To go into that any further is wasting time and what is important are the lab and x-ray results. That means the dialogue turns necessarily into a private concern of the more or less empathic doctor, who happens to also care as a human being for the patient. But it does not flow into finding a therapy and it does not flow into the approach to the patient. The necessary strategies only follow from the hard data. I can also see how hard it is to establish psychosomatic medicine in the hospital or just to appreciate it. There might perhaps be a psychologist, if the hospital is a bit more progressive, who will be asked, may be, to also speak to the patient. But the doctor who is in daily contact with the patients has no inkling about this, about how to lead a dialogue. He has never had any training in it and he has also had no teacher in that field. That's how I see it.

Dr C told me that a humane encounter was just as important to him as it was for his patients and that he would not want to be working as a doctor if that was not possible:

> I might rather give up my job, because I am also a musician. I would have a much deeper kind of fulfillment in music if I didn't have the possibility of meeting the patient as I have learned it in homeopathy on one hand and as I have come to know it as a systems therapist on the other.
>
> I do not want to do anything that is not satisfying. And the satisfying part is the encounter with the patient, because here I am alerted to the deep suffering, because

> here, with the way I lead the dialogue, the patient is ready to speak about things which have upset him a life time, but for which he had never found an open ear before.

Dr D also spoke about the deep satisfaction he felt in his work, which he thought came from the insights and understandings about people he gained in his homeopathic clinic. His enthusiasm, he explained, came through using a particular approach within the homeopathic method, which helped him to discover the very root of the problems that his patients brought to him:

> to understand what is happening here, why it is as it is, why he has produced these weird symptoms. What is really happening here? That is the fascinating thing, when I can recognize a theme. When somebody tells me his life story and suddenly a theme crystallizes. And it becomes completely obvious that it is that particular theme. It is so much more fascinating, it is for me personally much more fascinating, it is so much more alive and much more varied.

I was wondering, after the predominantly positive accounts about the doctor-patient relationship, if practicing homeopathy was an insurance against the abuse of power, which had often been identified as problematic in the conventional medical setting. It was surprising to hear that, despite the constructive effects homeopathy purportedly had on the doctor-patient relationship, Dr C still did not think that the practice of homeopathy alone would suffice to prevent abuse of power by the doctor:

> I don't see that it is much different to orthodox medicine. The unresolved issues of the doctor flow into the doctor-patient relationship as much as the unresolved issues of the patient. What sort of game is played, also what kind of power game is played, we cannot eradicate through the method. Only, in the context of homeopathy it is not quite as dangerous. There are enough homeopaths though who would give a remedy, a high potency for example, and then they refuse to tell the patient the name of the remedy.
>
> I mean the power games are of course present in Homeopathy too. The only chance that I can see is that there will be more self-discovery. That it becomes part of the medical training. That the physician learns to reflect about his own position. That he goes to Balint groups. That he learns to articulate himself and experiences something corrective as well. As long as that is not the case, all methods are at risk

From the accounts that were given in the interviews it appeared that, in comparison to conventional medicine, the holistic perspective of homeopathy had a significant and positive influence on the relationship between the participants and their patients. As mentioned previously, when the patient's health problem is approached with this understanding, the subjective, internal plane with the individual expressions of suffering has to receive at least as much attention as the objective and measurable parameters. The connection between

traumatic life events or difficult social circumstances and the formation of sickness needs to be taken very seriously, and the homeopathic doctor also has to listen carefully to patients' descriptions of sensations and their interpretations of symptoms as these might give valuable hints towards finding the correct remedy. Although all of this is considered to be an integral and routine part of taking a homeopathic case history, it represents in effect a natural aid for the homeopathic practitioner to relate to the patient as a whole person. In contrast, the biomedical physician, due to the fact that s/he has to take the narrow focus on the disease, has to struggle to respond to the legitimate need of the patient to be first of all seen as a person (Kleinmann, 1995). As Dr C described, case-taking in conventional medicine is a very structured and limiting process. It is designed to bring order into the patient's narrative "by reconstructing the patient's story and extending it along logical lines of inquiry" (Montgomery Hunter, 1991, p.53). Much of what gives illness its context and individual meaning for the patient is stripped away, leaving only what is considered to be relevant for diagnosing disease. Although every healing approach has to translate the symptoms and signs of sickness into its own specific categories in order to make them amenable to therapy, for biomedical practice subjective reports are, although necessary, at the same time untrustworthy unless verified by objective parameters.

> Thus, the doctor is expected to decode the untrustworthy story of *illness as experience* for the evidence of that which is considered authentic, *disease as biological pathology.* In the process, the doctor is taught to regard experience – at least the experience of the sick person – as fugitive, fungible, and therefore invalid (Kleinmann, 1995, p.32).

The interviewees were still able to recall the psychological tension that was brought on by following the conventional case-taking process, but simultaneously wanting to relate in a more ordinary and humane way, all in an atmosphere of time pressure. Judging from their remarks about this issue, they surely would have concurred with Kleinmann, who depicted the biomedical doctor as being in the very difficult position for having to act 'against the grain' and 'with both hands tied behind the back'. Naturally, this does not promote an easy flow in the interaction with patients.

Some insights on how primary care doctors deal with this inbuilt conflict in their daily practices can be gained from the already mentioned study by Barry and colleagues (2001). The researchers investigated what places the 'voice of medicine' and the 'voice of the lifeworld' were given in 35 case studies of the interactions between primary care doctors and their

patients. Their research expanded on Mishler's (1984) study by using a more complex methodology. Through linking the findings from pre-and-post-consultation interviews with patients, discourse analysis of the consultations, and post-consultation interviews with the doctors, the focus was not only on the dynamic in the actual encounter, as it was for Mishler, but also took into account patient expectations, the success of the consultation from the patient's perspective, and feed-back from some of the doctors.

The researchers called it "strictly medicine" when both doctor and patient stayed predominantly within the voice of medicine. "Lifeworld blocked" was used when the patient tried tentatively to bring in the voice of the lifeworld, but where "these glimpses were immediately suppressed as a result of the doctor using the structural sequence of question control" (Barry et al., 2001, p.494). The term "lifeworld ignored" was used when patients spoke in the voice of the lifeworld, but "the doctors completely ignored this and conducted the whole of the communication in the voice of medicine". "It is as though the patient tries valiantly to be listened to on his terms but slowly gives up and retreats into the voice of medicine" (Barry et a., 2001, p.495). And finally, "mutual lifeworld", where both patients and doctors predominantly used the voice of the life world. This communication was perceived by the researchers as the most relaxed, using

> …open-ended questions, active and open listening without interruption; humor; questions directly concerning the lifeworld and voiced in the natural language of everyday life; and empathic statements of recognition, acknowledgement and validation of the patient's feelings. There was a sense that the patient was treated as an equal partner with their own expertise to offer in the diagnosis and treatment of psychological problems (Barry et al., 2001, p.497).

As can be read from the final statement mutual lifeworld was reserved to consultations where there were psychological problems. It seemed to the researchers that only then did these GPs find it legitimate to conduct the encounter in the voice of the lifeworld.

The results from Barry et al.'s research should be taken very seriously as they clearly reflect, which patient situations are often not matched adequately by the typical contemporary medical encounter in the primary health care setting. For single, acute, physical problems like, for example, tonsillitis, hayfever, ear infection the "strictly medicine" consultations were mostly, although not always, rated as satisfactory by patients. None of the patients had a prior appointment and all were aware of the even greater than normal time pressure on the GP. Also

the "mutual lifeworld" consultations were judged positively by patients, but as mentioned, they only occurred when patients presented with psychological symptoms like anxiety or sleeping problems, or in cases where physical problems were deemed to be of psychosomatic origin. These patients were also mostly given longer consultation times by their doctors. However, the concern this research raises comes from the findings about the two other scenarios. Both the dynamics of "lifeworld blocked" and "lifeworld ignored" had unsatisfactory to very unsatisfactory outcomes for the patients.

> There appears to be a lot of side-stepping, ignoring and avoidance of lifeworld issues by doctors that might be construed as being unable to see the patient as a unique being.
>
> In particular, the Lifeworld Ignored consultations showed most evidence of an active dialectical struggle between the two voices. Here patients repeatedly returned to the concerns of the lifeworld and doctors repeatedly ignored them (Barry et al., 2001, pp.502-503).

Most patients in these consultations were suffering from chronic health problems that had a significant effect on their daily lives and they tried to convey those difficulties. The doctors, rather than responding to the patients' lifeworld questions and concerns, however stayed within their biomedical schedule.

> The problem seems to lie with the patients with chronic, ostensibly physical conditions, whose lifeworld concerns, including psychological responses to their conditions, are seen as invalid and irrelevant to the consultation (Barry et al., 2001, p.503).

This situation naturally caused problems for the patients. They did not feel heard and therefore their most pressing and deepest worries were not responded to. This impeded communication also led to potentially hazardous misconceptions for some patients about the management of their medication. The doctor's perspective presented the mirror image of the patient's dissatisfaction. Doctors considered the patients with chronic conditions and with complex bio-psycho-social agendas difficult to manage. Multi-leveled problems are not amenable to a purely biomedical approach and a large number of lifeworld agendas takes a lot of time and skill to untangle. In many instances patients bring problems that seem too broad and the systemic restrictions too great, leaving doctors with a sense of being overwhelmed and unable to really make a difference, as Kleinmann (1988) has highlighted by re-telling the accounts of different physicians. No wonder therefore that some GPs call those people with chronic multi-level problems their "heartsink patients" (Barry et al., 2000, p.1248).

That there might be a link between these findings and the growing popularity of complementary and alternative medicines, particularly amongst people who suffer from chronic health problems, can certainly not be dismissed (White, 2000). Looking back at the interviews the contrast is immense between the spirited account Dr D gave about his job satisfaction in his homeopathic clinic, and the challenge the GPs felt, when they were expected to respond to non-biological complex health problems, armed only with a biomedical framework and a few minutes of consultation time. Although the focus has to be foremost on the patient, the doctor's predicament cannot be ignored if the aim is to create healthy doctor-patient relationships.

Kathryn Montgomery Hunter (1991) is an author who has written in detail about the specific nature of the medical discourse and the alienating effect on patients when their illness narrative is re-interpreted to fit into the biomedical disease categories. For Montgomery Hunter there seems to be no real solution to this situation, apart from appealing to doctors to remember that there is more to a patient's illness than just the medically constructed story.

> The incommensurability of the experience of illness and the medical accounts of it may be an ineradicable part of Western medicine. As both an outgrowth of the clinical ontology that facilitates the daily work of medicine and the inevitable consequence of medicine's appropriation of the patient's story, it is almost certainly unavoidable (Montgomery Hunter, 1991, p.134).

The promoters of the so-called "patient-centered medicine", however, make a strong case for finding a way, which enables doctors to incorporate the patient's lifeworld, as they believe this is crucial to an ethical practice of medicine. Like Mishler, who saw the side-lining of the patient's lifeworld in the medical encounter as a moral problem, these authors also argue that the biomedical system has inherent negative effects on the doctor-patient relationship, which need to be addressed.

> Medicine has perennial moral problems, two of which are particularly serious in the present age: insensitivity to suffering and abuse of power. The distancing produced by our abstractions makes us especially prone to the first; our greatly enhanced prognostic and therapeutic power makes us especially liable to the second (Stewart et al., 1995, p. 18).

Many doctors would feel misrepresented by the claim that they are insensitive to suffering and abuse their power and one can confidently assume that most doctors chose their career with a belief in the goodness of the healing vocation. Barry and colleagues (2001), however highlight

the insidious and unintended effect the "voice of medicine" can have on patients in the medical encounter.

> These distorted patterns of the voice of medicine are incompatible with the more natural, undistorted communication patterns of the voice of the lifeworld. The voice of medicine has doctors maintaining control within a power imbalance. As a result the coherent and meaningful accounts of patients are suppressed. The result is a struggle in the consultation between the different modes of the two voices and resulting disruption and fragmentation of communication. This struggle is sometimes invisible (Barry at al, 2001, p.489).

The authors also add: "The struggle need not signify any lack of moral intent on the part of the doctor."

The issue of power had also been addressed in the interviews, and interestingly, although homeopathic medicine in itself can never cause as much harm to patients as modern technological medicine and although the dialogue with patients is not constrained in the same way as described above, power issues were not seen to be reserved to the biomedical context alone. Being in the position of the physician, to whom a patient comes for help, can be enough to encourage a sense of hierarchy. In the opinion of the interviewees, the best safeguard against abuse of power lay in the self-awareness of the medical practitioner. Some mentioned their belonging to a "Balint-group", which operate in a format where doctors present difficult situations with patients to one another to reflect on their own feelings and their own input in the incident. Again, although the need for greater self-awareness and emotional openness is promoted to conventional medical practitioners (Balint, 1957, Epstein et al, 1993, Marshall & Smith, 1994; Clarke & Coleman, 2002) there was an agreement amongst the interviewees that the biomedical training produces the opposite effect. Renee Fox (1999) made observations about medical students, and described their internal dilemmas when they were trying to adapt to the culture of medicine. The process these students went through she called "training for detached concern" where they were "struggling to attain the sort of dynamic equilibrium between composure and compassion that will enable them to function professionally without (to use their word) becoming too 'dehumanized'". However the coping mechanisms they develop were often in the form of emotional defenses, "...defenses that not infrequently are tipped in the direction of self-protective detachment" (Fox, 1999, p.18).

The other side of the coin of the detachment from the patient's humanity can be the simultaneous detachment from one's own, a toll that had also been referred to by the

participants. Loss of job satisfaction and, the worst-case scenario, a higher than average risk of suicide for physicians were mentioned by the interviewees as being the downsides of practicing conventional medicine. These problems are also well recognized in the literature as the symptoms of the particular stresses that the work as doctors in the milieu of modern medicine can produce (Miller & McGowen, 2000).

Precious time

This section on the subject of time allocation in medical practice was not only inspired by the strong response of the participants, but also by my own and most other people's experience as patient in a rushed medical consultation. The point all interviewees highlighted as positive was that they were now able to spend substantially more time with their patients than they used to when still working in conventional medical practice. Lack of time, they thought, had an extremely detrimental effect on the doctor-patient relationship. It was simply impossible to go into people's problems and get an appreciation of what was going on for them when there were only a few minutes of contact.

Dr E told me that she was recently reminded of what it was like not having enough time for her patients, when she filled in for a colleague to cover his conventional, public insurance funded practice:

> I have had eighty patients in one morning, and I was running from one to the next and I knew very well that here was somebody I should talk to, because it was obvious that he was having problems, but I also knew there were already three others waiting outside, and the best thing I could do is to tell him that he should find a psycho-therapist, but I have only got three minutes. I always know after I have done this kind of work again that that's not for me.

Comparing this experience with the account Dr D gave about time management in his homeopathic practice really highlighted the contrast. He said that particularly on their first visit it was crucial that patients were given a lot of time.

> At the first consultation it is mostly not under one and half hour to two hours, sometimes longer. In difficult cases it can be three hours. There is ultimately no limit if it is necessary. Sometimes it is faster. It all depends on how one can enter into a dialogue with the patient, or in fact it is less a dialogue but it is rather about what the patient communicates himself. And one should try to bring oneself in as little as possible, but just start it off. But in orthodox medicine it is about "what symptoms do you have", "let's see that we get control over the symptoms as quickly as possible" and little regard for what really matters.

Dr D tried to give plenty of space for patients to come out with their own, uninterrupted descriptions so that he could gain a comprehensive understanding, which needed to be as immediate and authentic as possible. He said, the greatest distinguishing factor between case taking in homeopathy, compared to conventional medicine, lay in the broadness and openness of enquiry and it was necessary to allow a lot of time for this:

> Well it matters to understand the patient in all his facets, I think. To understand why he needs this symptom right now; or why he has developed it exactly three years ago. What happened, what had changed in his environment, in his life style what were the events? Or why do always the same things occur? There are for example patients who injure themselves over and over and it is interesting to find out why and whether it is always the same dynamic. Then there are the questions that are asked to try to illuminate the life history. What has happened in childhood? What wishes, what yearnings, what dreams? I work for example a lot with dreams, because dreams give an access to the unconscious. They show the things in an un-compensated way, because human beings tend to compensate their true feelings a lot and suppress their emotions. To uncover, as well as it is possible, what is the real deep emotion, what is the central theme in this story.

It appeared to me, however, that his consultations might be especially time consuming because the main focus of his interest seemed to lie on the psychological aspects of his patients. When I pointed that out to him he answered:

> Yes it looks as though it is like that, the way I do it. It looks as though I would rely on the psychological. But I think body and soul express the same. But sometimes it is easier to understand the language of emotion than the language of the body. And that is the fascinating thing that the body speaks the same language, even if we often don't understand it. That is the advantage of homeopathy. You always want to know: "How are those symptoms exactly? What are the pains like?" There is a difference if pains are stabbing or pressing. That is a different dynamic. Or how patients describe things. Alone the choice of words expresses a lot about what is going on in this person. One of my patients expressed it like this: "The pains are creeping from out of the corner like a snake". When people use metaphors, there is a lot behind that. In the way they experience the pain, they often experience everything else as well. They experience their environment as though a malicious snake constantly threatened them, it comes out. Always the same image, from the pains to the dreams, to the daily expressions, the experiences, they always reveal as one thing. It might look as though the emphasis is too much on the psychological, but it is a major part. In every second, in every moment we are emotional beings first of all, not machines that work purely physically. To the contrary, at every moment people are primarily influenced by their emotions and their actions follow accordingly.

After hearing Dr D's answer I became aware that I had framed this last question from the usual dualistic view, in which body and mind are two separate entities, rather than from a holistic perspective where they are not separable. This view is so deeply engrained in our

thinking that we think it is natural to have different approaches to each of the two dimensions. It is generally understood that more time will be needed for the exploration of psychological problems. Psychotherapists, as a rule, reserve substantially longer consultation times for their clients than general practitioners would for their patients. For Dr D however, because of his view, that the physical aspects of his patients could not be separated from the emotional/mental elements, it was obvious that he would need enough time to get the whole story.

Research on time management in primary care has shown that lengthening the booking times up to ten minutes per consultation in a British general practice it already made some difference and achieved an increase in satisfaction for patients and doctors (Williams & Neal, 1998). Another study from the Glasgow Homoeopathic Hospital (Mercer et al. 2002) showed that enablement of patients was linked to the perception of empathy by doctors, which, in new patients, could clearly be linked to the length of consultation time. A similar message comes from a survey of 25 994 adults, who attended 53 British primary care practices. The degree of enablement people felt after the consultation correlated most significantly with the duration of the consultation and how well people knew their doctors. Increasingly, doctors speak out about this topic, particularly as the demands for a more patient-centered approach is growing. In a study that explored the shared decision making process in general practice with regard to the use of medication (Stevenson et al., 2000), the researchers found that in most cases not even the basic requirements were covered, like giving sufficient information or enquiring about the patient's view. Doctors had the opportunity to give their feedback about the barriers to following through all four stages of the shared decision making process.[22]

> Unsurprisingly, the pressure of time was commonly cited as a factor which reduced opportunities for shared decision making, and one GP commented that it would take an hour to satisfy all four characteristics (Stevenson et al., 2000, p.838).

Insufficient consultation time in the conventional medical setting is a regular complaint of patients but also of physicians, who find themselves powerless to improve that situation,

[22] The definition of "Shared decision making" for this research was taken from Charles et al. (1997). The four stages were described as: eliciting patients' preferences to match treatment options to lifestyle and values; transferring technical information on treatment options, their risks and benefits; asking patients questions after treatment preference has been voiced, to make sure it is not based on misconception; physician to share his or her treatment recommendation and reasons for it, or affirm the patient's preference.

particularly in places where a corporate structure has taken charge of the health care system. The roots for this state of affairs are found predominantly in the requirement for economic efficiency in order to finance a technological, profit-orientated medicine, which is becoming increasingly more expensive to deliver. In this situation a high turnover of patients together with other limitations that are imposed on the therapeutic encounter are considered to be a financial necessity. Both the resulting constraints on consultation times and on medical freedom are well known to give rise to difficult ethical challenges, partially because of their detrimental effects on the doctor-patient relationship (Taylor, 1984; Parmley, 1995; Gibbs, 2000; Green & Bloch 2001). How the different physicians and authors respond to these problems, however, depends on their analysis of the causes that underlie this situation and also on their assessment of how entrenched the existing power structures are.

Often the causes are seen to be located entirely external to the medical profession (McKinlay & Marceau, 2002; Marcus, 2002) and the whole biomedical endeavor. Marcus for example points to the "powerful economic and political forces that shape the delivery of health care and obstruct reform" (Marcus, 2002, p.2381), in effect claiming in his article that adverse influences on the effective and ethical delivery of medicine come solely from the outside. He does not draw any connection between the premises and aims of modern technological medicine and the problems that have arisen on the many different levels.

Lyng (1990), in contrast, clearly shows the link between the growing disintegration of the patient-doctor relationship and the medical scientific definition of health and illness. His claim is that the more identical the actual practice of medicine has become with the scientific medical knowledge system, the more the relationship between patient and doctor has suffered. To make the initial success of scientific medicine and the now increasing dissatisfaction understandable, Lyng takes us back to the beginning of the 20th century. In America, at that time, allopathic medicine had aligned itself with science through establishing scientific research at medical faculties and including science into the medical curriculum. Due to great public support allopathic medicine rose to prominence, ousting all other medical sects, like for example homeopathy. According to Lyng, most historians are satisfied that "the story ends here", as they believe that the success of biomedicine can be well explained by the convincing power that science brought into it. However, the developments become much more plausible when one follows Lyng's analysis that looked more closely into what really happened at the

time. Traditional allopathic medical practitioners obviously would not have been able to turn into biomedical doctors overnight and some were not even keen to do so at any case.[23] Therefore, although medicine promoted itself as scientific its actual practice lagged far behind this ideal. Lyng points to this "powerful contradiction" that had opened between the "ideological/theoretical dimension of the system and the realm of actual medical practice". This contradiction however, rather than being detrimental, Lyng sees as the absolutely necessary ingredient in the success of the medical profession:

> The fact that people did not become alienated toward medical scientific practice but actually came to patronize regular physicians in increasing numbers suggests a lack of identity between medical ideology and actual medical practice. After the reform of medical education, the public did look more favorably upon the medical profession because they could see that medicine was moving in the same direction as other scientifically based applied disciplines. At the same time, when people visited their doctors, they were treated in essentially the same way as they had been treated in the past. Physicians did not approach their patients in the way dictated by the medical scientific model – that is, as "representative instances of a standard disease category." Rather, they viewed patients as bio-psycho-social entities with personal histories, and their efforts to define and treat the patient's problem typically reflected this view (Lyng, 1990, p.213).

In recent decades, according to Lyng, this contradiction is becoming less and less pronounced and medical practice increasingly resembles the theoretical underpinnings of scientific medicine.[24] The "powerful political and economic forces", mentioned by Marcus (2002) have supported this development but were only eager to do so because of their inherent synergy with the premises of the biomedical model. Understanding human beings primarily as biological entities is compatible with basic corporate interests, because it provides the rationale to look for pharmaceutical and technical solutions to health problems, which are suitable to be marketed in the broadest possible way and for the most profit. For that reason, health care perspectives that locate illness on a broader scale than the physical body, like all holistic healing approaches, are unlikely to ever get the same support of corporate philanthropies that scientific medicine has enjoyed (Lyng, 1990). Those same forces, however are now contributing to the demise of the doctor-patient relationship. Not only the patient, but also the doctor, can be understood as a standardized entity within the frame of biomedicine.

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[23] In fact there was a definite anti-reductionist movement amongst medical doctors in European countries and in the US at that time, which is the subject of the book "Greater than the parts. Holism in biomedicine 1920-1950" (Lawrence, C and Weisz, G. editors, 1998)

"Ever larger populations of patients and practitioners now confront one another in the medical encounter as anonymous individuals engaged in a strictly functional exchange relationship" (Lyng, 1990, p.219). The impersonal nature of doctor-patient contact is increasingly becoming the norm. Consequently, according to Lyng, patients do not expect that personal relationship with their doctors any more. "For patients who accept the profession's claim that it has insured the general competency of its members, one physician is as good as another for providing the services they need" (Lyng, 1990, p.219). Without any major distinguishing features between doctors, patients will look for the most affordable health care services and will find them in efficiently run medical centers, where consultation times are kept to the bare minimum.

The participants of this research also identified the link between the biomedical conceptions and the problems that afflict the patient-doctor relationship. Their response was to remove themselves individually by practicing outside the publicly funded, biomedically orientated health care system and by predominantly offering non-conventional healing modalities. Similarly, but on a broader political level, another group of physicians and authors have started to promote an "integrative medicine" as a further way to remedy the growing problems in health care. Integrative medicine, as the term indicates, aims to include non-conventional approaches into mainstream health care (Weil, 2000; Gaudet & Snyderman, 2002; Snynderman & Weil, 2002). These authors also concur with an understanding that there is an association between the underlying premises of scientific medicine, the therapeutic interventions that it produces and the resulting economic consequences, which have a harmful impact, particularly on the doctor-patient relationship.

Making treatment decisions – the problem with informed consent

Informed consent, as prerequisite for autonomous decision-making, has been one of bioethic's frequently debated issue. Much has been written about the most suitable process. An implicit assumption, at least these days, is that the medical knowledge that is imparted to the patient rests on a scientific basis. Because homeopathy, and also most of the other alternative therapeutic approaches that were used by the participants are, as a rule, not statistically evidenced, at least not to the same degree as conventional treatments, informed consent, in the

[24] Although there are movements towards a patient-centered medicine, evidence based medicine has become the

commonly conceived way, was obviously not possible. There could be no weighing up of statistical probabilities with regards to risks and benefits of interventions. For some authors this would be reason enough to condemn their practice as unethical (Gruner, 2000). However, other authors view the issue from a broader perspective and offer approaches that could be used in this context (Sugarman, 2003; Stone, 2002). Therefore it was interesting to find out how the interviewees dealt with this situation, particularly as they were all registered physicians and, one can assume, very aware of this issue.

When I talked to Dr A about the difficulties homeopathic doctors would have in providing an informed choice, he said:

> Often this question will not need to be asked in that form because it is clear from the outset that the patient comes to me because he wants to be treated homeopathically for this or that ailment.

When I countered that I still could imagine situations where treatment decisions had to be made for conditions on which conventional medicine had scientific data and homeopathy did not, he said:

> There we are back to the methodology where the two methods are totally different. Orthodox medicine, because of its external approach, can afford to use statistical methods, whereas for a homeopath there is an individual, who needs to be looked at as a single case and where an individual decision has to be made, which the patient also has to make for himself. I give him the information that I can give from my perspective but I also won't take the decision away from him. I say get advice from the orthodox doctor and I give you my opinion and then the patient has to decide for himself.

Dr A then went on to qualify his position further by explaining to me how he would weigh off the different options together with his patient, when the solution to the problem was not clear-cut:

> When there is one of those doubtful cases, let's take enlarged adenoids with decreased hearing, where the ENT specialists advises surgery and says "that will solve the problem", and I as homeopath say "lets wait a bit with surgery and see if we can get it sorted with homeopathy", then we set a time frame, lets say of half a year, and then we will see if homeopathy can achieve it by then. And if yes then that's okay, if not, then one can still do the operation. Although coming from my homeopathic understanding, the operation will not be solving the dynamic disturbance but is merely representing a removal of symptoms. Therefore it is not a question of either or, but a question what is most useful for the patient at this particular moment. But in principle, a dynamic approach would be preferable.

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more powerful driver.

The other participants had given similar answers and also assumed that, by the sheer fact that people were choosing them as their practitioner, they were giving their consent to be treated with a non-conventional method. But apart from trusting that they had a general agreement, the interviewees said they would involve their patients very much in the process of making treatment decisions. Dr D described how he dealt with consent in his practice:

> The relationship is such that we do it in a consultative way. If things are unclear I say, go to the specialist and have it looked at and see what he would say to that and what he would prescribe. Then she will inform me what he had said and what the diagnosis is and what he suggested with regards to medication and then we discuss it together and decide if it would be useful and if we should follow it or if not.

Before looking at the issue of informed consent in CAM it might be useful to review how informed consent is conducted in general practice as these settings compare most closely. Both operate in the primary health care context and have to deal with the wide range of complaints people present to their practitioner. It is understood, of course, that by now medical doctors are fully aware of the need to give sufficient information to their patients so that they can make considered treatment decisions. However, when looking at the research, the reality in primary health care seems to be quite remote from the ideal of informed consent. The reasons behind this are worth reflecting on, because there are, most likely, parallels to non-conventional practices. There are a number of inherent obstacles for general practitioners to give valid scientific information on medications, which is a major part of general practice. In addition it seems that doctors do not perceive informed consent as having the same significance here as it would have for invasive procedures (Kondo et al., 2000). Many of the inherent obstacles have been discussed in Chapter Three: the scientific data about medication mostly do not apply to the patient population the GP has to deal with, as there is often co-morbidity, which was not accounted for in the research population. Co-morbidity also often requires a cocktail of drugs, which as a combination has no scientific database. And then there are the many patients with symptoms that do not meet the criteria for a medical diagnosis or who are presenting in early stages of disease (Naylor, 1995; Knotterus & Dinant, 1997; Culpepper & Gilbert, 1999; Rosser, 1999; van Weel & Knotterus, 1999). These are fundamental issues that impede gaining a sound scientific knowledgebase. But in addition, it has also emerged that patients do not always receive sufficient information on their prescriptions because of their doctor's lack of communicating about them (Stevenson et al, 2000). Even in an outpatient clinic for hypertensive patients, where there was only one main

condition and a limited amount of treatment choices, the researchers found at the end that "patients' knowledge and understanding were disappointing" (Kondo et al., 2000, p.45). A study on communication about drugs in general practices found that, when new medications were suggested by doctors, rather than speaking in technical terms they tended to refer to them in simple and very accessible ways. They would, for example, name them according to their purpose: "something to help with the cold", "something a bit stronger", or refer to how they looked: "these little fellas", "the brown one" (Stevenson et al., 2000, p.833). Less than half the doctors mentioned side effects and the scientific details about probability of effectiveness did not come into the conversations at all.

The question is why this should be the case in this day and age where most people allegedly want to be fully informed and doctors have been trained to respect that request for the last few decades. What should be made of this situation? Is this only a sign that further improvements are needed, or does it also tell us something about the reality of medical practice? The lack of consultation time was mentioned earlier as a barrier but there might also be other reasons, which are not so openly acknowledged. In many instances in general practice it is ultimately impossible to ascertain what benefited the patient: the actual effect of the treatment, the placebo effect of the treatment, the attention and care given by the doctor or by other people, or the natural healing process. In this situation the question for a doctor is, whether it is wise to insist on full information, which, if informed consent was taken seriously should include the scientific details also on medications. However, in day-to-day general practice most doctors do not have these specific data at their fingertips. But even if they had easy access to the detailed research findings, should they talk to their patients about them? With our knowledge about the importance of the placebo effect (Beecher, 1955; Reilly, 1998), would they not deny the benefits of this phenomenon? Are primary care physicians unconsciously or consciously aware of this and, even though it goes against the Zeitgeist, are quietly practicing in a way that gives the placebo effect a chance too?

Brody (2002) has pondered on this issue and whether it would still be right to insist on full information if we had empirical data that showed that the efficacy of a treatment was reduced substantially after giving full disclosure to patients on its placebo effect. He poses this question in response to suggestions by some authors, that it would be acceptable to refer

patients for CAM treatments as long as patients were told that the effectiveness of non-conventional treatments are solely due to the placebo effect. Turning it around Brody asks:

> Are you also going to insist that every patient receiving a conventional remedy be fully and frankly informed as to the percentage of efficacy of that remedy that is due to PE [placebo effect] rather than to the "pure" pharmacological potency of the drug? If not, why not (Brody, 2002, p.81)?

It is highly unlikely, as the above-mentioned studies have shown, to find a primary care doctor who would go into those details with their patients. Despite the otherwise high profile of informed consent these days, this issue is not usually brought to the surface. This might be just an oversight. But it could also signify a tacit awareness by doctors that they need to protect their patients against the loss of a healing opportunity, which is known to be stimulated by suggestion and belief.

Seen in this light, the argument that there should be stringent standards for informed consent in the CAM setting (Boozang, 1998; Gruner, 2000) does not seem in line with the reality of conventional primary care practice. Sugarman (2003) also noted that this was in excess of what would be expected from scientific medicine. However, the advice Ernst and Cohen (2001) are giving to practitioners of non-conventional therapies is:

> Therefore, in cases of uncertainty, a prudent strategy for the CAM provider would be to tell patients about the degree of uncertainty associated with the efficacy and safety of the treatment, as of the availability and risk-benefit ratio of other treatment options. (Ernst & Cohen, 2001, p.2292).

Both Sugarman (2003) and Stone (2002) have analyzed the three-step model of informed consent, which was introduced by Beauchamp and Childress (1994), to see how this model would apply to the specific situation of CAM therapies. The three steps are

1. threshold, which requires competence and voluntariness
2. information, which consists of disclosure, recommendation and understanding
3. consent, which entails decision and authorization.

Sugarman (2003) and Stone (2002) identify a number of difficulties, particularly, and as to be expected, with step two. Stone therefore discusses the feasibility of skipping the second step altogether and

> ...to view consent as a *threshold* permitting the therapist to treat. Although known risks to treatment would still have to be disclosed, the patient's consent would become a broad agreement to receive therapy, which would not require the practitioner to

> describe the process or consult the patient on each aspect of therapy (Stone 2002, p.161).

Although Stone realizes that CAM practitioners often take this approach, she finds it problematic for both patients and practitioners. Making the wrong assumption about a patient's consent could lead to legal consequences for the practitioner. Her suggestion therefore is:

> …that the individualized approach to care extends to an individualized approach to information given on the basis what the particular patient wants. This would allow patients to formally waive their autonomy and opt for a beneficence-based model in which the therapist concentrates on healing and the patient on being healed (Stone, 2002, p.162)

Why patients might want to reduce their autonomy, however, at a time where "individualism and individual rights permeate every other aspect of the culture" Stone regards to be an interesting question. She tries to explain this counter trend, by suggesting that some people might have an unspoken wish to actually receive a paternalistic treatment from the CAM practitioner. This would give them the sense of being in a "safe, holding space in which mind/body can be brought back into healthy balance", which she believes, was also the reason why "many CAM practitioners do work in an unashamedly paternalistic fashion" (Stone, 2002, p.162).

Sugarman (2003) argues for a shared medical decision-making process as the best way to aid patients in making an informed choice with regard to non-conventional and scientifically non-validated treatments. The term "shared decision making" has been used by other authors as well, each giving it a slightly different slant (Charles et al., 1997). What Sugarman is trying to stress about shared decision-making as being particularly useful for this context, compared to informed consent as it is normally understood, is that, rather than just being based on the ethical principle of respect for autonomy, shared decision-making also relies heavily on the principle of beneficence. The added dimension of beneficence, Sugarman claims, makes it easier for clinicians to perform their duty in a manner that patients have traditionally expected and, therefore, this is intuitively a much more appropriate process. In shared decision-making the doctor does not simply convey information adjusted to the patient's ability to understand and his or her value system, but also offers an opinion about a preferred treatment option. The process is based on mutuality, where the doctor explores what the patient believes and values

and is also open about his or her own position. Shared decision-making appears to be superior to other methods, as empirical data have shown, both with regards to process and to outcome (Clouser & Hufford, 1996; cited in Sugarman, 2003) and "unlike informed consent, shared decision-making is not necessarily a formal and discrete process, rather it can be woven into the entire context of clinical encounters" (Sugarman, 2003, p.249).

When reviewing the literature on informed consent for the CAM setting, and comparing it with the statements the participants had made about their approaches to it, some interesting congruencies as well as incongruencies could be noted. The common mode of interaction between the interviewees and their patients was very similar to the kind of shared decision-making process Sugarman (2003) has described and also to the individualized, patient-centered approach Stone (2002) has suggested. There was also the strong belief that patients, because they had specifically chosen to consult the participants who were clearly identified as homeopathic physicians, had given an implicit consent to be treated with homeopathic medicine. Although this general intention by patients was taken for granted, all participants appeared to take very seriously the communication of different treatment options.

The issue of paternalism, which was highlighted by Stone (2002) as being common amongst CAM practitioners, did not seem to be of any significance. Instead the participants found it problematic if they had to interact with patients who showed a tendency of being too dependent, as has been shown in the first section of this chapter. They certainly did not want to foster a dynamic that required the patient to surrender their self-determination, which Stone had claimed was typical for many patient-practitioner interactions in the CAM setting. Perhaps it was due to their conventional medical training that the interviewees had a broader awareness about the issue of power in medicine and the inherent pitfalls of a paternalistic approach.

Because of the broadness of their knowledge, which included biomedical treatments as well as homeopathy and other non-conventional therapies, the participants were of course in an exceptional position to provide an overview of approaches. Neither practitioners of only CAM modalities nor the average conventional medical practitioner would be able to do this to the same extent. In recent times these difficulties in bridging the knowledge-gap have been recognized as a problem not only for CAM practitioners, but also for biomedical physicians,

who in the extreme case can face legal actions for omitting to mention that there are alternative and complementary treatment options (Brophy, 2003; Weir, 2003; Winslow & Shapiro, 2002).

Judging treatment effectiveness – the challenge of cancer

Another area that interested me was how the participants came to be convinced about the effectiveness of the different therapies they were suggesting and, as a second point, what they took as evidence that the treatment was beneficial for their patients. This issue was particularly crucial when patients consulted them with life threatening conditions, like malignancies. When questioned about this, all of the interviewees answered that, apart from building on traditional knowledge, they trusted personal experience. The experience they referred to came either from their own use of homeopathic treatment or from the feedback they had from other people or their patients. Also, none of the interviewees had any doubt in their ability to judge if a treatment had been effective in an individual case. In this situation self-assessment by the patient was the main gauge, but it was combined with the knowledge base they had accumulated as doctors and as homeopaths.

When I asked Dr A what his response would be if he was told that scientific research would not confirm the effectiveness of homeopathic treatment, he said:

> Well my experience contradicts that. So first I would question the study and the study design, because there is a fundamental difference and one cannot use the same method for very different approaches. It is certainly a methodological problem. The results of these studies have to do with their set-up.

To the often-used argument that people naturally feel better because homeopathic doctors could give them much more attention during their consultations and allowed for long conversations, Dr D replied:

> When you have a good conversation that is good for the patient, but there is a big difference if you give a right remedy at the same time or if you don't give a right remedy. The difference is clearly noticeable. And you can show this very well in an acute illness. Let's take the example of tonsillitis. I could have communicated really well with the patient and he might feel relieved, but the tonsillitis will stay unchanged if I give the wrong remedy, then they [homeopathic remedies] are just ineffective little globuli. But if it is the right one then the patient is markedly improved within two hours. One can see that also in one's own mistakes. And in chronic conditions, you know exactly if a remedy has worked or not. When you come to lab results, lab results don't just change because of a conversation.

Dr B also spoke from a place of strong conviction about the effectiveness of homeopathic treatment:

> I never had a bad feeling even when I was treating people, who were severely ill. Often they survived longer with homeopathy, particularly when they had one of those chronic conditions. And of course I don't mean the treatment of injuries, for that we have accident surgery [Unfallchirurgie] or another example would be obstetrics. But with everything else like cancer or the chronic diseases I have come to the conclusion, like Hahnemann, that when you treat those patients with gentle remedies and with attention to lifestyle that they are better off than with all the things that are used today.

There was also great skepticism amongst the participants about the value and reliability of statistics. When challenged that single cases do not have the convincing power as clinical trials and statistics Dr E quite fiercely defended her stance with the "test-of-time" argument:

> Well homeopathy has existed for two hundred years and there are also statistics. And the shamanic things are 6000 years old or older, they are there from the stone ages and they have worked well. And Acupuncture is also very old, I am not sure how many thousand years old, but there are certainly enough results, only that nobody has written up computer lists, but if it hadn't worked it wouldn't have survived that long.

However, when I asked some of the participants, what they would suggest to their patients when they were consulted for a cancer problem, their responses turned out to be quite diverse. It was interesting to juxtapose the three different stances. Positions ranged from viewing orthodox cancer treatment as a first line approach and considering homeopathy only in a supporting role, to a differentiated outlook, which made the treatment plan dependent on the kind of cancer, and to a completely negative perception of orthodox cancer treatments with the inclination to rely solely on alternative approaches.

For Dr A the probability that cancer would respond to homeopathic treatment alone seemed not certain enough for him to justify using it on his patients as an exclusive therapy. This did not mean, however, that he could not see a place for homeopathy, however, only as an adjunct.

> From my homeopathic perspective it is very uncertain if there is a chance to heal cancer with homeopathy. And therefore I principally advise the patient better to go the biomedical way. This does not mean though that I wouldn't treat the dynamic roots on which this illness did develop, because I believe that there will also be a greater prospect for success with the biomedical treatment when this level is also worked on. But I don't see it as an either or. In fact I am trying to avoid talking him out of a conventional therapy, but I rather want to help him to do what will be ultimately best for him.

Dr A saw the biomedical cancer therapies, despite their problems, in general as the most appropriate approach and he would actively try to dissuade people from opting for homeopathy. When he speaks about the greater likelihood of success, it seems that refers more to quantity of lifetime that is gained by going along this treatment route, than to quality. For Dr A saving the life of the patient appeared to be the paramount consideration. He had no confidence that homeopathic treatment could save the life of his patient. At one stage in the interview he implied that he would not enter a therapeutic relationship with the patient if he was asked to treat a malignancy only with homeopathy or other un-orthodox therapies. He pledged though that he would certainly not abandon the patient but use alternative treatments to support the patient's general health.

Dr A's stance could seem to have a paternalistic flavor, for being so unmovable even when patients had made their choice clear that they did not want conventional treatment. Within Western societies, where autonomy of patients is highly valued and quite often overrides medical judgments, Dr A could be seen as being out of line. However it is in effect not dissimilar to other medical situations described by Tsukamoto (1996), where the professional integrity of the doctor collides with the wishes of the patient. Dr A's position is effectively pro-life and, with his belief about the ineffectiveness of homeopathy for cancer, by treating the patient in that way, he would see himself as withholding life-saving therapies to a patient. For the patient, Dr A's reluctance might become more understandable if he was to explore the illness, the prognosis and the goals of treatment thoroughly together with the patient and particularly if he was open about his own values, which puts survival higher than quality of life, as has been suggested by Quill and Brody (1996). Through this process the patient would be enabled to determine where quantity of life was ranking for him or her, if that had not been already the case, and it might become clear whether or not s/he would be better supported by another homeopathic doctor.

In contrast to Dr A, Dr E did not think that the problem could be properly tackled by taking a blanket approach. She thought that one had to first distinguish between the different kinds of malignancies and look at the scientific research data. Before making a suggestion to her patients about a treatment plan Dr E said she would want to know what could be expected in the particular case from conventional cancer therapies. To really test her position I asked her what she would do if it were one of her children who needed treatment.

> That is the question. During my training I worked in pediatric oncology and there are tumors where they have really good results, like with lymphatic leukemia they have I think an eighty percent cure rate. There you have to really differentiate. Eighty percent cure rate we won't manage with alternative medicine. There I would say they should go ahead but also look into the question of why he got it and in addition accompany with alternative medicine, particularly as all the side effects are less severe when you treat with homeopathy as well. But then there are some kinds of cancers, monocytic leukemia or such like, where orthodox medicine knows that there is no chance of cure. They still use chemotherapy, and the people feel terrible but end up dying anyway. In that case I would reject it.

Dr E seemed to have put a lot of effort into researching the effectiveness of conventional cancer therapies when she worked in pediatric oncology in order to have a sufficient knowledge base for her decisions:

> I made a very thorough list for myself for which childhood tumors conventional therapy is effective. For example a sarcoma, if you cut that out, the chances are quite good, or the same for a Wilm's tumor. There are some where the chances are certainly acceptable for the children. There I would do it; but with added (alternative) therapy of course. These are the few that I had noted down, where I would do it for my children but only in conjunction with alternative medicine.

When I asked her if she would use chemotherapy for herself if she were to suffer from cancer, she was absolutely clear that she would not.

Dr E's approach to the question of cancer treatment appeared very thoughtful, as she tried to finely tune it to the individual circumstances. She made the effort of updating her medical knowledge on the different tumors, so that she could distinguish which cancers responded well to conventional treatments and where success rates were expected to be only minimal. She then tailored her advice either to use non-conventional treatments as the main therapies or just as a support. The best possible outcome was not only the possibility of survival but she would also bring quality of life into the equation. But as with Dr A, it was paramount to Dr E. that she was transparent for her patients about her own value system. In a situation, where there are so many unknowns, the patient has to be able to compare his or her own values with those of the doctor in order to judge the validity of the doctor's advice.

Like Dr E, Dr B also stated that he would decline conventional cancer treatment for himself. His view on what orthodox medicine had to offer for cancer treatment was altogether

pessimistic and predominantly critical. Based on the theory of cancer he subscribed to, he could not see much point in the orthodox approach:

> One has to differentiate. In childhood there are a few malignant tumors that are histologically malignant but not biologically, because they often tend to reverse spontaneously. And here they use chemotherapy and then claim that they have saved lives. But in the great majority of cancers, all epithelial cancers like lung cancer, breast cancer, stomach cancer, bladder, uterus, in all those kinds, chemotherapy has not at all shown to bring about a higher survival rate. But then they say quality of life. But that is also wrong. I have seen patients who have come back saying: "I never want to go back there again for chemotherapy. That was the worst thing that I have ever experienced in my whole life."

With an opinion that veered so far away from conventional understanding and appeared quite strongly pitched against conventional treatment, I wondered how he would go about advising his patients on the best course of action:

> To those patients who ask me I am very honest that there are also other avenues even when they have cancer or other incurable diseases. But I also say that we are not only criticized by the medical profession, but also by society, which has been wrongly informed. We are judged very, very critically. There is an unbelievable, non-justified belief in the possibility of a cure and in the successes of medicine. That is the problem.

When I asked him how he approaches a person who suffers from cancer and what he suggests as treatment options, he said:

> Well one healing approach is the homeopathic, but I also treat them according to Kneipp, as that is very effective, and the two are complementary and it increases my success significantly. Then I look at life style, which is a very important prescription, and that also increases my therapeutic success. And then of course the medical dialogue [Ärztliches Gespräch], an honest conversation about the present situation, the true prognosis. That also requires knowledge about the other method. I would not call myself an expert of chemotherapy, but I still know from my medical training and from my clinical experience, what chemotherapy is.
>
> Some people entrust themselves to the medicine that I offer and want to live like that until the end. And then there are others, who say: "No that is not enough for me, I want to be certain, I want to do what today's science has been able to achieve." And I have to accept that. But I must say I try quite passionately to convince people of the contrary. But of course I don't have the power to coerce them.

The last statement about having the power of coercion, Dr B meant to be seen in contrast to the conventional health care system, which he claimed was implicitly threatening the patient either with abandonment or with mal-treatment:

> they [the patients] come to me privately and I have no means to pressure the patient into anything, in contrast to the other medicine, which has the means for coercion.

> They would say: "well when you are dying you will want to come back to us…" and such things I would not say.

In another statement, Dr B's greatest concern about conventional cancer treatments became clearer. When I asked him how he would respond if it was proven that conventional therapies were the only effective way to eradicate cancer, he said:

> Even if one was, let's assume right, that one would be more successful with this method than with another one, I still would have to ask the question: Is this method morally justified? Does it agree with respect for human life, does it agree with respect for this personality? Even if one was correct with a particular method, let's say with chemotherapy, but that would then change the patient's whole zest for life, and change his spontaneity and his initiatives and his sense of life, his whole life plan is changed, and let's say that would add one more year of survival in terms of days, I would still ask the question if I should have been allowed to do that or not.

Dr B's stance was also based on the belief that the limits of medicine had to be acknowledged and death accepted as a natural part of life. For him the Hippocratic mandate of "First do no harm!" became particularly significant when illness was terminal. In that stage he thought invasive medical interventions were only injurious and not helpful. To explain how he would rather see the role of the doctor in that situation he drew from the history of medicine:

> In antiquity it was held like that that the average physician was allowed to treat simple illnesses, very good physicians treated serious illnesses, and no physician was allowed to treat terminal illnesses. Maybe it was motivated by pragmatism so that the reputation of physicians was not threatened. But may-be it was for reasons of respect. I prefer to believe that. One should not do any heroic interventions on an already very weakened organism. If I can't treat him, I have to console him, stroke him and when he dies then he dies that is out of my control. Nowadays we do that differently.

In accordance with his general outlook about the negative effects of many aspects in modern medicine, Dr B saw conventional cancer treatments as clearly detrimental and wanted to provide a complete alternative to them. There were hints of a missionary zeal, when he said that he would be trying his best to convince patients of the options that he sees as better, even risking that "better" meant a lesser chance of survival. Although he considered himself as not having any coercive powers, and it was certainly true that patients were not required to rely on him, it still could be difficult for people who were in such a vulnerable phase of their life to resist the pressure. The premises on which he based his claims of therapeutic success were, while not unreasonable, nonetheless theories, and therefore required the same caution as anything else that has not been confirmed to be effective in practice. On the other hand it could also be considered courageous of him, in view of the danger it might pose for his

professional career to provide alternative medical care (Dew, 2003), even though Austria has a less litigious climate. Therefore legal repercussions following an unfortunate outcome, as in the case of Charell versus Gonzales, which was cited by Ernst and Cohen (2001), are not quite as likely. Nevertheless, to find a medical practitioner who is prepared to offer a non-conventional approach in a life-threatening situation can be very difficult. For those people who have an alternative worldview and to whom the treatments of modern medicine are not congruent with the rest of their chosen life style, Dr B would be the most suitable doctor.

As has been discussed in the previous chapter, it is not wise to rely purely on scientific research for medical knowledge (Tonelli & Callahan, 2001; Kiene, 2001). As Kiene argues, much can be learned about effectiveness from single case studies. The participants had come to believe in the effectiveness of homeopathy through other means than scientific research data. They trusted the reports and teachings of others, their own experience and also the "test-of-time", believing that the method would not have survived through the centuries if it were not useful. However, without the back up of scientific research studies, the judgment whether homeopathy or other non-conventional therapies are effective becomes particularly relevant when practitioners are consulted by patients who suffer from life-threatening illnesses, like cancer. Although all participants thought of homeopathy as being an effective therapeutic approach, the three doctors, who were asked how they would treat cancer, took very different positions. Their advice for their patients was built on a combination of judgments, which involved two different aspects. One was their individual assessment of homeopathy's effectiveness in cancer. The other came from their personal belief of what would constitute a good outcome. There were great variations in what each of the three interviewees thought homeopathy could achieve in that situation, ranging from not being effective enough to being acceptable as main treatment. Therefore each doctor told the patient something different. In addition, every one of the three doctors also had a differing understanding about what would constitute the best outcome. For Dr A, one might infer, it was length of life, for Dr E, a combination of quantity and quality of life, for Dr B, it was a life that could be lived authentically. Although this discrepancy in opinions is not confined to homeopathic doctors, it certainly becomes more prominent because of the broader scope of treatment within a holistic understanding of illness. On top of this, the individual homeopathic doctor will also have more room to bring his or her own view into the encounter with the patient. In conventional medicine, unless a patient's condition has been pronounced "terminal", a longer life span

gained would be the major aim of treatment. It becomes therefore particularly important for homeopathic doctors to be open about all these aspects. This means that they should share with their patients that their assessment of homeopathy as a treatment for cancer is based on a personal judgment. They also need to ascertain if their own treatment priorities correspond with those of their patients.

Conclusion

The focus of this chapter was the doctor-patient relationship in the context of the homeopathic practicing method. It was found that the homeopathic setting made it easier for the participants to develop a relationship that was more satisfying for both patients and practitioners than it was in conventional medical practice. Longer consultation times were seen as a major factor. An important ethical issue is the preservation of patient autonomy in the medical encounter by providing sufficient information to the patient to make an informed choice. The ability of patients to give informed consent in the commonly perceived way without the back-up of a scientific knowledgebase was naturally reduced in the homeopathic practice. Instead participants carried out a shared decision-making process, which allowed patient autonomy but also emphasized the principle of beneficence. The need for homeopathic physicians to be aware of their own values and to share them openly with their patients became particularly evident in relation to their advice to patients who consulted them for life-threatening or malignant conditions. The way the five participants characterized their interactions seemed to be captured best by using the model of "doctor as trusted companion". The doctor as trusted companion is more than the knowledgeable expert, as s/he maintains a consciousness about the shared humanity with the patient. Conducive to this attitude were the emphasis on the subjective experience of the patient in homeopathy and the understanding of illness as an effort of the live organism to maintain homeostasis. In addition, the strong mandate for non-maleficence in the homeopathic method and the underlying holistic perspective prevent the tendency to detached alienation, which has been found to endanger the doctor-patient relationship in conventional medicine. This tendency in biomedicine can be traced to the conceptualization of the human body as a biological entity and the redefinition of the experience of illness into diseases. It represents an inherent threat to a humane doctor-patient relationship as it deprives the biomedical endeavor of giving valuing to the subjective dimension, which opens the door for an objectification of patients by doctors.

In the recent history of the medical profession there have been many episodes, where doctors have breached the Hippocratic vows of their vocation and abused their powers. The worst of those violations have been publicly denounced. However, the underlying understanding of biomedicine was never disputed on those occasions. Only a few people have openly acknowledged this problem. Viktor von Weizäcker, a famous German Neurologist and medical writer, is one who did. After the trials of Nazi doctors at Nuremberg he is quoted saying that "standing trial were not primarily simplistic, derailed, or corrupted individual physicians but 'the spirit of scientific medicine'" (Welie, 1995, p.44). The restoration of the spirit of medicine cannot be achieved by focusing on the ethics of individual physicians or of the whole medical profession, but has to begin by rejecting the conceptual premises of biomedicine as the predominant foundation for medical practice.

Chapter Six

The Four Axioms of Human Health

The main aim of this thesis is to get an understanding about the possible meaning and the ethical significance of the growing popularity of non-conventional therapies. Underlying the practice of every healing approach is a specific method, which is based on an epistemology and, in the last instance, on a particular ontology. How we respond to illness in a therapeutic way depends on what we perceive illness to be. Although there is a great variety of non-conventional medicines, it has been found, as already discussed in Chapter Four, that all healing approaches ever recorded in human history seem to respond to one of the four basic axioms or ontologies of illness (Bauer, 2000; Pieringer, 2000). It would be unlikely, however, that these four axioms, are an arbitrary selection; they will instead much rather reflect the essence of our fundamental human needs. When seen from this perspective, an understanding of the conceptual premises of a healing system will lead at the same time to an understanding of the underlying human need this therapeutic approach is responding to. Therefore, when considering the increasing use of complementary and alternative medicines, the research question of this thesis could be reframed into asking: Which of the basic human needs are the different therapeutic approaches aiming to satisfy? Or, in other words: Which human needs are not addressed by conventional medicine but might be addressed by alternative and complementary medicines?

It is these last questions that this chapter will be exploring. The investigation will start by looking at the participants' views and conceptions about life, illness and healing. Although all participants stated that they had adopted the homeopathic concepts as their basic premises for their therapeutic approach, they gave quite varied responses when explaining their outlook. However, they all remained within a holistic framework. Illness was never seen purely as a physico-chemical dysfunction in need of correction, nor only located within the individual's physical body. The concept of healing was also pitched much wider than the conventional medical view. In the second section the focus will be on the issue of human suffering. For all participants suffering not only had some intrinsic meaning, but also could only be dealt with through giving it meaning. A balance had to be found between following the medical mandate

of relieving suffering, and assisting patients in reaching a greater self-awareness through illness, which was believed to ultimately lead to a better health status. In the third section the views of the participants will be put into context with the perspectives of people who use complementary and alternative medicines to establish if there is a congruency or if the opinions of the interviewees are exceptional. The fourth section will look at the arguments of a number of medical authors who have also focused on a practice of medicine that is based within a broader understanding of health and illness than what is proposed by scientific medicine. The parallels become evident but so does the difference to the research participants, which lies in their willingness to transcend the dualistic position and adopt a truly holistic perspective. The great challenge of a multileveled understanding of illness is the difficulty determining which therapeutic focus should be taken. In the fifth section it is suggested to approach this challenge in a similar way to Beauchamp and Childress, who crystallized the four principles for biomedical ethics from both common morality and the medical tradition in order to provide a usable ethical framework.

For this purpose a framework is proposed that draws on the four historical medical axioms that have been introduced in Chapter Four, and which is also reminiscent of Aristotle's "four parts of the soul". These illness axioms can be taken to indicate the range of fundamental human needs, which could be defined as: maintaining homeostasis of the physical body; being emotionally connected with other human beings and the surrounding world in general; having control of one's life direction and external environment; finding meaning and coherence within a bigger context. In this thesis it is postulated that a humane and effective health care can only be achieved when all four human needs are receiving the appropriate attention. The predominant focus of scientific medicine lies on the third axiom of having control. The scientific endeavor is concerned with control and mastery of the external environment, of which the human body is seen as being a part. The increasing appeal non-conventional therapies appears to lie in their ability to address aspects of the other axioms that go beyond the limited range of modern medicine.

Human life and the notion of a vital force

As has been described in Chapter Two, the conceptualization of health and illness in homeopathy is fundamentally different to science-based medicine. The five participants were practicing as homeopathic doctors but also used other alternative approaches and continued to

apply, to a greater or lesser extent, orthodox medical treatments. Considering the different conceptualizations of each therapeutic method, one could imagine that they might find it hard to bring together belief systems that seem to be so contradictory. The enquiry into the interviewees' conceptual understanding began with the questions "What is human life?" and "What do you understand the life force to be?" as it could be expected that their belief about health and illness would be based on their ontology of life.

The interviews also touched on the participants' religious or spiritual beliefs. These are the first focus of this section, as their choice of homeopathy as their preferred healing modality was closely connected. All participants held a spiritual view, but not everyone was a member of a church. Dr A, in fact, made some very critical remarks about the Catholic church during the interview. All participants confirmed that their spiritual beliefs fed into their work, in the way they conceptualized this world, human life and illness, and also how they related to their patients. Dr E told me that she had actually come to appreciate her original religion again through the spiritual dimension of her work. As a child she had been brought up in the Catholic faith but then she had distanced herself from it for some years. I asked her to describe what impressed her so much about it prompt a return to the church again:

> Uhm – higher providence, or a higher plan, and a phenomenal one too. No living being can come up with something like that. One can really only see single parts of it and think, wow.. It is not as we thought that there is a coincidence here and another coincidence there. Behind all of it is in fact a thread that runs through it [roter Faden]. We can see little bits, but the big plan you can only sense. But one can feel its presence.

Dr D used the word "soul" when he was explaining his conception of homeopathy:

> Every substance, every plant, every rock etc has an essence [Wesen] so to speak; one could also call it soul. There is an essence, a soul in human beings, there is one in the remedy and I think the fundamental thing that Hahnemann developed was this potentization[25]. Only through that was it possible to find access to that essence, which otherwise stays hidden from us. And it is that, which has the ability to touch the resonance of the vital force. For me there is nothing wondrous or astonishing in that. The astonishing thing is only to have succeeded in finding it. That is the wonderful part about it. But that it works is not really astonishing.

When I asked him if he meant to make a link to religion by using the word soul he answered:

[25] The process of serial dilution followed at each step by vigorous shaking of a substance, which is believed to make it a more potent remedy.

> The original meaning of "religion" is "to re-connect" and homeopathy does in fact nothing else than to guide back to something that once was. That means it is about the restoring of health, the restoring of something that once before existed.

When I talked to Dr A about his views, his answers also gave me the key to understand how he was able to integrate the different premises of the therapeutic interventions he was using in his clinic. Dr A had developed a belief system that allowed him to use the whole spectrum of healing approaches, including scientific medicine, without being conceptually inconsistent. The conversation we had about this subject is most likely the best way of representing his ideas:

> MCG: The homeopathic idea about life is fundamentally different to the biomedical idea of life. What is yours, or better what is life in your understanding?
> Dr A: Life is consciousness – in the last analysis it is consciousness, all of it are phenomena of consciousness. This is a fundamentally spiritual attitude. And there are different degrees of insight into consciousness and for the highest degrees of insight it is only consciousness and for lower degrees of insights it is a mixed form of consciousness and matter. And we are on a medium level of insight. And therefore this mixed kind of medicine represents an adequate way for me.
> MCG: And this can be attributed to your personal attitude to life?
> Dr A: Yes it was a development towards that; and with respect to homeopathy it is the internal – the internal is just another word for consciousness for me, because we experience consciousness inside; how we are, how we feel, what we think, they are all internal processes. But they are phenomena of consciousness. And homeopathy looks at these phenomena of consciousness, at the internal events; and also at what might represent the inner meaning of a plant, a mineral, an animal; it is consistently focused on the internal.
> MCG: When you hear for example that genes have been discovered that can explain the development of schizophrenia; how do you respond as a homeopath to this?
> Dr A: I would assume that that is correct.
> MCG: And how do you integrate this into your picture?
> Dr A: Matter and mind [or spirit; German: Geist] are not separate – I tend to give mind a greater importance and for me therefore matter is an expression of mind and because of this, there will be a change in matter when there is a change in mind. So if there are genes for schizophrenia there are genes for schizophrenia, that's not a problem.
> MCG: But for you mind comes first. Or are the genes first?
> Dr A: Simultaneously; as I said at the beginning, for me the mental/spiritual is a primary phenomenon not just an appendix. Science sees it just as an epiphenomenon of matter.
> MCG: So you don't mean that one is caused by the other, let's say the mental dependent on matter or reverse, matter dependent on the mental, but something exists simultaneously?
> Dr A: Yes I would say something simultaneous but where the very last word is not matter any more but also not mental in the usual sense, but something that transcends these two categories.
> MCG: Do you think this attitude that you have is related to your homeopathic work?

> Dr A: This attitude has definitely something to do with my homeopathic work, because I was embroiled in this struggle: how much do I have to be in opposition to biomedicine, or not? And now I have found an inner peace to that; therefore it is not a problem for me any more. I think both has its place, they are just different avenues, and I try to find the area where one might be more useful or suitable, or where the other is more suitable.

It was this viewpoint that explained Dr A's opinion on other medical issues as well. I asked him what the ethical problems were, from his perspective, that were associated with biotechnological developments like organ transplantation or genetic modification:

> I don't believe that organ transplantations or gene-technology would go without changes to consciousness. I think one should also be observant of that, and not just look at it from the outside, but also ask oneself: "What are the changes in consciousness when I do this or that?" And that applies to the person who performs it and to the person who endures it. What would happen if I would get genes from Schwarzenegger? How would my consciousness change? Would I still want it?
> If you were to ask me if I thought that the heart of somebody else also carries part of the consciousness of that somebody else, I would answer with yes. Because everything material also has an aspect of consciousness and I view it, as I said, as two sides of the same thing. So I do believe that this piece of heart that comes from another individual also carries with it some of that consciousness, the organ consciousness of this individual, and therefore a piece of that individual's consciousness

I was wondering what "organ consciousness" meant for him and asked him to elaborate further on this:

> I believe that there is an organ consciousness. You can see that clearly in acupuncture. The heart has particular consciousness qualities associated with it, the kidney different ones and the lungs again different ones and for me it is a nice example that also organic, material things are having consciousness-like qualities, inner qualities.

The responses of the interviewees to the question "What is human life?" ranged from participants stating that there was something indefinable but still clearly obvious that distinguishes a dead body from a living person, to life as ultimately representing an expression of a bigger consciousness. Common to all was the position that human life was not explainable in purely materialistic terms, and could not be reduced to its chemical and physical parts, but that it contained also emotional, mental and spiritual elements. Part of the homeopathic theory is the existence of an animating force, the so-called life force or vital force. I was interested in what terms the interviewees, who were of course all scientifically trained, would explain the concept of the vital force to me.

Dr D:

> It is just that force that distinguishes dead matter or the dead body from the living. It is that force that lets life arise and is life preserving, which makes it happen, like starting from the grain of seed that suddenly sprouts and a tree grows out of it, up to the human being. This force, this energy, this spirit or whatever one should call it, it is of course difficult to capture that in words. But we know somehow that there is something that distinguishes us from a dead organism.

Dr C:

> "Life force" is a concept of a "beyond". It is not a concept within space and time. We are speaking of vitality inside space and time, which can be more or less emphasized. But "life force" is a hidden principle, in which there is no weight or measure. "Life force" you can define in different philosophical ways. You could call it "the force of the alive", or "the force that causes one's existence" etc, which carries all and produces all. And that is a meta-term, which would never come into being inside the realm where things can be weighed and measured. That concept has the deepest relevance for me.

Dr D's answer was very close to the classical homeopathic theory, whereas Dr C put his emphasis on a broader spiritual meaning.

Homeopathy, like the majority of traditional, complementary and alternative healing systems, is based on the concept of a vital power to explain biological phenomena, which is fundamentally different from biomedicine with its purely materialistic conceptualization. In the vitalistic understanding the existence of a life force is regarded as essential for all life forms. This life force is considered to be an animating and ordering principle, which infuses the whole of the organism. In traditional Chinese medicine it is called "qi", in ayurvedic medicine "prana", and in homeopathy "vital force". The life force is seen to be distinct from, and transcending the purely chemical or physical forces. In the "Organon of Medicine", Hahnemann, the founder of homeopathy described how he pictured the vital force.

> In the state of health the spirit-like vital force (*dynamis*) animating the material human organism reigns in supreme sovereignity.
> It maintains the sensations and activities of all the parts of the living organism in a harmony that obliges wonderment. The reasoning spirit who inhabits the organism can thus freely use this healthy living instrument to reach the lofty goal of human existence (Hahnemann, [1810] 1983, pp.14-15)

In the West the notion of vitalism has a very long history as an ontology of life. In Antiquity its most prominent proponent was Aristotle, who saw "the soul as the Form of the body" (Lawson-Tangcred, 1986, introduction to Aristotle, De Anima, p.59), by this making a clear distinction between form and matter. The belief can be tracked in various manifestations

throughout the centuries (Kaptchuk, 1996). Vitalism surfaced particularly strongly in Germany during the 18th century, but as Engels (1994) claims, contrary to common assumptions, not as ontological vitalism, with a metaphysical basis, but as methodological vitalism, in order to make a preliminary conceptual distinction between living forms and inanimate matter. In more recent times, biologists and authors like Driesch (1909, cited in List, 2001) promoted vitalism in its metaphysical understanding again. Driesch, after using expressions like "something-like-a-soul", a "psychoid", to describe what he considered to be an animating force, finally returned to Aristotle's term "entelechy" (Cassirer, 1950).

> The entelechy is the formative power of the organism, different from the physicochemical forces and not to be set on the same level with them. All merely physical or chemical factors are but means employed by the organism; they do not make life, though they are used by life and enlisted in its service (Cassirer, 1950, p.196)

Modern science rejects vitalism as an explanation for life because of "its teleogism (conflation of an endpoint with a cause) and essentialism (predeterminism)", which scientists dismiss "as metaphysical and therefore insufficiently empirical" (Franklin, 1995, p.1346). The vitalist perception of life, as Driesch suggested it, was, however, also criticized by J.C. Smuts (1927). It was Smuts who had coined the term holism and introduced another conception of life, but also of matter and mind. Smuts' understanding goes very much beyond the strictly materialistic and mechanistic. Despite this view, he argued that a vital force, perceived in a metaphysical way, represented something analogous to the physico-chemical forces and was in effect the other side of dualism, because it was conceptualized as a distinct and separate entity.

For Hans Jonas (1966), the sheer fact that life has become an issue for human kind to wonder about is worth reflecting on, as this shows that life is not considered the primal and "natural" state. According to Jonas, early man, contrary to us, felt embedded in a living world and perceived his surrounding as pan-vitalistic.

> To early man, standing on his earth arched by the dome of its sky, it could never occur that life might be a side issue in the universe, and not its pervading rule (Jonas, 1966, p.8)

In those times it was death that represented the inexplicable exception. Modern man, confronted by a vast, lifeless universe, a "field of inanimate masses and forces" (Jonas, 1966, p.10) has come to see life as the exception in a world made up of dead matter. Jonas has

therefore called it “the problem of life”, which he believes is neither solvable with the dualistic conceptions of the Renaissance, where matter and consciousness were held in separation, nor with the post-dualist materialist monism that prevails in our time.

Despite all the efforts, that have gone into comprehending what life actually is, so far it has not been possible to grasp it and “neither philosophers, theologians, nor scientists can offer a clear understanding of life” (Franklin, 1995, p.1345). Nevertheless, when it comes to moral questions

> …the vitalistic notion of life as something inexplicable and deserving of reverence and protection is far more prevalent than the more mechanistic and instrumental account dominant within science (Franklin, 1995, p.1348).

All participants used the term “vital force”, which identifies them as vitalists. However, because of other responses of the interviewees, I was not certain whether they did believe in a separate, metaphysical force, as promoted by Driesch. Some participants, like Dr D, might have used the homeopathic concept of the life force perhaps also as a mental tool to describe something typical to living beings that can otherwise not be expressed with any of our scientific terms. Still, as the interviewees were all religious or spiritual people it is also quite possible that they perceived life in metaphysical terms. Although there are some people who, while religious, reject a vitalistic explanation of life because of their otherwise predominantly scientific outlook, it is more likely that somebody who can relate to a Higher Power will find the vitalistic perception less of an intellectual challenge. Therefore, considering that in a 1993 American survey ninety-five percent of people declared that they believed in God (Larson & Larson, 2002) it is not surprising that the vitalistic notion is still more prevalent even today.

When looking back at Dr A’s explanation of his underlying concepts, they came across as an interesting mix, which is reminiscent of Spinoza’s philosophy in “Ethics” (1677) and also of J.C. Smuts’ in “Holism and Evolution” (1927). Dr A’s belief in the simultaneousness of matter and spirit resembled Spinoza’s, who conceptualized the world as being simultaneously extended in space and time, and at the same time, operating on a mental/spiritual level. His description on the evolutionary process from pure matter to pure consciousness resonated with what Smuts wrote:

> From matter to life, from life to more life and higher life; from higher life to mind, from mind to more and higher mind, and to spirit in its highest creative manifestations (Smuts, 1927, p.185).

In fact the holistic concept, which Smuts introduced, seemed to come closest to the overall views of the participants. Holism, as Smuts defined it, is "an operative factor in the universe", an all-underlying organizing, ordering, regulating principle. It begins with the organization of atoms, and follows through from molecules to the emergence of life, to mind, and ultimately spirit. Smuts criticizes our common present thinking for keeping conceptually separate the realms of matter, life and mind, even though we experience them together in ourselves.

> If indeed there were no common basis to matter, life, and mind, their union in the human individual would be the greatest mystery of all. What is in fact united in human experience and existence cannot be so infinitely far asunder in human thought, unless thought and fact are absolutely incongruous (Smuts, 1927, p.2).

Having accepted the concept of evolution, where life emerges from matter and mind from life, Smuts strongly disagreed with scientists that matter should continue to be given a place that will

> … infer its primacy and self-sufficiency in the order of the universe, and to reduce life and mind to a subsidiary and subordinate position as mere epiphenomena, as appearances on the surface of the one reality, matter (Smuts, 1927, p.8).

Instead, he argued, we need to change our view of matter and cease seeing it in the old, purely mechanical way.

> The matter which holds the secret of life and mind is no longer the old matter which was merely the vehicle of motion and energy (Smuts, 1927, p.10).

Seen from this viewpoint, matter, life and mind are, although of different quality, not separable in the way science is portraying them to be. For physicians who share this kind of perspective, homeopathy is an attractive proposition. In homeopathy, the physical body, the emotions and the mental aspects are also considered to be interrelated and not separable from each other.

Concepts of illness

After hearing about the interviewees' understanding of the life force and about their view on human life, other questions explored the interviewees' concepts of illness and healing. It emerged that every participant had a particular angle or emphasis in the way they made sense of these phenomena. There also seemed to be an underlying searching or openness, which gave the impression that they did not regard their theories as something that was cast in stone

but rather as something that was in development. Dr C confirmed this impression and went on to compare all illness theories with tools, which were only as good as their usefulness. For him this also applied to the beliefs on which conventional medicine was based and he made a plea to bring all the different insights together and use whatever was best:

> The scientific world is equally a construction of reality as is the spiritual or the systemic or whatever else. It is a good tool. You can do things with it. But you can also act systemically, or act homeopathically. For the insider it is definitely a good tool. If these tools were not put into competition with each other in the sense of "either/or" then there would be no problem at all.

The great importance of including the subjective aspects into the conception of illness was seen by the participants as the major distinguishing feature between alternative healing systems and the way conventional medicine operates. All participants found that biomedicine was incomplete and presented a skewed picture because of its failure to acknowledge the significance of subjectivity. Dr A was highly critical of conventional medicine for only valuing what could be perceived objectively:

> Medicine only looks from the outside at the phenomena. It does not consider inner phenomena.

When I asked him to explain what he saw as "inner phenomena" and how they were accommodated in homeopathy, he told me:

> Inner phenomena are mental and spiritual phenomena, which are intrinsic to human beings. They are given space in many alternative healing systems. In homeopathy the emotional symptoms are an integral component in the selection of a homeopathic remedy and have been so from the very beginning, from Hahnemann's time.

Dr A also referred to the systematic process, called proving, in which homeopathic substances are tested on healthy individuals to learn about their effects. The symptoms and sensations provers experience will be brought together to provide the characteristic drug picture of the homeopathic remedy.[26]

> Also the proving of homeopathic remedies is a method, which aims to observe or to find out the changes that happen within a human being after taking a substance. By doing this we can learn something about the inner events and the inner meaning of remedies. One could also say that one learns about the spirit-like quality or what one could call the dynamic effect. There are several descriptions of it, but it is always about the inner world. Whereas orthodox medicine is, by its own definition, a science based medicine, and it only looks at what is measurable and what it can quantify. It is primarily about test results and physical findings and not about the state of being [Befund versus Befinden].

[26] For an in-detail description of homeopathic drug provings see: Wieland, 1998

In contrast, homeopathy took the subjective perception as crucial, whereas in conventional medicine, the subjective experience was "specifically avoided in order not to spoil the experiments". Even though, Dr A valued the subjective perception, he did not see it as more important for his work as a doctor than the objective. He considered both to be "primary dimensions" neither which should be neglected. In his practice, he said, he had no difficulties bringing both approaches together.

Participants' views on the nature of illness could be summed up with headings like: "illness as a dynamic process", "illness as un-tunement", "illness as resistance to the life force", "illness as symbol" and "illness as opportunity".

Illness as a dynamic process

Dr D explained how he comprehended illness as a complex dynamic process where the disturbance lies on the level of the vital force, and in which symptoms serve as signals. In orthodox medicine, he said, illness was merely perceived as a physical defect caused by an external agent, often only by one single cause, like a bacterium or virus. Therefore conventional therapeutic intervention was directed towards eliminating that one cause. Homeopathic treatment, in contrast, aimed at a fundamentally different source of the problem:

> In homeopathy you see that completely differently; Hahnemann expresses it completely differently. Not that the symptom is the illness but the symptom is only a signal, the sign of the illness. The illness is something deep seated, something deep seated that concerns the vital force as such. Hahnemann himself has explained that already. That means that the disturbed vital force is the real problem. If you want to view it from a contemporary perspective, then illness is a process. I personally see it not as though suddenly something falls from the outside onto a human being, not as though suddenly a virus comes along and disturbs the whole system but it is something that develops slowly, a process, a dynamic occurrence with an energetic background.

When I asked Dr D what made him sure of this assumption, he said:

> You can see that in the course of a treatment when the dynamic gets reversed. We meet the patient at a particular point in time when he has gone through a particular dynamic, that means it is the snap shot of a moment in a long development, and I want to influence this in a regulating way so that the process will turn towards the direction of health again. Illness and health are in fact the same, only the two sides of a coin.

Dr D's understanding of illness and health was that of a continuum, along which the patient is moving in a dynamic process. It can go towards the direction of illness or towards health,

either of which had to be perceived as coupled and could not be seen as completely separate entities. Dr D, and in fact all homeopaths, see his understanding confirmed when, after homeopathic treatment, the illness process seems to reverse its course along the same continuum. In this situation the patient feels better in general, but old symptoms re-appear, often in a way that makes one think of a film being played backwards. This phenomenon had already been observed by Constantine Hering, one of the old masters of homeopathy, and in homeopathic circles is called "Hering's formulation".[27]

The notion that health and illness need to be seen together can be found outside homeopathy as well. For example, Aaron Antonovsky (1987), a medical sociologist, also argued against perceiving health and illness as a dichotomy when he formulated his theory on salutogenesis. He called it the "health ease/dis-ease" continuum.

> We are all terminal cases. And we all are, so long as there is a breath of life in us, in some measure healthy. The salutogenic orientation proposes that we study the location of each person, at any time, on this continuum (Antonovsky, 1987, pp.3-4).

Conceptualizing health and illness as a continuum will automatically produce a different attitude than if they are perceived as polar opposites, of which one is desirable, the other in need of eradication. It will mean, for example, that it is not possible to define an absolute "normal" state of health or an absolute "abnormal" state of disease, giving much more room for the acceptance of variations along the continuum. It will also mean that there is an appreciation of an unending and inherent precariousness in living, which the organism needs to meet in a constant effort to maintain its homeostasis.

Illness as "un-tunement"

Dr B's explanation of illness was very much in line with the original homeopathic teachings. He used Hahnemann's term "un-tunement" in his description of the nature of illness:

> Hahnemann spoke about illness as an un-tunement [Verstimmung], an un-tunement of the organism, an un-tunement of the activities of life. He also meant the emotional un-tunement, but not only that, but also a sort of weakening. A person who could cope, for example, with a degree of exposure to the cold yesterday, might not be able to do so today. And it has to be possible to strengthen him back to the point that he will be resistant again.

[27] Hering's Law: cure proceeds from above downward, from within outward, from the most important organs to

Dr D's understanding was also influenced by Sebastian Kneipp, a prominent 19th century Bavarian priest and hydrotherapist. Common to both Hahnemann and Kneipp was the belief that symptoms are indicators of the condition of the vital force and that a therapeutic response has to be directed to this level:

> Kneipp used to classify people when he said: "Now see, this person is weakened, and therefore needs warmth. This one is robust and you can use a cold application to stimulate his circulation so that his blood gets distributed everywhere and his vital spirits will awaken again." When the mother realizes that the child is starting to eat again, she knows that the vital spirits have returned.
> In materialistic pathology when you find a tumor you consider that to be the cause of the illness. For us homeopaths or other medical practitioners who are more dynamically orientated, it represents a symptom, which is an expression. It is a consequence but it is not the cause.

When asked where one would locate the real cause of illness as a homeopathic doctor, he answered:

> There I need to be very humble. It lies in our finiteness, in our vulnerability, in our imperfection. Each of us has already certain inherent imperfections and through the different life conditions and circumstances, poisons, starvation, neglect, we weaken the body further.

The acceptance or non-acceptance of what Dr B called "our inherent imperfections" is another great division between conventional and alternative medical approaches. Treatments like homeopathy are not aimed at altering what has been naturally given, but intend to bring, as Hahnemann put it, what is "un-tuned" or out of tune, back into its best performing condition. When, through illness physical structures change, helping the organism back into its equilibrium can give rise to a repair on a physical level as well, but as a secondary effect. The stance behind approaching illness in this way is a belief that the best healing method is one that respects the inherent wisdom of the organism. Through thorough observation of all phenomena that the living body exhibits, including subjective sensations, the practitioner can understand the signs of the different kinds of imbalance and through gentle interventions aid the organism to find its homeostasis again.

However, as Dr B remarked, no human being is perfect but everybody carries inherent flaws, which, in his mind have to be taken as a given and which are not open for change. At the same time, however, by being aware of the specific vulnerabilities of an individual's organism,

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the least important organs, and in the reverse order of the appearance of symptoms (Vithoulkas, 1980, p.231).

specific measures of prevention and support can be taken to enable the person to live to the fullest within the limits that had been biologically set. Social and environmental conditions, which Dr B called the "life circumstances", are considered to have a significant impact and will therefore need to be considered in relationship with the organism as a matter of course. Part of a holistic view is the acknowledgement of the close interrelationship between all levels of existence. Lyng (1990) describes this aspect of the holistic health perspective:

> A great deal of organic disfunction [sic] is associated with either excessive or deficient exchange between the organism and the environment. An individual who ingests, absorbs, or inhales either too much or too little of certain substances will experience physical distress. Socio-ecological conditions that structure or effect nutrition and substance abuse are crucial causal factors in the phenomenon of organic disfunction. Equally important are socio-ecological factors that relate to the prevalence of environmental toxins. Air, water, and soil pollution are causal factors in many diseases that characterize modern society (particularly the cancers). The holistic health approach views imbalances in this realm as particular important precursors of organic disfunction (Lyng, 1990, pp.83-84).

The consequence of this understanding is that neither social nor environmental influences can or should be separated from the individual's health problem. A holistic attitude therefore does not only affect the treatment choices of the individual patient, but, at the same time, turns out to be a political position. How we organize our societies and treat the natural environment will have a direct effect on the individual's health and these dimensions cannot be neglected in a comprehensive holistic approach to health care. Lyng (1990) believes that it was the inherent political agenda of holistic health movements of the past, like Thomsonian medicine and homeopathy, which was responsible for their decline. These movements had many followers in the United States in the nineteenth and early twentieth century, but, as Lyng (1990) argues, because they went against the "prevailing structure of dominant socio-economic forces" they could not succeed in the end, but were replaced by a kind of medicine that had an ideology which did not challenge the interests of those forces, and because of its underlying paradigm promised to be supportive of them. Scientific medicine, as already mentioned in a previous chapter, enjoyed massive financial backing by corporate philanthropies. People's health problems, viewed from the scientific perspective, could be located on "the level of body tissues and microbes" (Lyng, 1990, p.194).

> In doing so, the paradigm medicalized all social problems, "defining them out of political struggle and even religious morals, and giving them over to technical expertise and professional management" (Brown, 1979, p.129 cited in Lyng, 1990, p.194).

The profound impact of this combined force between economic power and scientific medicine on health care approaches, which promote a holistic view, is still very much felt in present times. Not only are holistic healing systems now relegated to being "alternative and complementary" to scientific medicine, they are also considered less valid health care measures with little legitimization and severely attenuated political strength.[28] Berliner and Salmon (1980) have noted the withdrawal of contemporary holistic medicine from the wider social and environmental context.

> The philosophical thrust of holistic medicine assumes emotional and spiritual dimensions of the individual transcending the physical body. Yet even this expansion still centers on the internal dynamics of the individual to the exclusion of external reality. This, of course, differs from the social medicine of the 19th century, which defined the totality to include the physical and social environment as well as the human organism (Berliner & Salmon, 1980, p.144).

This change can be interpreted as a reaction to the historical developments, the prevailing economic structure and the ideology of individualism. However, Berliner and Salmon warn that, because of the focus on self-responsibility and self-care, and lack of responsiveness to social and environmental issues by holistic health practitioners

> …holistic medicine could easily be formulated into a social mechanism for allaying criticism of present inadequacies in health care delivery and the social production of disease (Berliner & Salmon, 1980, p.145).

Another aspect from Dr B's explanations, which is a part of the acknowledgement of the organism's inherent self-regulating forces but also its given limitations, is an underlying trusting attitude in the ultimate benevolence of nature. Rather than seeing nature as a threat and therefore believing that she needs to be mastered as defense against her destructive powers, nature is imbued with notions of wisdom and rightness. The most reasonable healing approach is seen as being one that works in harmony with nature's intentions, rather than to take control over singled-out aspects.

> Alternative medical therapies provide patients with the generous rhetorical embrace of a benevolent "nature". In alternative medicine, nature is innocent and wholesome and is iconographic symbol of virtue (Kaptschuk & Eisenberg, 1998, p.1061).

Conventional medicine, on the other hand, has produced highly sophisticated measures, in order to influence or rectify some of the inherent, nature-given imperfections that can lead to illness. Most people would agree with viewing them as beneficial, at least for the individual

[28] For further discussion on this subject see also: Larkin, (1983) Occupational Monopoly and Modern Medicine.

patient. Who could argue against insulin, cataract surgery, artificial heart valves, hearing aids, just to name a few? However, the latest developments have prompted warnings. Medical interventions are increasingly used for purposes that go further than the traditional goals of medicine. The combination of powerful medical technologies and an acceptance that their use shall be extended to remedy dissatisfaction with our innate, individual limits, have made the emergence of serious ethical problems predictable. So-called enhancement medicine and the drive for "better children", "superior performance", "ageless bodies" and "happy souls" have become the subject of recent writings in bioethics (Elliott, 2003; The President's Council on Bioethics, 2003). The notions of "mastery of nature" or "human beings playing God" are cited and warnings given about the impending hubris from following this path. Despite the concerns regarding this trend, The President's Council on Bioethics (2003) makes it clear in its report, that it sees a very distinct difference between using medical technologies for therapeutic purposes or for purposes that it calls "beyond therapy".

> Therapeutic medicine, though it may use the same technologies, should not be regarded as "mastery of nature," but as service to nature, as we come to know, through medical science, how it might best be served (The President's Council on Bioethics, 2003, p.286, footnote).

> When a physician intervenes therapeutically to correct some deficiency or derivation from a patient's natural wholeness, he acts as a servant to the goal of health and as an assistant to nature's own powers of self-healing, themselves wondrous products of evolutionary selection (The President's Council on Bioethics, 2003, p.285).

Although many physicians might perceive themselves in the role of aiding the patient back towards wholeness and functioning, the scientific method has, nevertheless, been devised with the vision of mastering nature in mind. Leon Kass is certainly correct when he argues, "Mastery of the means of intervention without knowing the goodness of the goals of intervening is not, in fact, mastery at all." (Kass, 2003, p.8). However, the intention of control and mastery needs to be acknowledged in all scientific endeavors, even as part of a medical science, which is used purely for a therapeutic end in practice. For physicians, who have adopted the scientific mindset it is difficult to not just want to manage disease but to keep sight of their task of serving nature, as for this there has to be a broader understanding of medical truth, which provides a more reverent interpretation of human life and illness. By regarding the human organism as imbued with its own inner wisdom, the homeopathic concept of illness as un-tunement, on which Dr B based his approach towards his patients' health problems, makes it easier for physicians to see themselves in the role of serving nature.

Illness as "resistance", as "symbol", and as "opportunity"

Dr C's conception of the underlying causes for illness was also based on homeopathic theories but was, at the same time, strongly influenced by the family systems approach he used in conjunction with homeopathy. When I asked him to explain his interpretation of illness, he gave an interesting description of illness, which he saw as a resistance to the vital force:

> I understand illness to be a process of resistance against this force that carries us, a denial of this force, a rejection of this force. And if you want to see it religiously, a being curled up in oneself and not being in contact with that force. In a psychoanalytical sense it would be the resistance against yourself, against all that is you. Because you are not just in space and time but you are also in your hidden part – well, I always see two sides in human beings. One that appears in space and time, which starts with being born and ends with death and which articulates itself in a specific form here as a person. And simultaneously I see a human being also as an expression and as being carried by a hidden side, which is beyond space and time.

I was wondering what he thought was leading to this resistance. He started off by describing it in homeopathic terms, as "miasmatic predispositions", which Hahnemann had fashioned in relation to particular constitutional weaknesses:

> These predispositions are in homeopathy the miasmatic; the tuberculous, the psora, the sycosis, the syphilitic, they are obstacles to the path to unity. But on top of that we also have genetic predispositions, which can be an obstacle; we have the family conditioning, which is a big obstacle, meaning the systemic conditioning. All the systemic dynamics that a child notices will be a hindrance for her to find a deep connection to herself. If I am in resistance to my father or my mother, in rebellion, or in any kind of unresolved conflict, the life force, which carries me, cannot flow.

Dr C also referred to the homeopathic concept of "diathesis". He explained this as representing a mental stance, which humans were born with:

> A human being isn't a blank page, first of all not materially, because we are determined by the miasmatic and genetic dispositions, but also not blank from our mental origins. The human being exists between heaven and earth, between mind and matter. And the mental dispositions, which we bring with us, the ideologies which we are given through the system of our family, the stances to ourselves, to the world, these all present obstacles on the path to ourselves.

When listening to Dr C's illness interpretation I was struck by his unique outlook, in which the different theories and experiences of a medical practitioner, family systems therapist, and homeopath seemed to have melded with the cultural meanings of a central European country

that was strongly influenced by Catholicism and burdened by its history.[29] Similarly to Dr B, he perceived the human being as inherently limited, but not only through pre-dispositions, either genetic or miasmatic, but also through an innate mental stance and emotional experiences that imprint themselves in childhood. For Dr C the roots of human illness lay in a combination of factors, located simultaneously on a material and on a mental/spiritual plane, and affected by the past as much as by what the patient was creating in the present. However, these underlying causes for illness, or obstacles as Dr C called them, were not perceived by him as merely pointless sources of suffering, but provided an opportunity for reflection and growth:

> I can say this is illness or that can bring about illness, but I can also say, this is such an irritation and such a disturbance that the person has the opportunity to wake up to himself. If I am in normal good health, I wander through this world without questioning. But if my miasm or my diathetic predisposition catches up with me, I am challenged to take a position and that is something deeply human, typically human. That is an opportunity to wake up to oneself through taking a position to oneself and the world.

This belief that illness provides a chance to understand something about oneself and about the incongruences within one's life also came up in the interview with Dr E. She gave an example from her practice:

> I had a patient who told me that she had eczema on her hands over many years, a thing I had myself in younger years but not since I used homeopathy. And she said that for a long time she did not comprehend what was going on. She put ointments on it and with homeopathy it also went away a bit, but then it came back again. And then she realized that she took too much into her hands and never delegated and never handed over to others. And when she understood that and changed, the eczema went away and did not come back.

It was through the right interpretations of her symptoms that Dr E's patient found the solution, not only for her eczema, but also for a bad habit that might eventually have had greater health costs for her. In her case by discovering the meaning, the Gestalt of the problem expressed in the eczema, that she could move more towards the stage of "ease" along the health-ease/dis-ease continuum.

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[29] All participants conveyed a similar spirit to Kurt Goldstein's 'holistic rationality' (Harrington, 1998). It can be assumed that all participants were conscious of the kind of holism that was prevalent in the time of National Socialism, which was highly mystical, intuitive and irrational and helped justify the crimes against humanity.

Kleinmann (1988) also describes a situation where an illness had a similar symbolic significance for one of his patients. He was asked to see a young man, who suffered from an acute paralysis of both his legs. This man had previously been in good health. A serious conflict with his father, who wanted him to take over the family business, preceded the sudden development of his medically unexplainable condition.

> After lamenting that his father regarded his artistic interests as silly and unmanly and had always criticized his son for being "effete and effeminate," the patient began to rehash a lifetime of frustrating interactions with his family autocrat who had terrorized the patient since childhood.
> "I never have been able to stan, stan, stand up on my own two feet before my, my, my father," he stuttered. Moments later, almost as suddenly as it had come on, his paralysis began to disappear. Over the course of a half hour it was entirely gone, leaving no physical consequences (Kleinmann, 1988, p.41).

In these situations it is the hidden meaning underlying the health problem that, once recognized, was able to bring about the change. But there are also many other ways in which meaning has been associated with illness, either positively, as a path out of suffering, or negatively, leading into it. The way one signifies life's circumstances and events can bring about illness or, conversely, a healing response. The increased rates of death by heart attacks, which cluster around 9 am on Monday mornings, or "Black Monday Syndrome" as this phenomenon has been termed, was found to be an example of the power of meaning (Dossey, 1991). Research showed that job dissatisfaction lies behind "Black Monday Syndrome".

> In 1972 a study done in Massachusetts for the Department of Health, Education and Welfare found that the best predictor for heart disease was *not* any of the major *physical* risk factors (smoking, high blood pressure, elevated cholesterol, and diabetes mellitus) but *job dissatisfaction.* And the second best predictor was what researchers called "overall happiness." This finding fits with the fact that most persons below the age of fifty in this country [US] who have their first heart attack have *none* of the major physical risk factors for coronary artery disease (Dossey, 1991, p.63).

Dossey also cites studies which point to the health promoting effects of positive significations. One such study was undertaken by Suzanne C. Kobasa (1979), who looked at a group of 200 business executives from the same company, all in high-stress positions. Many had experienced heart attacks, but there was also a group of executives who stayed healthy despite the same work stresses. The difference lay in the meaning these people gave to the events they encountered.

> The healthy individuals possessed what psychologists called a capacity for "optimistic cognitive appraisal," meaning that they had a way of "seeing the cup half-full rather

> than half-empty." When stressful events occurred, they did not regard them as the end of the world but as a natural and inevitable part of their lives (Dossey, 1991, p.67).

Illness as meaning in the sense of illness as indication of an underlying theme was one of the four illness axioms (Bauer, 2000; Pieringer, 2000) that were introduced in Chapter Four. Recognition of the illness theme, of the "pathic creation" requires a way of perceiving, which is open and puts aside, as much as possible, any preformed conceptual constructs.

From the perspective of modern medicine, illness is interpreted as being no more than a physical disturbance, which either resolves itself or will be corrected by medical treatments. Although there is an appreciation about a link between psyche and body, as is expressed in the term "psychosomatic illness", conceptually it is not coherent with the scientific premises and therefore the main focus stays on the physical. The very real chasm that lies between the medical disease categories and what people experience when they are ill has been described by a number of authors (Kleinmann, 1988; Frank, 1995).

Healing

All therapeutic approaches employ treatments to restore a diseased organism back to a healthy state. This applies to conventional medicine as well as to any other healing system. If healing does not happen spontaneously, a synergistic effort of an external therapy together with the body's ability to respond is needed to achieve this process. Although the term healing is generally understood, the notion of healing has a much greater significance and a broader meaning amongst homeopathic practitioners than what is commonly found amongst practitioners of conventional medicine. Where in conventional medicine the removal of symptoms or a normalization of laboratory tests indicate a therapeutic success, this is not necessarily considered so in homeopathic thinking. In fact a lot of what was seen as success in conventional medicine would be regarded as suppression in homeopathy and rated negatively.

The participants clearly distinguished healing from the suppression of symptoms, because healing was a process that needed to take place on all levels, physical, emotional, mental and spiritual. Suppressing illness symptoms, in contrast, was understood to be causing chronic ill health by weakening the organism and rendering it less capable of dealing with the normal challenges of life. The participants also pointed to another important difference between the therapeutic focus in homeopathy compared to biomedical interventions. Exactly what it was

that needed healing in a patient was not considered to be self-evident, as the root cause of an illness might lie on a different level than the presenting symptoms.

Dr D explained this thinking:

> But as I said, blocking is far away from healing. Homeopathy goes beyond that. There is this question in homeopathy, you know in the Organon, section three, "What is it that needs healing in this illness?" And that question: "What is it that needs healing in this illness?" that is an interesting point. Well one could say: "The illness is what needs to be healed." But that question, to ask what it is that needs healing in this illness that is the fascinating aspect in homeopathy. It isn't really just a biochemical mechanism that has been upset. And it is not really a virus or some bacteria that need to be fought.

When I asked him to elaborate more on how he would look for this problem that needed healing, he told me that it was a question of standing back and trying to understand the underlying dynamic:

> You can see in those beautiful case studies what the real issue is. What is it that needs to be healed? What is really the problem? What is the underlying problem in this human being that this development could occur? Why was that necessary? Why was it necessary that the body had to produce a symptom? Why was he thrown out of balance? These are the interesting questions. And it is possible to demonstrate that because you can see it very nicely when a remedy really has hit the right point. But that is the difficult part in homeopathy to find this point, to find the remedy, which truly gets into the center of this dynamic. But when it is successful and when you then observe what develops from here, then you can clearly see what it was that needed to be healed in that particular case.

Each homeopathic remedy is understood as encapsulating a particular pattern or theme, or what Sankaran (1992) called the "central disturbance". The central disturbance refers to an issue that is deeply problematic for a person and expresses itself on all levels, physical, emotional mental and spiritual. It is the most difficult but also the most rewarding task for a homeopath to grasp this theme in a patient and find the remedy which represents it. When Dr D said that it is then that you can see what needed to be healed, he referred to the process that happens when through successful homeopathic treatment this disturbance begins to settle and whatever was bothersome and presented an ongoing irritation for the patient seems to lose its grip.

In Dr A's view the different therapeutic approaches were acting on different levels. Surgery, he explained, could solve a physical problem, but it would not touch the dynamic disturbance, which was the underlying cause of the illness. Still, he did not deny that there was an

important place for surgical treatment, particularly in the case of a life-threatening situation, but he was very clear that a healing approach that could influence the problem at its dynamic core would ultimately be a better solution.

> The operation will not solve the dynamic disturbance but is merely representing a removal of symptoms. To treat the dynamic occurrences, which also encompass the spiritual, psychological and mental is not possible with orthodox medicine, except by using psychotherapy. Therefore it is not a question of either or, but a question what is most useful for the patient at this particular moment and principally a dynamic approach would be preferable.

Dr E took quite a different angle. She also appreciated the significance of symptoms from a homeopathic perspective but for her an active learning process was required by the patient. A complete healing process could only occur when the patient had attained a deeper understanding about him/herself. This became very clear when Dr E spoke about what she was trying to achieve with her treatments:

> That people really heal. Not only that the rash disappears from the skin but also that the reason for the skin to produce a rash disappears. And that people have less and less a need for getting sick – they are learning something too, as soon as it starts to tingle in the nose they'll start to think "why is my nose full of something?" [German saying: "Ich habe die Nase voll" – which would translate to "I am sick of it"] And when you learn this in time you might not need to get the illness at all.

Dr E gave physical symptoms the symbolic meaning of "messengers" that were letting us know about an issue in our life, which we might otherwise ignore to our detriment. Even with homeopathy, she claimed, real healing could not take place, without having received and understood the message. What this message was, however, she said was often hard to grasp.

> Well that goes more into the spiritual realm. That's why I also went into shamanism, to learn to understand why one repeatedly meets the same thing, why one repeatedly gets the same illness. One has to learn to look at it. Homeopathy, as good as it normally is, will only be a momentary treatment of symptoms when the cause doesn't get resolved, which is that one needs to change something in the way one lives.

Dr E thought that this awareness was also a preventative strategy:

> If you learn it quickly you don't have to become seriously ill. If you think straight away: what is it that I have to learn? Rather than: what symptoms do I have, what remedies do I need? But "What do I need to learn?" then one doesn't have to get seriously ill.

For Dr E healing was a truly holistic process. Homeopathic treatment alone in which the disturbance is supposed to be influenced by the well-chosen remedy was not fully sufficient to

her. Because of her belief that there also had to be a raising of consciousness, her approach demanded active involvement and willingness to reflect from her patients. When I asked her what she thought about patients who resorted to conventional medicine, she answered:

> There you don't have to think much yourself, you can hand it over. That can be very suitable for a lot of patients. There are people who just want pills, they want to swallow something and all is gone. That is okay too, that is also a decision.

That this was not a good decision in her eyes, Dr E made very clear. However, she acknowledged the successes of modern medicine, particularly the increase in life expectancy, but had strong reservations. Symptoms, she said, might be controlled but there was a price that had to be paid for a long life that was achieved by conventional medical treatments, as they did not lead to "real healing":

> Now they all reach eighty but are chronically ill for forty years. That is the other side of that. They survive but they are chronically ill. Some don't even notice that that is bad.

What the concept of healing meant for the participants was closely connected to their shared holistic understanding of illness. A complex, multi-layered system like the human organism could be disturbed in many ways and on all the different levels. Healing would not just occur on the physical body, but was considered to represent a much deeper process, which could be influenced through mental and emotional avenues. Great care had to be taken to identify the level on which the disturbance took place. True healing, was understood as a holistic restoration back to a healthier state, which ideally meant having strengthened the organism to meet the ongoing challenges of daily life and the freedom from ongoing medical treatment.

There is an interesting paradox in these high ideals of healing when considering the low-tech interventions used in homeopathy or other non-conventional healing approaches. Although health is not comprehended in the same idealistic and static way as in the 1947 WHO definition of health, which is "complete physical, mental and social well-being", the aim nevertheless is that patients become physically and mentally empowered and independent of ongoing medical treatment. Comparatively, the "Four Goals of Medicine" (Special Supplement, Hasting Center Report 1996) seem very modest[30].

[30] These four goals were defined as: 1. The prevention of disease and injury and promotion and maintenance of health. 2. The relief of pain and suffering caused by maladies. 3. The care and cure of those with a malady, and the care of those who cannot be cured. 4. The avoidance of premature death and the pursuit of a peaceful death.

Suffering

The meaning of human suffering was an issue, which was explored specifically with the participants. Suffering is a condition doctors want to relieve, but the participants, rather than seeing suffering in a purely negative light, also stressed its meaningful and valuable aspects. I wondered how they reconciled this tension and how they would identify the moment when suffering changed from having a predominantly beneficial and purposeful side to simply being hideous.

Although in Dr C's understanding of illness, suffering definitely had a purpose, he was clear, however that treatment should never be denied and was very critical about any practitioner who was doing that:

> We had a good teacher, Dorczi, who is in his grave now. He introduced something that he set against this elitist attitude that you can find amongst homeopaths, amongst psychotherapists and also amongst orthodox physicians. He set against this attitude the "indication of the fellow man", that means that even if you are aiming - as a homeopath for example in a classical sense - for the absolute simillimum[31], when somebody stretches his hand out to you because he is drowning, then you have to take hold of it.
> That means, the main thing is first of all, that we act as human beings toward fellow human beings, not even as doctors towards patients.

If it became obvious that he was not able to alleviate the symptoms of his patient with the therapeutic approaches he could offer, he would not have any difficulties resorting to an orthodox treatment. But then, and he was eager to get this point across, it was crucial not to stop here with the relief of the presenting symptoms but to continue with homeopathic or another non-biomedical treatment:

> I think in orthodox medicine it is about diminishing suffering and therein lays its great potential. But the danger of leaving it at that is great; that you don't see, that you don't want to look at what it is that expresses itself in this acute manifestation, at what brings about the illness.

Dr D also stated his willingness to employ orthodox treatment, even psycho-pharmaceutical drugs, in order not to let his patient suffer. He explained to me what he would do if he had not been successful in relieving the distress of his patient with homeopathic treatment:

[31] The particular homeopathic remedy, which matches the symptoms of the patient in the closest way and promises to be most effective.

> Well that is a frustrating situation [laugh]. That happened in one case of mental illness for example, when somebody had a severe depression and it wasn't possible to find the remedy. That is particularly difficult in some of the neurotic depressions. It is very difficult to really understand what is happening there.
> You reach the point then when you say, rather than leaving him to suffer so badly it is a lesser problem for him to take some psycho-pharmaceuticals for a while. And when the patient has realized what it is all about, then he can still stay on them whilst we continue to search for the homeopathic treatment and eventually we will find the solution and we can reduce them again.

All interviewees agreed that there was a limit and that they would only tolerate the suffering of their patients up to a point. If there was a dangerous decline in the patient's health or when the symptoms were not at all resolvable with homeopathy or other alternative measures, they all thought it was right to resort to conventional treatments if they promised relief, even if the healing process was not necessarily furthered by the intervention.

The participants addressed the issue of suffering from two perspectives: One, the purely philosophical perspective, which went into the meaning and potential purpose of suffering; the other, the place of symptoms and suffering through illness and through the therapeutic process. There was quite a difference in opinion amongst the participants when it came to the question of whether suffering and illness were providing a potentially beneficial opportunity, for example as a chance for people to gain a greater knowledge of themselves. On the other hand, there was general agreement when it came to the place of symptoms and suffering within homeopathy. Cassell (1982, 1991) argued that suffering and physical distress needed to be distinguished. Conventional medical doctors, he claimed, responded predominantly to physical distress and dysfunction, but did not recognize suffering enough. Cassell saw the mind/body dichotomy and medicine's focus on the physical, objectifiable level of illness as the reason for this state of affairs. This dichotomy does not exist in homeopathy and therefore when homeopaths speak about "symptoms" they might indicate physical discomfort or even distress, but they might also refer to an extended meaning that addresses the realm of suffering. Cassell could show that what is experienced as suffering is closely associated with the signification that the sufferer gives to a situation, which in turn depends on a multiplicity of factors including the person's temperament and constitution and the social and cultural context. However, he did not take into account that it will also depend on the way health and illness are viewed from the explanatory model of the specific healing approach the patient has chosen. Symptoms have a different connotation in a framework that operates within the

polarities of healthy versus ill, compared to one that perceives a continuum in health and illness.

Because in conventional medicine symptoms are equated with suffering the correct response is to try to eliminate them. In homeopathy symptoms are viewed differently and are responded to in a different way. Homeopathic theory sees all symptoms as signals of a disturbed life force and therefore as secondary phenomena. The therapeutic target in homeopathy is not the eradication of a particular symptom but a strengthening of the patient's organism as a whole. The approach addresses the patient's symptoms through stimulating an overall healing process that eventually takes care of the symptoms, ideally without causing additional distress. Because of the meaning symptoms have as signaling the condition of the life force, there are several instances during homeopathic treatment when symptoms can even be seen as positive. For example, old symptoms that return after the patient has taken a remedy are not considered as worrying, but instead show that the illness process is reversing back towards a healthier state. An acute flare-up of symptoms after homeopathic treatment is also not considered to be negative. This well-known response is called "first aggravation" [Erstverschlimmerung], a phenomenon that is interpreted similarly to what folk medicine sees as a healing crisis. The first aggravation, although potentially distressing to the patient, is in fact an indication that the remedy was well chosen, the organism has a strong life-force and that the prognosis can be expected to be good. Homeopaths also welcome symptoms that manifest on less vital organs, if at the same time they seem to have shifted away from what is considered to be a higher level of the organism; like, for example, from mental/emotional towards physical symptoms, or from symptoms of internal organs to the skin. A child whose asthma improves from homeopathic treatment, but who breaks out in a skin rash is considered to have progressed to a healthier state and it would be wrong to try to clear even a severe rash with external treatments as this could undo the healing process. Patients who receive homeopathic treatments are encouraged to view the significance of symptoms in that same way and thereby become aware that the healing process can entail its own arduous features. Although homeopathic treatments are gentle and as in any therapeutic approach the aim of treatment is for the patient to attain a state of wellness, the conception of a dynamic process along a continuum brings into consciousness how illness, healing and suffering are intertwined and cannot be divided.

This is quite in contrast to conventional medicine, in which there is a tendency to pass over the reality of suffering (Frank, 1995), even though medical treatments are often invasive and painful, not to mention the distress of illness in the first place. Surgical interventions, for example, or the treatments of cancer like chemotherapy or radiotherapy frequently lead to high degrees of trauma and suffering. Despite this, the hoped-for end result, the suffering-free state, stays in focus and the discomfort and pain of illness or the therapeutic process often remains unstated, as Frank illustrates in his description of a tabloid newspaper supplement about a cancer treatment center. The stories about the three cancer patients in the pamphlet do not tell anything that would indicate suffering; neither do the images of the treatment equipment. Frank explores this denial of suffering in modern medicine in his observations on the different illness narratives. He terms this one-sided emphasis on good outcome in biomedicine the "restitution narrative". In this narrative, Frank claims, suffering is excluded and the story line boils down to: "Yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again" (Frank, 1995, p.77); thereby "the emphasis is on life after treatment: returning to 'I'm fine!'"(Frank, 1995, p.79). The positive side of this can be that it helps people to maintain hope and optimism when facing a challenging diagnosis and invasive medical procedures. On the other hand, the exclusion of suffering in the restitution narrative can make it very problematic for people to deal with illnesses that do not have an effective medical answer, like chronic or terminal conditions. Ignoring suffering and only focusing on the eradication of disease and physical distress means, according to Cassell (1982), not meeting the traditional goals of medicine and running the risk of inflicting even more suffering on the patient.

The question about the purpose of suffering is a delicate one. In scientific medicine where illness represents mere dysfunction, human suffering is a notion that has no real conceptual place. Even though doctors might be tempted by the scientific framework to reduce suffering into disease and physical distress, the experience of illness, particularly if chronic or otherwise threatening of one's integrity, will most likely trigger other, more traditional views. Deeply embedded in Western man's psyche is the Christian heritage and this background will most likely provide the template for people to find orientation for their suffering. There have been two main interpretations of suffering in Christianity. One perspective originated in the Augustinian tradition, the other in the Irenaean. Suffering according to the Augustinian tradition is closely connected with evil, sin and redemption. In the Irenaean tradition, suffering "serves a fundamentally pedagogical function" for "without moral struggle there could be no

moral virtuosity, indeed no character at all" (Smith, 1987, p.257). Both those interpretations are used and have their examples in contemporary contexts. One has only to think about the stigma that is often given to AIDS or other sexually transmitted diseases to see how illness and suffering carry the connotation of sinning (Kleinmann, 1988). Or similarly there is the undertone of sinning when physical illness follows a lifestyle that is considered unhealthy, like indulging in too much alcohol or food. Equally present is the notion of suffering as a pedagogical challenge, which has been represented by some of the participants. Frank (1995) calls it the "quest narrative" when illness and suffering is reframed in that way. He quotes a poignant statement from Deborah Kahane's research on women with breast cancer. "I would never have *chosen* to be taught this way but I like the changes in me. I guess I had to go to the edge to get there" (Frank, 1995, p.128).

Other interpretations about the purpose of suffering, which are not related to religious meanings, come for example from the humanist Levinas or from the philosopher Nietzsche (van Hooft, 1998a). Although Levinas judged suffering as intrinsically useless, he believed that it provides, through the virtue of compassion, an avenue towards the fellow man, and therefore serves an "inter-human" purpose. Nietzsche, also a non-believer in a divine plan or inherent goal, saw suffering nevertheless as a means to the evolution and transcendence of man.

Elements of all these ideas about suffering could be found in the opinions of the research participants. They shared the belief that illness and suffering were not pointless as they helped towards a greater understanding of oneself and of life, potentially leading to a better and healthier existence. However, none of the interviewees saw suffering as so absolutely beneficial that they would not try to relieve it, or consciously abandon the patient to his/her pain, as a number of authors have accused practitioners of alternative medicine of doing (Saunders, 1996; Davidoff, 1998).

Illness meanings compared

To serve the aim of this research, which is to gain a deeper understanding about the possible meaning and ethical significance of the growing popularity of non-conventional therapies, it seemed important to also draw a comparison between the views of the interviewees and the perspectives of people who use alternative healing approaches. The reason behind this is the

assumption that this research will hold greater weight if it can be shown that there is indeed congruency. For the comparison the most typical aspects were taken from the participants' statements and judged against the research studies into the perspective of patients who used non-conventional treatments. Many patients, as discussed in Chapter Four, had consulted CAM practitioners for pragmatic reasons, like insufficient relief from conventional treatments or fear of side-effects. Often they had no obvious holistic perspective initially, but adopted a more holistic understanding in the process of getting to know more about the CAM treatment and its associated theory (O'Connor, 2002). Still it can be said that when patients who accessed CAM expressed their views on the subjects of life, health, illness, healing and human suffering they mirrored those of the five participants, which shows that they were not unique to them as homeopathic physicians.

There is, for example, much agreement about the significance of spirituality, particularly during illness, between the interviewees and patients who use complementary health practitioners (McGregor & Peay, 1996; Blais et al., 1997; Kelner & Wellman, 1997; Astin, 1998) and in fact also with the general public (Kleinmann, 1988; Cassell, 1995; Larson & Larson, 2002).

The notion of vitalism, which was highlighted in the interviews, seems also to be the prevalent intuition in the general population. Most people agree that they can perceive a specific quality in living beings that is absent in inanimate matter or dead bodies and for this reason would reserve a higher moral status for live entities (Franklin, 1995). Similarly, the vitalistic understanding of health is very common globally, and is not only the dominant belief in non-Western countries (Eskinazi, 1998) but increasingly so in the West (Jonas et al., 2003).

The belief that body, emotions, mind and spirit should not be seen as separable could be found in the statements of the interviewees and also in patient surveys (Kelner & Wellman, 1997; Astin, 1998; Launsø, 2000). The inherent consequence of this understanding is that all health care practitioners need to value the dimensions that can only be perceived in a subjective way. This view was strongly promoted by the interviewees, who had chosen to practice homeopathy because they appreciated the inclusion of the subjective dimensions, which is required in this therapeutic approach.

Another important conviction that the interviewees held was that that human beings are embedded in bigger contexts, which were those of nature and of religion or spirituality. This perspective was replicated in the accounts about the beliefs of people who use non-conventional treatments (Kaptschuk & Eisenberg, 1998) and those prevalent in the general population (Larson & Larson, 2002).

The health care activities of patients, which Launsø (2000) described, could be seen as indicating the concept of illness as a dynamic process, for which an ongoing effort by the organism is needed so that equilibrium can be achieved and maintained.

The belief that illness can be taken on as a challenge, because it might point to a deeper meaning, is reflected in Frank's (1995) stories of some people's approach when facing a serious health problem. Frank described three different narratives through which people live with their illness, "the restitution narrative", "the chaos narrative", and "the quest narrative". Illness perceived as quest reflects the sentiment that by transcending one's predicament, greater awareness will be attained and progress made towards better health, if not on a physical level but certainly in a holistic sense. This stance was also shared by the participants, who would help their patients in taking on that quest, rather than supporting the restitution narrative, which Frank (1995) showed led to alienation from oneself and to dependency on the expert health professional.

The acceptance of the limits imposed on man by nature, which is in such contrast to the spirit of modern technological medicine, was another significant point that the participants made. This stance translates into a reluctance to use interventions that interfere with the natural processes of the organism and is reflected in the desire of people for low-tech measures and to learn how to tune into themselves in a better way (Launsø, 2000).

Another significant parallel between the interviewees and research findings on patients was the willingness to accept a range of explanations as what the root causes of illness might be and incorporate different therapeutic avenues (O'Connor, 2002), including the interventions of scientific medicine if they were needed (Siahpush, 1999).

Judging from these parallels it seemed reasonable to conclude that people choose to use non-conventional therapies because they have come to realize that the phenomena of illness and their experience are not sufficiently met by contemporary scientific medicine. For conventional physicians who are working within the constraints of a biomedical framework, it is naturally a struggle to attend to other than biological illness dimensions of their patient. Chapter Four included an overview of research on the kind of patients who use complementary medicines and what reasons they gave for this choice. Even though much has come to light, for example that it is particularly those people who suffer from chronic conditions who seek health care from non-conventional practitioners, much remains unexpressed according to Fulder (1996).

> In my experience, people find it hard to articulate the deeper reasons for change. But behind their frustration with modern medicine is a strong and intuitively held sense that what is lacking in modern medicine is respect. Patients may feel that the totality of their life brought them to this disease at this time. Yet the reductionist basis of modern medicine can hardly do more than fix a problem and send the patient on his way, without connecting to his feelings, questions, vulnerabilities, biography, and life experience. In that sense, however nice the medical staff, reductionism reduces the human being and takes its toll (Fulder, 1996, p.35).

This is a most significant statement because it identifies that modern medicine, despite its successes, contains a demeaning element through its reductionist approach, and it also highlights the difficulty in naming what exactly is missing and how this can be addressed.

Approaches towards a humane medicine

During the last few decades, a number of conventional physicians and authors have tried to tackle these issues in very similar ways and have also pointed out that the framework of modern Western medicine is not sufficient to give an adequate representation of the multiple aspects of illness (Engel, 1977; Kleinmann, 1988; Cassell, 1991; Frank, 1995; Stewart et al., 1995). These authors have noted that doctors who practice only from a scientific conceptual foundation possess merely the tools for responding to the patient's malfunctioning biology but not to the ill person and that this one-sidedness not only has consequences for an ethical practice of medicine but also shows up as being therapeutically deficient. Toombs (1992) has highlighted the fact that the subjective aspects of illness, or "illness-as-lived", are not given legitimate diagnostic or therapeutic weight in scientific medicine, and are therefore relegated to being optional adjuncts, subject to the discretion of the individual doctor to take note of or not. These authors have all argued how tremendously important it is that doctors listen to their

patients' stories, learn about their lives, their specific circumstances and backgrounds, and get more of an understanding of how people might have come to develop their illness and why they might deal with it in their own particular way. Their writings show that health care, which gives attention to the subjective, social, environmental and spiritual dimensions of patients would not only be more humane but ultimately also more effective.

For a better understanding of the critical arguments from within conventional medicine it will be informative to look further into the writings of the two prominent medical authors Kleinmann (1988) and Cassell (1991), and then compare them with the interviewees'. Kleinmann (1988), for example, strongly criticizes biomedicine for its inability to handle the emotional world of patients in an adequate way and for its failure to respond to meanings that patients give to their illness experience, particularly in its care of people with chronic conditions.

> These are the activities with which the practitioner should be engaged. The failure to address these issues is a fundamental flaw in the work of doctoring. It is in this very particular sense, then, that we can say of contemporary biomedicine: in spite of remarkable progress in the control of disease, it has turned its back on the purpose of medicine (Kleinmann, 1988, pp.253-254).

The aspect of care, Kleinmann argues, is undervalued in contemporary medicine and for this reason medicine does not do justice to the problems of the many chronically ill patients who make up an increasing majority of people needing health care in Western countries. In order to bring about the improvements that are needed, he suggests a radical change from a disease-centered to a meaning-centered model of medical practice. To help understand the meanings of illness in the individual patient Kleinmann advocates for an ethnographic approach to the patient's illness narrative and for an interpretation of the patient's story, in which four different types of meanings need to be distinguished. These four types or layers of meanings are "symptom symbols, culturally marked disorder, personal and interpersonal significance, and the patient and family explanatory models" (Kleinmann, 1988, p.233). Before an appropriate therapeutic response can be formulated, these illness meanings have to be understood by the physician. However, Kleinmann also realizes that, to bring about such a meaning-centered health care model, the change would have to happen simultaneously on all levels, including health care delivery, the medical research arena, and in medical education.

The other strong critic of contemporary medical practice is Eric Cassell (1991). He poignantly recalls the moment, during a luncheon discussion with colleagues, when he realized that a change had occurred in medicine and it had become dominated by its scientific ideal.

> It was the general belief that no one would ever again rise to prominence as a clinician as a sole result of expertise in the care of patients. How different from the end of the nineteenth and in the beginning of this century, when doctors aspired to greatness because of their abilities with the sick. During the decades that followed World War II, such individualism came to be viewed negatively – science became the physician, although necessarily working through the hands of individuals. Similarly the term "anecdotal medicine" came to be seen as the equivalent of subjective contamination and to stand for sloppy, unscientific medicine (Cassell, 1991, p.13).

Cassell sees this development as extremely detrimental to the care of patients. Science, he argues, should not be the dominant force but have its place in the service of medicine, so medicine can fulfill its task to respond to the needs of the sick. To help reverse this trend, Cassell (1991) appeals to physicians to return to the traditional goals of medicine; namely to focus again on helping the sick. He believes that this will be more likely if doctors gain a greater understanding of the nature of human suffering and learn to appreciate it as a deeply subjective experience. Cassell's subjective understanding of suffering, however, has no conceptual place within biomedicine and therefore his stance "implies that the hope of a scientific treatment of suffering is a forlorn hope" (Edwards, 2003, p.59).

Cassell, similarly to Kleinmann (1988), emphasizes that the subjective dimensions of the individual patient have to be taken into account because they are crucial to appropriate health care. He also highlights the need for physicians to become aware of the social and cultural context of their patients and the personal meanings that are given to an illness. These physicians and writers obviously have a very similar agenda with the homeopathic physicians who were the participants in this research. Their criticism of contemporary medicine and also their appreciation of the patient's individuality and subjectivity sound in many ways alike; so does their desire for a more humane and also more appropriate and effective healthcare. However, there are also some fundamental differences.

Whereas the research participants and also many patients who use alternative medicines subscribe to a holistic perception, in which all dimensions, physical, emotional, mental and spiritual, are understood as inseparable, which implies that disturbances can originate on all levels, this is not conceived in such a way by the authors above. Although neither Kleinmann

nor Cassell stop at the limited concept of de-personalized disease, they seem however to add the "person" by attending also to the psychological and social aspects.

> The goal is to find out what is happening in the body (pathophysiology) as well as who the patient is; to uncover what (about the pathophysiology, the patient, or the context) threatens the patient, and why it does so at this time (Cassell, 1991, p.155).

Cassell identifies the mind/body dualism in medicine as being the greatest hindrance for proper care of suffering patients, particularly because of Western medicine's emphasis on the physical aspects of illness. However, by juxtaposing the patient's subjectivity and objectivity, he in fact upholds this dualism (Edwards, 2003). Dr A in contrast takes a very different approach, through which he tried consciously to link the two dimensions. He maintained that inner phenomena were not really separable from what could be objectively perceived, but both represented primary dimensions and, although distinct, needed to be seen as aspects of the whole.

Another difference between the research participants and Kleinmann (1988) and Cassell (1991) lies in what they regard as counting as legitimate sources for medical knowledge. Obviously, the research participants drew their therapeutic skills from a wide variety of healing approaches in order to respond to the specific needs of their individual patients. To enhance the equilibrium of the patient's organism and strengthen his or her vital force, for example, the participants might use homeopathy or acupuncture. To find an understanding about the underlying meaning of a particular illness they would perhaps take a psychotherapeutic approach, or go into an in-depth dialogue with the patient, or perform a shamanic ritual. If a health problem required it, the participants might also resort to a biomedical treatment. The knowledge of all those therapeutic interventions had been obtained by the participants from a great variety of sources, including scientific findings but certainly not confined to them. Cassell, in contrast, appears not to accept alternatives to the scientific method for gaining reliable medical knowledge.

> There is no question that if you want to treat sick persons based on the mechanisms of disease – and any other way would be inadequate – then science is essential to medicine (Cassell, 1991, p.214-215).

> Caring for the sick cannot be done without the kind of controlled, rigorous research and disciplined thinking that science brings to the understanding of nature (Cassell, 1991, p.28).

The scientific understanding, however, still mostly in line with Descartes, renders nature as res extensa, as something that can be objectively observed from the outside, measured and quantified, and as something that is open to external manipulation and control, but not from a subjective, internal level. As already argued in previous chapters, medical knowledge that derives from that conceptualization has fundamental limitations because of its specific singular focus.

Kleinmann takes a broader stance by requesting that medical research should not focus so predominantly on biological and clinical science, but give more attention and resources to "anthropological, sociological, historical, ethical and literary studies (The human sciences of medicine)" (Kleinmann, 1988, p.266). Only through this extended research approach, he believes, will physicians develop the necessary attitudes, knowledge and skills to practice a meaning-centered medicine.

> Until the academic discourse of medicine is expanded beyond the languages of molecules and drugs to include the language of experience and meanings, however, medical science will reinforce the profession's resistance to the problems of illness rather than contribute to the broadening of that vision. Research that avoids the human side of disorder places the profession and its practitioners in iron chains of restricted knowledge (Kleinmann, 1988, p.266).

The fact that there have to be repetitive reminders that the true purpose of medicine is to respond to patients' suffering is a puzzling phenomenon in itself. Even more surprising is that despite these appeals and despite the efforts of many agencies like, for example, bioethicists, health care planners, medical educators, and so on, to transform the medical encounter, the situation does not appear to have improved over the years. Although Jonas et al. (2003) refer to the conditions in the US the experience of other Western countries is not so dissimilar.

> In the main these attempts have not improved patient satisfaction, have left physicians and nurses feeling disenfranchised and have failed to contain escalating costs reflected in the increasing percentage of the nation's gross domestic product (Jonas et al. 2003, p.36).

However, both Kleinmann (1988) and Cassell (1991) seem to trust that the solution to those problems lies in the restoration of modern medicine to a more humane endeavor. Even though both authors are keenly aware of medicine's shortcomings in seeing the patient in his or her complexity, and although both acknowledge the limitations of the biomedical framework, neither appears to seriously consider an integration of other healing approaches into regular

health care. Kleinmann shows that he is clearly knowledgeable about different healing systems and he is aware of the fact that particularly chronically ill patients tend to access a wide range of alternative practitioners on a regular basis. He recommends therefore that physicians should find out what other treatments, apart from conventional medical approaches, their patients are using.

> Respect for the patient's viewpoint should include a willingness to learn about the so-called alternative practitioners. It should also mean that the physician tries to determine when resort to folk healers and their treatment is useful and when folk healing is potentially harmful (Kleinmann, 1988, p.262).

Despite this acknowledgment of non-conventional treatments, Kleinmann's statement only seems to indicate that he accepts the wishes and choices of patients. It certainly does not come across as recognition that the active inclusion of non-biomedical healing approaches, due to their underlying holistic perspective, could be the catalyst for a change towards a more humane approach to health care.

The difficulty of honing complexity

Since Kleinmann wrote his book in 1988 the popularity of non-conventional approaches has increased steadily and it has become more pressing to acknowledge, comprehend and respond to the message that this movement is sending. Before going any further however it might be useful to take a step back and reflect on the reasons for medicine's present predicament. The underlying problems have been identified as lying in medicine's adoption of a problematic theoretical framework and the investment of the maximum amount of mental and material resources in this agenda. However, the initial invention of the framework was meant to counteract the age-old difficulty that physicians meet when dealing with illness, as illness elusively presents in the form of innumerable phenomena (Coulter, 1975). Coupled with the threat that illness can also lead to death, it seems only reasonable that one would wish to extract an accessible and manageable construct from the diverse characteristics of the human organism. Descartes' reframing of the living body into one that resembled the workings of an inanimate machine can be seen as such an attempt. Drew Leder (1992) retraced the formation of Descartes' concept and discovered that it was indeed motivated by his concerns with mortality, and the hope that he held for himself and for humanity to escape from the chains of sickness, aging and death. Perceiving the body purely as a machine, independent from an animating soul, where death only occurs because "some one of the principle parts of the body decays" (Descartes cited in Leder, 1992, p.19), made it not only possible to imagine it as eventually fully comprehensible, but also provided the moral permission for previously prohibited interventions. Descartes' conceptual approach greatly simplifies what is otherwise too complex to manage, through splitting off all the elements that are dissimilar to the inanimate world, namely everything that is subjective. From his framework it becomes allowable to dissect the human entity, defined now as *res extensa* , into its different physical parts and take control over it. This Cartesian revelation is, as Leder states, "at the core of modern medical practice" (Leder, 1992, p.23).

> Once we analyze a natural object into its component parts and their interactions – that is, see how it is made – we can make it ourselves, or alter it in the desired directions. Herein lies the enormous power of modern medicine. We have learned to understand, remake or transform, components of the body-machine. When disease intervenes, we can intervene too (Leder, 1992, p.23).

The power that this approach has given to medicine is indisputable as it has lead to an unprecedented level of effectiveness in the treatments of human illness. However, in the last

decades it has also become increasingly apparent that the Cartesian approach has brought with it some very problematic aspects, as its power to do good is at the same time a power to do evil. This is evident in the danger of adverse effects from medical interventions but has possibly an even greater and more insidious fallout on more profound levels. Thinking within the mechanistic frame not only distracts physicians from their duty to engage with the patient-as-person, it also promotes the alienation of patients from themselves and undermines their understanding and valuing of their own subjectivity. In addition, Leder argues that its failure to address certain health problems, chronic illness in particular, could be seen as a sign that illness does not eventuate merely where the Cartesian paradigm suggests, on the material level of human existence, but that it also takes place on subjective, non-material levels and that it can be caused and also relieved through them.

> There is mounting evidence that emotional stress, intersubjective losses, and personality styles can play a crucial role in bringing about illness. Similarly, one's response to treatment may depend upon such "subjective" factors, as one's affective state, one's "will to live", or the quality of the treater-patient relation. Such humanistic variables continually peek through the cracks in the façade of mechanistic medicine (Leder, 1992, p.23).

The intertwined nature of objective and subjective aspects in illness needs to be fully appreciated before an approach to health care can be devised that is simultaneously effective and humane. Otherwise one might be misled into simply demanding that the subjective aspects that have been taken away should be added again. This seems to be the route which Cassell (1991), for example, has taken and which is in effect also where a bio-psycho-social or patient-centered approach in medicine is leading (Lyng, 1990; Leder, 1992).

> Even those who seek "holistic" alternatives often find themselves caught in dualistic terms, asserting the importance of mind, soul, or spirit, vis-à-vis bodily events. Such a framework fails to rethink the body itself and develop a systematic alternative to the machine-model which for so long governed our thinking (Leder, 1992, p.24).

A conception that separates out objective and subjective aspects, or body and mind, is not able to account for those illness phenomena, which have been found to contain a multiplicity of material and immaterial aspects at once. Therefore a medicine based on this understanding will have to be therapeutically insufficient. To meet the reality of human illness and to devise appropriate therapeutic responses the framework needs to accommodate the intertwining multidimensionality of illness. It has to be holistic, but at the same time accessible. There are different suggestions on how to approach this task, two of which are examined here.

Leder (1992) argues that we first have to reform our perception of the human body. The fundamental problem with the Cartesian paradigm, according to Leder, lies in the conception of body-machine, which has led to a conceptual conflation of *lived body* with *dead body*. Adding subjective features will not revive the dead body, but a complete mental shift is needed to stay away from this conflation. He reinforces his argument by referring to the German language, which makes a clear distinction between lived body and dead body. In German the word *Leib* delineates the lived body and *Körper* refers to the dead body.

> The notion of "lived body" rejects this conflation. It holds that the body of a living being has an essential structure of its own which cannot be captured by the language and concepts used to explain inanimate nature (Leder, 1992, p.25).

Conceiving the lived body means seeing it as an entity with intentionality and as being in relationship with "other people, other things, an environment". "Moreover, in a significant sense, the lived body helps to constitute this world-as-experienced" (Leder, 1992, p.25). However, Leder takes great pains not to imply a juxtaposition but to communicate the "intertwining" of intentional and material.

> The body is not simply a thing in the world, but an intentional entity which gives rise to the world. Yet to be the latter is not to negate the former. While the body has a subjective role, it is also a body-object, a material thing (Leder, 1992, p.27)

If this perception became dominant, he believes, that

> …we would arrive at a medicine of *intertwining*. That is, our notions of disease and treatment would always involve a chiasmatic blending of biological and existential terms, wherein these terms are not seen as ultimately opposed, but mutually implicatory and involved in intricate "logics" of exchange (Leder, 1992, p.28).

> As the lived body is a multi-levelled structure of conscious and autonomic functions, a place where psychological history is sedimented, interpersonal relations enacted, biological mechanisms homeostatically maintained, a medicine of intertwining recognizes multiple points of possible intervention (Leder, 1992, p.30).

Leder's exposition about a "medicine of intertwining" resonates with the concepts the research participants shared in the interviews. It stresses the need for a fundamental shift in perception about the body in medicine from the mechanistic dead corpse, to the intentional entity of the lived body. His perspective is in principle holistic, but at the same time he also alludes to different aspects of embodied human existence, in which he identifies some structure within the holistic complexity.

Where Leder (1992) suggests that medicine first needs a conceptual reframing of the body to find its way out of the Cartesian paradigm, the researchers and physicians Jonas and colleagues (2003) and Reilly (2001) propose a practical approach. Their claim is that those aspects in health care that promote healing have been neglected since the advent of scientific medicine as there has been too much emphasis on the physical causes of diseases. The traditional purpose of medicine was in the act of healing, and therefore, these authors argue, by redirecting the focus onto healing again, medicine could be brought back to its true task. This would also serve to unite the different healing approaches as they would all concur in this endeavor.

> All therapeutic avenues meet at life's innate healing or destructive processes. So direct study of human healing might serve as a unifying focus, bridging disparate worlds of care – a truly integrated medicine (Reilly, 2001, p.120).

Healing is identified by these authors in holistic terms.

> Healing is a dynamic process of recovery, repair, restoration and transformation of the mind, body and soul on the path to becoming more whole. Healing occurs at many levels of the human system – mental, physical, emotional, and spiritual (Jonas et al., 2003, p.36)

Reilly (2001) and Jonas et al. (2003) take the multidimensionality of illness as a given. What they believe is needed now is to translate this perspective into a greater understanding of the factors that enhance human healing. Jonas et al. recommend doing this by "investigating the impact of optimal healing environments".

> An *optimal healing environment* is a system and place comprised of people, behaviors, treatments and their psychological and physical parameters. Its purpose is to provide conditions that stimulate and support the inherent healing capacities of the participants, their relationships and their surroundings. This environment can include both general and specific physical, behavioral, psychological, social and spiritual components including medical treatment (Jonas et al., 2003, p.38).

However, while it is one thing to acknowledge the multidimensionality of the healing process, it is another to find a way to capture the specific needs that arise from the dynamics in the individual patient's life so that there can be an appropriate therapeutic response. Although the first important step is the recognition that a person's existence occurs simultaneously on many levels, the biological, emotional, mental, social, environmental, and spiritual, all of which have an influence on the health of an individual, or can be affected by illness, this recognition alone does not yet make the situation accessible.

Looking back over the options that have been given so far for approaching human illness, three principally different ways can be identified. The first approach is to reduce the body into a machine and treat all illness on the basis that it is a defect. One could call this mechanical automatism. Here, the perspective is anchored solely in the material level, and subjective experiences therefore can only be defined as epiphenomena of matter. This position is one of materialistic monism and becomes highly problematic when applied to human life as it is not only insufficient in relating to the different dimensions but can also be regarded as amoral, as all human values, experiences and aspirations are degraded by this attitude.

The next stance that has been described gives the workings of mind and of subjectivity equal importance to material and mechanistic processes. Human experiences, values, interpretations and desires are granted recognition as crucial for a humane medicine. However, this dualistic position is difficult to uphold as matter and mind are perceived as entirely separate, and the conceptualization fails to explain the interchange between the two realms. Particularly in the present Zeitgeist in which *matter* increasingly dominates, as can be seen for example in the focus on genetic determinism, the dualistic counterpart *mind* will hardly be given equivalent weight. The failure, so far, to reform the practice of modern medicine into the humane endeavor that Cassell or Kleinmann have envisaged could be taken as evidence for the correctness of this prediction.

The third perspective is the belief in a simultaneous and inseparable multidimensionality of human illness. This is the holistic perspective, which is at the center of many non-conventional approaches. The fact that the popularity of practices that use this thinking is steadily increasing is taken here to indicate that their conceptual basis resonates better with the experienced reality of illness, than what is given by the other two perspectives. However, this holistic conceptualization throws us back to the place where the sheer amount of different levels and phenomena can hinder the clarity that is needed for finding a rational therapeutic approach to illness. As has already been discussed in Chapter Four, human beings need structures to manage complexities, and therefore, what is suggested here, is to look for a conceptual structure through which an orientation can be found to capture the many aspects of health and illness.

The challenge has some similarity to that which was faced by bioethics, where a broad and diverse field of moral theory and the practical realities of biomedicine also required some structure for ethicists and for doctors to hold on to and to work with. Beauchamp and Childress suggested the four principles as a solution. These four principles have proven to be highly successful guides, even if one might not concur with them. By providing simple and clear points of reference they are not only easy-to-use prompts for clinicians in day-to-day medical practice, but also helpful in situations where difficult clinical dilemmas need to be considered.

The major difficulty regarding human illness is to moderate its holistic complexity without resorting to the distorting and demeaning process of reducing human life into the workings of a machine, or juxtaposing body and mind as though they were different entities when clearly our embodied experience is that of the simultaneous existence of the two. In contrast to the principles of bioethics, which mainly emerged as the result of philosophical deliberations, when it comes to illness a valid guiding system can only be developed by keeping *embodied man* firmly in the center. This means it has to be based on an anthropological approach, which utilizes the empirical observations of human beings and tells us about the ingredients that are necessary for them to thrive. It also shows us where to look in the case of illness, because what makes us thrive will turn into the contrary when it is deprived or disturbed.

The four axioms of human health and illness

There are at least two sources that one can refer to for gaining such an understanding. One source has already been introduced in Chapter Four. It is based on the analysis of medical history, undertaken with the aim of finding out what illness ontologies there had to be in order to make a particular therapeutic approach appropriate. This analysis shows that there are four basic "illness axioms" or ontologies, and that any healing system responds to one of the four (Bauer, 2000; Pieringer, 2000). Pieringer relates these axioms to the four major known thinking styles and alerts us to the most suitable epistemic method for each axiom. If one was to understand illness as disruption of wholeness, then these four axioms could also lead us to what it is that human beings need to create and maintain this wholeness:

1. Illness as loss of balance: the need for the organism to maintain homeostasis as a basic requirement for biological existence

2. Illness as disruption of interpersonal communication: the need for relationship and connectedness with others, as expression of man's emotional life
3. Illness as a physical defect: the need to influence and control the material environment, including the objectively perceived aspects of the human body
4. Illness as "pathic" creation: the need for meaning and coherence of life within a wider context

The other source goes back to Aristotle, who took a teleological perspective by identifying four "parts of the soul" as making up the human being: the vegetative, the appetitive, the deliberative, and the contemplative (Aristotle cited in van Hooft, 1998b). Van Hooft looked to Aristotle's philosophy for an understanding of human suffering and came to characterize it as "the frustration of the tendency towards fulfillment of these various aspects of our being". In the language of today, Aristotle's four parts of the soul might be expressed as "a person's biological functioning, their emotional and desiring functions, their practical and rational lives, and their sense of the meaning of their existence". Although four different aspects of human life, they are fundamentally interconnected and not separable, in fact "always combined into a whole". Therefore "our wholeness and integration as persons" depends on the fulfillment of all four.

> The fulfillment of the biological level of our being is the basis of health, while fulfillment of the appetitive or conative part of us is a feeling of satisfaction, wellbeing, and zest for life. The deliberate or practical aspect of our lives is fulfilled when we perform our tasks as we are able (whether or not we are successful), while fulfillment of the contemplative aspect of our being is our having a sense of meaningfulness of life (van Hooft, 1998b, p. 126).

The striking congruency that one can discover in these two sources becomes less astonishing when one considers that they are based on empiricism, rather than on a mental construct like the mechanistic conceptualization of Descartes. Both sources have encapsulated human life into four very similar categories. In the case of medical history it emerged from the analysis of illness perceptions over the ages; in Aristotle, it came from empirical observation of human beings and the belief that these aspects need to be fulfilled in order to arrive at the wholeness of human existence. Although also reductionist in a sense, when these four categories or axioms are used in combination, they can provide an accessible route to comprehending the whole person. When all four aspects are considered and attention is given to the specific factors operating at each level, then we might be able to capture the complexity of human

health and illness better than we do at present. Even a very preliminary reflection on the four axioms will provide a glimpse of how such a holistic approach could be carried out.

Starting with the first axiom, which is that of biological homeostasis, one might first think about what factors disturb or support the individual organism's own efforts to maintain its internal balance against the external environmental challenges. A general knowledge of what it is that human bodies need to thrive will be required. But this is not enough as there also has to be a specific understanding about this particular organism's reactions and needs. General knowledge will give guidelines for the usual amounts of nutrients and fluids, the required length of sleep, the normal range of temperature. But in the appreciation of different degrees of "plastic-powers" (Nietzsche cited in Danzer et al., 2002) each individual living organism is capable of, no generalized approach will do justice to that uniqueness. Some people are sensitive to cold environments, others feel uncomfortable in hot places, some will manage longer periods without food, others will become irritable and feel faint in the same situation. What is known in general about the needs of human bodies has to be moderated by responding to the individual. Although this is the level of the material physical body, which can be objectively observed and its physiological parameters measured, these aspects cannot be comprehended within the Cartesian inanimate machine model. To support the living body in its efforts to maintain equilibrium there has to be the understanding that it is a self-organizing entity with its own internal wisdom. Therefore it will be unlikely that a therapeutic response would be adequate if a general regimen was imposed on every patient who was diagnosed with the same disease. This axiom of homeostasis demands that the biological aspect of each patient needs to be approached not only from the perspective of general knowledge but that subjectively experienced sensations have also to be taken seriously because they provide information about the requirements of the individual organism.

The second axiom, which is not dissimilar to what Aristotle called "appetites", refers to our sense of connectedness, which includes our desires, emotions, enjoyment of life and the relationship we have with our fellow human beings and also with the world in general and with our own bodies (van Hooft, 1998b). In case of illness it indicates that something has been disrupted for the patient in the realm of feelings and sensuality. As van Hooft points out, a disturbance on the physiological level, which he calls "malady" causes suffering also on this second level.

> We no longer feel at home in the world and in our own body. Even the things that we normally enjoy doing such as listening to music or conversing with friends lose their luster when we are ill (van Hooft, 1998b, p.127).

But this is by no means only a one-way road. Everybody who has experienced the feelings of profound grief and loss will be able to relate to the severe effects these can have on the physiological level and how they can also affect other parts of our functioning, like our mental clarity. In a holistic conception of human health this area has to be explored as much as the biological aspects and granted the significance it deserves. Disruption on this level can come in many forms and guises, ranging from chronic disturbances in the ability to relate to others, which might have its causes in a childhood spent in a dysfunctional family environment, to the acute effects of emotional trauma. It can have its cause in detrimental inter-human dynamics that occur on the micro-level of the family or on the macro-level of a particular culture in a particular time. However, problems that are considered to belong to this axiom are not confined to the functioning of human relationships but extend to one's relationship with everything that is in our sensual range. Therefore the aesthetics of an environment, the sounds and smells that surround us, the sense of harmony within the natural world can all stimulate well-being and enjoyment or, on the contrary, contribute to a lack of it with its consequences for our general sense of integrity.

In the third axiom illness is perceived as a defect of the physical body, in need of repair. Aristotle describes the third part of the human soul as the part which is concerned with deliberation. This refers to the ability of human beings to make abstractions, plan, analyze a situation, and move between theory and practice. The external world is the object which we endeavor to control and to master. Our rational mind allows us to detach ourselves even from our own bodies and perceive it as something external. For our understanding of the human body, this ability makes it possible to analyze its physical parts and figure out its normal functions and, in case of abnormality, devise means to rectify the situation.

Although this is the main way in which this axiom is utilized in medicine, when it is addressed for the provision of a holistic health care, the approach cannot only go along this line of body as object, but also has to take the patient as a deliberative being into account. For example, it is important to know how much a person can affect the direction of his or her own life. If the capacity to self-direction is curtailed it will have a detrimental effect on the

patient's overall health. Curtailment of a person's self-determination can occur in many ways, for example, through the restrictions that some cultures put on certain members of their society, or through poverty or a constraining workplace. It can also eventuate from within, for example through limited mindsets that allow the subject to venture only along narrow mental avenues. By stimulating and assisting the cognitive powers of patients and their ability to take active control, the radius of their capacities can be increased. It also becomes obvious that social injustices and environmental pressures need to be acknowledged for the influences these can exert on the individual person.

Modern Western medicine strongly relies on the third axiom and predominantly promotes the knowledge that comes from the external perspective of our organisms as objects. However, because this primary focus is not only typical for medicine, but also for modern Western culture in general, it has created a somewhat paradoxical situation. On the one hand human bodies play the role of objects in medicine, and are therefore stripped of self-determination, but on the other hand they are "owned" by persons with a strong demand for individualism and self-determination, even in those cases where their desires are manipulated by the forces of societal norms. Demanding patient autonomy in the decision-making process about medical treatments has been one way to manage that paradox. However "body as object" also fits well into the general cultural outlook of Western societies, which have a tendency to turn a great number of things into commodities, including health and medical care. Although the holistic perspective includes the feature of human cognition and the understanding it offers, it does not endorse its dominance, as it would also not endorse the over-emphasis of any of the other axioms.

The fourth axiom is concerned with meaning. Bauer (2000), the medical historian, described the explanation of human illness within this axiom as the influence of "supernatural beings or forces". Pieringer (2000) reframed this into the more contemporary form of "illness as pathic creation", where illness is perceived as part of a broader context, which connects us to the problem of human existence. It can be an expression of a specifically perceived context, as for example a sign of the original sin in the Christian belief, or can serve to demonstrate something hidden but related to our being in this world, which illness helps to understand. In Aristotle's view the contemplative part of the human soul has to be fulfilled to bring about the sense that life is meaningful (van Hooft, 1998b).

Although broad and elusive and often termed the "spiritual needs" of people, this aspect is nonetheless acknowledged by many authors and clinicians as a crucial element for human well-being, particularly pronounced during terminal illness (McClain et al., 2003). The sense of coherence, which Antonovsky (1987) described as being beneficial for health, is related to the belief in a bigger meaningful context in which one's life is embedded. Even the extremely threatening conditions of a concentration camp were overcome through preserving the sense of meaningfulness (Frankl, 1964). Meaningfulness can be found in many forms. How we construct our particular meanings, however, is determined by the multiplicity of factors that had influenced our lives, culturally as well as individually (Kleinmann, 1988; Dossey, 1992).

These four axioms are suggested as a framework for a holistic approach to health care as, when taken together, they encapsulate the elements that make up human life. They can be framed as four different illness ontologies, each in need of a therapeutic response that is matched to its characteristic, but with the Whole always in the center. They can also be seen as delineating fundamental human needs, which have to be addressed to allow human life to flourish, as Aristotle would have proposed.

Conclusion

This chapter began by exploring the interviewees' conceptual foundations. Their statements about the ontology of life, health and illness showed that all held a holistic perspective most closely comparable with the philosophy of J.C. Smuts (1927). The homeopathic concept of a vital power was used, but it appeared to be more in the way of a conceptual tool to describe the specific nature of life rather than vital power being considered as a mystical force. Their understanding of the cause of illness was not confined to that provided by homeopathic theory, which is "illness as an un-tunement of the organism", but could also incorporate scientific explanations, inter-subjective and emotional reasons as well as having an underlying spiritual meaning. Healing and human suffering were the other subjects that were examined. Healing was seen as a restoration of the organism's integrity in all its dimensions. Human suffering was not perceived as meaningless, but nevertheless it needed to be relieved. In intractable cases the participants would resort to conventional treatments, even if they believed that they were not ideal.

The interviews highlighted the great difference that existed between the premises underlying biomedical practice with its scientific, materialistic understanding, and the conceptual foundations of the participants. To ascertain if the participants' perspective was exceptional or in line with patients who use non-conventional therapies, a comparison was made between the findings of the interviews and other research studies. There was noticeable congruency of views across all the subjects that were addressed by the participants.

The chapter then considered the standpoint of some conventional clinicians and authors (Kleinmann, 1988; Casssell, 1992) who have also criticized modern medicine for its lack of humaneness. Although there was much agreement with the participant's perspective, there were also fundamental differences. Where there was a holistic understanding among the participants, these authors promoted a dualistic approach, which on analysis seemed insufficient to account for the multidimensionality of illness.

The difficult task of devising a conceptual framework for human illness was appreciated when reflecting on the proposal of Descartes to perceive the human body as being similar to a machine. This understanding, although reductionist, at least makes the body and its illnesses more accessible. Now, however, it has become increasingly obvious that this framework is neither sufficient nor ethical and that it needs to be replaced by a more comprehensive understanding. Leder (1992) suggested a conception of the "lived body" for this purpose, whereas Jonas et al. (2003) and Reilly (2001) approached the problem from the angle of healing.

The challenge with a holistic understanding is its great complexity, which hinders conceptual accessibility. In the search for structure without relinquishing the notion of intertwining multidimensionality the findings of medical historians on the four different illness ontologies promised to offer a solution. This approach found its confirmation in Aristotle's observation of the four parts of the human soul. A framework that is based on these four axioms of human health might aid the implementation of a holistic health care.

When viewed through the lens of these axioms, the thrust of most present-day therapeutic efforts is directed along the third axiom, the human need for control and mastery, which has the body as its object. The great expansion of technological medicine is the physical

manifestation of this focus. Many of the challenges and dangers that accompany the technological responses to human illness, suffering or discontent have already been named in reports like that of the International Project of the Hastings Center (1996) and in particular the President's Council on Bioethics (2003). They warn that if mankind continues in this direction, more rather than less human suffering is predictable. At present our measures are aimed at restraining those developments although with only very moderate success. The convincing-power of biotechnology appears to be stronger and seemingly able to fulfill the insatiable desires that people have for the treatment of their ailments or the enhancement of their bodies.

The question this thesis wanted to raise was: What might be the underlying meaning and ethical significance of the increasing popularity of complementary and alternative medicines? The answer seems to be that more and more people are looking for something that technological medicine cannot offer. They are seeking to reclaim those aspects that are underdeveloped and neglected in modern Western medicine. Physicians have been advised to take a more holistic health perspective (Stewart et al, 1995) but this request can hardly be fulfilled without a coherent conceptual framework and in the face of powerful economic interests that will continue to promote the Cartesian paradigm. Contrary to Kleinmann's (1988) claim, that medicine holds the key to the solution, it appears more likely that the solution has to come from outside.

Bioethics has been focusing on making biomedicine more humane but without seriously questioning if this is possible by relying on the scientific perspective to give us the representation of human illness. The increasing demand for non-conventional treatments tells us another story, one that leads to a broader appreciation of human life and human illness than that given by biomedicine. It reminds us of the intertwining multidimensionality of illness, which scientific medicine has been trying to ignore, and it brings us back to a knowledgebase that takes account of the four fundamental requirements for human life to flourish. Rather than trying to restrain that which is not restrainable, putting the emphasis on what makes a full human life might provide the counter-weight that is needed.

Chapter Seven

Conclusion

This thesis was inspired by the wish to gain some comprehension about the underlying meaning of the increasing popularity of CAM and its ethical significance. Although many issues have been raised in the literature in connection with this phenomenon, as for example the lack of scientific validation of the majority of these non-conventional approaches, not enough is understood about what is motivating this popular movement. CAM is an umbrella term for a great variety of different therapeutic modalities (O'Connor et al., 1997) which, at first glance, seem to have in common only their marginalized status in Western health care systems. On closer view, however, it becomes obvious that despite the great diversity of CAM there is a unifying principle to which the majority of CAM approaches subscribe. This common bond lies in the holistic perspective that, in its purest form, perceives the human organism as a multidimensional entity made up of physical, emotional, mental and spiritual aspects, which is at the same time embedded in broader environmental and spiritual contexts. The ontology of illness, although also diverse in the different CAM modalities, basically rests on this holistic perspective in most of their therapeutic approaches. The difference in conceptualization is therefore the most fundamental distinguishing factor between biomedicine and CAM, as biomedicine is based on a materialistic framework that understands illness as a physico-chemical dysfunction.

This fundamental conceptual level became the focus of this thesis, because it seemed to hold the greatest prospect of finding some answers to the question of why people are increasingly using CAM. The rationale for this assumption came from the realization that an ontology of illness cannot be morally neutral because it not only provides the conceptual framework for understanding the causes of illness and finding the suitable therapeutic answer, but an ontology of illness defines, at the same time, how the human organism and human life should be understood.

This project was first approached by gathering empirical data. The most suitable candidates for research seemed to be homeopathic physicians, as their experience of both conventional

and alternative medicine promised to give valuable insights into the practical realities and conceptual understanding of both therapeutic modalities, which were not likely to be found anywhere else. Homeopathy was consciously chosen as representative of CAM for a number of reasons. Firstly, its conceptual premises are significantly different to those of biomedicine. Secondly, homeopathy, like scientific medicine, was developed in the Western world and therefore shares the same cultural roots, making it easier to focus on their respective frameworks without having to consider different cultural understandings. Homeopathy has also stood the test of time with a two-hundred-year long history and a recent resurgence. The empirical research data collected from homeopathic doctors provided the springboard for the theoretical exploration, which investigated three major issues in relation to CAM and then went into the analysis of the different ontological premises and their ethical consequences.

The first issue examined was the demand for scientific validation of CAM, which was appraised from a number of angles. The great difficulty for CAM in gaining access to credible research institutions and sufficient funding emerged as a significant obstacle to scientific validation. It could also be shown, by assessing the reality of evidence-based practice in conventional medicine, that the level of evidence that is demanded of CAM is not achieved by conventional medical practice. The fundamental question of how much therapeutic certainty can be gained from scientific research trials for the individual patient in practice was also asked. The findings led to the conclusion that there are too many methodological and practical limitations to reasonably claim that scientific research trials can be the ultimate arbiter for medical knowledge. Finally a not uncommon clinical situation was explored, in which the physician insists on relying on scientific evidence whilst dismissing the patient's subjective experience, and was found to be ethically problematic.

The increasing tendency towards pluralism in health care was the next issue that was addressed. Patients who use CAM do not, as a rule, limit themselves to one therapeutic modality only and there is also a growing trend among conventional physicians now, particularly in primary health care, to use a variety of therapeutic approaches. The epistemological challenge of pluralistic practices and the search for a suitable methodology was examined. A theoretical analysis made it obvious that the research methods that have been developed for scientific medicine can only do partial justice to therapeutic modalities that are based on different illness ontologies. A number of other research approaches, which are claimed to be appropriate were investigated but were found to also be inadequate for the

task of providing a suitable methodology. Only one proposal for a research approach was found to hold the potential of finding suitable epistemological responses to the diverse illness ontologies. This particular approach takes account of the four fundamental illness axioms that had been identified in the history of medicine and makes use, at the same time, of the four different epistemic pathways that are known to mankind: the analytical, the phenomenological, the dialectical and the hermeneutical.

The third issue, which was examined, was the influence of the different conceptual frameworks on the doctor/patient relationship. The interviewees found the approach of the homeopathic method conducive to a positive and respectful interaction, as the patient's subjectively experienced symptoms and sensations take the center stage in homeopathic consultations. The notion of respect was found to be broader than the commonly understood "respect for patient as person" by extending to respect for the "patient as organism" with its own inherent wisdom. In contrast to homeopathy, biomedical practice relies predominantly on objective findings and subjective details are only valuable if they can be reframed and fitted into a predefined disease category. This objectifying process leads to a degree of alienation of physicians from their patients and presents an obstacle to a humane doctor/patient relationship. Research findings that built on Mishler's (1984) observation about the use of the "voice of medicine", which often thwarts the "voice of the lifeworld" in biomedical consultation, were used for a deeper comprehension of the issue. Another important point made by the interviewees was the lack of consultation time in biomedical settings, and the much greater rapport they now could build with their patients because of a sufficient time frame. The fact that there is a link between the underlying scientific framework of biomedical practice and the increasingly detrimental influence of external, economic forces on the conventional doctor/patient relationship was highlighted. Another issue, which was specifically raised with the interviewees, in view of many critical voices from within conventional medicine, was that of informed consent. The lack of scientific research of homeopathy and other CAM approaches means informed consent, taken in the strict sense, is not feasible. However, by engaging in a thorough shared decision making process the patients of the participants were still enabled to make an informed and autonomous choice. The homeopathic doctor/patient relationship that the interviewees described had a very specific quality, which was not captured by the models that had been offered in bioethics so far. It came closest to the model of "doctor as covenant", but was even better represented by the phrase "doctor as trusted companion".

Throughout the discussion of these specific issues the underlying conceptualization of the different healing approaches provided the point of reference. In the final chapter the moral content of different illness ontologies was approached directly. The qualitative inquiry first

went into the interviewee's conceptual understanding of life. It emerged that the participants perceived life in a vitalistic way which, although contradicted by the scientific explanation, resonates with the perception of the majority of people. Illness was described in a variety of terms, ranging from illness as a dynamic process, to the homeopathic understanding of illness as un-tunement, to illness as symbol or opportunity and illness as resistance to the life force. Never was illness considered to be merely a physical dysfunction, as the biomedical framework prescribes (even though in reality most doctors may hold a broader view). The notions of healing and suffering were also seen in a more extensive way than commonly found within biomedicine and, rather than being only important in relation to the physical, were imbued with meanings. In summary, the statements by the interviewees revealed that the homeopathic illness ontology takes account of all human dimensions, making it possible to respond simultaneously to the patient as person and to the patient as physical organism. It was for that reason that the participants had chosen this modality, and they admitted that it also made it easier to maintain their own full humanity during their work, which included their spirituality, than it had been in conventional medical practice.

The theoretical part of the final chapter looked at two issues: one, the moral content of different illness ontologies; and two, the challenge of finding a conceptual understanding that can take account of the multidimensionality of human illness whilst providing a theoretical structure that can be used in the clinical setting. The writings of two physicians, Kleinmann (1988) and Cassell (1991), were examined for their intention to inspire a restoration of conventional medicine to a more humane endeavor. However, despite their poignant insights and their critique of biomedical practice, these authors mostly challenge the biomedical approach for hampering the humane treatment of suffering patients and for ignoring their subjective experience. The underlying materialistic, reductionist illness ontology of biomedicine is not explicitly questioned, even though Kleinmann clearly shows, through the stories of his patients, how meaning can translate into physical illness events.

The second line of reflection went into the human need for structure in the face of unmanageable complexity, particularly in relation to illness and its life threatening potential. This was, according to Leder (1992), the motivating force for Descartes to devise the conceptual framework of the inanimate body machine that still dominates medical thinking today. The Cartesian model turns the human body into a tangible and controllable object, devoid of subjectivity. Leder criticizes the incongruity with our lived reality and counters Descartes with the conception of "lived body", which cannot be explained in the terms of inanimate matter. Leder anticipates that simply through a conceptual shift to "lived body" medicine might change into a more human and effective endeavor. The authors Jonas et al.

(2003) and Reilly (2001), who have a similar intention, approach the complexity of illness phenomena by focusing on the notion of healing.

This thesis deems all the above conceptual approaches unsuitable to provide a basic structure for a whole-person conception of illness and thus it offers an alternative proposition. This refers back to the four axioms of human illness identified in the history of medicine (Bauer, 2000; Pieringer, 2000): illness as loss of balance; illness as disruption of interpersonal communication; illness as physical defect; illness as pathic creation. These axioms present the mirror images of Aristotle's conception of man and his/her "four parts of the soul": the vegetative, the appetitive, the deliberative, and the contemplative. Aristotle saw suffering as "the frustration of the tendency towards fulfillment of these various aspects of our being" (van Hooft, 1998b, p.126). Understood in this way these four axioms could provide not only a useful theoretical structure to help manage the complexity of human illness, but could at the same time serve as pertinent reminders of what is required so that human life can flourish.

From the research findings it appears that there might indeed be a connection between the increasing popularity of CAM and their underlying holistic perspective. However, even though there are many parallels between the participants' views and findings from other research studies this link cannot be made with certainty as it is quite possible that investigation of other CAM modalities, for example, might have led to different nuances. It also needs to be stressed that the intention of this thesis was not to promote an abandonment of biomedicine but to come to a better understanding through an analysis of illness ontologies of different therapeutic approaches.

Although this research has answered questions it has also brought out a number of issues that require attention. In this conclusion, however only the most fundamental implication in relation to the discipline of bioethics shall be mentioned. This is a conceptual issue and therefore in line with the general concern of this thesis.

Bioethics in its present form emerged because the traditional guiding principles of medical ethics seemed insufficient to deal with twentieth century developments. Social changes, but even more the metamorphosis of medicine into a scientific and technological enterprise made a new approach to ethics in relation to the health care arena necessary, as this new course of medicine not only led to powerful and effective therapeutic interventions, it also gave rise to previously unknown harms and ethical dilemmas, which have gone to the very core of

mankind's understanding of itself. It seemed that the task at hand for the new discipline of bioethics was to stem the negative fallout whilst holding on to the benefits of this valuable medical potential. Now it is becoming increasingly obvious that this position is untenable as the pace in which biotechnology develops, including its ethical challenges, far outruns any bioethical deliberations. However, the problem is more fundamental than timing, but lies, according to McKenny (1997), in the close bond between the two disciplines of bioethics and biomedicine because of their common vision.

McKenny (1997) considers the change of medicine into a scientific and technological enterprise as an actualization of, what he calls, the "Baconian project", which has as its underlying goal "To relieve the human condition of subjection to the whims of fortune or the bonds of necessity" (McKenny, 1997, p.2), in short, to master nature. McKenny criticizes the "complicity of standard forms of bioethics in this Baconian project" and identifies the negative consequences that come from this connection as being twofold.

> First, while relief of suffering and expansion of choice are laudable goals, standard bioethics provides no moral framework within which to determine what kinds of suffering should be eliminated and which choices are best. Medicine is therefore called on to eliminate whatever anyone might consider a burden of finitude. Second, standard bioethics is incapable of addressing moral implications of the way technological medicine constructs and controls the body. The result of this twofold impoverishment is that standard bioethics is silent on many of the most urgent moral questions raised by the technological transformation of medicine (McKenny, 1997, p.2).

This thesis has drawn attention to the link between the underlying ontology of different therapeutic approaches and their moral content and consequences for practice. It was also argued that an epistemology is dependent on the ontology that informs it and that the knowledge derived from a particular epistemology has to be assessed in relation to the ontology from which it originated. The knowledge about human illness, produced by scientific methods can only go as far as the underlying ontology allows. In scientific explanations of human life, health and illness there is no room for dimensions that go beyond reductionist, dualistic, or even materialistic understanding. Although the biomedical conception has provided the theoretical basis for the development of powerful medical tools it can neither give insights into the fullness of human life, nor can its knowledgebase give more than only partial information on human health and illness.

This realization has far-reaching implications for bioethics as it requires a fundamental rethinking of its conceptual positioning with regard to the metaphysics of medicine. Bioethics, in order to be able to address the moral challenges of technological medicine effectively, will need to stand on a conceptual basis that includes human values already at the level of ontology of illness and not only as an attribute that is added. Following this research it can be concluded that a holistic perspective would provide that theoretical foundation. From this conceptual place, bioethics could not only be less biased but it could also be broader. Instead of concerning itself predominantly with the setting of limits in the arena of technological medicine it could revive the original mission of ethics, which is the contemplation and promotion of what makes a good human life.

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