UNCONVENTIONAL MEDICINE IN EUROPE

David Aldridge

(Excerpted from Advances: The Journal of Mind/Body Health Vol. 10, No.2. Spring, 1994)

People regularly label and manage their symptoms for themselves, avoiding medical experts as long as possible. The current turning away from orthodox medical care is less a matter of dissatisfaction than a demand for mixed pluralistic health care.

1 Introduction

In the Summer 1993 issue of Advances, various authors looked at the state of unconventional medicine in the United States using as a basis an article published in the New England Journal of Medicine (Eisenberg et al. 1993). A debate about unconventional medicine has also been taking place in Europe within the past decade (Aldridge 1990b; Fulder & Munro 1985; Vaskilampi 1982; Wharton & Lewith 1986; Yung et al. 1988). In this paper I will be referring to some topics of that debate relevant to both continents. In particular, I will emphasize the practice of unconventional medicine in Europe.

While the term unconventional medicine is used in the New England Journal study and in Germany, there has been a lengthy discussion in some countries about how best to describe the modalities referred to by this term. While the terms alternative and natural medicine were used in most early publications (Inglis 1979; Warren Salmon 1984), in England the term complementary medicine became adopted as being less pejorative and more accurately descriptive of actual practice (Aldridge 1990a; Lewith & Aldridge 1991). In the English perspective, the medical initiatives being offered were not seen as alternative to conventional medicine, nor were they viewed as unconventional, since conventions in medicine are subject to change. Instead, the practice of homeopathy, acupuncture, and the like were seen as viable complementary approaches in the general delivery of health care.

This paper generally follows the English practice. It uses the term complementary medicine to refer to what is often called "alternative" or "unorthodox medicine." "Complementary medicine" indicates approaches that are independent from modern scientific medicine but have a potential for working with such medicine in a broader context of health care delivery. That is, they "complete" the delivery of health care rather than being an "alternative" in opposition to orthodox medicine.

As in the United States, there has recently been a governmental call in England suggesting a radical restructuring of health care with an emphasis on consumer-based service. This emphasis reflects a growing movement throughout Europe in which health care initiatives respond to consumer demand. Some of these initiatives are stimulated by interest in what is currently regarded as "complementary" medicine (Lewith & Aldridge 1991).

This emphasis on consumer choice and demand reflects the reality of health care use. People regularly choose how they wish to maintain and promote their own health. Only we who work in the health care industry--treating patients, training doctors, and researching medicine--focus solely on hospital medicine and medical consultations.

The reality of health care is that people label and manage their symptoms for themselves, engage in preventive action and avoid (the perils of) consultation with an expert--medical, psychological, or sociological--for as long as possible using their own initiatives and solutions. Seeing the doctor is usually at the end of a chain of attempted solutions to a problem, attempts that often involve near relations and neighbors. (One element in this chain does appear to be changing. When patients do contact a doctor, they have begun to demand a more equal relationship, such that the doctor functions as an expert guide who will aid them in their own choice rather than an authority who will tell them what to do. As the patient-doctor relationship continues to move in this direction, it will demand the appropriate support of teaching methods in medical schools [Aldridge 1992].)

One reason for the popularity of complementary medicine is that the practitioner recognizes the involvement of the patient in his or her own health care. Other reasons for choosing complementary therapies include: that such therapies may include a psychosocial approach to problems (Armstrong 1987), that the patientÕs search for health is understood in terms of reasons and intentions, and that there is an acknowledgment by both parties to cooperate in health care. In general, the turning away from orthodox medical care is less a matter of dissatisfaction (though not always--see Furnham & Bhagrath 1993, and Lynoe & Svensson 1992) than a demand for mixed pluralistic health care.

In the light of today's consumer demands, it may be prudent for health care decision makers to consider how health care can be delivered in a pluralist health care culture--one that acknowledges the triad of modern scientific, traditional, and complementary medicine. European countries have attempted to integrate alternative medical approaches (Lewith & Aldridge 1991), and perhaps we can learn from each other the optimal conditions for a mixed health care system. Such a perspective means moving away from the idea that there is one form of medicine usually delivered or administered by a doctor to a homogenous consumer group represented by "the patient." Instead, we have varying formal and informal initiatives for delivering health care to varying populations, some of whom may demand treatment for their ailments and others of whom may aspire to improve their sense of well-being.

Such is the current melting pot of ideas. Small wonder governments are wondering what to do.

If we are to implement a consumer-based health plan that emphasizes choice and includes "complementary" medicine, then it will be necessary to promote an atmosphere of permissive legislation for the control and licensing of a broad spectrum of practitioners, and to develop financing and delivery arrangements for different modalities (Anon 1988; Enthoven & Kronick 1989). The structure of such arrangements will depend on consumer knowledge about health care delivery and organization. Information about competing treatments may also bring about an improvement in health care and reduce the escalation of health costs (Anon 1988; Enthoven & Kronick 1989).

New attempts to collect information must begin at the primary interfaces between the medical practitioner and patient, and between medical practitioner and his or her sources for referral. This means an emphasis on local networks for local needs.

However, we must first understand the complex process of "health production"--which has many sources: adequate nutrition, basic social welfare, adequate education, the elimination of poverty, prevention and promotion programs, primary care initiatives, personal lifestyle changes, community initiatives--before we can try to improve it, particularly in the field of chronic illness. An understanding of health production must also be supplemented with measurement tools that express the values of the formal producers (practitioners) and the consumers with whom they meet (patients). Epidemiological methods must be developed to establish baselines from which the success of health care initiatives can be measured and outcomes can be monitored (Aldridge 1990b; Crofton 1986). It is imperative, then, to develop a common language for health outcomes. This language must be understood by consumers (patients), deliverers (practitioners), and providers (those who pay).

When we speak of health care, we must take note that we are not only concerned with economic aspects of health but also with the practice of "caring." It is this qualitative demand that has shaped the health care debate and stimulated the inclusion of "complementary" medicine.

2 Health Care and Political Will General Conditions

Meeting health care needs is a matter of social strategy and political will.

True, health is not a homogenous concept; it is differentially understood. Medicine, too, is not an isolated discipline but an agglomeration of concepts taken from a variety of fields, only some of which belong to the natural sciences. Further, the social understandings of health and how to practice medicine are not fixed. Patients and primary health care professionals negotiate solutions to health care needs from an extensive cultural repertoire of possibilities. This repertoire is composed of understandings that come predominantly from Western medicine but also from folk and traditional medicine and modern understandings of "complementary" medicine (Vaskilampi 1991).

However, there are factors common to a variety of health understandings. These common factors include health promotion and prevention, health maintenance and treatment. Further, such factors are influenced by economic strategies, and cannot be divorced from considerations of community welfare. Poor housing and poverty mock any talk of initiatives based on consumer demand. There has to be a minimum level of income whereby people are fed and housed before the luxury of health choice can be exercised.

At the governmental level, economic factors exert a powerful influence on health care thinking. They encourage a short-term political solution of expediency rather than a long-term outlook of necessity. Governments come and go. Chronic illness has its own insidious course.

Furthermore, it is relatively easy to assess and define the cost of specialty tests and surgical procedures. Such an emphasis can inflate the demand for such tests equating the "best" with the most expensive. It is not so easy to assess costs with the "softer" procedures of complementary medicine. For example, psychotherapy is permitted under insurance plans in the United States for the treatment of significant psychiatric disease but not for marital stress, lifestyle counseling, and situational depression (Glenn 1988). It may be that some complementary medical practices, which include an emphasis on lifestyle, health promotion, and health education, coupled with "low" technology, can offer low-cost alternative health care (Edelmann 1988).

This is not to suggest a two-tier system of low, cheap complementary medicine for the poor and a high, expensive scientific medi cine for the affluent, rather that a plurality of approaches may meet a wide spectrum of need. However, it should be noted that as of the moment neither the need, nor the means available to meet it, have been clearly demonstrated. The necessary research is still wanting.

Nonetheless, in the light of inappropriate medical procedures in some Western countries and marked national differences throughout Europe in the pharmaceutical preparations and therapies that are prescribed (Anon 1988), it appears that "complementary" medical initiatives not only have an important role to play in cost reduction but also have a place as appropriate treatment regimens. For example, for stress-related disorders, complementary practices like relaxation, massage, biofeedback, and psychotherapy are often appropriate, yet they often are not reimbursable in the United States. Their usefulness is suggested by the estimate that stress disorders cost the budget $150 billion a year and result in 55 million working days being lost (Moskowitz 1988).

Mixed primary health care delivery will need to be coordinated. There is evidence throughout the world that such an integration of differing medical initiatives can be successfully achieved (Leibrich, Hickling & Pitt 1987; Lewith & Aldridge 1991). However, we must bear in mind Cassileth's important reminder in her comment in the Summer 1993 Advances that the all-embracing promise of orthodox medicine and complementary and lifestyle approaches threatens to medicalize many of what are currently self-help activities (Cassileth 1993).

3 Current European Practice in the Delivery of Complementary Medicine

Throughout Europe, complementary medicine has grown from the bases of naturopathy, homeopathy, manipulative techniques, and traditional medicines. There are national cultural differences that favor differing approaches as I shall show below. Until recently, about all that governments knew of complementary medicine was that its popularity was increasing. Now, with proposals for harmonizing its practice occurring throughout Europe, governments are taking a closer look. Most have no idea of how many of their people use complementary medicine, why they use it, how much it costs them, how it affects the total costs of health care, and whether its use should be encouraged or discouraged. The little that is known shows wide variation. However, government initiatives in Holland and Germany have set in motion nationwide appraisals of complementary practice and have instigated active research plans. In England, the Research Council for Complementary Medicine has attempted to provide a brokerage agency between varying streams of complementary medicine practice and statutory agencies, and has initiated a journal (Complementary Therapies in Medicine) that attempts to integrate research interests and clinical practice.

In the following paragraphs, I briefly describe the situation in various European countries.

3.1 Belgium

The Consumers Association in Belgium has initiated research into complementary medicine (Sermeus 1987). In Belgium anyone who practices medicine, complementary or orthodox, without being enrolled with the Belgian General Medical Council is committing a criminal offense. Recognized doctors have clinical and diagnostic freedom to carry out whatever treatments they think fit. Those who choose complementary medicine may still find themselves in conflict with their professional organization, which requires them to treat patients "taking all reasonable care given the current state of scientific knowledge."

About one in four Belgians visit a complementary practitioner. Homeopathy is the most popular treatment, followed by natural remedies, manipulative treatments, acupuncture, and phytotherapy (a form of natural medicine using plants or botanical remedies). Middle-aged women belonging to higher socio-economic groups are overrepresented among consumers of complementary medicine. General practitioners offer most of the available homeopathy (85 percent) and acupuncture (63 percent), with specialist doctors delivering the rest. Physiotherapists provide most of the osteopathy. Although the social security system does not directly reimburse for specific complementary treatments, doctors can indirectly include such reimbursement in their fees. There has been no serious research into the financial implications of complementary medicine as a health care alternative.

3.2 Denmark

Complementary medicines are accepted by the population of Denmark as a legitimate form of treatment, and this is reflected in the legal acceptance of alternative health practitioners. As in Germany, there is a liberal acceptance, which is legally supported, of the right of citizens to seek help where they can find it according to their own beliefs (Rasmussen & Morgall 1991). In 1987, the Danish Institute for Clinical Epidemiology published results of a national study of the nationÕs adult health, and it was clear that, while costly, alternative treatments were being used by at least 10 percent of the population. Rarely was there any data indicating that an alternative was chosen because of dissatisfaction with traditional medicine; usually, specific illnesses were seen as warranting particular initiatives. However, complementary medicines are generally used as a supplement to orthodox medical care, not as a substitute for it. Rasmussen proposes that such treatments be described as "noninstitutionalized" treatments (Rasmussen & Morgall 1991).

3.3 Finland

Finnish law does not recognize alternative medicines. Only medically qualified doctors are allowed to practice medicine, which is interpreted as the right to diagnose and take fees. Acupuncture, however, is accepted as part of orthodox medical practice and is included in the medical curriculum. More than a quarter of the Finnish adult population have used some form of complementary medicine. This category may be subdivided into traditional folk medicines (massage, bone setting, and cupping) and more recently introduced forms (natural medicine, manipulation, acupuncture, and hypnosis). Whereas the newer forms are attractive to a younger urban population, traditional medicines find favor with an older, less well-educated rural population. There are no payments for complementary medicines from public or private health insurance (Vaskilampi 1991)

3.4 France

In France the practice of complementary medicine is illegal unless provided by an orthodox medical practitioner. A medical practitioner is free to prescribe whatever treatment is appropriate. Homeopathic remedies are used by one in six of the population and are prescribed along-side conventional remedies by medical practitioners. Acupuncture and homeopathy are taught in some medical faculties. Chiropractic remains illegal, yet 13 percent of the population go to chiropractors and are reimbursed by health insurance programs. About one in four general practitioners care for patients using complementary treatments. The cost of acupuncture, when legally given by a qualified medical practitioner, is reimbursed by the social security system. Homeopathic remedies qualify alongside allopathic remedies for a state subsidy of 70 percent of their price (Bouchayer 1991).

3.5 The Netherlands

Orthodox and complementary medicine are integrated in the Netherlands, and this has been actively encouraged by the government. Clinical and sociological research has been commissioned to provide a basis for policy decisions. Complementary medicines are flourishing in response to public demand, with acupuncture, anthroposophical medicine (an approach based on the teachings of Rudolph Steiner), homeopathy, manipulation, and paranormal healing the most popular. As in most other European countries, practice is currently restricted to medical doctors with a university training. More women than men visit complementary practitioners; generally poorer members of the population use paranormal healing. The cost of complementary treatments is reimbursed by private and state health insurance when prescribed by a general practitioner. This includes homeopathic and anthroposophic medicines (Visser 1991).

3.6 United Kingdom

There is no restriction on complementary practitioners under British law, and doctors may now refer patients to complementary practitioners, provided the doctors maintain ultimate responsibility for the management of the patients. About one in eight of the British population use complementary medicines, the most popular being herbal remedies, manipulation, homeopathy, acupuncture, hypnotherapy, and spiritual healing. Middle-aged, middle-class women predominate, although users of complementary medicine do not necessarily differ from those using orthodox medicine. Some patients probably use both forms of health care. Complementary medicines are not paid for by the state. Some private insurance programs reimburse patients who attend approved complementary practitioners (Thomas 1991).

3.7 Germany

In the Federal Republic of Germany, as in other European and non-European countries, the use of unconventional medicine has been on the increase in recent decades. There is not only a growing number of patients demanding unconventional therapies but also an increasing amount of interest on the part of medical practitioners. Current support for complementary medical research in Germany is based on a parliamentary decision which has forced the appropriate ministry to respond and act.

In Germany the concept of "therapeutic freedom" allows the individual the right to choose any form of therapy, providing the person can pay for it. A liberal market economy and an acceptance that there is more than one truth in a personÕs perception of his or her own health has led to a pluralist health service that can accommodate developing alternatives. However, this freedom, which survived National Socialism, is now coming under threat from European Community regulations concerning the marketing of particular medicines. The use of psychotherapy has also run into regulatory problems, with doctors and psychologists arguing about the independent right of psychotherapists to treat and refer patients and about the fact that only 75 percent of the treatment costs would be covered by health insurance. Psychologists argue that having to pay 25 percent of the costs would mean that many patients would forego treatment (Tuffs 1993).

The Kur in West Germany exemplifies characteristics of the plurality of German health care. The Kur is an institutionalized bathing activity that is also used for health promotion. Naturopathic treatments are used alongside modern biomedical technology. Kur clinics are supervised by qualified orthodox medical practitioners but also use licensed naturopathic healers (Heilpraktiker). The medical directors of such clinics often include some aspect of their own philosophy for therapy. Treatments may include bathing, massage, exercise, and dietary considerations.

It is important to emphasize that the Kur tradition is also part of the tourist industry. Some Kur activities are reimbursable, either fully or in part, by insurance companies. In West Germany, free-time bathing, not necessarily swimming as a sporting activity, and sauna are leisure activities. Health care activity in this system not only belongs to the medical domain but extends to a whole series of diverse activities, including diet and leisure. Patients who attend a Kur clinic have often been treated in a hospital first. These patients fall into four main groups: patients who need rehabilitation after an accident, patients with a chronic or a serious disease condition, older patients who want to maintain their health and continue working, and those who need a rest cure after retirement. Health care in this approach is not only about promoting well-being in younger patients, which might be considered a luxury, but also keeping older patients fit enough to stay in the employment market.

The legislative framework for practicing medical alternatives in West Germany is permissive (Unschuld 1980). Patients can choose whom to consult: orthodox practitioners, complementary practitioners, or naturopathic healers. This situation has developed, not without controversy and vigorous debate, in a philosophical tradition that has tried to understand the basic human condition in health and illness (Risse 1976).

In general, the plurality of German health care is best understood as a social, historical, and cultural phenomenon (Maretzki 1987; Maretzki & Seidler 1985). German Romantic philosophy in the nineteenth century attempted to criticize a natural science that was seen as fracturing nature. The maintenance of health was seen as springing from a unity of mind and body, the harmony of the individual with other human beings, and a concern for the natural environment. This does not seem a far cry from our current concerns with environmental pollution, the ravages of modern living, and the debate about holistic medicine.

Naturopathic medicine developed into a system of ideas that attempted to reform the dehumanization and excessive curative interventions of some medical practices. To implement these reforming ideas it was necessary to develop economic strategies for public health finance and insurance programs. These were developed in parallel with a legislative framework that supervised the practice of naturopathic healing, including the inspection of the premises of such healers and licensed practitioners.

West German medical care incorporates both modern scientific medicine and the traditional nature-oriented medicine. The curative role of herbal medicines, mineral waters, and natural food diets, and the health promotional activities of fresh air and exercise, have remained part of recognized health care activities within the wider culture of German humanism. Complementary medicine, which includes the "newer" therapies of yoga and acupuncture, then, is part of a continuing tradition of medical pluralism, not a return to traditional methods.

About 70 percent of the German population have used natural remedies at some time or other. An inquiry among general practitioners revealed that about 60 percent prescribe natural remedies regularly or sporadically (Matthiessen, Roblenbroich & Schmidt 1992; Tuffs 1992). According to information supplied by the National Association of Drug Manufacturers, the proportion of herbal remedies on the German pharmaceutical market currently stands at between 20 and 30 percent.

The German government has instigated a continuing project for research in "unconventional medicine." Five directions have been chosen for further study: acupuncture, anthroposophical medicine, homeopathy, physiotherapy, and phytotherapy (Matthiessen, Roblenbroich & Schmidt 1992).

Several important points have emerged from the German experience in regard to research of complementary therapies.

1. It is possible to conduct scientific research of an acceptable standard, but it is necessary to discriminate the pseudoscientific from the scientific.
2. There is a pool of people in clinical centers and university research departments who are capable of doing research or who can develop research methods suitable for the complementary therapies.
3. It is important to establish an independent research committee that can offer help and guidance with detailed research planning such that research proposals are of a necessary standard for submission to the relevant research council and funding organization. A scientific committee should include members of the various "interest" groups.
4. A successful feature has been to relocate a research project in a university department, thereby lending academic credibility and also promoting independence from any specific complementary therapy organization.

4 Conclusion

Amid the diversity of these national approaches, there are some common strands. For example, middle-aged, middle-class women are most frequent users of complementary medicines, although this may only mean that a certain minimum level of disposable income is needed to pay for treatment. If governments decided to subsidize complementary medicine, then many more people might use it. For governments, substituting one medical approach for another may also have financial implications--complementary medicines are often considered to be cheaper.

It is evident that local initiatives throughout Europe have promoted complementary practice in primary health care. As this continues, criteria to judge quality of care will be needed. Some European Community states already have them; what is needed is a forum for these states to share their experience. Sooner or later the nettle of scientific validation of complementary medicine will have to be grasped. So far little has been done: complementary practitioners have generally been unwilling to submit their work for assessment, and governments have lacked the political will to fund research. However, the tide is turning, and support is now occurring in Germany (Matthiessen, Roblenbroich & Schmidt 1992), Holland, and the United States (through the National Institutes of Health).

Three initiatives originating from the European Economic Community are likely to hurry things along. The first is a directive to review all drugs and remedies--including herbal, homeopathic, and anthroposophical medicine. The second is a research program, adopted by the Council of the Ministers of the European Communities, to look at how complementary medicine may be integrated with existing systems of health care delivery. The third is a directive that complementary practitioners should have completed three years of government-approved tertiary education. This should lead to common European standards.

What we must consider is that there is a crisis in the delivery of modern health care, and the demand for various forms of complementary medicine are but a reflection of that crisis. While dissatisfaction with orthodox medicine might be an attractive reason for alternative practitioners to give for their popularity, orthodox medicine itself has been critically aware of its own need for quality control, all the while it has attempted to paper over the cracks in its practice with exhortations about its homogeneity of theory.

What is tragically hidden behind the bickering of professionals about their own rights to treat is the coming challenge to health care delivery in the next century. This challenge is posed by the continuing presence of chronic diseases; the recurrence of infectious diseases, long thought to be absent, and their resistance to antibacterial agents; the appearance of new viruses; our steadfast refusal to acknowledge that the poor, already burdened by poverty and lack of education, are expected to carry a disproportionate share of illness (Angell 1993); and the likely inability to meet the projected health care costs for the elderly. By the year 2030, the populations of Europe will have large numbers of people aged over 65 years--in Britain 19 percent, Italy 22 percent, Germany 26 percent, Sweden 22 percent, Switzerland 29 percent (Anon 1989). The potential health care costs for these populations are massive. Active campaigns of health promotion, collaborative health care initiatives, and low-cost treatment approaches must be planned now while the future elderly are still young.

Health care, like the natural world, has an ecology. Short-term changes may bring immediate political benefits, but without a concern for long-term changes and an overview of the whole system, continuing damage to communities may occur. If health care is delivered as a commodity, then we fall prey to perceiving health only as a materialistic representation and will offer only short-term solutions. If we consider health as a process that can be actively promoted within the span of a personÕs life by the allocation of appropriate resources, and if we view health as being maintained by an appropriate lifestyle, then the expensive, but not inevitable, end process of treatment may in some cases be avoided. To plan such a long- term coordinated strategy takes political will and can be accomplished only by the active collaboration of those in health care delivery and consumption.

In a long-term strategy, when treatment does occur, consumers could be offered alternatives that fit the ecology of their own lives. Modern scientific medicine as it is delivered in primary health care will inevitably be at the core of such a pluralistic provision. How much we want of our lives to be medicalized as a result of health promotion activity is another matter (Cassileth 1993), and whether conventional medicine can provide accurate preventive advice and the means to implement it remains to be seen.

The future delivery of health care will also depend on accurate information about the management of resources. To assess health care we will need accurate and appropriate tools of assessment. In this way quality can be raised and rising costs reduced. However, quality care is an elusive factor, dependent on the assessor. Costs, while being easier to identify, may reveal not an inefficient system but one that is financially underresourced, and there we must turn to the motivation of political will. In addition, we will need coordinated research activities into the efficacy of different medical approaches, and this will require both that we encourage an interest in conventional medical scientists in complementary medical research and that we develop the expertise of complementary medical practitioners so that they can investigate their own practices (Lewith & Aldridge 1993).

In one article in Advances that sparked these comments, Smith and his doctor colleagues wonder about what to tell their medical students (Smith et al. 1993)--yet another difficult question to answer, if we keep going as we have been in medical education, packing an already full curriculum with even more demands (Aldridge 1992). Medical students are keen to learn about complementary therapies in Europe, but that does not help us in maintaining a perspective on what they may indeed need rather than want.

So far in medical education we have consistently ignored the fact that most health care occurs in the community and, instead, have concentrated on hospital-based medicine. Even more shamefully, we have ignored the expertise of medical anthropologists and medical sociologists who have exhorted us to broaden our understandings of health practice. Indeed, given the amount of information available, it appears that we steer our students away from what for us is uncomfortable knowledge (Aldridge 1992).

Finally, rather than producing a generation of super-doctors crammed with learning and bristling with their specialist expertise, we may be better advised to develop the person who can initiate new activities pertinent to local communities, who can talk and listen to patients and their families, who can communicate and collaborate with fellow health workers. Sounds something like the old family doctor, doesnÕt it? One thing is for sure, we will not bring about any health care changes with any meaning for the future unless we tackle the relationship between privilege and health, a topic that also was featured in an important editorial in the New England Journal of Medicine (Angell 1993). How we bring mind/body medicine to the poor is urgent (Edelmann 1988).

David Aldridge, Ph.D., an associate professor for Clinical Research Methods at UniversitŠt Witten Herdecke (Witten, Germany), is the coeditor, with George Lewith, of Complementary Medicine and the European Community (Saffron Walden: CW Daniel, 1991).

References

Aldridge D. 1990a. "Complementary Medicine in Europe: Some National Perspectives." Complementary Medical Research. 4:1-3.
Aldridge D. 1990b. "The Delivery of Health Care Alternatives." Journal of the Royal Society of Medicine. 83:179-82.
Aldridge D. 1992. "Of Ethics and Education: Strateg
ies for Curriculum Development." Journal of the Royal Society of Medicine. 85:594-7.
Angell M. 1993. "Privilege and Health--What is the Connection?" New England Journal of Medicine. 329:126-7.
Anon. 1988. "Fallible Doctors. Patient's Dilemma." The Economist. 17 December:21.
Anon. 1989. "Economic and Financial Indicators. Aging." Economist. 18 February:109.
Armstrong D. 1987. "Theoretical Tensions in Biophysical Medicine." Social Science and Medicine. 25:1213-18.
Bouchayer F. 1991. "The Role of Alternative Medicine: The French Experience." In Complementary Medicine and the European Community. Edited by Lewith G & Aldridge D. 45-60. Saffron Walden: C.W. Daniel.
Cassileth B. 1993. "This Study ÔMedicalizesÕ Self-help Activities by Labeling Them Unconventional." Advances. 9:12-3.
Crofton J. 1986. "Introduction--The Challenge to Epidemiology and General Practice." Journal of the Royal Society of Medicine. 79:1.
Edelmann D. 1988. "Bringing Mind-body Medicine to the Poor." Advances. 5:27-30.
Eisenberg D, Kessler R, Foster C, Norlock F, Calkins D & Delbanco T. 1993. "Unconventional Medicine in the United States; Prevalence, Costs and Patterns of Use." New England Journal of Medicine. 328:246-52.
Enthoven A & Kronick R. 1989. "A Consumer Choice Health Plan for the 1990s." New England Journal of Medicine. 320:29-37.
Fulder S & Munro R. 1985. "Complementary Medicine in the United Kingdom." The Lancet. 2:542.
Furnham A & Bhagrath R. 1993. "A Comparison of Health Beliefs and Behaviours of Clients of Orthodox and Complementary Medicine." Brit. J. Clin. Psychol. 32:237-46.
Glenn M. 1988. "The Resurgence of the Bio-medical Model in Medicine." Family Systems Medicine. 6:492-500.
Inglis B. 1979. Natural Medicine. Glasgow: Fontana.
Leibrich J, Hickling J & Pitt G. 1987. Exploratory Research into Complementary Therapies. Wellington, New Zealand: Health Services Research Unit, Dept. of Health.
Lewith G & Aldridge D. 1991. Complementary Medicine and the European Community. Saffron Walden: C.W. Daniel.
Lewith G & Aldridge D. 1993. Clinical Research Methodology for Complementary Therapies. London: Rodder and Stoughton.
Lynoe N & Svensson T. 1992. "Physicians and Alternative Medicine--An Investigation of Attitudes and Practice." Scan. J. Soc. Med. 20:55-60.
Maretzki T. 1987. "The Kur in West Germany as an Interface Between Naturopathic and Allopathic Ideologies." Social Science and Medicine. 24:1061-68.
Maretzki T & Seidler E. 1985. "Biomedicine and Naturopathic Healing in West Germany. A Historical and Ethnomedical View of a Stormy Relationship." Culture, Medicine and Psychiatry. 9:383-422.
Matthiessen P, Roblenbroich B & Schmidt S. 1992. Unkonventionelle Medizinische Richtungen-Bestandsaufnahme zur Forschungsituation. Materialen zur Gesundheitsforschung Band 21. Bonn: Wirtschaftsverlag NW.
Moskowitz R. 1988. "Establishing Health Insurance Coverage for the Treatment of Stress-Related Disorders." Advances. 5:61-4.

Rasmussen N & Morgall J. 1991. "The Use of Alternative Treatments in the Danish Adult Population." In Complementary Medicine and the European Community. Edited by Lewith G & Aldridge D. Saffron Walden: C.W. Daniel.
Risse G. 1976. " 'Philosophical' Medicine in Nineteenth-Century Germany: An Episode in the Relations Between Philosophy and Medicine." Journal of Medical Philosophy. 1:72-92.
Sermeus G. 1987. Alternative Medicine in Europe. A Quantitative Comparison of the Use and Knowledge of Alternative Medicine and Patient Profiles in Nine European Countries. Brussels: Belgian ConsumerÕs Association.
Smith R, Brody H, Greenbaum D, Rovner D, Watson R & Zaroukian M. 1993. "Seven Doctors Talk About Unconventional Medicine." Advances. 9:14-25.
Thomas K. 1991. "Non-orthodox Health Care in the U.K." In Complementary Medicine in the European Community. Edited by Lewith G & Aldridge D. Saffron Walden: C.W. Daniel.
Tuffs A. 1992. "Germany: Acceptable Alternatives (NEWS)." The Lancet. 340:107.
Tuffs A. 1993. "Psychotherapy in Germany (NEWS)." The Lancet. 342:294-5.
Unschuld P. 1980. "The Issue of Structured Coexistence of Scientific and Alternative Medical Systems: A Comparison of East and West German Legislation." Social Science and Medicine. 148:15-24.
Vaskilampi T. 1982. "Culture and Folk Medicine." In Folk Medicine and Health Culture: Role of Folk Medicine in Modern Health Care. Edited by Vaskilampi T & McCormack C. Kuopio: University of Kuopio. 2-15.
Vaskilampi T. 1991. "The Role of Alternative Medicine: The Finnish Experience." In Complementary Medicine and the European Community. Edited by Lewith G & Aldridge D. Saffron Walden: C.W. Daniel. 101-12.
Visser J. 1991. "Alternative Medicine in the Netherlands." In Complementary Medicine and the European Community. Edited by Lewith G & Aldridge D. Saffron Walden: C.W. Daniel. 113-24.
Warren Salmon J. 1984. Alternative Medicines. Popular and Policy Perspectives. NY: Tavistock Publications.
Wharton R & Lewith G. 1986. "Complementary Medicine and the General Practitioner." British Medical Journal. 292:1,498-1,500.
Yung B, Lewis P, Charney M & Farrow S. 1988. "Complementary Medicine: Some Population-Based Data." Complementary Medical Research. 3:23-8.